Maternal and Child Health Services Title V Block Grant

Oregon

FY 2022 Application/ FY 2020 Annual Report

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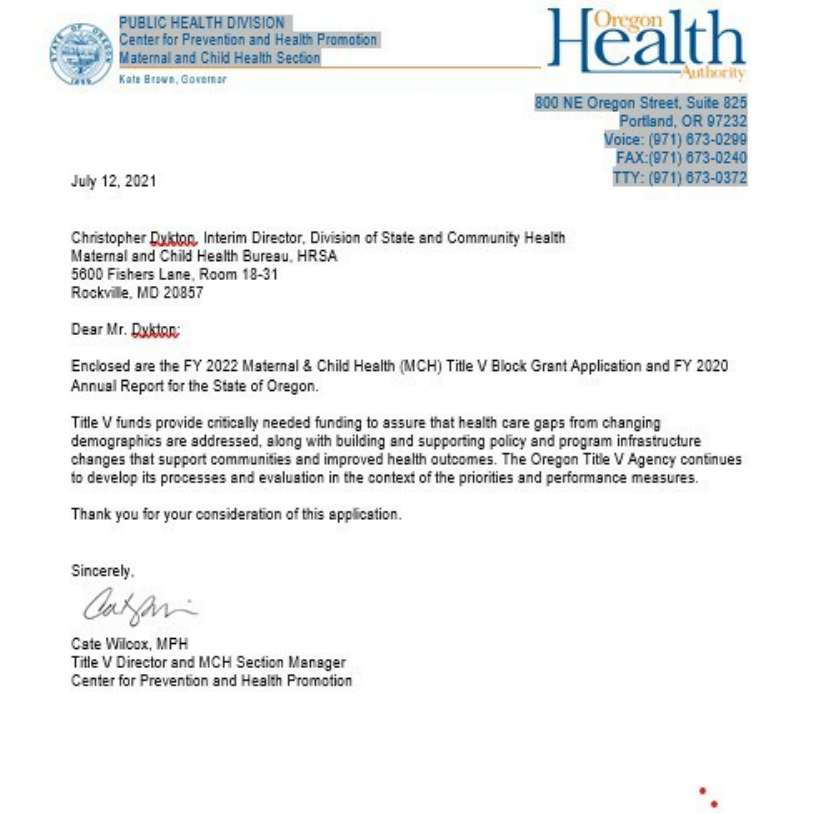
I. General Requirements

I.A. Letter of Transmittal



PUBLIC HEALTH DIVISION
Center for Prevention and Health Promotion
Maternal and Child Health Section
Kate Brown, Governor

Oregon Health Authority

800 NE Oregon Street, Suite 825
Portland, OR 97232
Voice: (971) 673-0299
FAX:(971) 673-0240
TTY: (971) 673-0372

July 12, 2021

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

Dear Mr. Dykton:

Enclosed are the FY 2022 Maternal & Child Health (MCH) Title V Block Grant Application and FY 2020 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 2021 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: January 31, 2024.

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: January31, 2024.

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 (PHD) Maternal and Child Section (MCH), its 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's Institute on Development & Disability. A leadership team makes Title V program and policy decisions and ensures alignment across the programs and agencies. Designated state priority leads oversee state level program and policy work and provide technical assistance and oversight to local public health and tribal Title V grantees. Title V Maternal, child and adolescent health (MCHA) also has a tribal liaison who supports the work of the tribal Title V MCAH grantees. The state priority leads, Title V coordinator, Title V MCAH and Children and Youth with Special Health Care Needs (CYSHCN) research analysts and Title V MCAH tribal liaison coordinate work across populations/domains. MCAH work is also integrated and coordinated across priorities through perinatal and women's health, injury prevention, and foundations of MCAH teams.

Findings from the Title V five-year needs assessment guide the identification of Oregon's Title V needs and priorities. These in turn inform development of the structure and work of the program, guided by Title V staff and leadership, as well as grantees, families, and community partners. Ongoing needs assessment and surveillance activities are conducted in the interim years to support development of evidence based/informed activities, monitor progress, identify emerging issues, and modify approaches as needed.

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 is allocated to OCCYSHN to address the Title V CYSHCN national and state-specific cross-cutting 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.

Population needs, Title V priorities, strategies, and plans

Oregon's 2020 Maternal Child and Adolescent Health (MCAH) Title V Needs Assessment identified six national and three state-specific priorities for 2021-2025. These are: well woman care, breastfeeding, prevention of child injury and bullying, medical home and transition to adult health care for CYSHCN, toxic stress/trauma/ACEs, social determinants of health and equity, and culturally and linguistically responsive MCAH services (CLAS). An overview of Oregon's priority Title MCAH V needs, strategies, progress and plans for each domain is outlined below.

Maternal/Women's Health

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

Needs/priorities

Based on the 2020 MCAH needs assessment, high quality, culturally responsive preconception, prenatal and inter-conception services are a priority need for this maternal/women's health. This need is being addressed through work on well-woman care (NPM 1). Social determinants of health; health equity; safe and supportive environments; stable

and responsive relationships and resilient, connected families and communities are cross-cutting needs that also impact this population and are being addressed through both NPM 1 and Oregon's cross-cutting systems domain work.

Strategies

Well woman care strategies focus on: support for behavioral health needs, home visiting workforce development; access to culturally responsive preventive care for low income and undocumented women; and development/engagement of community based advisory groups.

Perinatal/Infant Health Domain

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 ECHO surveillance systems; early hearing detection and intervention (EHDI); breastfeeding support; Univerally Offered Home Visiting, and integration of perinatal/infant health into programs and policies across state and local agencies.

Needs/priorities

Based on the 2020 needs assessment, improved nutrition is a priority need for perinatal/infant health, which will be addressed through work on breastfeeding (NPM 4). Social determinants of health; health equity; safe and supportive environments; stable and responsive relationships and resilient, connected families and communities are cross-cutting needs that also impact this population and are being addressed through both NPM 1 and Oregon's cross-cutting/systems building work.

Strategies

Breastfeeding strategies focus on: support/implementation of workplace laws and policies; workforce development including training and enhanced diversity; culturally appropriate approaches for work with tribal communities; access to culturally responsive preventive care for low income and undocumented women; and development/engagement of community based advisory groups.

Child Health Domain

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 2020 needs assessment, enhancing safe and supportive environments; stable and responsive relationships; and resilient/connected families and communities are needs for Oregon's children. The need to address social determinants of health and health equity also impact this population. These needs will be addressed through work on child injury (NPM 7), as well as through Oregon's cross-cutting/systems building work.

Strategies

Child injury strategies focus on improved data capacity; use of child injury data to inform policy; enhanced workforce capacity; partnerships and coalition-building including around shared risk and protective factors.

Adolescent Health Domain

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 inform policies and programs that reflect their

needs through youth action research.

Needs/priorities

Based on the 2020 needs assessment, enhancing safe and supportive environments; stable and responsive relationships; and resilient/connected families and communities are needs for Oregon's adolescents. The need to address social determinants of health and health equity also impact this population. These needs will be addressed through work on bullying (NPM 9), as well as through Oregon's cross-cutting/systems building work.

Strategies

Bullying prevention strategies focus on workforce development; bullying prevention education in schools; development of partnerships and shared initiatives; and Positive Youth Development staegies, including youth participatory action research.

Children and Youth with Special Health Needs (CYSHN) Domain

Title V CYSHCN provides leadership and support for the development of comprehensive, coordinated, family-centered 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 strategy development.

Needs/priorities

Based on the 2020 needs assessment, assuring high quality, family-centered, coordinated systems of care for CYSHCN, increasing health care equity and culturally and linguistically responsive services (CLAS), and reducing disparities are needs for Oregon's CYSHCN. These priorities will be addressed through work on NPMs 11 and 12 and all three state priorities.

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 implement family-centered shared care planning; supporting cross-systems community-based standing teams to perform care coordination functions for the population of CYSHCN; supporting regional and state learning collaboratives to address the needs of the CYSHCN population; and promoting regional and state level infrastructure development to support CSCC.

Health Care Transition (HCT) strategies are integrated with those of MH given their interrelationship. Child health teams will identify youth with special health care needs and build capacity to support cross-systems care coordination. We will continue with our quality improvement projects begun as part of our CMC CoIIN work. This includes professional development for both pediatric and adult providers, as it increases their capacity to provide necessary HCT services. We also will continue to educate families about HCT and its importance.

Life Course and Cross-cutting/Systems Domain

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. Work in this domain crosses all priorities and is the primary focus of our state-specific priorities.

Needs/priorities

Based on the 2020 needs assessment, Oregon's MCAH needs in the cross-cutting/systems domain include: enhancing safe and supportive environments; assuring stable, responsive relationships and resilient, connected families and communities; improving lifelong nutrition; increasing health equity; addressing social determinants of

health; and assuring high quality, culturally responsive preventive systems and services. All of these needs span the lifecourse and all MCAH populations. The Title V program addresses these needs through work in each of the domains and national priority areas, as well as through our work on our state-identified priorities of toxic stress, trauma, ACEs and resilience; culturally and linguistically responsive MCAH services (CLAS), and social determinants of health and equity (SDOH-E).

Strategies

The OHA MCAH Title V program addresses the cross-cutting domain priorities through a set of upstream "Foundations of MCAH" strategies. This approach reflects the integrated nature of work on social determinants of health and equity, trauma/ACEs, and equity/CLAS. Strategies are grouped as follows.

- Policy and systems strategies focus on equitable, anti-racist and trauma informed workplaces, institutions and services; systems to integrate screening and referral for SDOH-E; housing, food systems, and economic supports for families.

- Workforce strategies focus on skills and abilities of the workforce to deliver equitable, trauma informed and culturally appropriate services, and standards to address these.

- Community, individual and family capacity strategies focus on programs (e.g. home visiting) and community strategies that promote family health, safety, protective factors, resilience, and equity.

- Assessment and evaluation strategies focus on development and use of data on social determinants of health, trauma, and equity to drive MCAH policy and programs.

OCCYSHN strategies to address SDOH-E, trauma/ACEs, and CLAS similarly focus on integration of strategies and systems across Title V work to support CYSHCN and their 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. NPMS that have shown substantial improvement include 1: well woman care and 9: bullying. Both 4B: exclusive breastfeeding at 6 months and 7.1: child injury hospitalizations have improved moderately. NPM 4A: breastfeeding initiation has worsened slightly but is still above the national average. Moderate increases and decreases in NPMs are small and should be interpreted with caution.

Thirty-nine percent of CYSHCN had a medical home (NPM 11) in 2016-17 compared to 35% in 2018-2019 (National Survey of Children's Health). Meaningful improvement occurred between 2016-2017 and 2018-2019 on health care transition (NPM 12). During the former timeframe, only 17% youth with special health care needs received services necessary to make transitions to adult health care compared to 31% during the latter timeframe.

Among SPMs, one showed improvement; 1: prenatal stress, and two SPMs worsened slightly, 2: children with a healthcare provider who is sensitive to their family's values and customs, and 3: children living in a household that received food or cash assistance.

Title V partnerships and stakeholder engagement

See description in section III.A.2. below

III.A.2. How Federal Title V Funds Complement State-Supported 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 medical home and transition initiatives impacting CYSHCN; and expertise, advocacy, and partnership both within OHSU, and externally to strengthen systems and services, and improve and the health of children and youth with special health needs and their families.

The remaining 70% of Title V funding, administered through the OHA PHD, 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. The flexibility of the Title V program and funding have been critical to supporting Oregon's response to the COVID-19 pandemic at both the state and local levels. It allowed for quick an dnimble shifting of capacity to where it was most needed for the emergency response, which was not always allowed with other federal grant funds.

Stakeholder engagement and partnerships are central to all phases of Oregon's Title V work, enabling Title V to leverage work across the state on behalf of the MCAH and CYSHCN populations. They enhance 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. 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 statewide. 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.3. MCH Success Story

OCCYSHN completed its first participatory needs assessment studies in collaboration with the Latino Community Association and Sickle Cell Anemia Foundation of Oregon. Results of both studies showed that families of Black and Latino CYSHCN experience racism when seeking health care for their child. The results were timely given recent attention to racial injustice in institutions that include education, health care, and public health. OCCYSHN presented to AMCHP as well as to multiple local audiences of education, health care, and other service providers.

The impact of the COVID-19 pandemic this past year has been significant. It diverted state and local capacity that was intended to stand up Oregon's universally offered home visiting program, Family Connects Oregon, to the emergency response. It delayed identifying and onboarding the next cohort. The impact continued as local communities continue to respond to the vaccine roll out and help get their communities opened again. Even with this, 4 of 7 Family Connects Early Adopter sites have begun providing services to families. The program has succeeded in adding this benefit to the Medicaid Coordinated Care Organization benefit package, has made progress supporting the contracting process for local public health and commercial health benefit plans, and is working on data integration to improve efficiencies and effectiveness. The focus is on starting small before scaling up the program and processes.

MCAH Title V played a central role in Oregon's COVID-19 response throughout the past year. Two specific examples are detailed below.

- MCAH staff led the rapid establishment the state-wide contact tracing infrastructure needed to contain the spread of the virus. This included collaborating with other PH response staff to: identify current local and state resources for contact tracing, create a plan to form an emergency response force of 100 contact tracers; create a state training apparatus; disseminate training and additional resources to the community; partner with community-based organizations to ensure that culturally-specific and responsive tools were available to combat COVID-19; and provide contact tracers and team leads to provide surge capacity for local public health;.
- MCH staff, including key members of the SSDI team, led a team that designed, built, and implemented a state IT data system which developed Oregon's contact tracing system (ARIAS) in record time. This work required close collaboration between Incident Management Team staff, information services staff, and experts at Microsoft to create a versatile and quickly deployable solution. It has been rolled out to every local health department and tribe in Oregon as well as community-based organizations and has several thousand users.

III.B. Overview of the State

Oregon's demographics, geography, economy, and urbanization

Demographics and urbanization

Oregon's population of 4.2 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. Oregon's population has increased faster than the national average and grown over 10% in the last decade. Growth has increased not only in urban, metropolitan areas but also in some rural areas. Approximately 65 % of Oregonians live in urban areas, 33 % live in rural areas and 2% live in frontier areas (Oregon Office of Rural Health). 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 (US Department of Agriculture). Portland is the largest metropolitan area, with about 2.5 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 76,000 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 from Idaho, Oregon and Washington participate in the Northwest Portland Area Indian Health Board

Oregon's population has been increasing at a faster pace than the U.S. population as a whole over previous decades. Higher population growth is associated with a healthy economy characterized by higher employment and overall economic prosperity. Additionally, faster population growth also exerts long-term effects on traffic congestion, expanding urban areas at the cost of diminishing agricultural land, greater demand for affordable housing, childcare services, and increased demand for public services, among others. Oregon's population change is greatly influenced by net migration. Currently, nearly 87 percent of population growth in Oregon is attributed to net in-migration. The contribution of migration in Oregon's population growth will play an enormous role once the natural increase (births minus deaths) is expected to turn negative in 2027. When that happens, then the entire increase in population will have to come from the migration component (Oregon Demographic Trends, 2019).

With increasing population mainly due to in-migration, Oregon's population is getting increasingly diverse in terms of race and ethnicity. Still, it remains one of the least diverse states in the country. In the 2020 Census, 75.1% reported as White only, which has continued to decrease over time. Hispanics make up the largest minority population at 13.4%, more than doubling since the 2000 Census. Other races have slightly increased, with Asians at 4.9%, Native Hawaiian or Other Pacific Islander 0.5%, African Americans at 2.2%, American Indian/Alaska Natives at 1.8% and 2 or more races at 4%. Approximately 15% of Oregonians speak a language other than English at home and about 10% of the population is foreign-born. About 10% of the population under 65 years has a disability (US Census).

Oregon's birth rate is declining, following national patterns, with 50.3 live births per 1,000 women ages 15-44 compared to the national average of 58.2 for 2019 (Oregon Vital Statistics Annual Report; CDC 2019 provisional data). In 2019, Oregon had 41,861 births, of which 66.3% were White, followed by 19.5% Hispanic, 5.7% Asian, 3.9% mixed race, 2.4% African American, 1% American Indian/Alaskan Native 0.8%, and 0.8%Native Hawaiian/Pacific Islander (Oregon Vital Statistics Annual Report). In 2020, 5.5% of the population was under 5 years of age, and 20.5% was under the age of 18 (US Census). Overall, the median age of Oregonians is 39.7 years, and as of 2017 the median age of mothers is 29 for all births (OVS, 2017).

Geography

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 (including recent climate disasters like wildfires, extreme heat, and ice storms), to delivering and accessing health services, and issues related to workforce capacity and training needs varying vastly in different regions of the state. Rural and frontier service areas have greater unmet need than urban areas (as determined by low score of 46.4 vs. 62.1 for urban service area). In rural and frontier services areas, ten have zero primary care provider FTE, 24 have zero dentist FTE and 21 have zero mental health provider FTE. While Oregon's five-year (2014-2018) average inadequate prenatal care rate is 59.6 per 1,000 births per year, the average rate in frontier service areas is 97.1. Of note the Warm Springs service area which serves tribal members has a rate of 196.5, which is triple the state rate (Oregon Areas of Unmet Health Care Need Report, 2020). Although the COVID-

19 pandemic has resulted in a significant increase in telehealth services, broadband internet services may not be available in rural and frontier areas. Overall, about 86% Oregonians have broadband internet subscriptions (US Census).

Geography presents a considerable barrier to accessing care for CYSHCN. Families living in rural and frontier Oregon counties experience challenges getting 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 especially difficult for CYSHCN and their families to access, due to a lack of providers throughout the state. The COVID-19 pandemic resulted in a sudden and substantial increase in telehealth services. It may be possible to leverage telehealth to improve or increase health care and services for rural Oregon CYSHCN with insufficient access to local providers. However, in order for telehealth services to be equitable, families need access to broadband internet, digital literacy education, and skilled translation services. Additionally, payment parity between in-person and virtual visits must continue to support providers offering telehealth as a care option.

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 (Oregon Blue Book, downloaded June 2021). 62.3% of the population in the civilian workforce aged 16 years and older, and percent of females comprise 57.9%; these are both similar to the national averages (US Census).

Prior to the COVID-19 outbreak, Oregon's seasonally adjusted unemployment rate had peaked in May 2009 at 11.6%, and unemployment rates steadily improved over the decade. In February 2020, Oregon's unemployment rate was 3.3%, placing it 21st among states (Bureau of Labor Statistics, 2020). However, the recovery prior to the pandemic was unevenly experienced around the state, with county level unemployment rates ranging from 2.8% to 6.3%, with southern and central Oregon counties experiencing greater unemployment (Oregon Employment Division, 2020). Oregon, like other states, has experienced unprecedented unemployment during the COVID-19 outbreak. In April 2020 every major industry in Oregon lost jobs as the economy suffered the largest one-month contraction in history, losing roughly 13% of jobs. Payroll employment in the leisure and hospitality industry fell an astounding 54.6% in April. While private education and health care are large sectors that have historically added jobs during recessions and expansions, these sectors shed the second-largest number of jobs in April 2020 when COVID-19 measures directly prohibited elective and non-urgent medical procedures and closed schools. Private-sector employers cut 30,300 jobs in April 2020 (Oregon Blue Book).

Oregon's median household income was $62,818 in 2020 which is similar to the national average. The overall poverty rate is 11.4%, which is slightly higher than the national average (US Census). Oregon began a new three-tier minimum wage rate on July 1, 2020. The tiers vary by geography, with the highest rate of $14.00 per hour within the Portland urban growth boundary, a standard rate of $12.75 per hour in other areas of the state, and a rate of $12.00 per hour in designated nonurban counties. Although Oregon's minimum wage is higher than most other states, private-sector workers in Oregon tend to work fewer hours per week and their average wage earnings are below the national level. One-third of Oregon's jobs paid an average wage of less than $15 per hour in 2019 (Oregon Blue Book). Wealth inequality across racial/ethnic groups persists with the median income of Black ($48,000), Hispanic ($56,900) and American Indian ($60,500) families with children being significantly less than the median income of white families with children ($89,100) (The State of America's Children 2021).

Almost all racial/ethnic minority populations have higher poverty rates than non-Hispanic Whites. In 2018, the unemployment rate for Latino Oregonians was 5.6%, compared to the 4.1% unemployment rate for White Oregonians. In 2014, the last year data was available for Black Oregonians, they faced an unemployment rate twice as high as Whites (Oregon Center for Public Policy, 2019). The 2019 poverty rate for children under 18 years is 13.1% and 12.7% for children under 6 years, the 10th highest in the US. Additionally, 5.6 percent of children under 18 (6.4% of children under 6) are very poor. Children of color have significantly higher rates of poverty than white children (10.2%) in Oregon: 20.2% for Hispanic children, 33.8% for Black children and 25.2% for Alaskan Native/American Indian children (The State of America's Children 2021). Eighteen percent of CYSHCN ≤18 years live in households with incomes below 100% of the Federal poverty level, although this estimate should be interpreted with caution due to small sample size (NSCH, 2018-19).

Oregon's strengths and challenges that impact MCH populations

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 are also key drivers of Maternal, Child, and Adolescent Health across the lifespan. The impacts – both direct and indirect – of the COVID-19 pandemic on Oregon's MCAH population will doubtless be unfolding for many years. This year's report was written to account for those impacts that are known at this time.

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 49% of Medicaid and CHIP populations as of November 2020 (Centers for Medicare and Medicaid Services). Oregon's CCOs are responsible for ensuring care for people covered by Medicaid. Despite the state's commitment to the Triple Aim, families and providers still report considerable challenges for the CYSHCN population. Families experience confusion about who is responsible for coordinating care for CYSHCN across multiple systems. While CCOs are required to provide specific care coordination activities for CYSHCN, implementation has been both complex, and uneven. Patient-Centered Primary Care Home standards and CCO incentive metrics incentivize primary care providers to prioritize CYSHCN within their practices. These incentives, however, remain inadequate in terms of payment resulting in inconsistency in types and amounts of covered CCOs will cover, leading in disparity, confusion and inadequate care. While coverage for Applied Behavioral Analysis (ABA) for children with Autism Spectrum Disorder is mandated, access remains uneven.

Education

Over their lifespan, children in Oregon have access to private and public preschools, Head Start, public schools, community colleges, universities, and graduate education. About 90% of persons in Oregon older than 25 years have graduated from high school (US Census).

Oregon's Early Learning Division (ELD) supports all of Oregon's young children and families to help them 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 582,661 students enrolled from kindergarten through grade 12. Among K-12 public school students in Oregon, 38.51% are students of color; 48% qualify for free or reduced lunches; 14.2% receive special education services, and 9% are English Language Learners. Oregon's 4-year high school graduation rate for all students is 80%, a significant increase over the past several years (Oregon Department of Education, 2020).

Every child in Oregon identified as needing special education has at least one of the disabilities defined in the Individuals with Disabilities Education Act. In Oregon, children must have a diagnosed physical or mental condition that is likely to result in a developmental delay to receive Early Intervention/Early Childhood Special Education (EI/ECSE) services. In 2019, 91,493 Oregon children (age 3 – 21 years) were in special education, and 4,338 children (age 0 – 3 years), received EI services (Oregon Department of Education). The educational impacts on CYSHCN from a year of distance learning (due to the COVID-19 pandemic) remain to be seen. Anecdotal reports indicate that many children in special education experienced particular difficulty with online education.

Oregon's higher education 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.

About 33% of Oregonian's have a Bachelor's degree or higher (US Census).

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 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 collaborates 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 (RUO). Title V was a key partner in its development, and now in its implementation. The ELC established the Raise up Oregon Agency Implementation Coordinating Team (RUOAICT) to drive cross-sector implementation of the RUO plan. The Title V Director sits on this team.

Early Learning Hubs ensure that systems are aligned so that children 0-5 and their families can access the services and resources they need to be ready for kindergarten. The Hubs are particularly relevant to CYSHCN because they create referral pathways for screening and assessment. They guide the programming for children with special health care needs. They ensure that systems are addressing the needs of families, as well.

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 achieving PCPCH recognition. Initially the program consisted of three 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 five tier levels, with the 5th tier being the highest.

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 systems. 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 communicable disease capacity in select communities; phase two 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.

Housing

Oregon has nearly 1.8 million housing units with 62.4% being owner-occupied (Census Bureau). Of households that spend 30% or more of income on housing, 51.6% rent, 31.4% had mortgages, and 14.9% own without mortgages. The median monthly housing cost for each group was $1,110 for renters, $1,699 for mortgaged owners, and $538 for owners without a mortgage. 2.2% of households did not have a telephone service and 7.5% 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 two 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.

Oregon has experienced an increased number of unhoused people, a crisis worsened by the pandemic. As of January 2020, an estimated 14,655 Oregonians experienced homelessness on any given day. Of that total, 825 were family households, 1,329 were Veterans, 1,314 were unaccompanied young adults (aged 18-24), and 4,339 were individuals experiencing chronic homelessness. The total number of homeless students is 23,141, as reported to the Department of Education (United States Interagency Council on Homelessness, January 2020).

Oregon Health Authority's roles, responsibilities and interests impacting Title V service delivery

Oregon's Title V work is interwoven with the priorities and initiatives of Oregon Health Authority (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 Coordinated Care Organizations (CCOs).

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, and the Oregon State Hospital. 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 public health authority (LPHA). Currently, there are 33 LPHAs and one health district serving three small rural county populations. LPHAs are legislatively mandated to provide ten 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.

Oregon Health Authority (OHA) Triple Aim and Strategic Goal

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. OHA also has a strategic goal of eliminating health inequities in Oregon by 2030. Title V's prevention and health promotion work supports the Triple Aim and the strategic goal through interventions with vulnerable populations at critical stages of the life course. Section III.E.2.b.iv 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 and Disability exists within the Department of Pediatrics at OHSU, and works with patients, families, clinicians, researchers and many other professionals to improve the lives of people with disabilities. They perform research, advocacy, and education. They provide health care to people of all ages who experience disabling conditions, and embrace the right of people with disabilities to determine the course of their lives and to live as fully integrated, contributing members of their communities.

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 in 2020 for the 2020-24 priorities. The SHIP priorities include: 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). Title V is a critical partner whose work is threaded across all the 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 through a long-term, systemic effort, and is required to report on those plans annually. The CCOs are also being measured and receive enhanced payment based upon, their health indicators in key MCAH areas such as pre-K well child visits, child and adolescent immunizations, preventive oral health, depression screening, and postpartum care. OHA chose to drop the longstanding adolescent well care visit metric in the 2020 round of CCO incentive metrics. This change impacted the selection of Oregon's MCHB priority areas for the new block grant cycle. In 2018 and 2019 a legislative requirement was enacted for CCOs to invest some of their profits back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on services to address health inequities and the social determinants of health and equity (SDOH-E), named the SHARE Initiative. CCOs may also use their global budgets to address members' social needs and community SDOH-E through health-related services (HRS). Title V works with the CCOs, providing technical assistance, data, and contracted public health and prevention services.

Oregon's system of care for meeting the needs of underserved and vulnerable populations, including CYSHCN

Populations served

About 6% of Oregon's population is under five years of age, and 21% is under age 18 (USCB, 2019). Overall, 18.7 percent of Oregonians under age 18 live below the federal poverty level (The State of America's Children 2021) .

The 2018-19 National Survey for Children's Health (NSCH) estimated that 20% of Oregon children 0 to 18 years have special health care needs. These CYSHCN were mostly White, non-Hispanic, with 19.2% having Hispanic ethnicity, and 12.2% identifying as other, non-Hispanic.

Nearly 68.2% of Oregon CYSHCN have a condition that affects their daily activities, and over 39.3% experience two or more functional difficulties (NSCH, 2018-19). According to the most recent state prevalence rates, 3.3% of Oregon children, ages 3 through 17 years, have Autism Spectrum Disorder (ASD), compared to 2.9% nationally (NSCH, 2018-19). In 2019, about 11,533 Oregon youth (age 3–21) receiving special education had ASD (Oregon Department of Education, 2019).

Of children and youth under age 21 insured, wholly or partially, through Oregon Medicaid in 2017-19, 10.1% met the criteria for having complex chronic disease (OPIP, OHA, and DHS 2020). These children are disproportionately from communities of color, with 6.7% Black/African American, 4.9% Native American, and 5.6% identifying as multiracial (OPIP, OHA, DHS, 2018). Twenty-one percent of Medicaid enrollees were categorized as having non-complex chronic disease. With 19.2% Black/African American, 17.8% multiracial, and 17.6% American Indian/Alaska Native (OPIP, OHA, DHS, 2018).

Oregon's Birth Anomalies (birth defects) Surveillance System (BASS) tracks the prevalence of select birth anomalies using birth certificate, hospital discharge, and Medicaid data. Data are collected on children who receive public health nurse home visiting services through the CaCoon program. The most prevalent conditions reported for CaCoon recipients in FY2020 were developmental delay, Autism Spectrum Disorder, and other chronic conditions. In FY2020, 40% of children served in the CaCoon program had multiple conditions.

While advances in clinical care and technology have reduced the mortality rates for CYSHCN, there is a consequent increase in morbidity due to chronic illness and disability. NSCH (2018-19) estimates suggest that fewer than 38% of YSHCN had worked in the previous 12 months, likely due to challenges in managing their own health, difficulty accessing available resources to support their health and disability related needs, and other social factors.

Health services infrastructure

Primary care and safety net health services are available through independent medical providers and through the

following facilities.

- Hospitals: 62 Hospitals
- Federally Qualified Health Centers: 32 FQHCs operating 232 sites
- Rural Health Clinics: 102 clinics in 30 counties
- Tribal and Indian Health Service: 18 clinics among 9 tribes and 10 counties
- School-Based Health Centers: 79 clinics in 26 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 144 designated primary care Health Professional Shortage Areas (HPSA), 124 mental health HPSAs and 134 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. In 2018, Oregon's Community Health Centers provided 1,780,420 visits for 393,324 clients, including 121,163 children. Of these patients, 19% were uninsured and 57% were covered by Medicaid (NACHC, 2018).

Oregon's safety net includes a robust network of school-based health centers (SBHCs) which are statutorily defined, certified and funded. During the 2018-19 school year, there were 79 SBHCs in 47 high schools, 6 middle schools, 11 elementary schools and 15 combined-grade campuses. During the 2018-19 service year, SBHCs provided 130,586 visits for 38,057 clients.

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. There are currently 16 CCOs serving Oregon's 36 counties. 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.

Integration of services

Integration of primary care, behavioral health and social services continues to be an area of opportunity in Oregon. Several cross-agency workgroups have been formed in the past several years to identify solutions to these issues. Most recently, in 2019 a Governor's Behavioral Health Advisory Council was created with the task of developing recommendations aimed at improving access to effective behavioral health services and supports for all Oregon adults and transitional-aged youth with serious mental illness or co-occurring mental illness and substance use disorders. This work will be closely aligned with similar state level efforts, including the State Health Improvement Plan, the Oregon Alcohol and Drug Policy Commission Strategic Plan, and the Oregon Tribal Behavioral Health Strategic Plan. Membership in these groups reflects the diversity of sectors that support Oregon's children and families in various settings, including schools, early learning, transportation, housing, criminal justice, and health.

Financing of services

Insurance coverage

According to the most recent Oregon Health Insurance Survey, more than 3.9 million Oregonians - 94% - are covered by health insurance. However, 11% were uninsured at some point in time in the past year. The percentage of the population that is above the Medicaid cut off of 138% Federal Poverty Level (FPL) but still below 200% of the FPL (and therefore unlikely able to afford health insurance unless provided by an employer) is 11% in Oregon (Oregon Areas of Unmet Health Care Need Report, 2020). 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 un-insurance by race and ethnicity are evident, with Asian Oregonians having the lowest un-insurance 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: The top three reasons Oregonians cited for not being covered by OHP were: concern 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% with Medicaid and CHIP. 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 (37%) of Oregon CYSHCN < 18 years were insured through Medicaid (NSCH 2018-2019).

In July 2017, the Oregon Legislature passed Senate Bill 558, known as the Cover All Kids Act, expanded the Oregon Health Plan to include all children and teens under 19, regardless of immigration status, up to a household income of 300% of poverty. The estimated impact is that 17,000 undocumented children and teens were newly 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 expanded coverage for Oregonians to access reproductive health services, especially those who, in the past, may have not been eligible. 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 Oregonians with private health insurance coverage, 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.

State revenues and budgets

Over 90% of the state's general fund supports 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 collections, the state continues to face budget shortfalls.

Oregon statutes and regulations with relevance for Title V Block Grant authority and state programs

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

considered each 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).
- SB 526 (2019), passed universally offered home visiting for Oregon newborns.
- HB 3391, the Reproductive Health Equity Act, provides expanded coverage for reproductive health services including preventive services with no cost sharing, and services for Oregonian who had previously been ineligible due to immigration status.

Ongoing Needs Assessment activities

OHA MCAH ongoing NA activities

Following the completion of the five-year Title V needs assessment, ongoing needs assessment for the MCAH population in Oregon was conducted throughout the year through various assessment and surveillance projects. Some of the ongoing activities have been described in previous needs assessment updates.

- Review of disparities and data trends in National Performance Measures, National Outcome Measures, and State Performance Measures.
- As a part of the increased focus on addressing social determinants of health, assessment and evaluation strategies, activities, and measures were developed at both the state and local level, to monitor and improve efforts to address upstream risk and protective factors for maternal and child health, with a specific focus on equity.
- In partnership with SSDI, quality improvement of the reporting functionality for local grantees was continued, with the development of new strategy, activity, and measurement structure, which enables local grantees to select specific, prescribed activities and measures for each of their selected strategies.
- Annual assessment of local grantee measurement and evaluation, with the provision of technical assistance as necessary.
- Production of a report on the Title V Five Year Needs Assessment for dissemination among partners, providers, and grantees.
- Ongoing 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.
- Ongoing 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.
- Shared results of Title V Needs Assessment Community Voices Project with other maternal and child health professionals at CityMatCH Leadership and MCH Epidemiology conference and Association of Maternal and Child Health Programs conference.
- Analyze racial and ethnic disparities in preterm birth, infant mortality, and SIDS/SUIDs related infant mortality, in partnership with the Collaborative Improvement and Innovation Network to Reduce Infant Mortality.
- In partnership with CSTE/CDC Applied Epidemiology Fellow and MCH Epidemiologist (CDC Assignee), conducted analysis on the association between adverse childhood events and cognitive disability using data from a four year race/ethnicity oversample from the Behavioral Risk Factor Surveillance System (BRFSS).
- In partnership with Oregon Injury and Violence Prevention Section and Health Management Associates, Title V staff attended a Shared Risk and Protective Factor training, with the goal of advancing OHA's State Health Improvement Plan, Healthier Together Oregon, and Public Health Modernization efforts. As a result of the training, Title V staff have a greater understanding of shared risk and protective factors across injury and violence and leading-edge work in applying this approach, what injury and violence prevention partners need to do to advance a shared risk and protective factors approach, and specific, executable actions and tools to support implementing a shared risk and protective factor approach.

OCCYSHN ongoing NA activities

III.C.1.a. In FY2021, OCCYSHN focused our needs assessment activities on dissemination. One of the key findings of our participatory needs assessment was that families of Black and Latino CYSHCN in Oregon experience racism when they try to get health (and educational) care for their child. We committed to the culturally specific organizations with whom we partnered, Latino Community Association (LCA) and Sickle Cell Anemia Foundation of Oregon (SCAFO), that we would *do something* with the results of our assessment. That commitment coincides with a rare opportunity to capitalize on current efforts to dismantle systemic racism. The partnership agreements we made with LCA and SCAFO included a commitment to disseminate results together. Therefore, we (a) finalized our final needs assessment reports, (b) had our LCA findings chapter translated into Spanish, (c) prepared issue briefs summarizing key needs assessment findings (e.g., experiences of racism, behavioral/mental health access challenges, health care transition status for Oregon YSHCN), (d) made numerous presentations of our findings, and (e) are working on a manuscript for submission to a peer-reviewed journal. To date, we have made six presentations:

Bisso-Fetzer, C., Gallarde-Kim, S., Martin, A.J., & Smith, C. (2020, August). *Culturally-specific service organizations and Title V CYSHCN: Building connections to improve equity for Oregon CYSHCN.* Presentation given at the 2020 annual Association of Maternal and Child Health Programs Conference, Arlington, VA.

Martin, A.J., & Gallarde-Kim, S. (2019, December). Understanding the needs of CYSHCN of color: Participatory needs assessment with community-based organizations. *Collaboration lab #4 – From data to action: Using and translating needs assessment data.* Webinar sponsored by the Association of Maternal and Child Health Programs.

Bisso-Fetzer, C., Gallarde-Kim, S., Martin, A.J., & Smith, C. (2021, January). *Racism in Oregon's health care system: Experiences of families of Black and Latino children and youth with special health care needs.* Presentation at the OHSU Department of Pediatrics Grand Rounds. Portland, OR.

Bisso-Fetzer, C., Gallarde-Kim, S., Martin, A.J., & Smith, C. (2021, January). *Racism in Oregon's health care system: Experiences of families of Black and Latino children and youth with special health care needs.* Presentation at the Oregon State Interagency Coordinating Council monthly meeting.

Bisso-Fetzer, C., Gonzales, O.J., Gallarde-Kim, S., & Martin, A.J. (2020, December). *Escúchenos! Immigrant Latino parents of children & youth with special health needs in Central Oregon share their experiences accessing health care.* Presentation to Latino Community Association Families and Partners.

Bisso-Fetzer, C., Gallarde-Kim, S., Martin, A.J., & Smith, C. (2020, November). *Racism in Oregon's health care system: Experiences of families of Black and Latino children and youth with special health care needs.* Presentation at the Oregon Nurse Home Visiting Community of Practice monthly meeting.

During OCCYSHN's virtual regional meetings in spring 2021, our Assessment and Evaluation Manager facilitated a discussion about the experiences of racism in health care settings, and local public health authority efforts to promote health equity and dismantle racism. Our FY2022 plan describes our planned needs assessment activities.

Also in FY2021, we disseminated results from exploratory analyses we conducted with Neal Wallace, PhD, describing service utilization and costs for Oregon children with medical complexity served in a recognized patient-centered medical home (i.e., Oregon's Patient-Centered Primary Care Home [PCPCH] program), compared with those who do not receive care in a PCPCH. This work is described in Report Section NPM 11.6, and the summary brief appears in Supplemental Document 1.

We continue to monitor changes in CYSHCN health status as updated National Survey of Children's Health results become available on CAHMI's Data Resource Center. The percentage of Oregon CYSHCN < 18 years who received services necessary to transition to adult health care increased since the completion of OCCYSHN's five year needs assessment remains problematic. While only about a third of Oregon's YSHCN (age 12 through 17 years) receive the transition services they need, the incremental improvement is encouraging.

OCCYSHN continues to work with OHA MCAH and other state partners on the NSCH oversample of children from minoritized race and ethnicity communities. (See Strategy 11.8 in block grant report.) OCCYSHN will implement participatory needs assessment activities to better understand the circumstances of special populations of CYSHCN for whom state-level data are not available. Additionally, we plan to implement a Photovoice project with young adults with mental/behavioral health conditions. (See Strategy 11.1.8 in the block grant plan.) We also continue to monitor

Oregon Pediatric Improvement Partnership, Oregon Health Authority, and Oregon Department of Human Services' health complexity analyses.

Changes in health status and MCAH needs

OHA MCAH changes in health status and MCAH needs

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

- Well woman care: The percent of women age 18 to 44 with a past year preventive visit in Oregon increased from 70.8% in 2018 to 72.0% in 2019.

- Breastfeeding: While the rate of breastfeeding initiation dropped slightly from 93.5% in 2016 to 93.2% in 2017, the change was not statistically significant, and remains higher than the national level. Exclusive breastfeeding at six months increased in Oregon from 31.6% in 2016 to 35.6% in 2017.

- Child injury prevention: The rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9, decreased from 127.1 in 2017, to 122.1 in 2018.

- Bullying prevention: The rates of parent reported bullying perpetration and bullying victimization both decreased from 2018 to 2019, from 16.1% to 16.0%, and 44.1% to 40.4%, respectively.

- Toxic stress, trauma, ACEs, and resilience:
    - From 2017 to 2019, the percent of new mothers who experienced at least 2 types of prenatal stress decreased from 44.8% to 42.8%.
    - Updated data was not available for the percent of mothers of two year olds with sufficient social support.

- Culturally and linguistically appropriate services:
    - From 2018 to 2019, the percent of children with a healthcare provider who is sensitive to their family's values and customs remained essentially static, decreasing 94% to 93.8%.
    - From 2017 to 2018, the percent of new mothers who ever experienced discrimination while getting any type of health or medical care decreased from 10.9% to 9.7%. While this decrease cannot be linked directly to Title V efforts, it does represent an improvement in the health care experiences of women in Oregon, including among marginalized communities.

- Social determinants of health and equity:
    - The housing cost burden among renters decreased from 68% in 2017 to 63% in 2018. Since there is a data lag, it will be approximately two years before the impacts of COVID-19 on housing burden will be able to be seen.
    - The percentage of children living in a household that received food or cash assistance increased from 42.3% in 2018 to 43.3% in 2019. This increase should be interpreted with caution due to the small sample size of the National Survey of Children's Health in Oregon.
    - The percentage of households experiencing food insecurity decreased from 11.1% (2016-2018 data), to 9.8% (2017-2019 data). It will again take time to see if there are COVID-19 impacts on this rate, due to a data lag.

OCCYSHN changes in health status and MCAH needs

III.C.1.b. OCCYSHN's 2020 needs assessment identified persistent challenges for CYSHCN accessing behavioral and mental health care (especially from culturally specific providers). The COVID-19 pandemic and its attendant stresses exacerbated mental health issues for CYSHCN and their families, and existing workforce shortages and insurance limitations persist.

Our needs assessment identified home health care services for CYSHCN as anemerging issue. Workforce shortages and insufficient insurance coverage make it hard for families to get help with the demands of caring for

CYSHCN at home. The emotional and economic impacts on families are significant. The Biden administration's proposal to allocate $400 billion to home and community-based services as part of a federal infrastructure plan could support efforts to alleviate these issues.

Although experiences of racism in health care are not new, the recent nationwide focus on racism presents an emerging opportunity to address the issue in public health. This requires organizational education and growth, and OCCYSHN is pursuing opportunities through training and internal discussion. It also requires partnering with culturally-specific organizations, and OCCYSHN will continue to foster and grow relationships begun during the needs assessment. The Family Involvement Program also partners with culturally-specific organizations, and offers bilingual family support and family trainings.

Changes in Title V program capacity and impact of those changes on service delivery

OHA MCAH changes in Title V program capacity and impact on service delivery

State level changes in Title V capacity have been primarily related to the impact of COVID-19. These include staff being deployed to serve the COVID-19 IMT response directly, staff filling in for those deployed to COVID-19 work, as well as reduced capacity of parents and caregivers who have needed to split time between work and care-giving for both infants/preschoolers whose childcare was closed, and school-aged children engaged in remote learning. Recently, our state-level capacity has also been impacted by staff taking 12-24 month postings in the newly established COVID-19 Response and Recovery Unit (CRRU), resulting in gaps and shifting personnel as positions are filled through job rotations. All Title V services and functions have continued through these shifts, and the state program has even managed to develop and implement a new framework for implementing the 2021-2025 Title V priorities. (All state Title V staff transitioned to remote work and delivery of services remotely in March 2020) However, time and capacity to focus on these changes has been limited given the current crisis.

At the local level, MCAH Title V capacity has been impacted to differing degrees throughout the state. All local public health authorities are engaged responding to the COVID-19 pandemic, and its multiple impacts on the MCH population. In some LPHAs MCH staff are playing key roles in their local COVID-19 response and have had to shift local staffing to support COVID-related activities for the MCH population – including health education, support for quarantine and isolation, contact tracing, assistance with access to vaccination, etc. For many grantees, staffing is limited, staff have resigned, and there are challenges to filling positions (especially in rural areas and where there are culturally/linguistically specific needs). These shifts, as well as increased needs of the MCH population resulting from the pandemic have resulted in some grantees needing to modify their Title V plans and change the Title V priorities on which they are focused.

OCCYSHN changes in Title V program capacity and impact on service delivery

III.C.1.c. Benjamin Hoffman, MD, CPST-I, FAAP, has been director of OCCYSHN since 2017. He has been a pediatrician for over 25 years, and he is a nationally recognized expert in child injury prevention and medical education. OCCYSHN employs 15 staff and 4 community-based Parent Partners, for a total of with 13.4 FTE. OCCYSHN's staff has experienced very little turnover in the last year, and the stability that comes with staff retention has allowed greater focus on programs and projects.

Although OCCYSHN's structural program capacity remains stable, many of our community partners work in health, education, and community systems that have been strained by the demands of the COVID-19 pandemic, making collaborative efforts more difficult to pursue. All OCCYSHN programs and projects based on in-person contact were affected.

Local public health authorities with whom OCCYSHN contracts to provide community-based care coordination services had to devote much of their available resources to COVID-19. Engagement with family members of CYSHCN could no longer be held in person. Although web-based efforts were quickly developed and implemented, many families lack recources necessary to access virtual care coordination or family support.

In addition, the challenges of COVID-19 have affected receipt of health care for CYSHCN. During the pandemic, well-child care was curtailed for many. Telehealth use was expanded, and payment parity with in-person visits allowed many families to access care when appropriate and available. However, not all families have access to reliable technology, or the skills to manage virtual visits, and remote care is not appropriate for many individuals or

issues.

Like health care, the education system faced radical adjustments because of COVID-19. Virtual learning was especially challenging for many CYSHCN receiving special education services, especially those with Autism Spectrum Disorder, or other developmental disabilities. Prior to COVID-19, the education system's ability to provide CYSHCN with education-related allied health therapies was already limited by funding and workforce shortages. Providing these therapies virtually is not ideal, and in many cases, it is simply not possible.

Efforts to operationalize needs assessment findings

OHA MCAH efforts to operationalize NA findings

MCAH Title V has re-structured our program framework in response to the 2020 Needs Assessment findings. The new framework, shown below, demonstrates our commitment to structuring Title V services to respond to the upstream needs of social determinants of health and equity, trauma/toxic stress/ACEs and resilience; and culturally/linguistically responsive services. These 3 state priority areas are being approached in an integrated manner as "Foundations of Maternal, Child, and Adolescent health. Work across the Foundations areas is focused on policy & systems; workforce capacity and effectiveness; community, individual and family capacity; and assessment and evaluation. Domain-specific work on national priorities (well woman care, breastfeeding, child injury, and bullying prevention) is also being conducted in sync with and using the lens of our Foundations work. All of the plans for the coming year in the state action plan reflect these efforts to operationalize our state's needs assessment findings.

OCCYSHN efforts to operationalize NA findings

III.C.1.e. OCCYSHN continues to operationalize key 2020 Needs Assessment findings. Our cross-systems care coordination efforts address persistent issues with medical home and health care transition for CYSHCN. Our findings regarding the racism experienced in the health care system by families of Black and Latino CYSHCN also drive our activities. We have disseminated those findings to our partners, and we will continue dissemination efforts. We are taking steps to review our work through an anti-racist lens, and to assess the needs of our partners for anti-racism technical support. These strategies are detailed in in our 2022 block grant plan.

Changes in organizational structure and leadership

OHA MCAH changes in organizational structure and leadership

Changes in OHA, PHD, and MCAH Title V leadership and staffing over the past year have included:

- Rachael Banks was appointed Oregon Public Health Division Director, Oct 27, 2020 after Lillian Shirley's retirement. Rachael, who had been Multnomah Co Public Health Director since 2017, brings a wealth of background in maternal and child health, as well many years of passion and experience in promoting health equity.

- Jessica Duke, Oregon Title V Adolescent Health Director and manager of the Adolescent and School Health Unit resigned in June 2020. Rosalyn Liu is the new manager of the Adolescent and School Health Unit.

- John Putz, MCH Assessment and Evaluation Unit manger, took a full-time assignment to support the COVID-19 Incident Management Team from March 2020 through September 2020. He has now returned to his position in MCH.

- Many state level MCH staff who lead programs and Title V work were deployed to work on the COVID-19 Incident Management team beginning March 2020. Those deployments lasted varying periods of time and most staff have now returned to MCH duties. Others have taken 12-24 month positions in the newly established COVID-19 Response and Recovery Unit (CRRU).

Changes in local level public health leadership have been extensive over the past year – both among administrators and staff leading MCH programs. The stress of the ongoing COVID-19 response on local public health is resulting in continuing resignations and challenges to local public health capacity.

- Approximately a third of local public health administrator positions have turned over in the past year (13 of

33).

- There has also been extensive turn-over in local public health MCH staffing due in part to retirements and resignations brought on by the stress of the COVID-19 response.

Changes in OHA organizational structure over the past year have been made in response to the COVID-19 pandemic. The pandemic response was initially managed through an emergency management/incident management team structure. During the summer of 2020, Oregon established the COVID-19 Response and Recovery Unit, or CRRU, to coordinate statewide efforts to prevent and mitigate the spread and effects of the pandemic. The CRUU is a shared unit of the Oregon Health Authority (OHA) and the Department of Human Services (DHS). It is expected to function for 12-24 months, with approximately 300 allocated FTE. One of the key structural changes associated with the CRUU that impacts the MCAH population is the development of community engagement specialists and contracts with multiple community agencies across Oregon to provide outreach and COVID-related support to their populations. Although this is not a change in MCAH Title V capacity, the impact of this structural and capacity change on MHAC population in marginalized communities around the state cannot be over-stated. There are currently 179 community agencies receiving funding to support the COVID-related needs of individuals and families in their communities. The work is being actively supported by a diverse team of community engagement specialists, whose focus is on reducing barriers and ensuring that local communities and agencies have the support they need from the state.

OCCYSHN changes in organizational structure and leadership

III.C.1.f. OCCYSHN's organization structure and leadership remain as described in the 2021 Main Narrative Section III.C.2.b.ii.a.i.

III.C.1.d. OCCYSHN currently contracts with 28 local public health authorities serving 29 counties to implement our care coordination strategies. (See Section 11.1 in block grant plan.) Collaborations with other CYSHCN-serving agencies are described in Section III.E.2.c.

Emerging public health issues and capacity to address them

Key emerging MCAH public health issues in Oregon this year include the direct as well as indirect impacts of COVID-19 on the MCAH population, as well as the related issues of racial justice and equity, and mental and behavioral health.

- Clearly COVID-19 is the largest emerging public health issue impacting the MCAH population in Oregon over the past year. As is the situation around the country, the impacts of the pandemic include both the direct impact of the disease – particularly the disproportionate impact on communities of color, as well as the economic and social impacts related to the ongoing closures, job losses (particularly for low-income families and women of color), women being forced to leave the workforce to care for children who are without childcare or school, etc., and inequitable access to vaccines. The heightened levels of stress and isolation have increased the risk for child abuse and neglect, while concurrently reducing children's contact with mandated reporters; so while reports have decreased, the percentage of emergency department visits related to child abuse and neglect resulting in hospitalization has increased significantly. Additional targeted Federal funding, as well as flexibility in use of Title V funding to address these issues are helpful. However, limitations in available qualified staff in many areas of the state (especially rural areas), as well as staff turn-over with the ongoing high stress nature of the response are presenting ongoing capacity challenges.

- The need to focus on racial justice and equity as core public health work has also been an emerging focus this past year. This is on ongoing issue, but the disparities and injustice of the past year – both due to the pandemic and to police and other racial violence - have elevated the issues and our need to focus public health capacity and resources directly on anti-racism work.

- Mental and behavioral health needs of children, youth and families have also escalated during the past year – in relation to both the above issues. Children, youth and families are experiencing unprecedented isolation and have been cut off from many of their usual forms of social and community support. The need for culturally

responsive services for children, youth and families has never been greater. The state is working to respond in a variety of capacities, but at this juncture needs far outweigh capacity.

Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Oregon's Title V needs assessment synthesized information about MCH population needs relative to the 15 national priorities areas, current state Title V priorities, and emerging Oregon MCH priorities.

Goals, framework and methodology
The goals of Oregon's MCAH Title V Needs Assessment are to: better understand the health status and needs of Oregon's women, infants, children and youth, including those with special health care needs, and their families; engage stakeholders, partners, and communities in discussion about Oregon's Title V MCAH work, and its alignment with key MCAH system changes and opportunities; meet the Federal Title V requirement to conduct a needs assessment of the MCAH population every five years; and use the results of that assessment to determine priorities for the state's Title V MCAH program. The framework of the needs assessment was determined by a set of research questions and guiding principles as outlined in Supporting Document 3.

Methodology: The needs assessment utilized mixed methods to gather information on the needs of women, children, infants and families in Oregon. These methods included:

1. Environmental scan of community assessments conducted across Oregon
2. Partner survey of 482 MCAH and CYSHCN partners
3. Community voices: A gathering of the voices of special populations of focus in partnership with community agencies
4. 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, and Medicaid.

(A graphic showing the structure of the needs assessment methodology and process is included in Supporting Document 3.)

Stakeholder involvement
Families, youth, and partners were engaged during the Title V Needs Assessment through the environmental scan, the partner survey, the community voices project, and a survey of school nurses.

Forty-one community assessments conducted in Oregon during the past five years were analyzed to ensure that efforts already conducted by communities were honored and not duplicated. Assessments from each county within the state were included, along with special population assessments conducted by community agencies. This analysis provided not only a ranking of national and state priority areas but allowed for community specific needs and emerging needs to be identified.

Respondents to the online partner survey included but were not limited to stakeholders from coordinated care organizations, hospitals, health clinics, early learning hubs, school districts, schools, colleges, and community agencies. These partners provided feedback on the importance of each priority area in terms of impact, equity, and impact of resource allocation, in addition to identifying emerging needs and systems issues. Responses were received from partners whose organizations worked with special populations of focus, including African American/Black, American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, Hispanic/Latinx, and immigrant communities, as well as individuals with disabilities. Partner survey questions are included in Supporting Document 3.

The community voices project allowed for the needs of six special populations of focus to be explored. These special populations included African American/Black families, Hispanic/Latinx families, rural families, homeless families, immigrant and refugee families, and LGBTQ+ youth, with a special focus on transgender youth. Mini grants were awarded to community agencies to collect the data, and each agency was supported in determining their own methods of data collection, that were the most suitable and culturally responsive. Methods utilized by the grantees included focus groups, listening sessions, Charlas (a dialogue), written surveys, and semi-structured in-person or phone interviews. The use of mini grants to agencies with connections to specific communities allowed perspectives to be collected that would not otherwise have been accessible. The RFP for the community voices mini grants is included in Supporting Document 3.

The Adolescent and School Health (ASH) section completed a survey of school nurses. ASH collaborated with Jaime Smith, the School Health Services Coordinator at Multnomah Education Service District (MESD) and OCCYSHN's Assessment and Evaluation Manager to collect data from school nurses across the state. The survey sought to collect data describing school nurses' experiences working with students who have Individualized Education Plans (IEP). ASH administered the questionnaire electronically; Mr. Smith helped disseminate it to all MESD nurses and others across the state.

Quantitative and qualitative methods

MCAH Data Collection

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. For each tool, we analyzed data for each national, state and emerging priority area. Our analysis included comparing Oregon to the US, disparities among racial and ethnic groups, and trends over time. We also analyzed the results of the partner survey and the community voices project to compare the level of need in different areas of concern.

Qualitative methods were used for the environmental scan, to code the open-ended results from the partner survey, and to analyze the results of the community voices project. NVIVO qualitative analysis software was used to code mentioned of need from each of these sources into a comprehensive list of maternal and child health topics.

OCCYSHN Data Collections

In addition to the data collection methods that we collaborated with PHD to implement, OCCYSHN Assessment and Evaluation (A&E) staff sought to more specifically understand the needs of Oregon CYSHCN and their families, including access to care and care coordination, and experience with transition to adult health care. We used a descriptive design that incorporated both quantitative and qualitative data collection methods to answer these questions. Our use of participatory needs assessment (PNA) to understand the needs of two CYSHCN Communities of Color is particularly noteworthy. A description of our methods follows.

Quantitative Data Collection and Analysis Methods

OCCYSHN's A&E staff relied primarily on the National Survey of Children's Health results. We extracted previously tabulated results from CAHMI's Data Resource Center (www.childhealthdata.org) and conducted our own analyses using the publicly available data file. We primarily used the 2016-2017 combined data file, but considered results from single years when Oregon state CYSHCN results were unavailable. A&E also included relevant quantitative results from the most recent National Core Indicator survey for Oregon, results from Oregon's Department of Education, and findings from several recent OHA Office of Health Analytics and Oregon Office of Rural Health workforce needs assessment reports.

Qualitative Data Collection and Analysis Methods

The National Survey of Children's Health provides a wealth of information but results that generalize to CYSHCN remain inadequate, particularly for CYSHCN of color. For example, we lack an estimate of the percent of Oregon CYSHCN who are Black. During our 2015 needs assessment, we received tremendous response to our family and youth surveys, but they did not well describe the experiences of families of CYSHCN of color. We also wanted to work directly with community-based organizations (CBO) to collect data (versus contracting with an external research firm) to ensure that funding went directly into the community and allow OCCYSHN to develop relationships with CBOs working in Communities of Color. Therefore, we sought to test a PNA approach to better understand the needs of CYSHCN who are members of Communities of Color and their families.

We first released a Request for Information (RFI) to obtain feedback from culturally-specific CBOs about our project proposal. We obtained input from an ORF2FHIC Parent Partner who previously worked for a culturally-specific CBO; we asked for his reactions had he seen the request come across his desk as his previous job. His insight was invaluable. We incorporated the RFI feedback we received into a Request for Proposal (RFP), which we then released only to CBOs who responded to the RFI. We awarded contracts to the Latino Community Association (LCA) and the Sickle Cell Anemia Foundation of Oregon (SCAFO). OCCYSHN partnered with LCA and SCAFO to develop culturally responsive data collection methods in their respective communities, which entailed both CBOs completing Institutional Review Board (IRB) training and participating in the development of the IRB protocol. LCA and SCAFO conducted 6 and 12 focus groups, respectively, in their communities, managed the transcription of their recordings, and participated in the analysis and dissemination of findings.

We also invited 43 stakeholders (ORF2F Parent Partners, CMC CollN Family Representatives, SCAFO and LCA team members, LPHA staff) to provide us input on our priority selection; 70% of stakeholders responded, and 70% of LPHA staff responded. A complete discussion of our methods and our timeline – including our approach for obtaining stakeholder

feedback on priority selection – appears in our full needs assessment report (see Supporting Document 2).

Data sources
Data sources included the US Census, vital statistics, survey data including the Pregnancy Risk Assessment Monitoring System, the Behavioral Risk Factor Surveillance System, the National Survey of Children's Health, the Youth Risk Behavior Surveillance System/Oregon Healthy Teens, Oregon's Smile Survey, and the National Immunization Survey, as well as Oregon hospitalization data. Other sources included 41 community assessments utilized during the environmental scan, partner survey data, and reports from the community voices project.

Interface between collection of data, finalization of priority needs and development of State's Action Plan
Stakeholders were presented with the findings of the needs assessment using an online platform, then asked to make recommendations for Oregon's priority needs. State Title V staff then met for a day long retreat to consider these recommendations, and to finalize selection of Oregon's priority needs. The final selected priorities for Title V focus were used to create the state's Action Plan.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Detailed results are available in the form of data tools at:
https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/MCHTITLEV/Documents/2020%20Title%20V%2
Samples of these data tools can be found in Supporting Document 3.

Women's/Maternal Health

Strengths and Needs
Social determinants of health (SDOH) are a key issue of concern for this population. In Oregon, racial and ethnic disparities are evident in SDOH such as income and housing, e.g. the percent of female headed households with children under five, who are in poverty and pay >30% of their income on rent. Maternal mortality is also an issue of concern in Oregon, and the state has recently established a maternal mortality review committee to investigate the cause of the rising rates and increased disparities.

Successes, challenges and gaps

Well woman care
Women in Oregon consistently have lower rates of well woman care compared to national rates. Barriers to care reported included health care provider and staff attitudes, distrust of health care providers/fear of practices, preventive care not being a priority, lack of culturally appropriate care, discomfort with pelvic examinations, transportation issues and lack of childcare.

Low risk cesarean
Rates of low risk cesarean deliveries are consistently lower in Oregon than nationally, although there are evident racial/ethnic disparities. Rates in Oregon area similar in rural and urban areas.

Oral health during pregnancy
More women in Oregon receive a dental visit during pregnancy than nationally, although there are stark racial/ethnic disparities in these rates. Oregon ranks 48th nationally for optimally-fluoridated public water systems; only 22% of systems have fluoridated water.

Smoking during pregnancy
The rate of women who smoke during pregnancy is higher in Oregon than nationally, although this rate has been decreasing steadily since 2014. There are also large racial/ethnic disparities in smoking rates during pregnancy in Oregon. American Indians, people with household incomes under $15,000, people on Medicaid, and those with no high-school

diploma are significantly more likely to smoke in Oregon.

Current efforts and needed strategies

Well woman care
Current efforts include Maternal Mortality and Morbidity Review Committee, adoption of a postpartum care incentive metric for Coordinate Care Organizations, and implementation of the Reproductive Health Equity Act. Well woman care was ranked highest among the national priorities in this domain in the environmental scan, partner survey, and community voices project.

Low risk cesarean
The Oregon Perinatal Collaborative has succeeded in implementing a “hard stop” policy to end elective deliveries prior to 39 weeks. Policy and programmatic supports are in place to increase the use of doulas in Oregon as a strategy to decrease cesarean rates. Black families reported that there is a high rate of cesarean delivery in their communities, due to misconceptions about this route of delivery, and due to doctors not giving them other options.

Oral health during pregnancy
Oregon builds partnerships to support the integration of oral health in Coordinated Care Organizations (CCOs). Latinx and immigrant/refugee families reported that oral health is a problem in their communities because of health care coverage for adults not including dental care. Rural families reported a lack of dental providers and affordable dental care as barriers to women receiving necessary oral health care.

Smoking during pregnancy
Through the Oregon Mothers Care Program, pregnant women who smoke receive interventions and referral to the Oregon Quitline. Oregon’s CCOs are monetarily incentivized to reduce cigarette smoking among their members. Rural families reported that smoking during pregnancy is prevalent in their communities.

Perinatal/Infant Health

Strengths and Needs
While the infant mortality rate in Oregon is lower than the national rate, racial/ethnic disparities persist in Oregon in this rate and in other perinatal outcomes, such as adverse experiences and toxic stress during pregnancy and infancy. Additionally, lack of access to high quality affordable childcare impacts a family’s economic security, with many families with young children living in childcare deserts.

Successes, challenges and gaps

Breastfeeding
Oregon has breastfeeding initiation rates higher than the Healthy People 2020 target of 82%. Both Oregon and national rates fall short of medical recommendations that children be exclusively breastfed until 6 months of age. Disparity exists for exclusive breastfeeding for six months with lower rates among Black, Asian, and Hispanic Oregonians.

Safe sleep
A higher percentage of caregivers report putting their infants to sleep on their backs in Oregon than nationally, however, the rate of SIDs deaths in Oregon is consistently higher. Oregon’s statewide Child Fatality Review team reviews infant deaths and provides a forum for prevention discussions. The Early Learning Division recently changed its childcare rules to promote safe sleep practices.

Current efforts and needed strategies

Breastfeeding
Oregon has laws and policies in place to protect and support breastfeeding, including 12 weeks of paid leave. Oregon has licensure of IBCLCs which provides a mechanism for payment of medical lactation management. Black families reported needing more culturally competent care and support in their communities to support breastfeeding, including support for return to work. Immigrant/refugee families reported needing more workplace breastfeeding support.

Safe sleep
MCAH developed and shared safe sleep educational materials with public health programs as well as other partners. Oregon's MIECHV program conducted a statewide CQI project on its efforts to reduce rates of sudden unexpected infant death (SUID) through safe infant sleep practices. DHS Child Welfare is interested in partnering with the Oregon Health Authority to train Child Welfare workers in safe sleep practices.

Child Health

Strengths and Needs
Early childhood disparities persist in multiple areas of health and well-being, including infant and maternal mortality, physical and oral health, and exposure to ACEs, trauma and toxic stress. CYSHCN and their families face significant barriers in accessing health care and other supportive services. More than one in five children in rural Oregon live in poverty, and children of color are disproportionately represented among young children in poverty.

Successes, challenges and gaps

Developmental screening
The rate of developmental screening is higher in Oregon than nationally. In Oregon, developmental screening is a CCO incentive metric. In 2018, 72.4% of children under three on Medicaid were developmentally screened. Work to improve developmental screening rates has been a focus of Maternal and Child health home visiting programs, and other Oregon partners.

Injury
Unintentional injury is the leading cause of death for children ages 1 through 11. Legislative successes include universally offered home visiting, easier ways to get rid of excess pharmaceuticals to prevent accidental poisonings, and a requirement for school districts to develop plans to prevent youth suicide. MCAH collaborated with Oregon Safe Kids to support state and local injury prevention through analysis and interpretation of child injury and death data.

Physical activity
While more 6-11 year-olds were physically active at least 60 minutes a day in Oregon than nationally, the proportion of schools that provided the required number of minutes of physical education instruction for the entire year to all students was only 7% for schools with K-5 grades and only 26% for schools with 6-8 grades during the 2015-16 school year. Legislative successes include the Student Success Act and Keep Oregon Moving.

Oral health
While more 1-17 year old children have had a preventative dental visit in the last year in Oregon than nationally, half of 6-9 year old children have had a cavity. Statewide, cavity rates are higher in southeastern Oregon and northeastern Oregon. There are racial/ethnic disparities in the percentage of 6-9 year old children with cavities in Oregon. Rural families reported a lack of dental providers and affordable dental care as barriers to children receiving necessary oral health care.

Exposure to secondhand smoke
While there is no significant difference in the percent of 0-17 year old children who live with someone who smokes in Oregon vs. nationally, there are disparities in this measure, between racial/ethnic groups, and children with and without special healthcare needs. Successes include a ban on smoking on the premises of licensed childcare centersand in motor vehicles with a child under 18, as well as on sales to youth under 21. Taxes on tobacco products have also been raised in 2020.

Current efforts and needed strategies

Developmental screening
Oregon home visiting programs conduct developmental screenings for all participating infants starting around four months of age. Oregon MIECHV participated in a statewide project to improve developmental screening and referrals. CCO data show some communities continue to have lower screening rates. Black, Latinx, immigrant/refugee and rural families indicated that developmental screening was a high priority need in their communities.

Injury
Home visiting programs offer parent education and support, assessments of the home environment and connections to resources for families with infants and toddlers. MCAH partners with the Injury and Violence Prevention Program and DHS to staff the State Child Fatality Review Team. Challenges include limited services and programs for children, limited capacity and resources for child fatality review teams, and no designated funding to support prevention and health promotion in childcare settings.

Physical activity
Oregon participates in the Children's Healthy Weight CollN, Blue Zones, OEA Choice Trust School Wellness grants, Fuel Up to Play 60 grants, Safe Routes to School, and Physical Education Expansion K-8 grants. Black and rural families reported a lack of safe environments as a barrier to physical activity among the children in their communities. Latinx families reported a lack of access to sports or recreational programs for their children, in addition to children having to stay home after school while parents worked, as reasons for child obesity in their communities.

Oral health
Oregon takes a comprehensive approach to address oral health issues across the lifespan through building partnerships to support the integration of oral health in the CCOs, delivering school-based oral health programs, promoting oral health prevention during childhood, and continued surveillance of the oral health status of all Oregonians. Local public health agencies are accountable for a developmental metric to increase dental visits for children 0 to 5 years old.

Exposure to secondhand smoke
CCOs will be monetarily incentivized for reducing cigarette smoking among their members. Efforts continue to encourage the Oregon Department of Education (ODE) Office of Child Care to ban cigarette smoking on the premises of certified childcare homes during business hours or when children are present.

Adolescent Health

Strengths and Needs
19% of Oregon youth live in a household below the poverty line, and 51% of households with adolescents experienced rent burden, with 27% experiencing extreme rent burden. A strength among this population is that 97% of Oregon youth have health insurance. Among 11th graders, 18% report having an unmet physical health care need and 22% an unmet emotional health care need. These rates are higher for youth with disabilities, LGBTQ+ youth, and Native youth; symptomatic of a lack of or limited culturally competent services for these communities.

Successes, challenges and gaps

Injury
Unintentional injury is the leading cause of death among 10-24 year olds, with injury related to motor vehicles being the most common cause among 15-24 year olds. Suicide was the second leading cause of death among 10-24 year olds in Oregon. The Oregon rate of youth suicide ranked 17th among all states. Rates among youth considering and attempting suicide have increased since 2013 and are higher among Native American youth, LGBTQ+ youth and youth with disabilities, reflecting a lack of resources and supports for these communities.

Physical activity
Less 12-17 year olds are physically active for at least 60 minutes per day in Oregon than nationally, and this percentage has been decreasing. Cis male 11th graders are more likely to have access to five days of physical activity compared to their cis female and gender diverse peers. Likewise, lesbian, gay and bisexual 11th graders have less access to physical activity than their straight peers. This could point to heterosexual and cis normative spaces/norms within physical education and physically active extracurricular activities. Only 2% of Oregon schools have established, implemented, and/or evaluated a Comprehensive School Physical Activity Program.

Bullying
Almost one in three 8th graders and one in five 11th graders have been bullied in the last 30 days, with American Indian,

Native Hawaiian/Pacific Islander, and LGBTQ+ students facing higher rates of bullying; reflecting systematic oppression faced by these communities in and outside of schools. The percent of youth missing school because they felt unsafe in the last month has increased since 2013, however youth who had a supportive adult at school were less likely to miss school because they felt unsafe.

Adolescent well visit
In Oregon, bisexual, transgender, and gender diverse 11th graders are less likely to have an annual well-visit than their heterosexual and cis gendered peers. A lack of LGBTQ+ friendly clinic space and staff could create unwelcoming environments that create these inequities. The percent of youth with unmet physical and mental health needs in Oregon is about on par with the national percent of youth without preventive care. However, this rate has been increasing over time, even as the rate of well visits has increased.

Oral health
Black 8th and 11th graders in Oregon have less access to preventive dental care than their White peers, pointing to the need to alleviate barriers and provide greater levels of culturally competent access in communities of color. Sixty-nine percent of 8th graders and 75% of 11th graders in Oregon report having ever had a cavity.

Exposure to secondhand smoke
Oregon's smoking prevalence among youth has been declining over time, but adolescents still have exposure to secondhand smoke. Almost a third of 8^{th} and 11^{th} graders in Oregon live with someone who smokes or vapes tobacco. Inequities in exposure to secondhand smoke exist, with more children with special health care needs living in households where someone smokes, as compared to children without a special health care need. There are also racial/ethnic disparities in exposure to secondhand smoke among Oregon youth.

Current efforts and needed strategies

Injury
OHA has focused youth brain injury prevention efforts on concussions sustained by sports activities. Legislatively funded pieces of the Youth Suicide Intervention and Prevention Plan invest in effective prevention programs and statewide infrastructure. Oregon also adopted legislation requiring school districts to adopt policies related to suicide prevention, intervention, and postvention, and is working on safe gun storage legislation.

Physical activity
Oregon has begun to implement legislatively required physical education minutes in grades K-8, and has legislatively mandated data collection. There is legislatively dedicated funding to Safe Routes to School infrastructure. Oregon participated in a Children's Healthy Weight CoINN to accelerate progress in implementing new physical education standards, including focus groups with school administrators. Transgender youth cited concerns of mockery in school-based locker rooms, fear of being outed and restrictions on participating in gender-based sports as barriers to physical activities.

Bullying
Legislation mandates that all schools have policies prohibiting bullying, harassment and cyber-bullying, including reporting requirements for all school employees. 2019 legislation established a statewide system to help districts decrease acts of harassment, intimidation, bullying, and sexual harassment. OHA designed a youth health surveillance question to measure perpetuation of bullying in 2019. Bullying was ranked the number one priority among Black, immigrant/refugee, and rural families. Transgender youth ranked bullying as second highest priority.

Adolescent well visit
Oregon's adolescent well-visit rates benefitted from incentivizing CCOs to increase well-visits among their members up until 2019. Oregon has had success in creating and disseminating guidance documents for the well-visit. Integrating health services into schools has been difficult in some communities due to a lack of providers and financial constraints. In 2020, Oregon's CCOs will no longer have incentives to increase adolescent well visit completion. Gender diverse youth cited inclusive, affordable care as a major issue, with cost and lack of parental support being reported as barriers to seeking specialty medical help.

Oral health
MCAH builds partnerships to support the integration of oral health in CCOs, the delivery of school-based oral health programs, and the promotion of oral health during adolescence. In 2014, the Oregon SBHC Program expanded the list of providers meeting SBHC certification standards to include dental health professionals. As of 2018, 15 SBHCs had dental providers. The Oregon SBHC Program participates in the Oregon Oral Health Coalition's K-12 subcommittee to inform the provision of technical assistance to school-based health centers for oral health services.

Exposure to secondhand smoke
MCAH works to develop a policy agenda that decreases youth exposure to tobacco products and decreases likelihood for initiation and use, including working with partners to analyze the impact of policy changes raising the legal age of purchase for tobacco and vaping products. Starting in 2019, Oregon's CCOs will have an incentive to reduce cigarette smoking prevalence among their members.

Children and Youth with Special Health Care Needs (CYSHCN)

Nearly one in five Oregon children under 18 years has a special health care need; 18% are Latino (NSCH 2016-17). Thirty-nine percent of Oregon CYSHCN receive care that meets the criteria for a medical home; the medical home qualities that CYSHCN are least likely to experience are effective care coordination and getting referrals for doctors or services (NSCH 2016-17).

Oregon children generally, and CYSHCN specifically, do not receive transition to adult health care services (NSCH 2016-17). Eighty-six percent of CYSHCN who receive care in a medical home, and 86% of CYSHCN who experience emotional, developmental, and behavioral conditions, did not receive transition services. This is consistent with findings from Oregon's CMC CollN project; one-third of the parents interviewed reported that their behavioral health provider did not provide notice that their child's care would end at age 18.

Most Title V partner survey respondents selected transition to adult health care as the priority on which to focus for Oregon CYSHCN. Respondents who work for organizations that primarily serve diverse communities (e.g., AI/AN, Black/African American) most often selected medical home as the priority on which to focus for CYSHCN. Respondents who work for organizations that primarily serve individuals with disabilities most often selected transition to adult health care as the priority.

Results of our PNA with SCAFO showed that families of Black CYSHCN commonly experience difficulty accessing behavioral/mental health and specialty services. They also often experience insurance coverage and re-authorization challenges or trying to find providers within their child's network. Family participants described having to persistently advocate for services for their children, e.g., one family member stated*, "I ended up calling and calling trying to get into the doctor, and they kept telling me to wait. One day I decided I'm gonna pack a lunch, I'm gonna go down, I'm gonna sit in this doctor's office, and I have all day until they give me a referral…We ended up getting that referral…"*

Families described having long wait times to get appointments and difficulties scheduling appointments. The types of challenges that families described related to culturally responsive care focused on the lack of black health care providers and experiencing racial stigmatization. For example, one family member stated, *"I got my son's medical records one time… and the comments that the doctor made – 'You can tell that she's a young, single, unwed mother.' …it has absolutely nothing to do with my son, the fact that he has a tumor on his optic nerve. He's miserable. He has seizures. He's on medication, so yeah, he's gonna cry for hours."*

Racial stigmatization creates conditions such that members of a racial/cultural group distrust the healthcare system and have low expectations of finding healthcare providers that represent their race/culture. These perceptions were described by family members of Black CYSHCN in 9 focus groups. For example, one family member described struggling with overcoming the perception in the Black community that if she asked for help with caring for her child, she will be separated her from her child. She appealed to the health care system to assure Black families that asking for help will not disadvantage them. In 7 focus groups, family members described that it was not realistic to envision having a Black health care provider for their child. Family members also faced barriers when they attempted requesting a Black health care

provider.

Five of SCAFO's focus groups were composed of family members of CYSHCN aged 18-25 years to discuss transition to adult health care. Families described needing to stay involved in their child's life after turning 18 because their child was unable to manage their care on their own or because the family member did not trust the health care system to well attend to their child's care needs. When talking about their involvement, family members often described challenges to communicating with their child's providers because of patient privacy.

Family members described not receiving supports from the healthcare system in the process of transition in 4 of the focus groups. For example, one family member felt that their child's healthcare provider did not provide the requested help in meeting their child's needs. Another family member encountered challenges in maintaining health insurance, which interfered with getting a referral to an adult provider. Yet another family member described the challenges in working with their young adult's specialists.

At the time of Block Grant report preparation, LCA and OCCYSHN were completing analysis of focus groups data with families of Latino CYSHCN in Central Oregon. Preliminary findings show that families experienced long wait times for care, lack of providers locally, and lack of quality care locally that make accessing health care challenging. *"I already decided to take him to Portland because as I said, I did not like how they treated me [locally]… it took three years for him to be diagnosed. When I took him to Portland, he already had his iron at 1, when what he needed was 57. And the [Portland] doctor said: "Why did it take so long? A little longer and his red and white blood cells would no longer serve him anymore, and if it had taken longer, he could have had leukemia…in Portland they quickly detected the problem he had. "*

Similar to families of Black CYSHCN, Latino families reported having to advocate persistently to ensure that their child received needed care in health care and education settings. We were not able to collect data from an adequate number of families of YSCHN 18-25 years old to find saturation in transition themes; however, it was clear from the families we did talk with that they were not prepared for transition to adult health care. Latino families also experienced racial stigmatization in health care settings and challenges with interpreters that included interpreters not being available, delayed appointments when an interpreter is requested, and frustration with interpretation quality.

When OCCYSHN solicited priority selection input from stakeholders, we proposed maintaining medical home and transition for 2021-2025 (see Supporting Document 2 for rationale). We asked stakeholders to rate the extent to which they agreed with our proposal using a Fist to Five consensus building tool. All respondents agreed with our proposal; 73% and 60% of respondents *strongly* agreed with maintaining medical home and transition respectively.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

In Oregon 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). 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).

Patrick Allen is the Director of the Oregon Health Authority under Governor Kate Brown. OHA has responsibility for health-related programs in the state. The attached organizational chart shows the eight Divisions within OHA: Agency Operations, Fiscal Operations, Equity and Inclusion, Health Systems, External Relations, Health Policy and Analytics, Public Health, and State Hospital. Title V sits under the Public Health Division (PHD), which is led by State Public Health Director Lillian Shirley.

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, directed by Kurt Freeman, Ph.D., ABPP, is located within the Department of Pediatrics in OHSU's School of Medicine.

Responsibility for programs funded under Title V (federal and state)
The PHD is made up of three centers, and Title V sits within the Center for Prevention and Health Promotion (CP&HP), 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, Tim Noe, and 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 VI. 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 CYSHCN. The remaining funds allocated to state level Title V activities are delivered through the Maternal, Child and Adolescent Health programs, and through Oregon's designated local health authorities and tribes. The Title V Program in the OHA and the Title V Program at OCCYSHN 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 to coordinate service delivery, build partnerships, identify gaps and opportunities in delivery systems, and advocate for actions and policies that improve health among maternal and child populations.

The CP&HP supports community MCH programs through intergovernmental agreements and formula grants with local health authorities and tribal governments. CP&HP also contracts with 211info to provide the MCH warmline for Oregon. 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. A wide range of MCAH programs which are not directly Title V funded are conducted across the PHD 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 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 management of the section managers and the CP&HP Director.

OCCYSHN contracts with local public health authorities to implement a range of care coordination interventions for CYSHCN and their families. Statewide, those interventions include the CaCoon public health nurse home visiting program, community-based shared care planning, cross-sector care coordination teams, and collaborative systems improvement projects (see Section III.E.2.a_b). Title V funds also support some staff effort on Oregon's CMC CoIIN project aimed at improving the transition from pediatric to adult health care for young adults with medical complexity. OCCYSHN contracts with 211info to support the collection of follow-up data that assess whether CYSHCN family callers pursued 211 referrals, and the outcome of those referrals. The Title V CYSHCN Assessment and Evaluation Unit and the Family Involvement Program are also overseen by the OCCYSHN Director.

III.C.2.b.ii.b. Agency Capacity

Oregon Title V leads and engages partners to develop and coordinate maternal and child health services, systems, and policies across the state. Together, the OHA and OHSU Title V offices assess population health and needs, collaborate and coordinate policy development and implementation, and plan and implement services that reach all the targeted MCH populations. The capacity of the Center for Prevention & Health Promotion and the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) to promote maternal and child health in each of the six domains is summarized below.

(i) 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.
- **The Screenwise Program** helps reduce cancer burden and health inequities in Oregon.
- **Women's Health initiatives** strengthen systems and services through the STEPS program support for pregnant and parenting students and the Rape Prevention and Education program.

Capacity for Perinatal and Infant Health

- The MCH Section's **Assessment and Evaluation Unit** conducts PRAMS and ECHO (3-year follow back survey).
- 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, as well as the CoIIN Infant Mortality Initiative, Maternal Mortality Initiative, nurse home visiting, and the **Oregon MothersCare** (OMC) **Program**.

Capacity for Child Health

- **The Early Hearing Detection and Intervention Program** facilitates Oregon's Newborn Hearing Screening mandate. The program receives federal grant support from the CDC and HRSA for EHDI.
- **The Oral Health School Dental Sealant Program** provides screening for dental sealants to elementary students in schools around Oregon.
- **Babies First!, CaCoon, Nurse Family Partnership, MIECHV, and Family Connects** form a system of public health nurse home visiting programs. Oregon's Family Connects program is rolling out the first statewide system of universally offered home visiting.
- **Title V's Infant and Child Nutrition Consultant** provides leadership to build environments and public policies that increase nutrition and healthy development. A joint appointment with WIC ensures coordination on work ranging from nutrition education to food security and breastfeeding support.
- The State **WIC Program** contracts with local health agencies to provide WIC services to over 110,000 pregnant and postpartum women, infants, and preschool children each month in all geographical areas of the state.

Capacity for Adolescent Health

- The **Adolescent and School Health (ASH) Unit** administers the Title V and other funds dedicated to support state level leadership and policy development for adolescent health, including youth sexual health, and to support the adolescent health work of LHAs and tribes.
- **School Based Health Center** (SBHC) Program administers Oregon's SBHCs, in which comprehensive physical, mental and preventive health services are provided to youth and adolescents in a school setting.
- 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.

Capacity for Children and Youth with Special Health Care Needs

OCCYSHN improves systems of care for CYSHCN with the following activities:

- Training, support, and consultation for health professionals statewide to improve capacity to serve CYSHCN.
- Support for communities to develop and sustain care coordination efforts for CYSHCN.
- Information, resources, and peer support for family members of CYSHCN.
- Integration of family perspective into systems of care improvement.
- Partnering with local public health authorities to provide care coordination for CYSHCN.
- Ongoing population-based assessment and evaluation to identify and address the needs of Oregon CYSHCN.
- Provide data and analysis to inform policy and administrative decision-making.

Capacity for Cross-cutting/system building

Having MCH, WIC, Adolescent and Women's Health, and Chronic Disease Prevention programs all housed in the CP&HP provides a unique opportunity for Title V to expand capacity and coordinate on cross-cutting/system building initiatives.

- 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.
- 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.

(ii) Title V program capacity to provide a statewide system of services for CSHCN

OCCSYHN engages in a variety of partnerships for public health impact, and collaborates on research, education, and policy efforts on behalf of CYSCHN. Additionally, in keeping with the National Standards for Systems of Care for CYSHCN, OCCYSHN's community-based programs focus on integrating care and services. As promoted in the Care Coordination System Standards (AMCHP *National Standards 2.0, page 10*), OCCYSHN supports local health department partners to facilitate cross-sector shared care planning, with a focus on family goals for CYSCHN. A percentage of these shared care plans focus on CYSHCN preparing for the transition from pediatric to adult health care. OCCYSHN's Family Involvement Program takes a variety of approaches to ensuring that family strengths are respected in the delivery of care. See OCCYSHN's State Action Plan Narrative (Section III.E.2.a_b) for a description of OCCSYHN's community-based efforts, and how they fit into a continuum of statewide systems improvements for CYSHCN. Medicaid covers all children eligible for SSI in Oregon, which further increases OCCYSHN's capacity to serve CYSHCN.

III.C.2.b.ii.c. MCH Workforce Capacity

(i) and (ii) State and local level Title V staffing, including Senior level planning, evaluation and data analysis staffing
Cate Wilcox, MPH, has been the Title V Director since 2013, and has 35 years of MCH experience. Other key MCAH staff include: Community Systems manager Jordan Kennedy, and Assessment and Evaluation manager John Putz. 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 & 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.

Benjamin Hoffman, MD CPST-I FAAP has been director of OCCYSHN since 2017. He has been a pediatrician for over 25 years, and he is a nationally recognized expert in child injury prevention and education. OCCYSHN employs 16 staff with 12.9 FTE, and 4 community-based Parent Partners. 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 half-time Office Assistant and a full-time Systems Quality Improvement & Innovation Manager.

OCCYSHN hires, contracts with, and supports four Parent Partners from diverse cultural and linguistic backgrounds, including Spanish and ASL. OCCYSHN is staffed with a Systems and Workforce Development (S&WD) Manager, four S&WD staff (including an RN as CaCoon Program Lead), a Family Involvement Program Manager and a Resource Specialist (both parents of CYSHCN), a Communications Coordinator, an Assessment and Evaluation (A&E) Manager, two A&E Research Associates and a Research Assistant, a Program Administrator and an Administrative Coordinator. IDD's developmental pediatricians, speech pathologists, occupational therapists, physical therapists, etc. are also available for consultation.

The direct delivery of local MCAH programs is provided by staff at LPHAs. There are approximately 2,000 county public health staff in Oregon, including 34 health department administrators, 510 public health nurses and nurse practitioners, and 130 other health professionals in Oregon LPHAs. Title V MCAH services are also delivered by five of Oregon's nine federally recognized tribes.

The direct delivery of OCCYSHN programs is provided by public health nurses, community-based physicians and mental health providers, Parent Partners, and other professionals who implement community-based programs around the state.

(iii) Parent and family members
The MCAH program has family member representatives on a variety of teams including the CollN initiative, the Maternal Mortality Review Advisory Board, and the EHDI Advisory Committee. All parent members are reimbursed for their time as consultants.

OCCYSHN hires, contracts with, and supports family representatives from diverse cultural and linguistic backgrounds, including Spanish and ASL.

(iv) Additional MCH workforce information
A variety of forces are driving changes in the MCH workforce in Oregon. Health systems reform and Public Health Modernization are 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 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. High levels of turnover in both state and local level MCH supervisors, administrators, and staff will likely continue in the coming five 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 success moving forward.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

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 MCAH 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 MCAH population. The table in Supporting Document 3 provides a detailed description of key collaborations and partnerships for the MCAH Title V program as listed below.

1. **Other MCHB investments**: State Systems Development Initiative (SSDI), Maternal, Infant and Early Childhood Home Visiting (MIECHV); Intimate Partner Violence CollN, Infant Mortality CollN; Children's Healthy Weight CollN, Healthy Start Grants
2. **Other Federal Investments**: Nutrition Program for Women, infants and Children (WIC), Early Hearing Detection and Intervention Program (EHDI), Birth Anomalies Surveillance System (BASS), Maternal Mortality and Morbidity Review Committee (MMMR), , Rape Prevention Education, PREP Teen pregnancy grants, Pregnancy Risk Assessment Monitoring System (PRAMS), CDC Immunizations, Preschool Development Grant
3. **Other HRSA Programs**: FQHCs
4. **State and local MCH programs**: Universally Offered Home Visiting, Local Public Health MCH Programs, Conference of Local Health Officials (CLHO)
5. **Other Oregon Health Authority programs**: Adolescent and School Health Programs, Injury and Violence Prevention Program, Tobacco Prevention and Education Program, Chronic Disease Prevention, HIV/STD, Newborn Metabolic Screening Program, Medicaid and CHIP, Healthy Systems, State Public Health Director's Office, Office of Equity and Inclusion
6. **Other governmental agencies:** Social Services and Child Welfare, Department of Education, Department of Justice, Early Learning Division
7. **Tribes, Tribal organizations and Urban Indian Organizations**: Oregon Tribes, Northwest Portland Area Indian Health Board, Native American Youth and Family Center
8. **Public health and professional educational programs and Universities**
9. **Other public and private organizations serving the MCH population**

OCCYSHN collaborates with state and community-based agencies and organizations, healthcare and community-based providers, and family members of CYSHCN. OCCYSHN's Family Involvement Program identifies and mentors family members of CYSHCN to provide their critical perspective to program and policy efforts, both within OCCYSHN, and at regional and statewide levels. OCCYSHN collaborated with OHA on revising implementation of statewide nurse home-visiting efforts. OCCYSHN benefits from collaborative relationships with OHSU's broad pediatric clinical programs, and with the Oregon Pediatric Improvement Partnership (OPIP). It partners with LPHAs, ESDs, and local health providers and professionals to implement statewide community-based programs.

In an effort to better serve some culturally specific CYSCHN, OCCYSHN collaborates with the Sickle Cell Anemia Foundation of Oregon and the Latino Community Association of Central Oregon. Additionally, the ECHO-based virtual learning communities implemented by OCCYSHN provide a platform for health and service providers across the state to collaborate on improving care coordination for CYSHCN.

OCCYSHN is leading Oregon's participation in an MCHB-funded Collaborative Improvement and Innovation Network (CollN) initiative (2017-2021). Oregon's project focuses on improving the transition from pediatric to adult health care for young adults with medical complexity. Implementation involves collaborating with Family Representatives (parents of young adults with medical complexity), and representatives of Children's Health Alliance/Foundation, OHSU General Pediatrics, and Shriners Hospital for Children.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Determination of priority needs and changes from previous five-year cycle
Methodologies used to identify and prioritize Oregon's MCAH needs are described in detail in Section III.C.2a above, as well as in Supporting Document 3. The seven state priority needs reflect the overarching MCAH needs identified through the Needs Assessment and provide a framework within which to address Oregon's selected NPMs and SPMs. Additionally, selected priority needs reflect the alignment of MCAH and CYSHCN priorities with other key state plans and work. The need and rationale for work on each NPM and SPM is detailed in each relevant data tool (available at https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/MCHTITLEV/Documents/2020%20Title%20V%2

Changes from the previous Title V five-year cycle reflect an increased focus on upstream impactors of health including social determinants of health and equity, as well as an evolving understanding of the foundations of lifelong health and the importance of addressing structural and system changes.

Relationship of Oregon's priority needs to selected NPMs and SPMs
Oregon's priority MCAH needs and their associated NPMs and SPMs are:

1. Safe and supportive environments
   This priority need will be addressed through work on: child injury, bullying, toxic stress/trauma/ACES & resilience, and social determinants of health and equity.
2. Stable and responsive relationships; resilient and connected children, youth, families and communities
   This priority need will be addressed through work on: well woman care, breastfeeding, child injury, bullying, toxic stress/trauma/ACES & resilience, culturally and linguistically appropriate services, and social determinants of health and equity.
3. Improved lifelong nutrition
   This priority need will be addressed through Oregon's Title V work on: well woman care, breastfeeding, toxic stress/trauma/ACES & resilience, culturally and linguistically appropriate services, and social determinants of health and equity.
4. Increased health equity and reduced MCAH disparities
   This priority need will be addressed through work on: well woman care, breastfeeding, child injury, bullying, medical home and transition to adult care for CYSHCN, toxic stress/trauma/ACES & resilience, culturally and linguistically appropriate services, and social determinants of health and equity.
5. Enhanced social determinants of health
   This priority need will be addressed through work on: well woman care, breastfeeding, child injury, bullying, medical home and transition to adult care for CYSHCN, toxic stress/trauma/ACES & resilience, culturally and linguistically appropriate services, and social determinants of health and equity.
6. High quality, culturally responsive preconception, prenatal, inter-conceptions and post-partum services.
   This priority need will be addressed through work on: well woman care, breastfeeding, toxic stress/trauma/ACES & resilience, culturally and linguistically appropriate services, and social determinants of health and equity.
7. High quality, family-centered, coordinated systems of care for children and youth with special health needs
   This priority need will be addressed through work on: medical home, transition to adult health care, culturally and linguistically appropriate services, toxic stress/trauma/ACES & resilience, and social determinants of health and equity.

Emerging issues not selected
Over 70 emerging issues identified through the NA were narrowed down to seven for data tool development and partner discussion (detailed tally and final selection in Supporting Document 3). The decision to continue two previous cycle state priority areas (trauma/ACEs and CLAS) and add one (social determinants of health and equity) was based on criteria including alignment with partners, where Title V could best add impact, and importance of the topic.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,150,471	$6,178,818	$6,129,512	$6,172,689
State Funds	$8,888,929	$9,068,855	$10,116,862	$11,960,373
Local Funds	$6,026,893	$5,594,166	$7,003,170	$9,707,490
Other Funds	$7,236,918	$7,531,186	$7,684,389	$9,783,913
Program Funds	$0	$0	$0	$0
SubTotal	$28,303,211	$28,373,025	$30,933,933	$37,624,465
Other Federal Funds	$38,871,933	$39,324,236	$37,139,702	$44,501,432
Total	$67,175,144	$67,697,261	$68,073,635	$82,125,897

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,178,818	$6,091,610	$6,172,689	
State Funds	$10,720,618	$21,856,666	$13,276,271	
Local Funds	$5,594,165	$6,377,931	$9,707,490	
Other Funds	$8,527,525	$10,176,807	$11,838,611	
Program Funds	$0	$0	$0	
SubTotal	$31,021,126	$44,503,014	$40,995,061	
Other Federal Funds	$39,882,886	$33,784,920	$43,526,340	
Total	$70,904,012	$78,287,934	$84,521,401	

	2022	
	Budgeted	Expended
Federal Allocation	$6,091,610	
State Funds	$22,291,675	
Local Funds	$6,377,931	
Other Funds	$10,108,921	
Program Funds	$0	
SubTotal	$44,870,137	
Other Federal Funds	$36,324,636	
Total	$81,194,773	

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 Department of Pediatrics at Oregon Health and Sciences University (OHSU). The total state funds and other funds expenditures include those 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 include the Newborn Metabolic Screening Program conducted in the Public Health Lab of the Public Health Division. Though this program is not within 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 funds. 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 section of this grant application.

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 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 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 Title V Program Purpose and Design

Oregon's Title V program relies on shared leadership between the Public Health Division's Maternal and Child Section, its 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 (Rosalyn Liu, interim), Title V CYSHCN Assessment and Evaluation Manager (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.

OHA MCAH Program Purpose and Design

Partnership and leadership roles

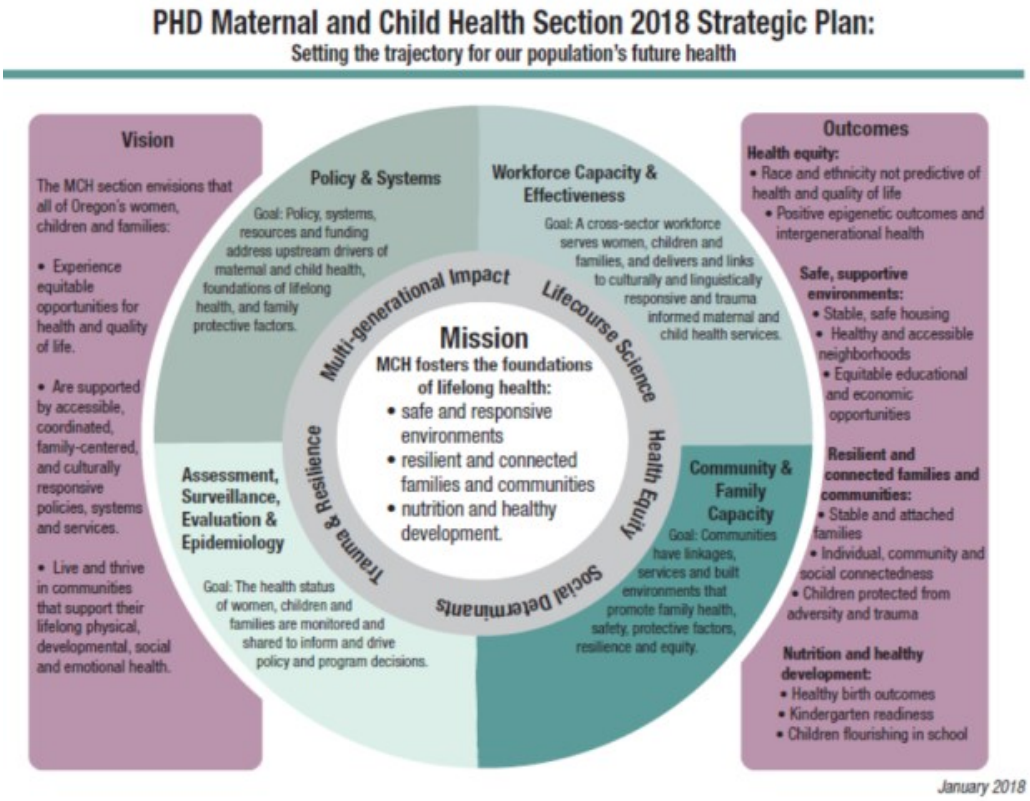
Within the MCAH Title V program, each Title V priority has a designated state lead who oversees state level program and policy work and provides technical assistance and oversight to the local level Title V grantees (public health and tribal) working on that priority (see Supporting Document #5). MCAH 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 coordinator also serves as the MCH Policy Lead, ensuring that system and policy work for Title V and other MCH programs (MIECHV, Early Hearing Detection and Intervention, Oral Health, etc.) are coordinated and integrated.

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, Act Early Advisory Committee, Childhood Obesity CoIIN, Raise UP Oregon Agency Implementation Coordinatin Team, Integrateing Care for Kids Frant Partnership Councils, OHA Health Disparities Advisory Committee, CCO Metrics and Scoring Committee, Oregon Pediatric Improvement Project, March of Dimes Perinatal Collaborative, State Health Improvement Plan committees (adversity and trauma, institutional bias, economic drivers of health and behavioral health), Trauma Informed Oregon Advisory Board, OHA Trauma Informed Policy Committee, Regional Kindergarten Readiness Network, 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.

Program Framework and Strategic Approach

The MCH Section strategic plan, and the Adolescent & School Health strategic plans (Supporting Document #4), 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 include life course science, health equity, social determinants, trauma and resilience, and multi-generational impact. The work is focused in four areas: policy and systems; workforce capacity and effectiveness; assessment, surveillance and epidemiology; and community & family capacity. Each area has a goal and several strategic priorities (see graphic below and Supporting Document #4 for complete plan), and Title V's work is integrated across all of these. The graphic below illustrates this framework.



The MCAH Title V program has adopted a new framework for the 2021-2025 grant cycle, illustrated in the graphic below. This framework reflects the findings of our 2020 Needs Assessment, and the Title V program's commitment to ensure that MCAH Title V work is focused upstream, using the lenses of racial equity, social determinants, and trauma/toxic stress – as well as the multi-generation and life course approaches outlined in the graphic above. The framework below illustrates how the MCAH Title V program is addressing our three state level Title priorities - social determinants of health and equity; trauma, toxic stress, ACEs and resilience; and culturally and linguistically responsive services (CLAS) – jointly as the foundations of maternal, child and adolescent health. This framework recognizes that work on all 3 of these topics is integrally inter-connected. It also reflects the understanding that work on our 4 national priorities (well-woman care, breastfeeding, child injury prevention, and bullying prevention) must also integrate a focus on Foundations work. The framework (see below), and the related set of strategies and activities (see supporting document 5) organize the Title V priority work into four core public health functional areas: policy and systems; workforce capacity and effectiveness; individual, family and community capacity; and assessment and evaluation. The goals of each of these areas are as follows:

- Policy and Systems: Policy, systems, resources and funding address upstream drivers of maternal, child and adolescent health, foundations of lifelong health, and family protective factors.

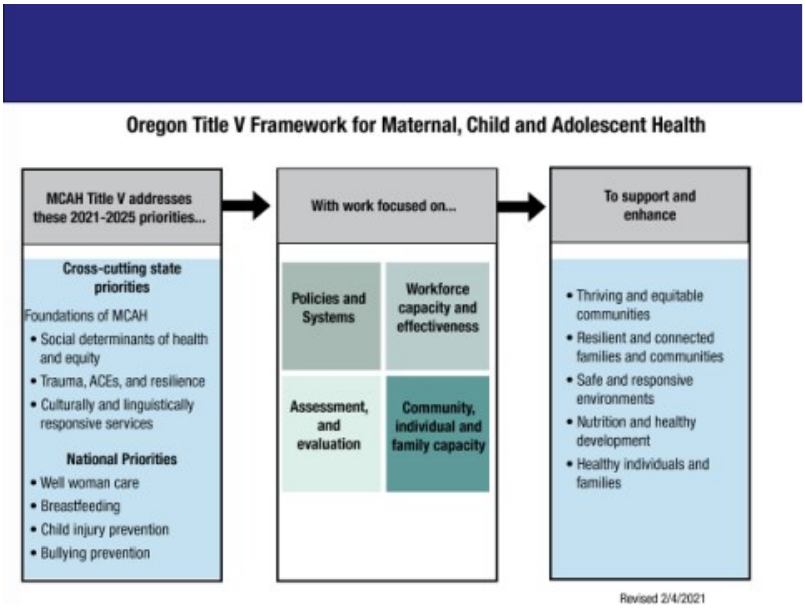
- Workforce Capacity & Effectiveness: Support a cross-sector workforce that serves women, children, youth and families, and delivers and links to culturally and linguistically responsive and trauma informed maternal and child health services.

- Community, Individual & Family Capacity: Communities, individuals and families have access to resources, services and built environments that promote family health, safety, protective factors, resilience, and equity.

- Assessment & Evaluation: Data on social determinants of health, trauma, and equity are monitored and shared to inform and drive policy and program decisions.

Note: Recognizing the inter-connected nature of the upstream" Foundations" work, MCAH strategies and activities

for our 3 state priorities will be merged under “Foundations of MCAH” and organized into the 4 key Foundations areas outlined above in the State Action Plan Narrative (Sections III.E.2.c).



Organizationally, 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 structure has been going through re-structuring and transformation for several years as part of Public Health Modernization. The goal of public health modernization is to ensure equitable capacity and focus on core public health functions across the state. The Title V program is working closely with Public Health Modernization, providing leadership for the MCAH community’s participation in this effort. Given the situation with the Title V pandemic over the past year, and the resulting stresses on local public health capacity, the need for equitable and consistent public health core functions is more apparent than ever. Public Health Modernization legislation passed in June 2019 allocating $25 million to enhance state and local public health modernization efforts. Legislation to allocate additional $45 million in public health modernization funding was approved in the 2021 Legislative Session. Title V strategies and activities are built around the foundational public health capabilities and support this transformation in practice.

OCCYSHN Program Purpose and Design

OCCYSHN’s mission is to improve the health and well-being of Oregon’s children and youth with special health care needs (CYSHCN). Our vision is that all Oregon CYSHCN are supported by a system of care that is family centered, community-based, coordinated, accessible, comprehensive, continuous, and culturally sensitive and responsive. We pursue this vision within the context of Oregon’s health care transformation, and the Title V Block Grant purpose and requirements. We are located within the Institute for Development and Disability at Oregon Health and Science University (Oregon’s only academic medical center), which allows for fruitful collaboration with influential health care providers, researchers, and change-makers.

We strive to ensure that Oregon CYSHCN receive well-coordinated care in patient-centered medical homes; that their care and services be culturally and linguistically appropriate; and that CYSCHN have an effective transition from pediatric to adult health care. In addition, in FY2021 we began work on two new cross-cutting state priority areas: addressing the impacts of social determinants of health and equity on CYSHCN, and promoting trauma-informed care.
OCCYSHN staff are Oregon’s subject matter experts on matters affecting CYSHCN. We inform health care policy,

administration, and practice with our data and evaluation expertise, our long-term experience with community-based care coordination, our relationships with health care providers and families of CYSCHN statewide, and our knowledge about Oregon's health care systems.

OCCYSHN brings a systems-based perspective to pursuing our priorities. We focus on health care systems, and the context in which they operate, as the primary locus of intervention to influence the infrastructure serving CYSCHN and their families. Our leadership role in improving systems of care for CYSHCN requires effective partnerships with the people, programs and institutions that make up those systems. (See Critical Partnerships lists for NPMs 11 and 12.) OCCYSHN convenes and participates in cross-systems, interagency collaborations on behalf of CYSCHN to strengthen systems of care. We are committed to integrating family members of CYSHCN into all efforts to improve the systems that serve them.

OCCYSHN's work is organized into three primary units: Family Involvement; Systems and Workforce Development; and Assessment and Evaluation. The Family Involvement Program ensures that family members of CYSHCN are supported, that their voices are heard, and that they have an active role in designing and implementing policies and programs that affect them. The Systems and Workforce Development unit partners with local public health authorities around the state on programs and projects aimed at coordinating care for CYSHCN, and improving local systems of care. The Assessment and Evaluation unit conducts surveillance, needs assessment, and program evaluation for OCCYSHN. Our programs and projects (see list below, with links for more information) combine the expertise of our work units to address our priorities and advance policy goals.
OCCYSHN's strategies to address national and state priorities were developed using 2015 and 2020 needs assessment results, reported experience of stakeholders about systems serving CYSHCN, and evidence-based/informed resources such as the *Standards for Systems of Care for CYSHCN* (AMCHP & NASHP, 2017; NASHP, 2020). We integrate learnings from technical assistance into our work, and we bring over thirty years of experience working with community and state partners to improve systems of care for Oregon CYSHCN.
OCCYSHN embraces innovative approaches to advancing our priorities. We use on-line platforms to build learning communities, and to engage family members of CYSHCN in care coordination. We are exploring the intersection of legal issues and health care systems as they impact CYSHCN. We recently conducted some of the first studies in the nation on the health care experiences of CYSHCN from families of color. As we implement our block grant strategies, we will continue to fine-tune our efforts and explore new approaches to improving Oregon's health systems infrastructure to improve the health and well-being of CYSHCN and their families.
OCCYSHN PROGRAMS AND PROJECTS

- Advocacy: OCCSYHN participates on committees, workgroups, and collaborations that impact CYSHCN. We also provide data and expertise to inform administrators and policy-makers.
- Assessment and Evaluation collects, assesses, and disseminates data about issues and interventions for Oregon's CYSHCN.
- CaCoon is a home-visiting public health nursing program. Nurses across the state work with families to coordinate care for CYSHCN.
- Community-Based Autism ID Teams use local medical-educational teams to establish a single, valid, and timely evaluations for autism spectrum disorders. Teams determine both educational eligibility for autism services and a medical diagnosis for children up to age five, and refer families to appropriate services.
- Family Involvement is a partnership between families and professionals. The Family Involvement Program empowers families of CYSHCN, and increases opportunities for those families to inform health care practice and policy.
- HERO Kids Registry (launching 2022) will be a voluntary, no-cost registry where families can provide vital information about their child to emergency responders and emergency departments.
- Learning Communities use video conferencing technology to discuss practice situations involving caring for children and youth with special health needs. Participants teach and learn from each other about coordinating care for CYSHCN, and strengthen their local systems of care.
- Policy Project This newly-formed collaboration between OCCYSHN and the Oregon Law Center improves systems of care by addressing legal challenges faced by families of CYSHCN.
- Medical Complexity Project The MCHB-funded Children with Medical Complexity Collaborative Improvement and Innovation Network (CMC CoIIN) improves the quality of life for children with medical complexity, the wellbeing of their families, and the cost-effectiveness of their care, through innovative care and payment models.
- Shared Care Planning is a process for coordinating care across health, education, and community service systems. OCCYSHN contracts with partners around Oregon to implement shared care planning for CYSHCN in their communities.
- Zetosch Funds come to OCCYSHN from the Oregon Community Foundation, to purchase educational equipment for CYSCHN. Implementation requires that OCCYSHN collaborate with health, education, and service providers statewide.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

OHA MCAH Workforce Development

Workforce strengths and capacity

The state-level Title V program funds 16 FTEs spread across 20 positions in the Public Health Division's Maternal and Child Health, and Adolescent and School Health units, as well as 2 FTEs at the 211info to provide the MCH Warmline capacity for Oregon. Currently, none of these positions are vacant.

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. At 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. The COVID-19 pandemic has stressed Oregon's state and local MCH workforce, as it has across the country. Staff have spent the last year filling multiple roles – supporting COVID-19 emergency response, doing their regular work, and filling in for absent or re-deployed co-workers. At the same time, they have re-structured their jobs to work and provide services remotely, while also supporting remote learning for their children, caring for sick family members, and navigating the stress and isolation of COVID-19 restrictions in their communities. The flexibility, dedication, creativity, and perseverance they have demonstrated is truly impressive.

Recruitment and retention

The state level Title V Program's recruitment and retention plan is firmly grounded in our commitment to racial equity and our racial equity policy and hiring guidelines.

- The MCH Section and Title V program is focused on implementing our racial equity policy to ensure recruitment and retention of a diverse and trauma informed workforce. The policy is included in Supporting Document #4.
- The MCH Section has implemented recruitment and hiring practices targeted at increasing equity in hiring and retention. The guidelines are included in Supporting Document #4.
- The MCH Section has an ongoing focus on racial equity work – including a contract with Engage to Change to support the MCH section to integrate anti-racist policy and practices. This work is intended to create an inclusive and supportive workplace that promotes retention of a diverse staff.
- Retention efforts in the past year have also focused on providing staff with remote work set-ups, flexible work schedules, shared work loads, and other mechanisms to enable staff to balance work and home responsibilities through the COVID-19 pandemic.
- In addition, new positions related to COVID-19 response have opened up opportunities for many MCH staff to move up in the agency. This has created gaps, but also prompted creativity and opened opportunities for MCH staff to move up within our Title V program. The Title V Director's flexibility and support has been a key factor in retaining Title V staff through this challenging period.

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, are a central focus of workforce development efforts including: public health modernization, health equity and cultural/linguistic responsiveness, and early childhood/home visiting. Due to COVID-19, support for the transition of both state and local level MCH work to remote work and service delivery has been a huge focus of the past year.

- 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 training opportunities, as well as the Northwest Center for Public Health Practice's training and leadership development opportunities. All of these activities have shifted to being conducted virtually over the past year.
- 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 received support from "Engage to Change" contractors to assess equity-related concerns and needs. All staff now have health equity as part of their workforce development plans, as well as dedicated time in their job descriptions to pursue this professional development. 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. Even with remote learning, Title V was able to support an internship for a student from a local high school throughout the school year.

- 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, Title V staff provided grantees with a series of webinars to introduce the new 5-year Title V priorities and strategies and provide technical assistance to develop local Title V plans. The webinar recordings and supporting materials are available on our website.

- A critical and ongoing consultation/workforce development activity is the training of new MCH supervisors and staff in local health departments around the state. Oreintation for new LPHA staff is conducted regularly by the State Public Health Division, and is supplemented by MCH program-specific training conducted by the MCH Nurse team.

- 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.

Training needs of MCH partners

The Title V program anticipates that training needs of MCH partners in the coming year will include support for implementation of the new Title V Foundations of MCH focus, as well as support for our new priorities of child injury prevention and bullying prevention. However, given the high level of stress and ongoing need for local partners to provide COVID-19 response and vaccinations, we are currently deferring any local training surveys and providing optional trainings until our local partners have more capacity to focus on these future-facing training needs.

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.

- The COVID-19 pandemic has created multiple opportunities for innovations in staffing structure and workforce financing. One example of this innovation is the transition to remote delivery of services such as home visiting. Another innovation relates to the engagement of diverse community partners in the delivery of public health services. The Public Health Division has traditionally funded local public health authorities and tribes for the vast majority of public health work in Oregon. Given the need to partner more closely with communities to address COVID-19 inequities, the Public Health Division expanded funding to nearly 180 community-based organizations across Oregon. It is our hope that this new funding structure will open opportunities beyond COVID-19, including for MCAH Title V to contract with more community-based agencies for MCAH work in their communities.

OCCYSHN workforce development

OCCYSHN staff expertise includes assessment and evaluation, community engagement and development, cultural competency, family engagement, family-professional partnerships, health literacy, health policy, public health nursing, child health, and special education. OCCYSHN has made strides towards diversifying its staff (e.g., age, ethnicity/race, sexual orientation). Continuing our internal work to dismantle racism and white supremacy may help us continue to recruit and retain a diverse staff. OCCYSHN compensation is currently an issue. OHSU is in the process of implementing a new compensation system, on the heels of a two-year salary freeze. Salary stagnation combined with uncertainty about the new compensation system could potentially impact retention.

Currently, OCCYSHN is recruiting a full-time Systems Quality Improvement & Innovation Manager. a new position in the Systems and Workforce Development unit. We developed the position to expand our capacity to influence systems of care for Oregon CYSHCN. We will fill it as soon as possible. The particular combination of skills and experience we seek are uncommon, so it may take some time to find the right candidate. We will also plan to recruit a part-time Assessment & Evaluation Senior Research Associate in FY2021.

OCCYSHN supports professional development for all staff. Annual goals for professional development and annual performance reviews are part of all staff positions. Staff professional development opportunities range from internal support for professional publications to participating in national and OHSU sponsored conferences and trainings. We are focused on educating ourselves about racism and other forms of oppression, so that we can better understand and address the needs of CYSCHN from families of color and other minoritized communities. Our internal Equity Workgroup engages in quarterly training and discussion on equity-related topics, and presents quarterly to OCCSYHN staff.

OCCSYHN provides professional development to public health nurses and other health and service providers, including Community Health Workers (CHWs), through Systems and Workforce Development efforts. These block grant activities include support, training, and technical assistance on cross-systems collaboration and care coordination. (See Strategies 11.1 and 12.1 of the block grant plan). Topics covered in virtual meetings of care coordination teams include engaging professionals and families in shared care planning, using an online care coordination platform, and family-friendly meeting facilitation. In partnership with Oregon State University, OCCYSHN has nearly completed developing an online training curriculum for CHWs. We have not formally assessed the CYSHCN workforce training needs, but the workforce development opportunities we have offered respond to requests from local public health authorities (LPHAs), and to our own observations of training needs. LPHA partners provide feedback in TA sessions, and at listening sessions during OCCYSHN's annual meetings. We also identify training needs by working with counties on cross-systems care coordination activities. High turnover within the LPHA workforce is an ongoing challenge to implementing community-based care coordination.

OCCYSHN's community-based autism identification teams (Strategy S2.2, ACCESS Program) build the capacity of physicians and educators around the state to evaluate children 0-5 for autism spectrum disorders (ASDs) and other developmental issues. Medical providers on ACCESS teams are trained to use a specific screening tool, and to collaborate with educators to evaluate for both medical diagnoses and educational eligibility. OCCYSHN employs an ASD expert to provide technical support and advice to ACCESS medical providers and team members. We also provide monthly cased-based learning sessions using the ECHO model. These ECHO sessions are open to other interested educators and physicians (outside the ACCESS program), to increase knowledge about education-medical ASD evaluations.
OCCYSHN's Children with Medical Complexity (CMC) Collaborative Improvement and Innovation Network (CoIIN) team is implementing a health care transition-focused quality improvement (QI) project with OHSU's General Pediatrics and Adolescent Health Clinic. We identified provider and clinic professional development needs through a root cause analysis, QI learning, and our five-year needs assessment results. To meet these needs, we are developing a 50-minute seminar about supporting the transition from pediatric to adult health care for children with medical complexity. We will pilot the seminar with pediatricians currently working on the CoIIN project. If it is well-received, we will offer it to other General Pediatric clinics later in FY2021. Ultimately, our goal is to develop an educational seminar for use in a range of health system and partner venues. (See Strategy 12.2 of the block grant plan.)

Our needs assessment findings confirmed that families of CYSHCN of color experience racism in health care settings. Given the deleterious effects of racism on health outcomes and well-being, OCCYSHN has worked with our needs assessment partners to disseminate the findings to health, education, and community service providers (see Section III.C.1.a.), with the goal of informing the CYSHCN workforce and improving health care and services for CYSCHN from families of color.

OCCYSHN partners with OHSU's Institute for Development and Disability's Child Development and Rehabilitation Center (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. CDRC offers 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 through direct care efforts. CDRC maintains the care model due in large part due to the support of Title V.

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 our capacity to address workforce 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.

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

OHA 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 family members and 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 was 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. Last year the CoIIN team contracted with StoryCenter to deliver a three-day digital storytelling workshop. This workshop developed Title V staff capacity in digital storytelling, while at the same time guiding six participants through a three-day process to create digital stories reflecting their lived experience with seeking childcare. The stories, along with information about how families can get involved in advocating for childcare policy can be found at: Oregon Infant Care: Parent Voices for Change on the MCH website.

- Since the end of the SDOH CoIIN project, parent storytellers have continued to partner with the Title V program to advocate for improvements in childcare. Two of the storytellers also partnered with the Title V Coordinator to deliver a workshop at AMCHP's 2021 Annual Conference.

- Oregon's 2020 MCAH Title V Needs Assessment had a strong family/community partnership component, including eight 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. Plans were made to engage additional families/communities this year but had to be put on hold due to the COVID-19 pandemic.

- 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. Youth engagement is also a key focus of work on the new Title V priority of bullying prevention.

- 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.

- Since COVID-19, the Public Health Division has greatly expanded the opportunities for under-represented families and communities to have input into all aspects of state Public Health work. A new Community Engagement Unit supports contracts with 179 community-based agencies to provide COVID-related services to their communities. These contracts have greatly improved the relationships with under-represented communities across the state, and the PHD's understanding and ability to support their needs well beyond COVID-19.

OCCYSHN Family Partnership

OCCYSHN ensures family partnership in all Title V CYSHCN activities through a robust Family Involvement Program (FIP). Tamara Bakewell, MA, who is the parent of an adult CYSHCN, manages the FIP. She is integral member of OCCYSHN's leadership team, helping to guide OCCYSHN's strategic planning and implementation. Ms. Bakewell serves on state-level committees and workgroups (see Strategies 11.1 and 12.1 of block grant report). She is also Oregon's Family Delegate to AMCHP.

The FIP Manager regularly invites families of CYSHCN to share their lived experience to inform OCCYSHN efforts. The FIP collaborates with Systems and Workforce Development staff to convene family listening sessions on topics specific to their work. Family quotes and examples are included in workforce training materials, and the FIP Manager represents the family voice at regional meetings, ECHO sessions, and other OCCYSHN activities. She also recruits family members of CYSHCN to review OCCYSHN's block grant application. FIP staff help track policy related to CYSCHN. They inform OCCYSHN's CoIIN quality improvement efforts, and they work on development and implementation of the ACCESS program and the HERO Kids project. (See NPM strategies 11.1 and 12.1, and SPM strategy 2.2.)

The FIP Manager coaches external stakeholders on integrating family input into their work, using the "Planning for Meaningful Family Involvement" tool she developed. This tool, deemed a "cutting edge" practice by AMCHP's Innovation Station in 2019, was revised in 2020 to make it even clearer and easier to use. The FIP Manager recruits family members of CYSHCN to offer legislative testimony on measures with the potential to impact them. She also recruits family members of CYSHCN to serve on external committees and workgroups, and to provide technical assistance to professional stakeholders. She coaches and supports family members on public speaking skills, to better equip them to share their message and influence systems change. Upon request, FIP Parent Partners provide external organizations with family-focused feedback on programs, policies, and written products.

OCCYSHN's FIP houses Oregon's Family to Family Health Information Center (ORF2FHIC). Staff include the FIP Manager, the Bilingual Outreach and Training Specialist, the Parent Partner/Resource Specialist, and three community-based Parent Partners (PPs). PPs support Oregon families to navigate health care financing, partner with providers in health care decision-making, access medical homes, prepare for health care transition, find and use community-based services, and access health screening.

Since its inception in 2011, the ORF2FHIC has served families through one-to-one peer support, group trainings, web-based information and resources, and family-friendly tip sheets, toolkits, and resource guides. PPs model advocacy skills, and help families find the information they need. PPs create content for the ORF2FHIC web and print communications. FIP collaborates with community partners to help them create accurate, up-to-date, plain-language materials for families. Non-English-speaking families of CYSHCN who contact the ORF2FHIC get interpretation services from culturally specific, community-based agencies. The Bilingual Outreach/Training Specialist translates materials into Spanish and disseminates them through Latino community organizations.

Each year ORF2FHIC hosts 12 to 15 informal family listening sessions around the state (or virtually). The gatherings are structured around topics of interest to families. Recent topics include preparing for health emergencies, navigating remote learning, and using telehealth. In these listening sessions, families of CYSHCN share valuable insight into the challenges they face finding and using health care and services. ORF2FHIC presents information gleaned from the listening sessions to OCCYSHN staff, and applies it to both internal and external quality improvement.

The FIP and ORF2FHIC serve Oregon families of CYSHCN. In the process, they provide OCCYSHN with critical first-hand information we can apply to improving systems of care for CYSHCN. OCCYSHN's efforts are informed and enriched by hearing directly from families of CYSCHN about the challenges they face.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

OHA MCAH Epidemiology Workforce

The Maternal and Child Health Section is supported by an Assessment, Evaluation, and Informatics (AE&I) Unit. The AE&I Unit consists of an Assessment, Evaluation, and Informatics Manager, the state MCH Epidemiologist, 8 research analysts, including the Lead Research Analyst who also serves as the Title V Research Analyst, 6 informaticists, and other program staff. The Public Health Division has strong connections with local academic institutions including the public health faculties of Oregon Health & Science University (OHSU), Portland State University and Oregon State University. Many doctoral level staff members at the Public Health Division have appointments at these universities. The Maternal and Child Health Section is currently hosting a CDC/CSTE Applied Epidemiology Fellow and has applied to serve as a host billet site for future fellows.

Currently, Dr. John Putz serves as the Assessment, Evaluation, and Informatics Manager. In this capacity he provides management-level oversight of epidemiological and scientific work. Dr. Putz serves on the Science and Epidemiology Council of the Oregon Health Authority's Public Health Division. He served as the State of Oregon's COVID-19 Operations Chief, Deputy Operations Chief, and Health Intelligence Chief, and Active Surveillance Director during the first six months of the pandemic response. Dr. Putz earned his B.S. (Honors and Cum Laude) in Psychology and Ecology & Evolutionary Biology from The University of Arizona, M.A. in Clinical Psychology from Indiana University, and Ph.D. in Public Health (Health Behavior) from Indiana University. Dr. Putz has significant experience in epidemiological work in non-profit, academic, local government, and state government sectors. He led the Indiana Research and Evaluation Office of Centerstone, the nation's largest provider of non-profit community-based mental healthcare services from 2010-2016. In that capacity Dr. Putz directed the evaluation, research, analytic, and surveillance components of federally funded mental health and infectious disease programs. This work included the establishment of a HCV screening, referral, and education program amongst persons living with serious mental illness (e.g., schizophrenia, bipolar mood disorder) and co-morbid addiction issues. Dr. Putz served as the national chair of Centerstone's clinical research advisory board and led the agency's national clinical research program (serving as Principal Investigator on government and industry funded clinical trials). Following his work at Centerstone, Dr. Putz served as Clinical Research Manager (2016-2018) at the Indianapolis city-county public hospital/primary care system (Eskenazi Health). In this role Dr. Putz chaired the agency's research committee and served as Research Integrity Officer for the agency.

Dr. Suzanne Zane currently serves as Oregon's State MCH Epidemiologist. Dr. Zane has been an epidemiologist with the Centers for Disease Control and Prevention since 1997, beginning with training in CDC's Epidemic Intelligence Service from 1997-1999 with the Division of Global Migration and Quarantine. She has been a scientist in the Division of Reproductive Health since that time, first as a maternal health epidemiologist, and for the past decade as a senior MCH epidemiologist assigned to non-CDC agencies to build epidemiologic capacity (2 years at the Northwest Tribal Epidemiology Center, serving the Federally-recognized Tribes of Oregon, Washington and Idaho, and 8 years at the Oregon Health Authority). She provides epidemiologic and scientific planning and oversight for Oregon Public Health Division's Maternal and Child Health Section surveillance and research analyses, which also include all oral health activities, and has a key scientific role in the Oregon PRAMS and Early Childhood Health in Oregon (ECHO) surveys and the Birth Anomalies Surveillance System, provides epidemiologic consultation to other state public health programs, and is the clinical epidemiologic interface between the MCH Section and external partners such as the pediatric cardiology department at Oregon Health and Science University and Oregon Child Protective Services/Child Welfare. Dr. Zane earned her MPH from the University of South Florida and her Doctorate in Veterinary Medicine from Cornell University.

The Lead Research Analyst for the Oregon Maternal and Child Health Section also fulfills the role of Title V Research Analyst for the state. This position is currently filled by Maria Ness. Prior to this position, she served as the Program Evaluation and Surveillance Manager at the Philadelphia Department of Public Health, Division of Maternal, Child and Family Health. Ms. Ness is a graduate of the two year CDC/CSTE Applied Epidemiology Fellowship, which she completed at the Oregon Health Authority's Maternal and Child Health Section. Ms. Ness holds a Master of Public Health in Epidemiology and Biostatistics from the University of Sydney. Ms. Ness is a prior recipient of the Robert Wood Johnson Foundation National Award for Outstanding Epidemiology Practice in Addressing Racial and Ethnic Disparities. In her role as Lead Research Analyst, Ms. Ness sits on multiple state level advisory boards, such as the Behavioral Risk Factor Surveillance System Advisory Committee, and the Student Health Survey Advisory Committee. Ms. Ness also provides epidemiologic consultation for the Policy Team within the Maternal and Child

Health Section.

OCCYSHN Epidemiology Workforce

OCCYSHN's Assessment & Evaluation (A&E) team is responsible for designing and executing studies that track the needs of Oregon CYSHCN and their families and meet the data and analysis needs of OCCYSHN staff. Currently four staff compose the A&E team:

- Alison Martin, PhD, MA, Manager. Dr. Martin began working with OCCYSHN in April 2014. Title V CYSHCN and CMC CoIIN funding support her at 0.90 FTE. (The University Center for Excellence in Development Disabilities and the Oregon Health & Science University – Portland State University School of Public Health each support her at 0.05 FTE.)

- Sheryl Gallarde-Kim, MSc, Research Associate. Ms. Gallarde-Kim began working with OCCYSHN in December 2012. Title V CYSHCN and CMC CoIIN funding support her at 1.0 FTE.

- Shreya Roy, PhD, Research Associate. Dr. Roy began working with OCCYSHN in May 2019. Title V CYSHCN and CMC CoIIN funding support her at 1.0 FTE.

- Raúl Vega-Juárez, Research Assistant 2 (1.0 FTE). Mr. Vega began working with OCCYSHN in January 2020. Title V CYSHCN and CMC CoIIN funding support him at 1.0 FTE.

Dr. Martin developed Dr. Roy and Mr. Vega's positions to expand OCCYSHN's assessment and evaluation capacity. In addition to serving as the Project Coordinator for OCCYSHN's CMC CoIIN project, Dr. Roy brought needed experience with advanced statistical analyses and journal manuscript preparation. Mr. Vega brought much needed support by collecting survey data and conducting literature searches. We have capitalized on the experience and skill sets of each staff member, while also creating additional space to develop new and existing skills and knowledge. One example of how A&E's additional capacity benefitted OCCYSHN in FY2021 centers on OCCYSHN's dissemination efforts. We had enough staff to prepare and present needs assessment results, and to develop briefs that summarize key needs assessment findings, while also working on manuscripts for CMC CoIIN work. We are recruiting a 0.50 FTE Senior Research Associate to oversee key evaluation activities associated with our home visiting and shared care planning strategies, among other responsibilities.

Limited data exist to describe Oregon CYSHCN and their families. OCCYSHN routinely uses the Child and Adolescent Health Measurement Initiative's Data Resource Center prepared data tables. When our research questions demand more complex analyses, we conduct them. We also use state-specific secondary data to describe subpopulations of CYSHCN. For example, we had financial resources to support a collaboration with Neal Wallace, PhD, to apply the Pediatric Medical Complexity Algorithm (Simon et al., 2014) to All Payers All Claims 2010-2014 data. These analyses allowed us to describe the percentage of Oregon children ages 21 years and younger with complex chronic disease, with their health care costs and utilization. We compared costs and utilization for those served in Oregon's patient-centered medical homes (PCMH) with those not served in a PCMH. (See Strategy 11.8 in block grant report and Support Document 1.) Our needs assessment report also uses results from Oregon National Core Indicators and Oregon Healthy Teens surveys. (See OCCYSHN's 2020 needs assessment, chapter 2.)

OCCYSHN conducts quantitative and qualitative primary data collections when additional data are needed. Examples of the former are the family and youth surveys for our 2015 needs assessment. Examples of the latter are the participatory needs assessment studies we conducted with the Latino Community Association and the Sickle Cell Anemia Foundation of Oregon. (See 2020 needs assessment chapters 3 and 4.) Our assessment and evaluation team is building expertise in conducting participatory research.

A&E also evaluates block grant activities. The staff has the expertise, knowledge, and skillsets needed to determine appropriate evaluation approaches; develop program evaluation plans and logic models; develop and implement data collection methods and procedures; develop and implement quantitative and qualitative analytic plans; and disseminate findings. Additionally, the A&E unit monitors program implementation. For example, every month they compute descriptive statistics on data describing the implementation of OCCYSHN's shared care planning strategy. These results allow the Systems & Workforce Development unit to monitor LPHA progress on shared care planning

requirements. In all of its work, OCCYSHN's A&E unit collaborates with OCCYSHN Systems & Workforce Development unit and Family Involvement Program. The A&E unit responds to program needs for data and analysis that advance OCCYSHN's ability to serve CYSCHN.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The Oregon State Systems Development Initiative (SSDI) program develops, enhances, and expands Oregon's Title V Maternal and Child Health (MCH) data capacity for the Title V Needs Assessment and performance measure reporting in the Title V MCH 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 MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation and evaluation. (2) Advance the development and utilization of linked information systems between key MCH 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 MCH Block Grant program.

Oregon's SSDI program has historically supported efforts to obtain access, and make available, the minimum and core data sets. As a result of these efforts, all of the 24 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 when working with internal partners' datasets such as Immunizations, Vital Statistics, Hospital Discharge, and Medicaid datasets.

Over the course of 2020, the SSDI program faced many challenges with staffing and partner capacity due to the COVID-19 response effort. Many project tasks had to either be put on pause during the year or work was shifted to focus more primarily on supportive efforts and pre-work that could be done without significant partner engagement. However, in late 2020 and the first quarter of 2021, the SSDI team was able to pivot back as some program teams began to see a return in capacity. One such key project was further enhancements to Oregon's Title V local plan and reporting database. This system, created and managed by the SSDI team, has been continuously enhanced to improve local reporting efforts to the state Title V program team. These reports are a critical component for the Title V program assessment, monitoring, and reporting efforts for the State Action Plan and assists the Title V program team members supporting local program implementation of Title V work. In early 2021, the Title V team introduced the revisions to the state and national priority areas and related strategies needed for FY2022 local plans. Additionally, the team received feedback from local programs that suggested activities related to each strategy would be very helpful for local programming.

The Title V team worked with local programs to develop the suggested content and wanted to enhance the structure of the reporting tool to contain those suggested program activities and directly align those suggested activities with appropriate measures which users could choose from. These enhancements would create continuity of structured data collection from the priority area which a local program chose to engage in, all the way through the strategy, activities, and measures that are reported on. The effort involved restructuring components of the data collection and tightening up those relationships between the data, and creating newly redesigned user interface components, thereby enhancing end-user ease of use, further improving the quality of reported data, and improving the Title V program's ability to analyze and leverage the data in local county and tribal support and Title V grant reporting. This effort also required the system to maintain a local program's ability to define their own strategies, activities, and measures throughout, thereby maintaining flexibility for local programs where needed. Historic data and reporting methods likewise needed to be maintained, so efforts were made to adjust the system in a way that made this a seamless transition for users. This work was completed in March in time for local health departments and tribes to complete submitting their FY2022 plans under this new structure on time. Subsequent projects are planned for later this year to support system updates for local reporting under their FY2021 plans, and for supporting planning and database migration work for public health home visiting programs which are a key component for MCH programming and reporting.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

OHA MCAH Other data capacity efforts

- Data enhancement activities:
  In 2020, the Oregon legislature passed a law that requires health care providers, including state programs, to collect race, ethnicity, language, and disability at a specific level of specificity, to allow for disaggregation of marginalized, underserved, or at risk communities. The guidelines for how to collect this data are known as REAL-D guidelines. The Maternal and Child Section has been implementing REAL-D guidelines into its programs and data collection in a stepwise fashion, with high priority surveys being transitioned first.

- National and state surveys and monitoring systems:
  The Maternal and Child Health Section has direct or indirect access to many surveys and surveillance systems. Systems that are coordinated directly by the section include the Pregnancy Risk Assessment Monitoring System (PRAMS), and its three year follow back survey, ECHO, the SMILE survey and Healthy Growth Survey, and the Birth Anomalies Surveillance System. The section also produces an annual Oral Health Surveillance System report. Staff from the Maternal and Child Health Section are involved in other state and national surveillance as members of advisory boards for the Behavioral Risk Factor Surveillance System and the Student Health Survey. Oregon is also contributing to a statewide race/ethnicity oversample for the National Survey of Children's Health.

- Availability/accessibility of state and local MCH data information systems:
  The Maternal and Child Health Section works in partnership with other departments to access state and local MCH data such as vital statistics, hospitalization data, Medicaid data, and WIC data. The Section also has its own programmatic home visiting data collection systems and collects data on Early Hearing Detection and Intervention.

- Collection and tracking of real time data:
  The Maternal and Child Health Section collects real time data on its home visiting and other programs, and is able to access this data through centralized databases hosted by the section. Home visiting programs include Babies First, CaCoon, Nurse Family Partnership, and MIECHV home visiting.

- Creation of data review boards:
  In the 2018 legislative session, Oregon passed House Bill 4133 which gave direction to the Oregon Health Authority to form the Maternal Mortality and Morbidity Review Committee. The committee conducts studies and reviews of incidents of maternal mortality and severe maternal morbidity in Oregon, examines whether social determinants of health are contributing factors to the incidence of maternal mortality and severe maternal morbidity, and shares findings and information with health care providers and facilities, social service providers, law enforcement, and many others. Members are appointed by the Governor and include a family medicine physician, an OB/GYN physician, a maternal fetal medicine physician, licensed registered labor and delivery nurses, licensed direct entry midwives, doulas, traditional health workers, community-based organization representatives, a medical examiner, and a maternal and child health subject matter expert from the Oregon Health Authority.

- Provision and sharing of data with other state and local partners:
  The Maternal and Child Health Section produces an annual report which summarizes the Adverse Childhood Experiences data from the Behavioral Risk Factor Surveillance System. The section produced a set of data tools in conjunction with the five year Title V needs assessment which was shared with partners. There is a formal process in place which is used by the section for sharing data reports with academic and community agency partners. The Maternal and Child Health section often delivers presentations of data to partners such as early childhood division partners, other sections within the Public Health Division, and legislators. The section is currently engaged in a partnership with the Injury and Violence Prevention Program to develop a shared risk and protective factor framework for prevention of injury, including child injury and adverse childhood experiences, which are both currently selected Title V priorities.

- Advances in information technology that facilitate automated data analyses and reporting
  The data collection for home visiting services is currently being revised and a new system is being developed, which will facilitate automated data analyses and reporting. The new data platform is known as THEO, and will be used for home visiting programs including Babies First and CaCoon, which are both partially funded by Title V, in addition to MIECHV home visiting programs.

OCCYSHN Other data capacity efforts

OCCYSHN provides block grant funding annually to OHA PHD to support collecting and cleaning home visiting data entered by LPHA public health nurses. We collaborate with MCH to obtain CaCoon data extracts on a triannual basis. The Assessment and Evaluation (A&E) unit computes descriptive statistics that include the number of CaCoon clients served, number of visits, race/ethnicity of the clients, and their insurance type. The A&E unit shares these results with the Systems and Workforce Development (S&W) unit to support program monitoring and improvement. OCCYSHN has contributed expertise to the design and development of a new data system (THEO) that will eventually replace the current data system (ORCHIDS).

As described in Strategy 11.6 of the block grant report, OCCYSHN's A&E Manager is collaborating with OHA's MCH epidemiologist, Dr. Suzanne Zane, on work with state partners to purchase an oversample of non-dominant ethnic/racial households for the National Survey of Children's Health (NSCH). OCCYSHN A&E continues to maintain data systems for monitoring and evaluating LPHA implementation of shared care planning activities (report sections 11.4 and 12.2). We also support the Oregon Family-to-Family Health Information Center by collecting and analyzing data, and helping them document the results to meet their annual reporting requirements.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

OHA MCAH Emergency Planning and Preparedness

Consistent with the goals and aims of the Title V block grant program, Oregon MCH is proactive in its emergency preparedness and response planning. Oregon MCH has been and continues to be involved in the ongoing State of Oregon COVID-19 pandemic response, was a critical component of the State's public health response to the 2015-2016 Zika virus epidemic, and is planning for involvement in the upcoming Pacific Northwest wildfire season as needed.

Oregon MCH contributes to the State of Oregon's emergency preparedness and response function through 1) training of staff in Federal Emergency Management Agency (FEMA) Incident Command System courses, 2) encouraging MCH staff to serve on the Oregon Health Authority Incident Management Team, 3) incorporating preparedness training and topics into staff professional development activities, 4) providing staff to serve on longer-term professional development opportunities ("job rotations") with the State of Oregon's newly created COVID-19 Response and Recovery Unit, 5) maintaining critical state data systems for the surveillance and response to public health emergencies, and 6) sharing appropriate guidance from MCHB to local grantees around allowable use of Title V funds to support emergency preparedness and response activities.

The State of Oregon has a written EOP which is realized at the agency level through the Oregon Health Authority's Health Security, Preparedness, and Response (HSPR) program and related Public Health Continuity of Operations plans. The HSPR program is funded by the U.S. Department of Health and Human Services through the U.S. Centers for Disease Control and Prevention (CDC) Cooperative Agreement and the Hospital Preparedness Program (HPP). HSPR ensures that Oregon's communities and hospitals have an improving level of preparedness for health and medical emergencies by supporting the development and testing of plans, providing training, managing volunteers and encouraging collaboration. These plans are reviewed on an ongoing basis and are adapted and improved upon following major Incident Management Team activation events.

The State of Oregon's EOP specifically considers the needs of the MCH population, which includes at-risk and medically vulnerable women, infants, and children. Inclusion of MCH staff on Incident Management Team activations, assignment of physician/epidemiologist resources specific to MCH populations for response activities, and partnership with local health authorities and community-based organizations that serve the MCH population helps the State to realize this goal.

Title V program staff are involved and consulted in the planning and development of the State's EOP through their ongoing participation in HSPR-led emergency preparedness and response activities. This occurs before, during, and after an Incident Management Team activation, disaster, or other emergency.

Title V leadership is part of the Incident Management Structure (IMS). Within the framework of the COVID-19 response Title V leadership and staff served in positions including Operations Chief, Deputy Operations Chief, Health Intelligence Chief, Branch Director, Unit Leader, Group Supervisor, and technical staff assignments (e.g., epidemiologist, nurse consultant, informatics specialist, contact tracer, case investigator, community liaison).

Based on ongoing Title V program needs assessment efforts and lessons learned from previous emergency responses, several critical gaps in emergency preparedness and/or surveillance data were identified that could impact the state's ability to adequately assess and respond to MCH population and program needs in a future disaster or public health emergency. These include 1) a need for MCH staff with dedicated FTE for emergency preparedness and response activities, 2) improved Continuity of Operations planning for MCH surveillance and survey programs (e.g., CDC-funded Pregnancy Risk Assessment Monitoring System), 3) readily deployable guidance to staff at the local level for their MCH related work in an emergency, and 4) planning for backfilling staff deployed for emergency response duties.

The Title V program has participated in the development of emergency preparedness and response training, communication plans and tools/strategies to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population. MCH staff are involved in all levels of these activities and continues to participate in them via the ongoing State of Oregon COVID-19 response.

The Title V program has participated in the development of coordination plans with public health programs (e.g., newborn metabolic screening, newborn hearing screening, immunization, home visiting, WIC, shelters and other MCH programs), to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population. Each program funded by Title V has adapted to the operational challenges posed by the ongoing COVID-19 response, including revisions to operational guidance at the

local level and support for ongoing data collection and surveillance activities at the state level.

OCCYSHN Emergency Planning and Preparedness

OCCYSHN is aware of gaps in emergency preparedness for families of Oregon CSYCHN, and we are working with local public health authorities to improve their capacity to address disasters (Strategy S2.3). The health, education, and financial well-being of CYSHCN and their families were impacted by the COVID-19 pandemic. During the pandemic, many CYSHCN did not have access to the allied health therapies that are typically offered in a school setting. Additionally, in the summer and fall of 2020, many Oregon families with CYSHCN were forced to evacuate their homes due to wildfires. Some families with CYSHCN had inadequate emergency transportation and shelter options, and many, including CYSHCN, faced health impacts from smoke inhalation. Fires are an ongoing reality in Oregon, as is the risk of earthquake. OCCYSHN has valuable expertise about CYSHCN to contribute to emergency planning.

At the onset of the COVID-19 pandemic, the Oregon Family to Family Health Information Center (ORF2FHIC), was contacted by FEMA Region 10 and Multnomah County with a request for information about the needs of families of CYSHCN. ORF2FHIC solicited, and submitted, input from family members of CYSHCN. Families expressed challenges accessing in-home care, medical food and supplies, and behavioral and mental health care. They expressed concern about oxygen supplies, hospital policies on treating people with disabilities, and the use of telehealth.

To further represent the needs of CYSHCN in the pandemic, ORF2FHIC's Resource Specialist served on the state's face mask task force to inform policy-makers on guidance for citizens who experience disability. ORF2FHIC also supported families of CYSHCN and collaborated with state and federal planners by disseminating COVID-19 safety precaution messages from the governor's office, and by sharing FEMA's informational updates via list-serve and social media.

To build capacity for families of CYSHCN to prepare for emergencies, ORF2FHIC's Parent Partners receive worked with experienced parents of CYSHCN to discuss disaster preparedness. We disseminated emergency planning for CYSHCN posters at the 2019 Safe and Secure Symposium, and at two Portland pediatric clinics. We collaborated with the Oregon Office on Disability and Health to distribute "Ready Now" toolkits for families throughout Oregon from 2013 – 2019.

OCCYSHN is ready and willing to inform disaster preparedness efforts about the particular needs of CYSHCN. OCCYSHN's Family Involvement Program recruited two parents of CYSHCN to serve on the state's Occupational Health, Safety and Emergency Services' Disability Advisory Council. Both parents have children with significant disabilities, and one is an immigrant to the U.S., who speaks English as second language. They offered insight to the council on specific challenges posed by evacuating and reunifying children who are unable to follow instructions, or who depend on technology to communicate.

OCCYSHN will continue strengthening systems of care by gathering and disseminating insights from family members of CYSHCN. We will hold at least one 2021 family listening session to discuss disaster preparedness. We will continue to seek opportunities to collaborate on Oregon's Emergency Operations Plan. OCCYSHN contributed to a toolkit for emergency preparation for people with disabilities and other vulnerable populations. The Family Involvement Program (FIP) Manager serves on the Emergency Medical Systems for Children Advisory Council, where she keeps abreast of the potential for pediatric hospitals to respond to a surge. The FIP will continue to serve as a resource to both state and federal emergency management programs.

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

III.E.2.b.v.a. Public and Private Partnerships

OHA MCAH public and private partnerships

Oregon's Title V program is strongly committed to collaborating with a wide range of partner agencies to expand the capacity and reach of the state Title V MCAH 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 MCAH population.

The public and private partnerships table in Supporting Document 3 provides a detailed description of key collaborations and partnerships for the MCAH Title V program listed below.

- **Other MCHB investments**: State Systems Development Initiative (SSDI), Maternal, Infant and Early Childhood Home Visiting (MIECHV); Intimate Partner Violence CoIIN, Children's Healthy Weight CoIIN, Healthy Start Grants

- **Other Federal Investments**: Nutrition Program for Women, infants and Children (WIC), Early Hearing Detection and Intervention Program (EHDI), Birth Anomalies Surveillance System (BASS), Rape Prevention Education, PREP Teen sexual health grant, Pregnancy Risk Assessment Monitoring System (PRAMS), CDC Immunizations, Preschool Development Grant

- **Other HRSA Programs**: FQHCs

- **State and local MCH programs**: Universally Offered Home Visiting, Maternal Mortality and Morbidity Review Committee (MMMR), Local Public Health MCH Programs, Conference of Local Health Officials (CLHO)

- **Other Oregon Health Authority programs**: Adolescent and School Health Programs, Injury and Violence Prevention Program, Tobacco Prevention and Education Program, Chronic Disease Prevention, HIV/STD, Newborn Metabolic Screening Program, Medicaid and CHIP, Healthy Systems Policy & Analytics, State Public Health Director's Office, Office of Equity and Inclusion

- **Other governmental agencies:** OR Department of Human Services, OR Department of Education, OR Department of Justice, Early Learning Division, OR Housing and Community Services

- **Tribes, Tribal organizations and Urban Indian Organizations**: Oregon Tribes, Northwest Portland Area Indian Health Board, Native American Youth and Family Center

- **Public health and professional educational programs and Universities:** see table in supporting document 3 for details

- **Health systems:** see table in supporting document 3 for details

- **Community and non-profit organizations** see table in supporting document 3 for details

- **Advisory boards and inter-agency work groups:** see table in supporting document 3 for details

Among the many partnership initiatives with which Title V MCAH is engaged, a few highlights from the past year are outlined below:

- MCAH Title V's transition to a more upstream focus on the "Foundations of MCAH" (social determinants of health and equity, trauma, toxic stress, ACEs and resilience; and culturally and linguistically responsive services), has aligned with opportunities to develop shared initiatives with both the State Health Improvement Plan (Healthier Together Oregon), and a cross-Center initiative focused on shared risk and protective factors (SRPF). The SRPF work is bringing together the state offices of Injury and Violence Prevention, Maternal and Child Health, Adolescent and School Health, and Chronic Disease Prevention to develop a shared strategic approach to violence prevention as well as improved lifelong health.

- Oregon's Title V staff supported a major Public Health Division expansion in partnerships with community-based agencies. In response to the COVID-19 pandemic, partnerships and contracts have been developed with over 170 community-based agencies to fund outreach, education, and support related to COVID-19. These agencies serve diverse and often marginalized communities throughout Oregon and bring culturally relevant services and funding to families and communities most in need.

OCCYSHN public and private partnerships

OCCYSHN collaborates with state and community-based agencies and organizations, health care and service providers, and family members of CYSHCN to improve the systems of care serving Oregon CYSHCN and their families:

- OCCYSHN's Family Involvement Program identifies and mentors family members of CYSHCN to provide their perspective to program and policy efforts, both within OCCYSHN and at regional and statewide levels. For example, we recruited family members of CYSCHN to provide feedback on an Oregon Health Plan outreach campaign, and recruited families to serve on Multnomah County's Health Security, Preparedness and Response Program advisory team.

- OCCYSHN partners with local public health authorities, education service districts, and health and service providers statewide to implement community-based programs. Additionally, ECHO-based virtual learning communities implemented by OCCYSHN provides a platform for health and service providers across the state to collaborate on improving care coordination for CYSHCN.

- OCCYSHN collaborates with OHA to strengthen the public health nursing home visiting workforce, increase alignment of CaCoon with OHA's Babies First! program, and develop the THEO home visiting data system.

- OCCYSHN partners with OHA and Oregon Pediatric Improvement Partnership, participating on the Integrated Care for Kids (InCK) steering and regional advisory committees. We provide advice and input based on our long-term and wide-ranging experience implementing cross-systems care coordination for CYSHCN.

- OCCYSHN leads Oregon's participation in an MCHB-funded Collaborative Improvement and Innovation Network (CoIIN) (2017-2021). Oregon's project addresses the transition from pediatric to adult health care for young adults with medical complexity. We collaborate with OHSU's Doernbecher Children's Hospital General Pediatrics and Adolescent Health clinic to develop and implement a quality improvement project. We are in the early phases of partnering with a private, metro-area pediatric practice collaborative to pilot our approach in a different setting. This collaborative, the Children's Health Alliance, has helped identify other private pediatric practices with which to collaborate.

- In an effort to better serve CYSCHN from diverse cultural and ethnic backgrounds, OCCYSHN collaborates with the Sickle Cell Anemia Foundation of Oregon, the Latino Community Association of Central Oregon, and the Portland-based African Youth Community Organization.

- OCCYSHN is leading a collaboration between Oregon Health Authority's Emergency Medical Services for Children program (EMSC), Oregon Portable Orders for Life-Sustaining Treatment (POLST) Registry, and Beyond Lucid Technologies LLC to develop a ground-breaking emergency information registry for CYSHCN. This innovative on-line platform allows families to record critical details about their child's health that can be available to medical providers responding to CYSHCN in emergency situations.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

The Title V MCH - Title XIX Medicaid Inter-Agency Agreement provides a framework for coordination between the two programs on issues related to the MCH population. Oregon's current Title V-Medicaid IAA was developed in 2017, and a five-year agreement was signed in April 2018. As part of the IAA, quarterly meetings were established as the mechanism by which the designated agency liaisons will monitor implementation of the MOU and update its provisions as needed. The MOU states that the agencies will "meet on a quarterly basis to share information, discuss and resolve current issues, and promote coordinated long-range planning" (p 12). Membership in the MOU quarterly meetings initially included designated liaisons from the 3 signing agencies: Title V MCAH, OCCYSHN, and Medicaid. Since implementation that group has expanded to include representatives from OHA Health Policy and Analytics, OHA Health Systems Transformation Center, and OHA Health Systems Behavioral Health, and OHA COVID-19 Response and Recovery Unit.

Purpose of Oregon's IAA is to enable Oregon's Medicaid, Title V MCAH, and Title V CYSHCN programs to carry out the mandate of cooperation contained in the related provisions of the federal statutes and regulations and achieve their shared goal of improving the health of women, children, adolescents, children and youth with special health care needs, and families in Oregon. Specific purposes are to:

- Develop and implement initiatives that address the underlying causes of preventable diseases;
- Increase coordination/collaboration between the Title V Program and Medicaid;
- Support a system of care across various agencies providing services for the maternal, child, adolescent, and children/youth with special health care needs populations;
- Formalize the responsibilities of each agency;
- Hold agencies accountable for their roles and responsibilities;
- Ensure policy continuity over time;
- Provide methods for communication and information exchange; and
- Meet the requirements of both Title V and Title XIX.

Objectives span 4 broad areas as follows:

- Programmatic, policy and relationship building
- Assessment, evaluation and data sharing
- Identification, outreach, and referral of population
- Reimbursement and finance

Outcomes of the Title V – Medicaid IAA partnership include:

- Coordination on shared legislative agendas and bill analyses.

- Quarterly coordination meetings at which policy and systems issues impacting our shared populations are discussed and addressed. Our Title V – Medicaid IAA partnership has met regularly – and more frequently than quarterly – during FY2021. In addition to regular discussion of policy and systems issues affecting our shared populations, and coordination on shared legislative agendas and bill analyses, our partnership achieved the following outcomes during FY2021:

    - Review and discussion of policy and systems issues related to Oregon's EPSDT program – including inconsistency of access to culturally appropriate treatment for a range of identified diagnoses.

    - Development and implementation of cross-agency shared projects to improve the health of the MCH population. This year's focus is on accessible and culturally/linguistically appropriate child and family behavioral health for communities of color.

    - Advocating for adoption of the 1-year postpartum Medicaid eligibility through state plan amendment that was made possible through President Biden's American Rescue Plan (ARPA). (Oregon is moving forward with this State Plan Amendment)

    - Contributing to the development of Oregon's 2021 1115 Medicaid Waiver. The Waiver forms the foundation for Oregon's Medicaid program, and the new 5-year waiver will further Oregon's ability to address equity and social determinants of health for Oregon families. The IAA group has been

engaged in the development of waiver concepts and concept papers, which will all have a focus on children and families. Throughout the coming year the IAA group will continue to contribute to the development and refinement of the Waiver to ensure that the needs of Oregon's MCAH and CYSHCN populations remain front and center.

- Developing a collaboration between OCCYSHN and the Health Evidence Review Committee (HERC) leadership to re-evaluate pediatric specific issues to ensure that children receive the care and services to which they are entitled. This issue surfaced during a quarterly review committee meeting discussion about part of the 1115 that waives EPSDT requirements and established the Health Evidence Review Committee (HERC). The purpose of the HERC is to develop a prioritized list of diagnosis/therapy pairs to be covered by the Oregon Health Plan, and establish a line on that list, below which would not be covered. The CYSHCN director, as a practicing pediatrician, raised concern that a number of diagnoses that fall below the coverage line uniquely impact children and not adults.

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

State Action Plan Introduction

This year's State Action Plan Narrative reflects the transition from reporting the last year of activity on the 2016-2020 Block Grant cycle, to the implementation of the new five-year priorities for the 2021-2025 Block Grant cycle.

- For national priority areas which Oregon is discontinuing in the 2021-25 cycle this will be the final year of reporting, and there will be no Application Year Plan. These include: child physical activity, adolescent well visit, smoking and oral health.

- For national priority areas which are new for Oregon in the 2021-25, there are Application Year Plans but no reports. These include child injury prevention and bullying prevention.

- For national priority areas which span both 5-year cycles, both plans and reports are provided. These include well woman care, breastfeeding, medical home and transition to adult healthcare for CYSHCN.

- The Cross-cutting domain, which addresses Oregon's state priority areas and performance measures reflects the transition of priorities across the cycles – as well as a change in how Oregon's Title V MCAH program is approaching its cross-cutting state-specific priorities.

    - A report is provided for each of the 2016-20 state performance measures: Toxic stress, trauma, ACES and resilience; Food insecurity, and Culturally and linguistically responsive services (CLAS).

    - For 2021-2025, the Toxic stress, trauma, ACES and resilience; and Culturally and linguistically responsive services are being continued. Food insecurity has been replaced by the more upstream and inclusive priority of social determinants of health and equity (SDOH-E).

        - OCCYSHN will continue to work on CLAS and has added work for SDOH-E and Toxic stress. OCCYSHN plans are included in the cross-cutting domain plan.
        - Title V MCAH has developed an integrated approach to the 3 new state-specific priorities: toxic stress/trauma/ACES/resilience, CLAS and SDOH-E. Recognizing the interwoven nature of work on these 3 upstream priorities, the Title V MCAH program is approaching them as an integrated "Foundations of MCAH" priority. Work on the Foundations of MCAH, including strategies and activities at the state and local level are divided into 4 areas: policy & systems; workforce capacity & effectiveness; community, individual & family capacity; and assessment & evaluation.

    - Other Title V efforts and investments which cut across priorities and domains and are described at the end of the cross-cutting section.

The graphic in Supporting document 4 illustrates the new Title V MCAH approach. The same supporting Document provides a summary of the local level strategies for each domain, as well as a table and map showing which local public health department and tribal grantees have selected to work on each priority.

The table below gives a brief overview of which priority topics have reports and plans in each domain.

Domain	Priority topic	Report (FY2020, 0ct 2019-Sept 2020)	Plan (FY2022, 0ct 2021-Sept 2022)
Women's and Maternal Health (reports)	Well woman care	X	
	Smoking	X	
	Oral Health	X	
Women's and Maternal Health (plan)	Well woman care		X
Perinatal and Infant Health (report)	Breastfeeding	X	
Perinatal and Infant Health (plan)	Breastfeeding		X
Child Health (reports)	Child physical activity	X	
	Smoking	X	
	Oral Health	X	
Child Health (plan)	Child injury prevention		X
Adolescent Health (report)	Adolescent well visit	X	
Adolescent Health (Plan)	Bullying prevention		X
CYSHCN Report		x	
CYSHCN Plan			x
Cross-cutting/Systems building (reports)	Toxic stress/ACEs	X	
	Food Insecurity	X	
	CLAS	X	
	OCCYSHN CLAS	X	
Cross-cutting/Systems building (plans)	Foundations: policy & systems		X
	Foundations: workforce capacity & effectiveness		X
	Foundations: community, individual and family capacity		X
	Foundations: assessment and evaluation		X
	OCCYSHN Trauma/ACES		X
	OCCYSHN CLAS		X
	OCCYSHN SDOH-E		X
	Other program activities		X

Women/Maternal Health

Linked National Outcome Measures

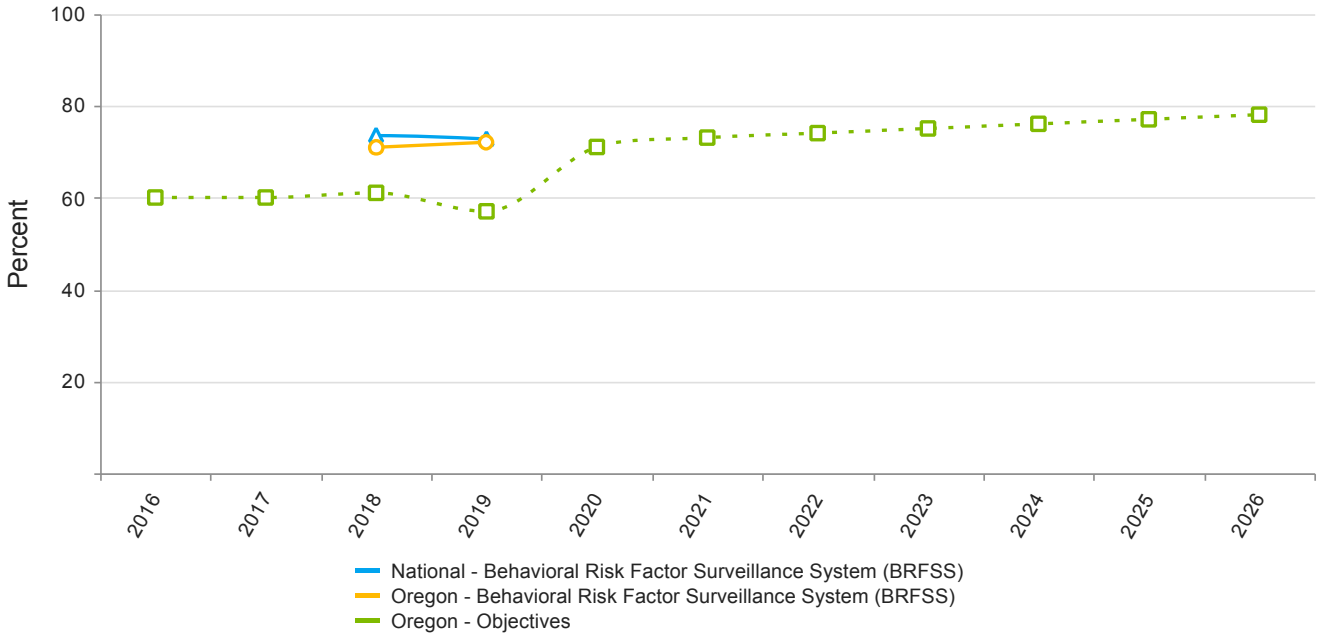
National Outcome Measures	Data Source	Indicator	Linked NPM

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	67.0	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	10.1	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	6.7 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	8.3 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	23.6 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	4.7	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	4.2	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	2.7	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.6	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	137.5	NPM 1 NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	94.8	NPM 14.1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2015	11.6 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	5.7	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	12.9 %	NPM 13.1
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-2018_2019	13.9 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.6 %	NPM 13.1 NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	12.1	NPM 1

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	12.7 %	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**	**2019**	**2020**
Annual Objective					71
Annual Indicator				70.8	72.0
Numerator				517,099	529,410
Denominator				730,360	735,342
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	73.0	74.0	75.0	76.0	77.0	78.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of new mothers who have had a postpartum checkup.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	89.5
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	90.0	90.5	91.0	91.5	92.0

ESM 1.2 - Among local grantees who select well woman care, percent who report improved knowledge, skills, or policies based on provided technical assistance.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	75.0	75.0	75.0	75.0

ESM 1.3 - Completion of environmental scan of organizations and partners for increasing diversity in the perinatal workforce.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 1.4 - Number of OHA Office of Equity and Inclusion Certified Community Health Workers.

Measure Status:	Active
State Provided Data	
	2020
Annual Objective	
Annual Indicator	604
Numerator	
Denominator	
Data Source	OEI
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	610.0	620.0	630.0	640.0	650.0

ESM 1.5 - Completion of environmental scan to determine role of Title V in perinatal behavioral health.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes

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 October 1, 2025 increase the percent of women with a past year preventive medical visit from 70.8% to 76.0%, through improved accessibility, quality, and utilization.	
Strategies	
1. Strengthen early identification of and supports for women's behavioral health needs	
2. Support advanced training, coaching and quality improvement activities for home visitors related to well woman care.	
3. Support efforts to improve diversity in the workforce	
4. Ensure access to culturally responsive preventive clinical care for low income and undocumented women.	
5. Establish community based perinatal, women's and infant health advisory groups to share best practices, strategize and impact policy change. Engage affected communities including people of color in leadership.	
ESMs	**Status**
ESM 1.1 - Percent of new mothers who have had a postpartum checkup.	Active
ESM 1.2 - Among local grantees who select well woman care, percent who report improved knowledge, skills, or policies based on provided technical assistance.	Active
ESM 1.3 - Completion of environmental scan of organizations and partners for increasing diversity in the perinatal workforce.	Active
ESM 1.4 - Number of OHA Office of Equity and Inclusion Certified Community Health Workers.	Active
ESM 1.5 - Completion of environmental scan to determine role of Title V in perinatal behavioral health.	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 - Percent of women who drink alcohol in the last 3 months of pregnancy

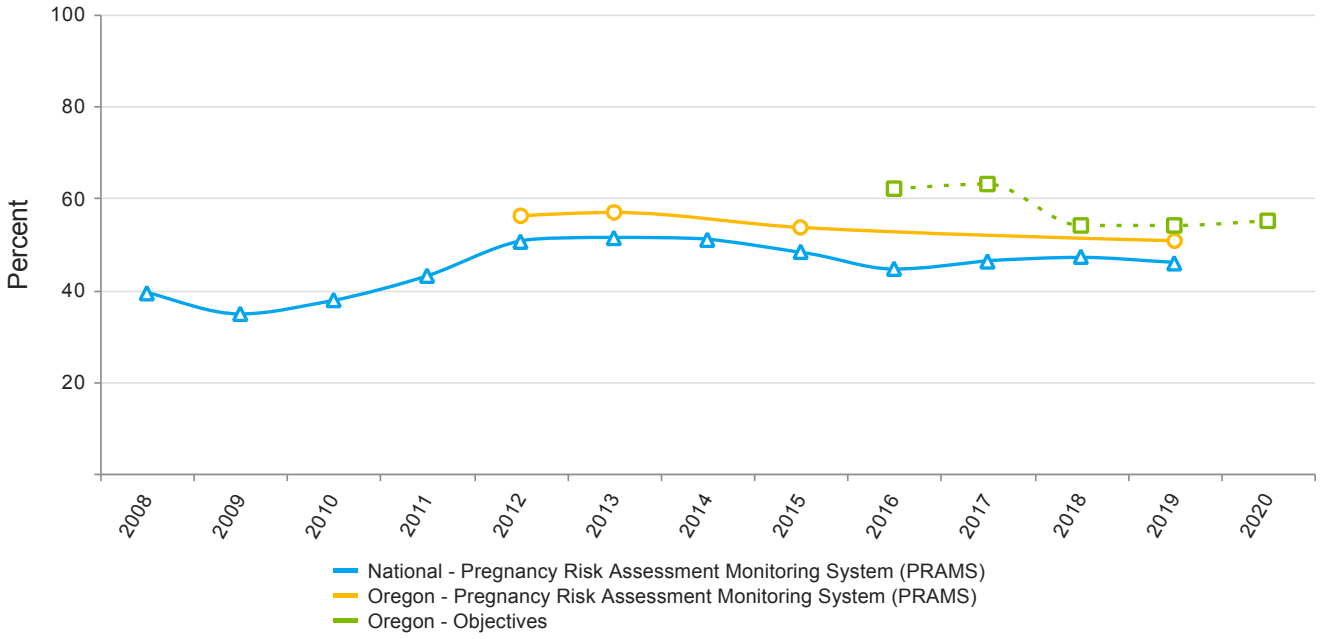
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

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

2016-2020: National Performance Measures

2016-2020: NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
Indicators and Annual Objectives

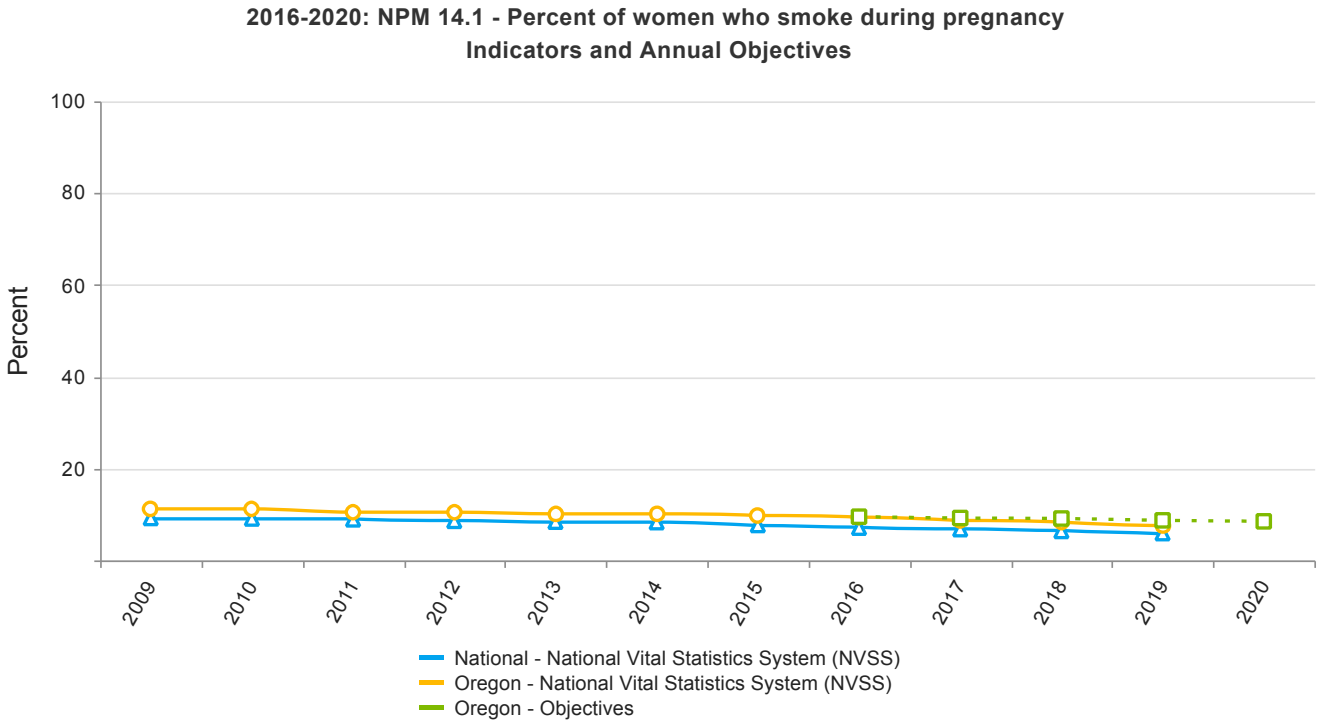


Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	62	63	54	54	55
Annual Indicator	57.0	53.5	53.5	53.5	50.6
Numerator	24,297	22,955	22,955	22,955	19,941
Denominator	42,656	42,925	42,925	42,925	39,412
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2015	2015	2019

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: 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**			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			7	7
Annual Indicator			7	7
Numerator				
Denominator				
Data Source			State Tracking	State Tracking
Data Source Year			2019	2020
Provisional or Final ?			Final	Final



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	9.6	9.3	9.2	8.8	8.6
Annual Indicator	9.9	9.5	8.9	8.4	7.5
Numerator	4,517	4,326	3,880	3,523	3,113
Denominator	45,489	45,405	43,455	42,041	41,722
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: 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**	**2019**	**2020**
Annual Objective	75	75	75	75
Annual Indicator	50	100	71.4	100
Numerator	5	10	5	7
Denominator	10	10	7	7
Data Source	Local grantee reports	Local grantee reports	Local grantee reports	Local grantee reports
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

2016-2020: 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**	**2019**	**2020**
Annual Objective	80	80	80	80
Annual Indicator	90.9	100	100	100
Numerator	10	10	7	7
Denominator	11	10	7	7
Data Source	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Well Woman Care Report

Priority: Well Woman Care

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

Interpretation of national performance measure data:

The percentage of women who received a past year preventive visit has increased in Oregon from 56.5% in 2017, to 70.8% in 2018, and to 72.0% in 2019. Although the rate has been increasing, Oregon remains slightly below the national average for this measure.

Strategies:

Strategy #1: 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.

- **Accomplishments:** A state/local public health nursing workgroup completed a revision of the clinical guidelines for the public health nurse home visiting programs that included updated guidance on postpartum physical assessment, social determinants of health screening and reproductive life planning. Monthly community of practice meetings were convened to support for home visitors statewide in their practice.

- **Challenges/emerging issues:** All home visits shifted to telehealth visits in response to the COVID-19 pandemic and public health nurses at the state and local level were moved to positions supporting the COVID-19 response.

Strategy #2: Use traditional and social marketing to educate the population and promote well woman care.

- **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 counties will be working to build their social media presence and will participate in community events to promote awareness around well woman care.

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

- **Progress on ESMs:** Unable to track statewide due to limited ability to host and participate in events due to COVID-19 pandemic. Crook County was able to reach 2,000 people through social media outreach.

- **Accomplishments:**
    - The Crook County Health Department (CCHD) used social marketing to increase the awareness of well woman care by posting monthly on Facebook and increasing the number of boosted Facebook posts to reach a wider audience. CCHD used traditional marketing to increase awareness by hosting booths at the local county fair, a Recovery Month event and other local events. CCHD continued the One Key Question initiative by screening every postpartum woman in WIC appointments and perinatal care appointments for pregnancy intention.

    - Malheur County Health Department planned to attend all 12 health fairs around the County but were only able to only attend 1 health fair as they were all planned after COVID-19 hit. However, they were able to share information at tabling events prior to COVID-19. They continue to provide information about the importance of Well Woman care in the clinic and insurance assisters inform women that this is a service that is covered by OHP and share educational handouts to them regarding the importance of well woman visits.

    - Marion County Health Department (MCHD) shared monthly ACOG infographic topics on their Facebook page from September to March. MCHD attended two health fairs. At the Teen Parent Program in October, Well Woman Care was promoted. The second one was for DHS Case Workers in both the Self Sufficiency and Child Welfare sections; information regarding home visiting services, the Maternal Child Health Coalition (MCHC), and well care for both women and adolescents was

provided. The MCHD also conducted a survey of local prenatal care providers to assess to what type of messaging they provide to pregnant women. The topics of interest were maternal mental health, infant safe sleep, intentional pregnancy planning, and marijuana use during pregnancy. MCHC was just beginning to analyze this data when the impacts of COVID-19 intervened.

- A workgroup of state and local maternal and child health and reproductive health partners met to plan activities for women's health week in May 2020, including a Governor's proclamation. Unfortunately, all activities were cancelled due to the pandemic.

- **Challenges/emerging issues:** One of the challenges encountered was ineffectiveness in reaching the target audience through social media campaigns, and lack of community engagement with Facebook posts. We learned that Instagram may be a better social media platform to reach our desired audience. There were some challenges with the One Key Question initiative due to a lack of follow through, and decreased continuity of care due to staff working from home because of COVID-19. Many health fairs and community events were cancelled due to the COVID-19 pandemic.

Strategy #3: 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.

- **Accomplishments:**
  - United Community Action Network in Douglas County began collaboration with the Douglas County Perinatal Task Force. A format, and a schedule of topics for trainings (lunch and learns) were determined.

  - The MCH Title V team participated in the planning for the Oregon Perinatal Collaborative virtual summit held October 2020. Speakers and active discussion included stress and racism in women's health, COVID-19, obstetric hemorrhage, birth equity, the eat, sleep console model and improving perinatal care for Black families. The MCH Title V team participated in bi-monthly meetings of the Oregon Perinatal Collaborative focused on COVID-19 and actively partnered on a project to improve care for pregnant women with a substance use disorder.

- **Challenges / Lessons Learned:** Challenges/emerging issues: COVID -19 became the number one priority of public health during this time and many trainings were not able to take place as planned.

Strategy #4: Provide access to well-woman care through Family Planning Clinics.

- **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.

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

- **Progress on ESMs:** 9 new partners were engaged in this work. New partners included the local newspaper and movie theater in Malheur County, clinical partners such as St. Alphonsus and St. Luke's Eastern Oregon Medical Associates, Planned Parenthood, Virginia-Garcia Memorial, and the student health services at Eastern Oregon University.

- **Accomplishments:**
  - The Baker County Health Department (BCHD) clerical staff and RN's have been working on a process to streamline the recall system for reproductive health clients to make it a more seamless process. The recall process flags female clients needing Annual Exams.

- The Washington County Reproductive Health Coalition continued to meet and increase knowledge and messaging throughout the county regarding well-women care. In particular, the partnering agencies connected with providers and residents by providing information on HPV vaccine, STI rates and HIV Prep--though flyers, in-person, and remote messaging. Shared training schedules were developed for partnering organizations. Much of the time prior to COVID-19 was spent planning for several events, eventually canceled due to the pandemic. The events included 1) The 2nd Annual Access Ambassador training--building peer to peer support in accessing reproductive health and sexual health care, and 2) The 5th Annual Teen Health Expo--which provides a venue for youth to procure information about healthcare and providers in their communities. The Coalition was on hold starting in March, and reconvened in September 2020. Information was shared with Coalition on new services soon to begin in Washington County.

- The Center for Human Development in Union County continues to ask the OKQ of all STI clients, making successful referrals to the reproductive health program. Unfortunately, clinical services offered were limited due to COVID-19.

- **Challenges/emerging issues:** One large challenge was the COVID -19 pandemic. The shutdown of businesses, medical facilities and other operations made clients think that public health clinics were closed too. Many feared that they would contract the virus by going to a medical facility, and they did not want to be around "sick people." It was difficult to schedule appointments for clients and have them attend their appointment due to fear of coming into the building. Many members of coalitions were redirected to address the challenges of the pandemic--both personally and professionally. Public Health staff were reassigned to work in Emergency Operations Centers. Interest among the coalitions appeared to wane. Moving to a remote meeting structure and providing interpretation services provided some mitigation of the challenges. COVID-19 impeded the asking of the OKQ in the STI clinics, highlighting the need to encourage clients to seek preventive care now more than ever.

Strategy #5: Use of the postpartum health care visit to increase utilization of well-woman visits.

- **Activities – State Level:** Provide guidance and technical assistance to Coordinated 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.

- **Accomplishments:**
  - In partnership with the Oregon Health Authority's Transformation Center, Coordinated Care Organizations were provided technical assistance to improve access to postpartum care visits. Consultation was provided regarding metrics, as some clinical care shifted to telehealth during the pandemic.

  - The MCH clinic for the Warm Springs Tribe adopted a new OB discharge form that was utilized by the new MCH RN. This proved to be a powerful tool for tracking and following up with postpartum patients.

- **Challenges/emerging issues:** The process for scheduling appointments changed again with restructuring for COVID-19 clinic operations.

Strategy #6: 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 assessment of access to well-woman/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.

- **Accomplishments:** Two introductory committee meetings of Oregon's new Maternal Mortality and Morbidity Review Committee were held in July and October 2019 to establish the process the committee would use for reviews. The first MMRC case review meeting was held via a virtual platform on August 18, 2020 and an additional case review meeting was held in October 2020.

- **Challenges/emerging issues:** The response to the emergence of SARS-CoV-2 and the resultant COVID-19 disease pandemic affected the ability of the Maternal Mortality Review Committee to complete its first and second in-person case review meetings which were scheduled in March and May 2020.

Strategy #7: Provide technical assistance to local grantees to support implementation of the well woman care priority area.

- **Activities – State Level:** Continue to plan and convene Learning Collaborative webinars for local grantees.
- **ESM:** 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 were provided technical assistance.
- **Accomplishments:** All local plans and reports were reviewed, and comments were provided back to grantees. Consultation meetings were held to review plans and offer technical assistance. Learning Collaborative meetings were held every other month through February 2020 when they were put on hold due to the COVID-19 response.
- **Challenges/emerging issues:** State and local staff ability to participate in planned Title V activities was limited during the pandemic.

Smoking Report

Priority: Smoking (Women)

National Performance Measure: Percent of women who smoke during pregnancy.

Interpretation of national performance measure data: The percent of women who smoked during pregnancy decreased from 2018 to 2019; from 8.4% to 7.5%, respectively. While this rate is decreasing, disparities by race/ethnicity and socioeconomic status remain. The highest rates are among Non-Hispanic American Indian/Alaska Native mothers (16.2%), mothers who didn't graduate high school (17.5%), unmarried mothers (15.9%), and mothers on Medicaid (14.4%).

Strategies:

Strategy #1: Provide technical assistance to local health agencies and tribes working on strategies to decrease tobacco use among pregnant women and children's exposure.

- **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.
  - 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 relevant print, electronic, and training materials to counties and tribes to increase knowledge around tobacco coverage benefits and the Oregon Quitline.
- **ESM:** 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.
- **Accomplishments:**
  - A new state staff person was hired in November 2019 to be the lead for Smoking Cessation priority area activities. The current Title V coordinator oriented the new staff member to this work throughout fall 2019. The priority lead contacted all Title V grantees who selected smoking as a priority area for an initial technical assistance call as part of her onboarding. The priority lead also reviewed plans and

coordinated technical assistance calls with Title V grantees during spring 2020.

- A new Native QuitLine was developed by the Health Promotion and Chronic Disease Prevention program in partnership with Oregon Tribes. The priority lead distributed information about this new program, including materials and promotional items, to Title V grantees. Smoking cessation materials were also distributed to pregnant clients via the Oregon MothersCare program. The Smoking Cessation priority lead worked with the OHA materials distribution center to maintain smoking cessation educational materials for all Oregon MothersCare sites to use.

- **Challenges/emerging issues:** The COVID-19 pandemic made completion of our planned activities very difficult. Many local Title V staff were pulled into community COVID-19 responses and traditional public health programs were temporarily "paused" or scaled back during the grant year. Local Title V staff lacked the capacity to participate in regular technical assistance opportunities for Title V activities.

- **Progress on ESMs:** All local Title V grantees who selected smoking as a priority area received at least two technical assistance contacts with the Smoking Cessation priority lead.

Strategy #2: 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.

- **Accomplishments:**
  - A new state staff person was hired in November 2019 to be the lead for Smoking Cessation priority area activities. The current Title V coordinator oriented the new staff member to this work throughout fall 2019.

  - The new priority lead initiated monthly meetings with staff from the Health Promotion and Chronic Disease Prevention Program and Maternal and Child Health (MCH) Section, including those working on smoking cessation, nutrition, and physical activity. Those meetings unfortunately had to be put on hold when the COVID-19 emergency was declared in March 2020 and staff were reassigned to the state COVID-19 response.

  - Another cross-division group was formed during the grant year to coordinate Public Health Division work related to substance use disorders. Two staff from MCH regularly attend this Alcohol and Other Drug coordinating team. These two staff participated in the development of a collaborative framework and action plan for Division-wide AOD prevention work. MCH staff contributed a health equity and trauma-informed lens to the planning and discussion to emphasize the upstream factors (e.g., chronic stress, trauma) that may contribute to tobacco and substance misuse.

  - Finally, the new Smoking Cessation lead served as the chair for the Oregon Health Authority's State Health Improvement Plan Behavioral Health subcommittee at the beginning of this grant cycle. Goals, strategies, and activities for the SHIP were finalized in fall 2019

- **Challenges/emerging issues:** The COVID-19 pandemic made completion of our planned activities difficult this grant cycle. Although we were able to complete many activities, we had set out to accomplish this grant cycle, progress was significantly slowed due to OHA agency staff being redirected to the state COVID-19

response.

Strategy #3: 5As Intervention within MCAH Programs including Home Visiting, Oregon MothersCare, Family Planning, and WIC.

- **Activities – Local Level:** (Lane, Coquille Tribal Nation, Tillamook, and Yamhill counties will conduct one or more of the following activities):
  - Conduct the 5As intervention with each client on Babies First! and Nurse Family Partnership (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.

- **Accomplishments:**
  - Lane County planned to implement 5As with each client on Babies First! and Nurse Family Partnership (NFP) caseloads who smokes. The County also intended to work with the WIC Quit Tobacco in Pregnancy (QTIP) staff on referrals for smoking cessation support. Activities were unfortunately impacted by the COVID-19 pandemic during the grant cycle.
  - The Coquille Indian Tribe developed a new protocol for screening clients for tobacco use and referring to the new American Indian and Alaska Natives QuitLine and cessation services. The new protocol was approved in February 2020. All staff received training on this protocol as well.
  - Tillamook County continued to implement 5As in home visiting and WIC. They partnered with their local Coordinated Care Organization (CCO) to offer Amazon gift cards to quit and stay quit. The county also made referrals to the QuitLine.
  - Yamhill County continued to implement the Healthy Futures Intervention tobacco cessation program in partnership with a prenatal care practice. This partnership has not only assisted with more overall referrals, but it has also helped foster mirrored messaging between the two organizations around smoking cessation. Yamhill County met with the prenatal practice in summer 2020 and asked about continued Healthy Futures programs. The practice had very positive feedback and asked to continue smoking cessation work, even if it is no longer a Title V priority area in the future.

- **Challenges/emerging issues:**
  - Lane County reported significant staff turnover in early 2020, so the County spent time on orientation. The County had also intended to implement an improved recording template for clients, but development and implementation were delayed due to the COVID-19 pandemic.
  - The Coquille Indian Tribe was able to train staff on their new screening and referral protocol, but referral implementation lagged due to COVID-19. The tribal clinic experienced staff turnover and reduced capacity as they responded to the pandemic. They are also challenged by the amount of staff time they can support with limited Title V funding.
  - Tillamook County reported challenges with loss to follow-up due to COVID-19. Several clients had to move out of the county, which is located on the Oregon coast, due to financial hardship and housing instability.
  - Yamhill County reported a decrease in the number of new women who started prenatal care early in their pregnancy. This delayed entry into care impacted the client's ability to enroll in the Healthy Futures program. At the same time the contact at the prenatal clinic began working remotely and only doing telehealth visits. While they were able to adjust to meet technical assistance needs in most cases, this created complications for executing the Healthy Futures program. The County found that the timetable they had initially created no longer fit the needs of clients and instead decided to shift the requirements of the program to focus on each participant being required to work with the Behavioral Health Specialist at the prenatal practice and then being offered a home visitor. As a result, there are some people who have enrolled and been referred to a home visiting program other than those offered at Public Health. Others have enrolled and declined to engage with a home visit program.

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

- **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.

  - 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.

- **Accomplishments:** The Coquille Indian Tribe developed a new protocol for screening clients for tobacco use and referring to the new American Indian and Alaska Natives QuitLine and cessation services. The new protocol was approved in February 2020. All staff received training on this protocol as well.

- **Challenges/emerging issues:** The Coquille Indian Tribe was able to train staff on their new screening and referral protocol, but referral implementation lagged due to COVID-19. The tribal clinic experienced staff turnover and reduced capacity as they responded to the pandemic. They are also challenged by the amount of staff time they can support with Title V funding.

Strategy #5: 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 MothersCare appointment, information on tobacco cessation benefits.

- **Accomplishments:**
  - State level activities: Smoking cessation materials were distributed to pregnant clients via the Oregon MothersCare program. The Smoking Cessation priority lead worked with the OHA materials distribution center to maintain smoking cessation educational materials for all Oregon MothersCare sites to use. The Smoking Cessation lead also worked with the Health Promotion and Chronic Disease Prevention section and OHA Transformation Center to promote and maintain a training module for physicians on tobacco cessation benefit coverage for pregnant people on Medicaid.

  - Local level activities: Lane County continued to provide information about smoking cessation benefits to Oregon MothersCare clients. However, OMC clients began to receive services virtually from March 2020 onward due to the COVID-19 pandemic, so the County had to adapt and find new ways to share this information with clients.

- **Challenges/emerging issues:**
  - State level activities: Many Oregon MothersCare(OMC) sites switched to remote visits during the COVID-19 pandemic and so did not distribute as many paper brochures as in the past. The Smoking Cessation lead worked with OMC sites to find health education materials online that could be shared virtually and/or find ways to distribute traditional health education materials (i.e., through the mail).

Oral Health Report

Priority: Oral Health (Women's)

National Performance Measure: Percent of women who had a dental visit during pregnancy.

Interpretation of national performance measure data:

The percent of women who had a dental visit during pregnancy decreased from 53.5% in 2015 to 50.6% in 2019. While the Oregon rate has been consistently been higher than the national average since 2012, the state rate is

decreasing while the national average is increasing.

Strategies:

Strategy #1: Increase awareness and engagement within the dental community of oral cancer and HPV.

- **ESM:** ESM 13.2.3: Number of oral health providers provided training on oral cancer and HPV.
- **Progress on ESMs:** 48 participants attended the oral health specific presentation at the HPV Virtual Summit.
- **Accomplishments:**
  - Collaborated with the state Immunization Program to update the brochure titled, "Oral Cancer and HPV: Protect Your Family" to be more health literate. The brochure is used by dental providers to promote the HPV vaccine with adolescents and parents/caregivers.
  - Participated on the planning committee for the 2020 Statewide HPV Virtual Summit, sponsored by the American Cancer Society and state Immunization Program, that was held on August 19-20, 2020. We engaged the dental community to attend the event and had the Dean of the Dental School at Oregon Health & Science University (OHSU) present on HPV and the dental community.
- **Challenges/emerging issues:**
  - The COVID-19 pandemic limited progress in this area. Several Oral Health Unit staff members were reassigned to help with the emergency response, limiting the amount of time staff worked on oral health and title V activities.
  - The pandemic did garner attention in having dentists administer vaccines. House Bill 2220 was signed into law on May 6, 2019 authorizing Oregon dentists to prescribe and administer vaccines beginning January 1, 2020. Dentists have been recruited to administer the flu and COVID-19 vaccine during the pandemic, but we hope to expand this to the HPV vaccine in the future.

Strategy #2: Provide technical assistance to school oral health programs and Title V grantees.

- **ESM:** 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:** Seventeen Title V local grantees were provided with technical assistance to promote dental visits for pregnant women.
- **Accomplishments:**
  - Seventeen grantees - fifteen local health agencies and two tribes - were provided with individualized technical assistance throughout the grant year.
- **Challenges/emerging issues:**
  - The COVID-19 pandemic limited progress in this area. Several Oral Health Unit staff members were reassigned to help with the emergency response, limiting the amount of time staff worked on oral health and title V activities. Local public health agencies and tribes also reassigned staff to help with the pandemic, limiting the time being spent on Title V activities.
  - Schools in Oregon were closed to in-person instruction on March 16, 2020 and remained closed for the remainder of the 2019-2020 academic year. School oral health programs were not consequently allowed to operate.

Strategy #3: 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.
- **Progress on ESMs:** Seven data sets in the OOHSS can be analyzed for oral health disparities.
- **Accomplishments:**
  - Seven data sources were identified within the Oregon Oral Health Surveillance System (OOHSS) can

be analyzed by race, ethnicity, language, and disability (REALD).

- Pulled together a workgroup to look at REALD for the 2022 Oregon Smile & Healthy Growth Survey.

- **Challenges/emerging issues:**
  - The COVID-19 pandemic limited progress in this area. Several Oral Health Unit staff members were reassigned to help with the emergency response, limiting the amount of time staff worked on oral health and title V activities. Since the pandemic has highlighted the need for REALD, we anticipate future policy changes in this area.

Strategy #4: Provide oral health preventive services or education and referral/case management services through Oregon's Home Visiting System.

- **Accomplishments:**
  - Benton, Jefferson, Jackson, Lake, Linn, Malheur, and Morrow Counties provided oral health education and referrals for dental care during home visits.

  - Benton and Jefferson Counties had all home visiting staff take the national, online Smiles for Life training.

- **Challenges/emerging issues:**
  - The COVID-19 pandemic limited progress in this area. Local public health agencies and tribes reassigned staff to help with the pandemic, limiting the time being spent on Title V activities. Beginning in mid-March 2020, in-person nurse home visiting services were discontinued. Those that provided virtual appointments were limited to providing oral health education and referral services.

  - Dental referrals became even more challenging during the pandemic. Dental clinics were only allowed to provide emergency services from mid-March until May 2020. Many dental clinics closed entirely during this time and were slow to open. It was challenging for a lot of clinics to meet the reopening guidelines due to staffing challenges and PPE shortages.

Strategy #5: Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health and the importance of dental visits.

- **Accomplishments:**
  - Benton County provided MCH clients with oral health education and referral services. They implemented an incentive program that gave electric toothbrushes to pregnant women who made and kept a dental appointment at the Johnson Dental Clinic.

  - Clackamas County worked on scheduling and intake processes to increase the number of WIC clients that received preventive oral health services as part of their Healthy Smiles Program.

  - Columbia County provided oral health education and referral services to their home visiting and MCH clients.

  - Hood River County collaborated with Advantage Dental to provide monthly oral health screenings and preventive services for clients in their WIC program.

  - Jefferson County Public Health provided hygiene supplies, education, and referrals around perinatal oral health at two Tri-County Community Baby Showers.

  - Josephine County collaborated with Siskiyou Dental to provide oral health education and fluoride varnish to low-income pregnant women and children participating in their WIC and public health programs.

  - Klamath County collaborated with the Klamath Basin Oral Health Coalition and Cascade Health Alliance CCO to increase the number of preventive oral visits during pregnancy. They developed oral health education materials for women and dentists on oral health during pregnancy.

- Klamath Tribes provided oral health education to pregnant women and added an annual dental exam to a checklist that mother's enrolled in their MCH program are required to complete.

- Lake County collaborated with Advantage Dental to provide oral health assessments, education, and fluoride varnish to their WIC clients.

- Polk County partnered with Capitol Dental Community Outreach to provide onsite dental services for pregnant women and children at Polk County Health Services.

- Wheeler County distributed the Bright Futures Oral Health pocket guide to families who came to the clinic for WIC services.

- **Challenges/emerging issues:**
  - The COVID-19 pandemic limited progress in this area. Local public health agencies and tribes reassigned staff to help with the pandemic, limiting the time being spent on Title V activities. Beginning in mid-March 2020, in-person programs such as WIC and nurse home visiting were discontinued. Those programs that provided virtual appointments were limited to providing oral health education and referral services.

  - Dental referrals became even more challenging during the pandemic. Dental clinics were only allowed to provide emergency services from mid-March until May 2020. Many dental clinics closed entirely during this time and were slow to open. It was challenging for a lot of clinics to meet the reopening guidelines due to staffing challenges and PPE shortages.

Strategy #6: Collaborate with primary care providers to follow the American Congress of Obstetricians and Gynecologists (ACOG) oral health recommendations for pregnant women.

- **Accomplishments:**
  - Tillamook County collaborated with primary care providers and other clinical staff within the Community Health Center (CHCO) to increase the number of pregnant women who received a dental visit. They provided incentives and worked to overcome barriers to access to care.

- **Challenges/emerging issues:**
  - The COVID-19 pandemic limited progress in this area. Local public health agencies and tribes reassigned staff to help with the pandemic, limiting the time being spent on Title V activities. Medical and dental offices were only allowed to provide emergency services from mid-March until May 2020. Many dental clinics closed entirely during this time and were slow to open. It was challenging for a lot of clinics to meet the reopening guidelines due to staffing challenges and PPE shortages.

Other Title V work in this Domain

Oregon's Title V program provides leadership for policy and system development efforts related to maternal/women's health including support for public health nurse home visiting programs (e.g. universally offered home visiting) and ensuring that health system transformation addresses the need for comprehensive, culturally responsive women's and maternal health services. A few specific areas are outlined below.

- Raise Up Oregon: A Statewide Early Learning System Plan identified prevention of sleep-related infant deaths as a priority for Oregon's early learning system. Starting in July 2020, MCH Title V convened and led a workgroup tasked with developing recommendations for a statewide coordinated effort to: 1. Identify vulnerable populations and risk factors in Oregon for sleep related infant deaths and 2. Identify and recommend effective, culturally appropriate prevention strategies.

- Title V also supported the Oregon MothersCare program which provides pregnant people with assistance to enroll in Oregon Health Plan, and links to prenatal care, home visiting, WIC, and other services, as well as perinatal mental health policy and education efforts.

- In 2018, the Oregon Legislature passed Oregon House Bill 4133 (2018 HB 4133) which gave authority and direction to OHA to establish the Morbidity and Mortality Review Committee (MMRC). Oregon's MMRC is a governor-appointed committee that reviews deaths that occurred during pregnancy or the year after the end of

pregnancy in Oregon. The committee determines issues that contributed to each death and decides upon recommendations to improve systems of care for pregnant people and ultimately decrease future deaths from happening. The MMRC is comprised of a multidisciplinary group of individuals throughout the state that have experience promoting maternal health and wellness, and includes representation from public health, mental health, community-based organizations, and healthcare professionals. The multidisciplinary committee and its activities are coordinated and staffed by the Maternal and Child Health (MCH) Section of the OHA Public Health Division in collaboration with Title V staff. The MMRC members were appointed by the Governor's Office in May 2019 and two introductory committee meetings were held in July and October 2019. The first MMRC case review meeting was held via a virtual platform on August 18, 2020. Two additional case review meetings were held in October and December 2020.

Well Woman Care Plan

Priority: Well Woman Care

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

Strategies:

Strategy #1: Strengthen early identification of and supports for women's behavioral health needs

- **ESM 1.5:** Completion of environmental scan to determine role of Title V in perinatal behavioral health.
- **State level activities/timeline:** Assess needs and opportunities for maternal behavioral health program/policy work over the next 5 years. Participate in and build upon inter-/intra-agency efforts to address maternal behavioral health needs, specifically substance use disorders and depression/suicide, such as the PHD Alcohol and Other Drug Prevention Team. Contribute to state level suicide prevention initiatives and advocate for inclusion of perinatal population in policy/program work. Assess and update State behavioral health resources website. Identify opportunities to support expansion of Nurture Oregon, a model of integrated maternity care and substance use disorder treatment.
- **Local level activities/timeline:** Malheur, Tillamook, and Union Counties and the Klamath Tribe will strengthen early identification of, and supports for, women's behavioral health needs. These local grantees will implement screening and referrals for perinatal mood disorders in clinical and community settings.

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

- **ESM 1.2:** Among local grantees who select well woman care, percent who report improved knowledge, skills, or policies based on provided technical assistance.
- **State level activities/timeline:** Partner with MIECHV and MCH Nurse Teams to offer trainings to home visitors with a focus on women's health. Plan and implement a statewide Community of Practice for nurse home visitors on preventing maternal mortality and morbidity. Make changes to the data collection system for the nurse home visiting programs so that it is easier to track attendance at post-partum and well-woman care. Support local nurse supervisors in using program data to improve practice.
- **Local level activities/timeline:** Provide or arrange for home visiting staff to attend training and participate in quality improvement activities that work towards increasing the number of home visiting clients that receive a post-partum care visit and an annual preventive visit.

Strategy #3: Support efforts to improve diversity in the workforce

- **ESM:**
  - ESM 1.3: Completion of environmental scan of organizations and partners for increasing diversity in the perinatal workforce
  - ESM 1.4: Number of OHA Office of Equity and Inclusion Certified Community Health Workers
- **State level activities/timeline:**
  - Develop partnerships with community organizations that support training of community health workers, including doulas, lactation counselors, and peer-based care models to identify ways that the Title V team can support the recruitment, training and integration of community health workers in women's health care.
  - Partner with MCH Nurse Team to develop the role of the Community Health Worker in the Babies First! and CaCoon Home Visiting programs.
  - Partner with MCH Nurse Team to convene partners to develop and implement activities aimed at

recruiting and retaining a diverse public health nurse workforce.

Strategy #4: Ensure access to culturally responsive preventive clinical care for low income and undocumented women.

- **ESM 1.1:** Percent of new mothers who have had a postpartum checkup.

- **State level activities/timeline:**
  - Identify partnership opportunities with state Screenwise and Reproductive Health programs to reduce barriers to care through culturally appropriate outreach, education, and patient navigation services. Continued partnership with the Oregon Perinatal Collaborative. Conduct a needs assessment, convene a stakeholder workgroup and implement recommended changes to refocus and revitalize the Oregon MothersCare Program. Work with ODHS/OHA partners to provide education and outreach promoting access to culturally supportive perinatal services
  - Partner with the OHA Transformation Center to provide technical assistance and support CCO's to achieve their postpartum incentive metric, and implement the 12 month postpartum Medicaid expansion as it becomes available.

- **Local level activities/timeline:**
  - Baker County, Morrow County and Linn County will provide community education on well-woman visits and woman's health. Education will include information on birth control and the importance of cervical screening and STI prevention, screening, and treatment.

  - Baker County will provide outreach at Community Night Out and school registration in August.

  - Morrow County will focus on outreach and engagement, especially among vulnerable communities such as low income and undocumented women.

  - Klamath County will gather information, build partnerships, and plan pilot project activities with clinics, WIC and Cascade Health Alliance CCO to explore patient connection/referral systems to improve access to Well Woman Care.

Strategy #5: Establish community based perinatal, women's and infant health advisory groups to share best practices, strategize and impact policy change. Engage affected communities including people of color in leadership.

- **State level activities/timeline:**
  - Provide technical assistance and facilitate shared learning among Title V grantees in community engagement best practices. Identify opportunities to build partnerships with community-based organizations and build internal capacity to engage parents/community members in Title V activities.

- **Local level activities/timeline:**
  - Douglas County will continue to provide leadership to a robust Perinatal Task Force that has been operating successfully for 5 years. This task force has workgroups including reproductive health, health equity, community events, training, breastfeeding, and can change workgroups based on gaps/needs in the community.

Strategy #6: Partner with state Maternal Mortality Review Committee to understand contributing factors to maternal morbidity and mortality.

- **State level activities/timeline:**
  - Support Oregon's Maternal Mortality Review Committee and use recommendations to inform Title V work and share information from Committee with partners.

Critical partnerships:

- Oregon Perinatal Collaborative
- Oregon's Healthy Start grantees (Healthy Birth Initiatives of Multnomah County and the Health Care Coalition of Southern Oregon)

- Oregon's MIECHV team and grantees
- Medicaid
- State Reproductive Health program

Other Title V work in this Domain

Oregon's Title V program will continue to provide leadership for policy and system development efforts related to maternal/women's health including support for universally offered home visiting and ensuring that health system transformation addresses the need for comprehensive, culturally responsive women's and maternal health services. Title V will also continue to support programs and initiatives such as Oregon MothersCare, maternal mental health, as well as oral health for pregnant women. Additional efforts for the coming year are outlined below.

- MCH Title V will be working with a communications agency to provide safe sleep message development and a communications plan that is informed by and targets Black and American Indian/Alaskan Native families and childcare providers. The messages and communications outreach will reinforce safe sleep messages in a multitude of clinical and community settings including childcare.

- MCH Title V team will partner with Oregon Department of Human Services to support Oregon implementation of Plans of Safe Care as required by the Child Abuse Prevention and Treatment Act (CAPTA). Plans of Safe Care implementation will be piloted in coordination with the expansion of Nurture Oregon, a model of integrated maternity care and substance use disorder treatment.

- Title V will continue to support Oregon's Maternal Mortality and Morbidity Review Committee (MMRC), a governor-appointed committee that reviews deaths that occurred during pregnancy or the year after the end of pregnancy in Oregon. The committee determines issues that contributed to each death and decides upon recommendations to improve systems of care for pregnant people and ultimately decrease future deaths from happening. The MMRC is comprised of a multidisciplinary group of individuals throughout the state that have experience promoting maternal health and wellness, and includes representation from public health, mental health, community-based organizations, and healthcare professionals.

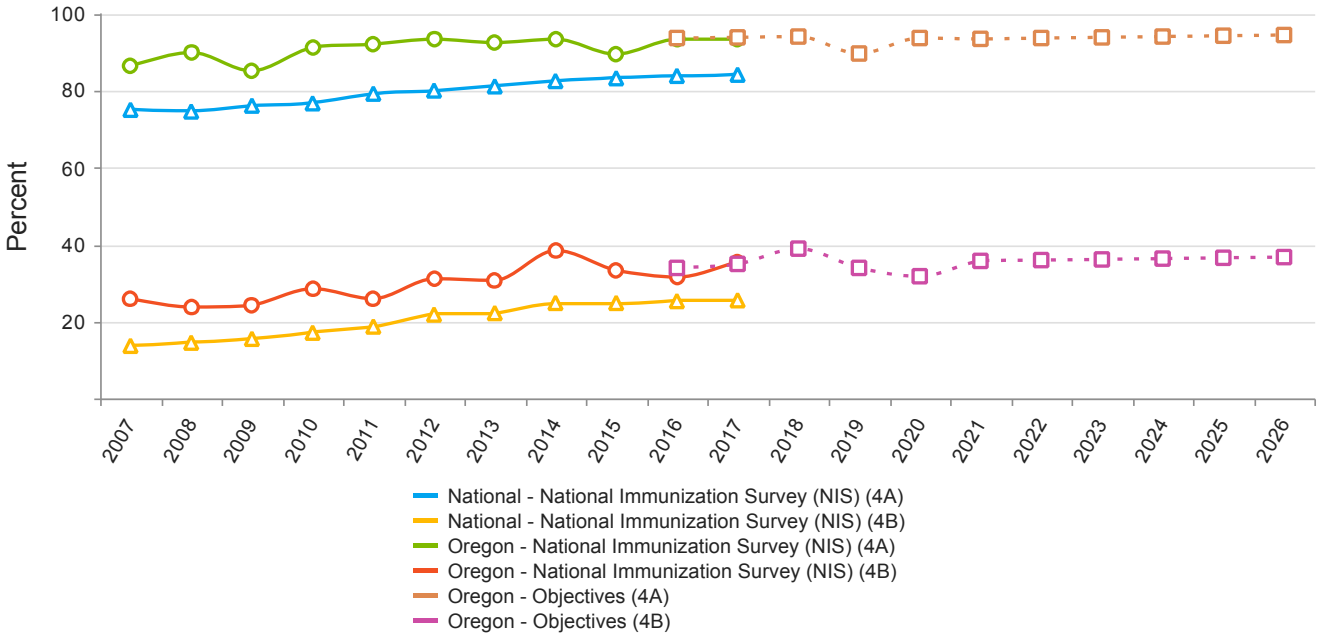
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	4.2	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.6	NPM 4
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	94.8	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**	**2019**	**2020**
Annual Objective	93.6	93.8	94	89.6	93.6
Annual Indicator	92.5	93.2	89.4	93.5	93.2
Numerator	37,456	44,505	38,219	35,799	35,964
Denominator	40,509	47,759	42,729	38,275	38,600
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	93.4	93.6	93.8	94.0	94.2	94.4

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	34	35	39	34	31.8
Annual Indicator	30.6	38.3	33.4	31.6	35.6
Numerator	11,501	17,140	13,911	11,640	13,431
Denominator	37,583	44,757	41,664	36,894	37,678
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	35.8	36.0	36.2	36.4	36.6	36.8

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Breastfeeding initiation among Non-Hispanic Black mothers.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	93
Numerator	
Denominator	
Data Source	Vital statistics
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	93.2	93.4	93.6	93.8	94.0

ESM 4.2 - Breastfeeding initiation among Non-Hispanic American Indian/Alaska Native mothers.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	89
Numerator	
Denominator	
Data Source	Vital statistics
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	89.2	89.4	89.6	89.8	90.0

ESM 4.3 - Exclusive breastfeeding at 6 months among Non-Hispanic Black mothers.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	57
Numerator	
Denominator	
Data Source	PRAMS-2
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	57.5	58.0	58.5	59.0	59.5

ESM 4.4 - Exclusive breastfeeding at 6 months among Non-Hispanic American Indian/Alaska Native mothers.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	67
Numerator	
Denominator	
Data Source	PRAMS-2
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	67.5	68.0	68.5	69.0	69.5

ESM 4.5 - Among local grantees who select breastfeeding, percent who report improved knowledge, skills, or policies based on provided technical assistance.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	75.0	75.0	75.0	75.0

ESM 4.6 - Completion of environmental scan of organizations and partners for increasing diversity in the perinatal workforce.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 4.7 - Number of OHA Office of Equity and Inclusion Certified Community Health Workers.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	604
Numerator	
Denominator	
Data Source	OEI
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	610.0	620.0	630.0	640.0	650.0

ESM 4.8 - Number of providers engaged in anti-racism or cultural humility training.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	30.0	30.0	30.0	30.0	30.0

State Action Plan Table

State Action Plan Table (Oregon) - Perinatal/Infant Health - Entry 1
Priority Need
Improved lifelong nutrition
NPM
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Objectives
By October 1, 2025 increase the percent of infants who are ever breastfed from 93.5% to 94.1%; and increase the percent of infants breastfed exclusively through 6 months from 31.6% to 32.8%.
Strategies
1. Promote & support laws and policies for pregnant & breastfeeding people in the workplace. Focus on populations with additional barriers.
2. Support advanced training, coaching and quality improvement activities for home visitors related to breastfeeding.
3. Ensure that providers who serve tribal members have training in culturally specific approaches to breastfeeding promotion and support.
4. Support efforts to improve diversity in the workforce
5. Ensure access to culturally responsive preventive clinical care for low income and undocumented women.
6. Establish community based perinatal, women's and infant health advisory groups to share best practices, strategize and impact policy change. Engage affected communities including people of color in leadership.

ESMs	Status
ESM 4.1 - Breastfeeding initiation among Non-Hispanic Black mothers.	Active
ESM 4.2 - Breastfeeding initiation among Non-Hispanic American Indian/Alaska Native mothers.	Active
ESM 4.3 - Exclusive breastfeeding at 6 months among Non-Hispanic Black mothers.	Active
ESM 4.4 - Exclusive breastfeeding at 6 months among Non-Hispanic American Indian/Alaska Native mothers.	Active
ESM 4.5 - Among local grantees who select breastfeeding, percent who report improved knowledge, skills, or policies based on provided technical assistance.	Active
ESM 4.6 - Completion of environmental scan of organizations and partners for increasing diversity in the perinatal workforce.	Active
ESM 4.7 - Number of OHA Office of Equity and Inclusion Certified Community Health Workers.	Active
ESM 4.8 - Number of providers engaged in anti-racism or cultural humility training.	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 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Breastfeeding Report

Priority: Breastfeeding

National Performance Measure:

- Percent of infants who are ever breastfed.
- Percent of infants breastfed exclusively through 6 months.

Interpretation of national performance measure data:

While the rate of breastfeeding initiation and exclusive breastfeeding at 6 months in Oregon consistently surpass national averages, disparities persist in these performance measures. Oregon continues to have state policies and practices in place that support breastfeeding.

Strategies:

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

- **Activities – Local 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 materials.

- **Accomplishments:** Coos county completed breastfeeding promotion videos promoted through 5 media channels including Facebook (17,072 views) and YouTube (1094 views). Videos that featured community members and those that used humor in the messaging were the most viewed. Additional promotion occurred at local clinics, hospital and a local theater for four months, receiving the most feedback from viewers than any other theater ad. The Coos County Breastfeeding Friendly Workplace Toolkit was updated with gender neutral language and included links to the promotional videos and other resources. The “Would You Like to Become Pregnant in the Next Year?” booklets were updated to include gender neutral language, a nutrition section, birth support information, postpartum depression, domestic violence for women, men and trans individuals, and breastfeeding and marijuana. The "eat local" logo was updated to include the parent wearing a facial covering as well as the inclusion of "come local" Spanish translation. VISTA promoted the breastfeeding project at a state WIC conference and to the local Chamber of Commerce. 614 English and 413 Spanish Breastfeeding Basics booklets were distributed to ODHS, Oregon Coast Community Action, Bay Area Hospital, Bay Clinic, North Bend Medical Center and Hispanic Leadership Committee.

- **Challenges/emerging issues:** COVID-19 put a damper on efforts to provide outreach to community members during farmers market and street fairs. Materials for the Lactation Station were purchased, but outreach service could not be provided.

Strategy #2: Fill unmet needs for peer support of breastfeeding.

- **Activities – Local Level:** Clackamas, Clatsop, Columbia, Multnomah, and Yamhill counties are implementing activities that increase peer support of breastfeeding.

- **Accomplishments:** Clackamas focused on building staff confidence in promoting breastfeeding services through specific messaging to clients. Through a process of shared learning and subsequent evaluation there was a significant increase in staff confidence. Clatsop pivoted from their initial plan to focus on providing needed breastfeeding support in the community since the hospital suspended their lactation services when the pandemic started. MCH collaborated with Le Leche League leaders to develop a plan to meet needs which included identifying program and provider supports in the community. Columbia initiated one breastfeeding peer support group led by home visit nurses prior to COVID-19. Breastfeeding resources in the community and online were identified and shared with clients. Multnomah focused on increasing participation of African American/Black mothers in peer breastfeeding programs; participation was maintained over the last year despite COVID-19. One partnership was developed with Multnomah County Maternal, Child and Family Health Services in response to hospitals discharging new mothers too early from hospital during pandemic. Staffing turnover has stopped and now clients are able to get high risk lactation counseling as well as consultations. Yamhill initiated a joint Nurse Family Partnership and WIC home visit service for breastfeeding. For the one mother who requested this service it was a positive experience (4 referrals had

been made). Beyond limited measured outcomes, they fostered improved communication and program understanding between NFP nurse home visitors and WIC peer support specialist.

- **Challenges/emerging issues:** Clatsop was not able to implement their original plan due to COVID-19 as the county paused their hospital lactation services. Columbia lost home visit nurses and was not able continue the peer support group during COVID-19. When staffed again support shifted to individual telehealth check-ins for just the most urgent needs. Multnomah is transitioning to analyzing breastfeeding and program data differently than in the past to improve monitoring and reporting. There is additional need for training in knowledge, skills and abilities for African American/Black breastfeeding peer counselors. Yamhill did not have interest from clients for a joint home visit from NFP and WIC breastfeeding peer counselor as clients felt confidence in accessing needed services. Between the two programs there were major difficulties in scheduling as staff had very different availability.

Strategy #3: Educate pregnant women about breastfeeding.

- **Activities – Local Level:** Clackamas, Clatsop, Columbia, Deschutes, Lincoln, Polk, Tillamook and Washington counties and Warm Springs tribe are implementing activities that educate pregnant and postpartum women about breastfeeding.

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

- **Accomplishments:** 44% of local grantees met their target for breastfeeding education among pregnant and postpartum women. Clackamas had success with staff engagement and training and found that mothers who did attend new breastfeeding classes (English or Spanish) provided positive feedback. Clatsop began the process of evaluating breastfeeding education in their home visiting program as first step in standardizing home visiting education. Although Columbia did not meet their target goal, greater than 50% of pregnant women did receive breastfeeding education. Deschutes met goal to provide lactation support & counseling to pregnant clients at home visits since staff capacity with breastfeeding expertise is good. Lincoln filled a 2-year vacancy for an International Board Certified Lactation Consultant (IBCLC) and offered prenatal and postpartum breastfeeding classes, with good postpartum class participation and client feedback. Polk provided breastfeeding education to all pregnant women served in various programs; educational packets were created and available digitally. The WIC breastfeeding policy was updated and shared with staff, serving to reinforce breastfeeding education. Tillamook shifted to virtual visits during pandemic, and met their goal of providing 100% of pregnant and breastfeeding home visit clients breastfeeding education. Most clients were able to receive incentives provided by the CCO. They implemented 2 partner agreements around consistent breastfeeding messaging. Washington met their goal of 100% of pregnant and breastfeeding mothers served by home visiting programs receiving breastfeeding education. Confederated Tribes of Warm Springs developed one PSA that highlighted the breastfeeding experience of community members which ran the month of August and almost all postpartum clients received breastfeeding education and lactation support within 2 weeks of delivery.

- **Challenges/emerging issues:** Clackamas had challenges with class scheduling and space availability. The biggest challenge was shifting breastfeeding education during COVID-19 which altered how support was provided. Remote group options were investigated but none were found that were accessible to all, so they pivoted to individual support, hence they did not meet their goal for classes offered. Clatsop did not complete their plan of standardizing breastfeeding education in home visiting programs due to COVID-19. Additionally, the North Coast Breastfeeding Coalition halted meetings and then disbanded during the pandemic making collaboration with partners difficult. Columbia experienced a lack of home visit nurses just before the pandemic hit, and then adapted to virtual breastfeeding services during COVID-19 which were accessible to some but not all clients. Also, during COVID-19, while some women were open to discussing breastfeeding, basic needs, such as food and housing, were more pressing. Deschutes had some staff turnover with breastfeeding expertise, however they were able to hire a nurse with IBCLC. Lincoln did not meet goal for number of classes offered and number of clients who participated. Though class attendance was positive, the effort to market classes was not worth the outcomes they were seeing. When COVID-19 came, staff focused work in other areas, they lost staff hours and they did not switch to an online platform. Polk was not able to implement most of their workplan due to COVID-19, unable to distribute breastfeeding education packets, or fully develop additional breastfeeding support policies. The Southern area of Tillamook is more rural and had more challenges due to lack of internet access and breastfeeding support. Confederated Tribes of Warm Springs was not able to conduct breastfeeding education in childbirth education classes due to COVID-19. For individual breastfeeding education while there were challenges in providing phone consultation and

teaching. Provision of online resources and DVDs successfully supplemented phone teaching.

- **Progress on ESMs:** Four out of nine grantees met (or mostly met) their target goal. Overarching reason that grantees did not meet their target was due to COVID-19. (Four who met their goal: Deschutes, Tillamook, Washington, and Confederated Tribes of Warm Springs.)

Strategy #4: Increase workforce support for breastfeeding through training and access to high quality services.

- **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.
- **ESM:** ESM 4.3: Number of health care providers trained in breastfeeding support
- **Progress on ESMs:** 39 providers were trained in breastfeeding support. Three of four counties who worked on staff training are rural counties challenged by frequent staff turnover. That all four grantees met their target goal for staff training (and during pandemic) is remarkable given the time required from staff. Providers represented nurses, community health workers and medical assistants, and training consisted of continuing education for certifications, breastfeeding competency training or support for certifications like IBCLC or Certified Lactation Educator (CLE).
- **Accomplishments:** Crook had one staff member achieve IBCLC certification. Deschutes supported three staff to became CLE and one staff become IBCLC certified. Douglas supported lactation care continuing education requirements for 75% of staff and education to increase competency for 8 staff. Grant trained 8 clinic providers and 9 Community Health Workers in breastfeeding support, as well as completing a brochure for families about breastfeeding support services.
- **Challenges/emerging issues:** Crook had a second staff member unable to complete IBCLC certification due to time required. Deschutes experienced staff turnover losing two staff with breastfeeding expertise. Douglas continues to experience staff turnover with two staff with IBCLC leaving. Grant has been challenged by staff turnover at the community clinic, from the manager to provider level. Partnership development and training of new staff is an ongoing need. State effort in support of this activity was minimal as lead staff spent most of the grant cycle year supporting the COVID-19 response.

Strategy #5: 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.
- **Accomplishments:** Presentations on the Coos County Breastfeeding Friendly Workplace Toolkit to Chamber of Commerce occurred in early 2020 and an additional presentation was provided during the Oregon WIC conference.
- **Challenges/emerging issues:** Workshops and employer support policies were not implemented due to COVID-19. The state MCH lead for this priority was deployed to the pandemic response for most of the grant cycle and was not able to work on this activity.

Strategy #6: Increase support of breastfeeding at childcare settings through policy, training and workforce development.

- **Activities – Local Level:** Clackamas and Josephine counties are implementing activities to increase childcare breastfeeding support.

- **Accomplishments:** Clackamas disseminated an initial survey about breastfeeding supports and training needs to a list of licensed childcare providers and received a disappointing response. This became an opportunity to conduct the survey differently, so they partnered with the Clackamas County Childcare Resource and Referral to resend the survey. Having a community partner send the survey resulted in a much higher response rate. Clackamas County initiated outreach and established relationships with the manager of the CCR&R and other childcare stakeholders through meetings and community outreach forums. Notably, Clackamas Workforce Partnership is leading community efforts to improve the quality and availability of childcare in the County. They hosted community forums and established workgroups to address the childcare crisis. The relationships that were initiated occurred right before COVID-19, causing childcare training plans to be put on hold. The Partnership was able to provide real time educational materials about breastfeeding during COVID-19 to the Clackamas County Childcare network, including providers that were open during COVID-19. The flyer included contact information for the WIC IBCLC.

- **Challenges/emerging issues:** Clackamas learned that community partners sending the childcare survey, as aopposed to government, led to a higher response rate. In-person training of childcare providers was not possible due to COVID-19. However, widespread capabilities for remote meetings and trainings provide a future opportunity.

- As a result of COVID-19, there are significantly fewer childcare providers. Josephine County was not able to carry out their plan related to childcare as COVID-19 impact reduced staff availability and childcare closures.

Strategy #7: Provide technical assistance to local health agencies and tribes working on strategies to promote breastfeeding.

- **Activities – State Level:**
    - The breastfeeding NPM is selected by 16 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.

- **Accomplishments:** Individual TA calls were conducted with each grantee upon plan submission and relevant resources were shared.

- **Challenges/emerging issues:** During most of the grant cycle the MCH lead for breastfeeding was deployed to Oregon's emergency management response team to lead contact tracing efforts.

Other Title V Work in this Domain

Title V provided leadership and technical assistance for linkages to prenatal care, oral health, maternal mental health, and other perinatal services; infant mortality reduction; PRAMS and ECHO 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.

Breastfeeding

Priority: Breastfeeding

National Performance Measure:

- Percent of infants who are ever breastfed.
- Percent of infants breastfed exclusively through 6 months.

Strategies:

Strategy #1: Promote & support laws and policies for pregnant & breastfeeding people in the workplace. Focus on populations with additional barriers.

- **ESM:**
  - ESM 4.1: Breastfeeding initiation among Non-Hispanic Black mothers
  - ESM 4.2: Breastfeeding initiation among Non-Hispanic American Indian/Alaska Native mothers
  - ESM 4.3: Exclusive breastfeeding at 6 months among Non-Hispanic Black mothers
  - ESM 4.4: Exclusive breastfeeding at 6 months among Non-Hispanic American Indian/Alaska Native mothers
- **State level activities/timeline:**
  - Update breastfeeding white paper, Achievable Goals, Infinite Rewards
  - Increase awareness of current laws and policies that protect against discrimination during pregnancy and support breastfeeding via updating the breastfeeding webpage
  - Strengthen/develop partnerships with Bureau of Business and Industry, Oregon Law Center, community groups and others
  - Promote resources with grantees and provide TA as requested
- **Local level activities/timeline:**
  - Coos County will increase awareness by educating businesses in their county using a locally developed toolkit for workplace breastfeeding support and providing education to pregnant and postpartum clients.

Strategy #2: Support advanced training, coaching and quality improvement activities for home visitors related to breastfeeding.

- **ESM 4.5:** Among local grantees who select breastfeeding, percent who report improved knowledge, skills, or policies based on provided technical assistance.
- **State level activities/timeline:**
  - Support grantees in identifying resources for advanced training and coaching for home visitors
  - Develop plan with MCH lead for continuous quality improvement in home visiting to assess or identify breastfeeding skills and training needs of home visiting staff and possibility for CQI project
- **Local level activities/timeline:** Ten grantees will provide or sponsor home visiting staff to attend advanced training and receive coaching to promote and support breastfeeding best practices including: Clackamas, Clatsop, Coos, Crook, Deschutes, Douglas, Jackson, Jefferson and Washington counties and Confederated Tribes of Warm Springs.

Strategy #3: Ensure that providers who serve tribal members have training in culturally specific approaches to breastfeeding promotion and support.

- **ESM 4.8:** Number of providers engaged in anti-racism or cultural humility training.

- **State level activities/timeline:**
    - Strengthen partnerships with Northwest Portland Area Indian Health Board (NWPAIHB), Intertribal Breastfeeding Coalition, tribal health clinics and other tribal partners to support nutrition and infant feeding work

    - Engage with WIC programs in tribal health clinics to learn and develop cross-program collaboration

Strategy #4: Support efforts to improve diversity in the workforce.

- **ESM:**
    - ESM 4.6: Completion of environmental scan of organizations and partners for increasing diversity in the perinatal workforce.

    - ESM 4.7: Number of OHA Office of Equity and Inclusion Certified Community Health Workers

- **State level activities/timeline:** Develop partnerships with community organizations who support training of community health workers, including doulas, lactation counselors, and peer-based care models.

- **Local level activities/timeline:**
    - Clatsop will identify and support bilingual community members interested in breastfeeding training to support families

    - Multnomah will convene/participate in a local community based perinatal, women's and infant health advisory group with focus on increasing workforce diversity

Strategy #5: Ensure access to culturally responsive preventive clinical care for low income and undocumented women.

- **State level activities/timeline:**

    - Promote anti-racism resources addressing perinatal health and breastfeeding through partnership with Nurturely, a non-profit organization that promotes equity in perinatal wellness and strengthens cultures of support for infants and caregivers.

    - Identify anti-racist and culturally responsive breastfeeding resources to share with grantees

    - Identify and leverage breastfeeding peer support services through programs (including WIC)

- **Local level activities/timeline:**
    - Harney and Josephine counties will implement and expand access to culturally specific breastfeeding peer support services

    - Tillamook will refer pregnant, postpartum, and/or breastfeeding women to establish primary care with a culturally and linguistically appropriate provider. In collaboration with their CCO they will implement a financial incentive program for prenatal, postpartum, breastfeeding and follow-up care.

Strategy #6: Establish community based perinatal, women's and infant health advisory groups to share best practices, strategize and impact policy change. Engage affected communities including people of color in leadership.

- **State level activities/timeline:**
    - Provide technical assistance and facilitate shared learning among Title V grantees in community engagement best practices.

    - Identify opportunities to build partnerships with community-based organizations.

- **Local level activities/timeline:**
    - Clatsop will re-engage past members of the North Coast Breastfeeding Coalition to participate in and lead in the re-establishment of the Coalition

    - Josephine will participate in a local community based perinatal, women's and infant health taskforce

Critical partnerships:

- All local grantees,
- WIC program,
- MIECHV program,
- Nurturely,
- Northwest Portland Area Indian Health Board,
- Bureau of Labor & Industries (BOLI)

Other Title V Work in this Domain

Title V will continue to provide leadership and technical assistance for linkages to prenatal care, oral health, maternal mental health, and other perinatal services; infant mortality reduction; PRAMS and ECHO 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. One specific upcoming activity is that a program evaluation of the breastfeeding priority for 2015 through 2020 will be conducted by Program Design and Evaluation Services (a PHD contracted evaluation group) to develop recommendations for future breastfeeding work.

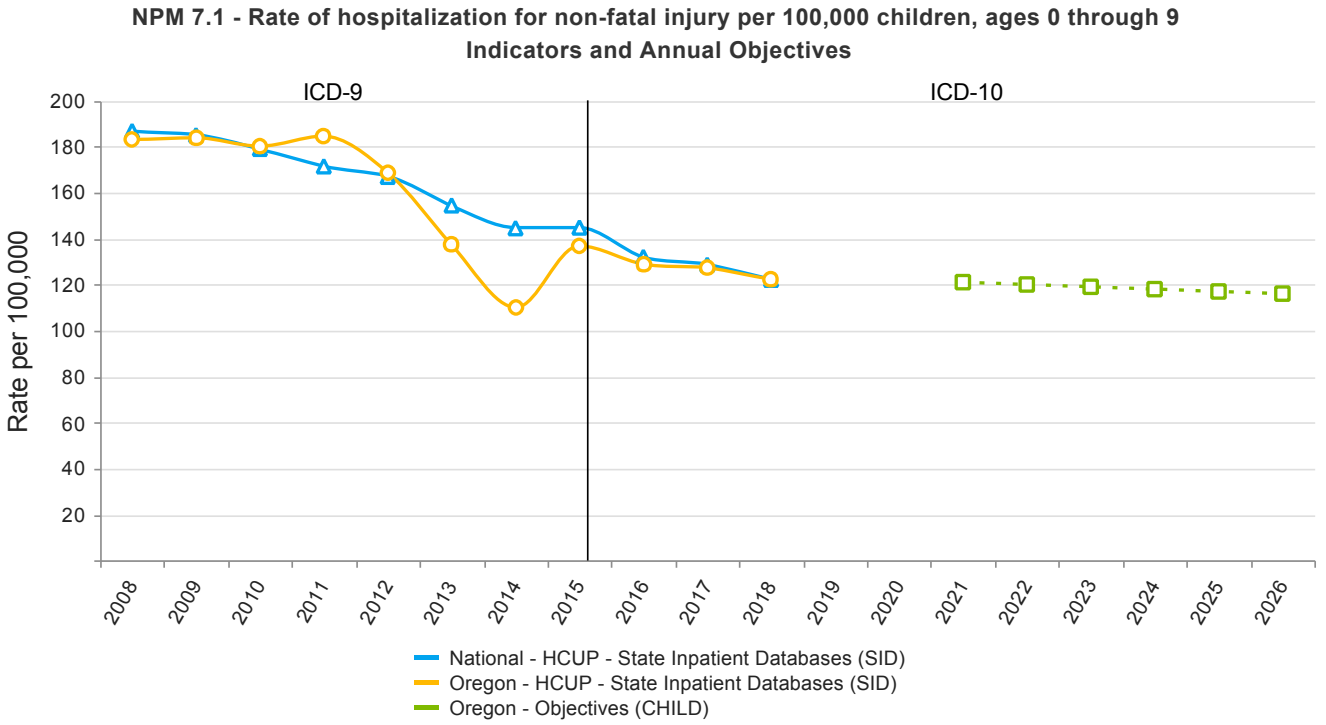
Child Health

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-2018	67.0	NPM 14.2
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	10.1	NPM 14.2
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	6.7 %	NPM 14.2
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	8.3 %	NPM 14.2
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	23.6 %	NPM 14.2
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	4.7	NPM 14.2
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	4.2	NPM 14.2
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	2.7	NPM 14.2
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.6	NPM 14.2
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	137.5	NPM 14.2
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	94.8	NPM 14.2
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	12.9 %	NPM 13.2
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2019	11.2	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	27.9	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	12.2	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	16.4	NPM 7.1

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-2018_2019	13.9 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.6 %	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-2018_2019	12.9 %	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-2018	14.6 %	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



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2019	**2020**
Annual Objective		
Annual Indicator	127.1	122.1
Numerator	609	582
Denominator	479,233	476,789
Data Source	SID-CHILD	SID-CHILD
Data Source Year	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	121.0	120.0	119.0	118.0	117.0	116.0

Evidence-Based or –Informed Strategy Measures

ESM 7.1.1 - Injury death rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	6.3
Numerator	87
Denominator	1,385,268
Data Source	Vital statistics and census
Data Source Year	2018-20
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	6.2	6.1	6.0	5.9	5.8

ESM 7.1.2 - Transportation injury death rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	2.2
Numerator	31
Denominator	1,385,268
Data Source	Vital statistics and census
Data Source Year	2018-20
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	2.1	2.0	1.9	1.8	1.7

ESM 7.1.3 - Drowning death rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0.9
Numerator	20
Denominator	2,335,113
Data Source	Vital statistics and census
Data Source Year	2016-20
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.9	0.9	0.8	0.8	0.7

ESM 7.1.4 - Poisoning injury rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	26.1
Numerator	362
Denominator	1,385,268
Data Source	Vital statistics and hospitalization data
Data Source Year	2018-20
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	25.9	25.7	25.5	25.3	25.1

ESM 7.1.5 - Among local grantees who select child injury prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	75.0	75.0	75.0	75.0

ESM 7.1.6 - Percent of engaged partner groups including other state departments, local grantees, and affected communities, that report satisfaction with level of engagement in the development of a collaborative child injury report.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	80.0	80.0	80.0	80.0	80.0

ESM 7.1.7 - Completed assessment of injury prevention risk assessment, education, and remediation in Oregon's public health home visiting programs.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes

State Action Plan Table

State Action Plan Table (Oregon) - Child Health - Entry 1	
Priority Need	
Safe and supportive environments	
NPM	
NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	
Objectives	
By October 1, 2025, decrease the rate of hospitalization of 0 to 9 year old children for non-fatal injuries from 127.1 to 117, by addressing upstream drivers of child injury.	
Strategies	
1. Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.	
2. Strengthen workforce capacity to address child injury prevention at the state and local level.	
3. Strengthen partnerships and coalitions to support child injury education, prevention plan implementation, and communication strategies.	
4. Improve data collection, analysis, interpretation and dissemination of child injury data to focus on prevention efforts.	
ESMs	Status
ESM 7.1.1 - Injury death rate among children 0 - 9 years of age	Active
ESM 7.1.2 - Transportation injury death rate among children 0 - 9 years of age	Active
ESM 7.1.3 - Drowning death rate among children 0 - 9 years of age	Active
ESM 7.1.4 - Poisoning injury rate among children 0 - 9 years of age	Active
ESM 7.1.5 - Among local grantees who select child injury prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance	Active
ESM 7.1.6 - Percent of engaged partner groups including other state departments, local grantees, and affected communities, that report satisfaction with level of engagement in the development of a collaborative child injury report.	Active
ESM 7.1.7 - Completed assessment of injury prevention risk assessment, education, and remediation in Oregon’s public health home visiting programs.	Active

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

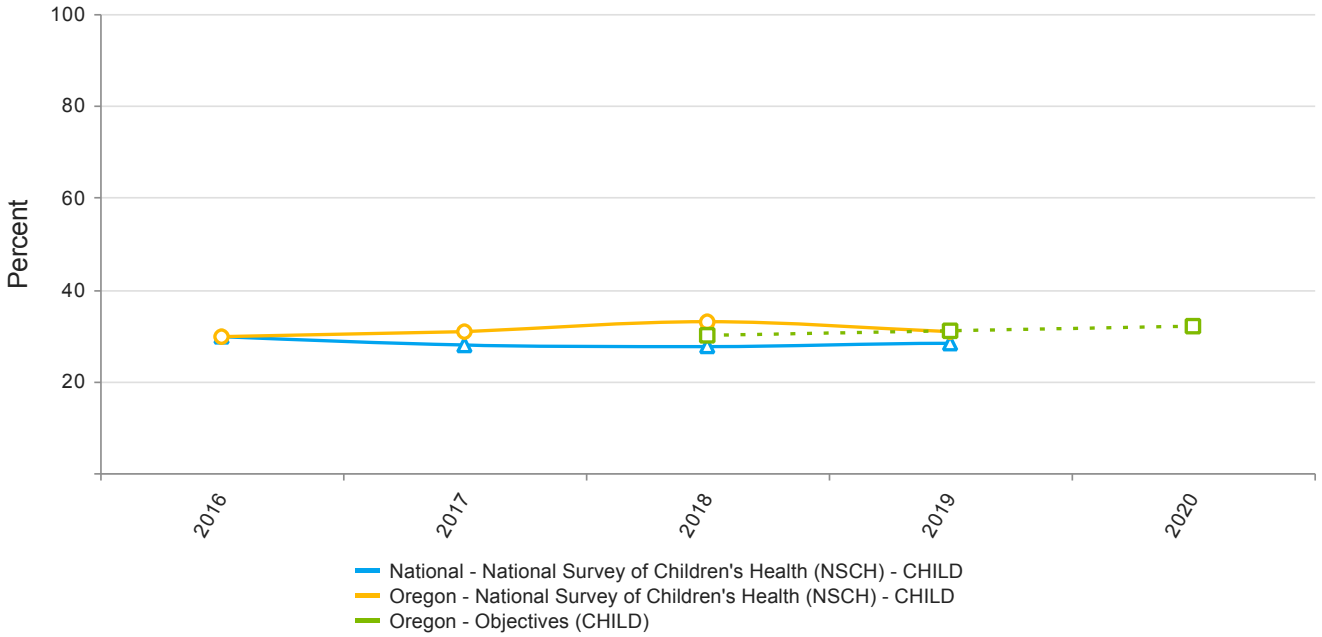
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

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

2016-2020: National Performance Measures

2016-2020: 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**	**2019**	**2020**
Annual Objective			30	31	32
Annual Indicator		29.7	30.9	32.8	30.7
Numerator		88,810	91,445	98,353	97,318
Denominator		298,807	296,257	299,920	317,301
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: 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**	**2019**	**2020**
Annual Objective	100	100	100	100
Annual Indicator	100	100	100	100
Numerator	5	5	6	5
Denominator	5	5	6	5
Data Source	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

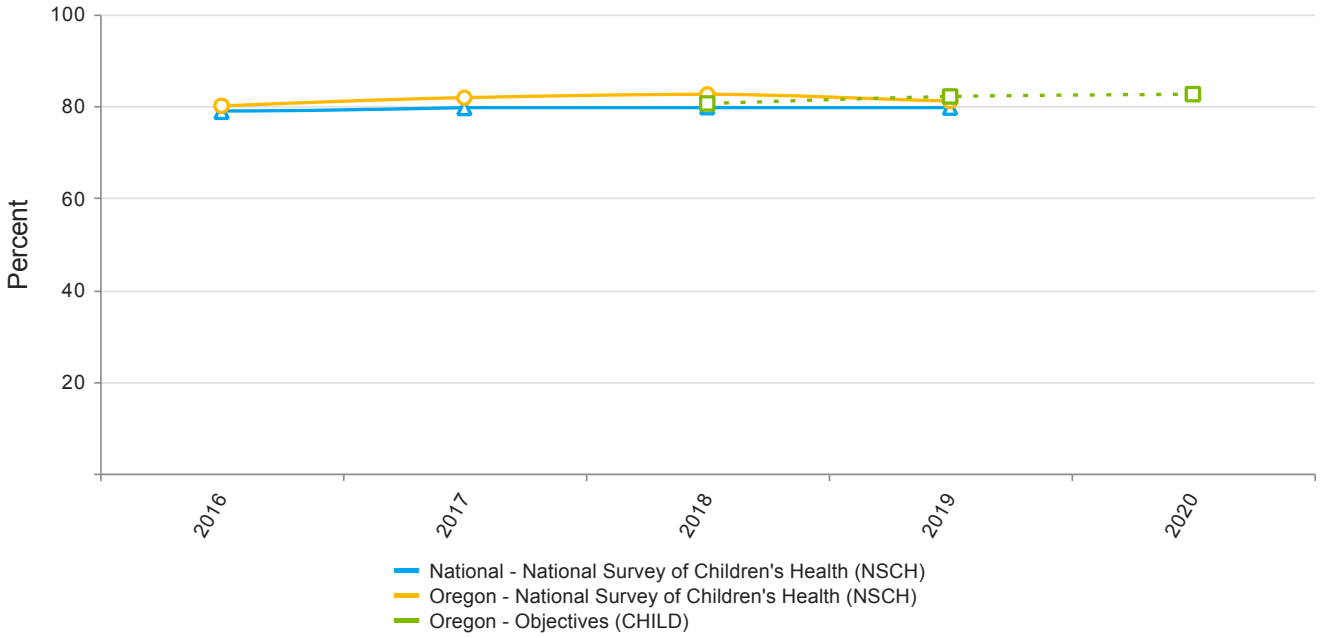
2016-2020: ESM 8.1.6 - Number of state early care and education systems addressed or influenced by Title V physical activity efforts during the grant year (CDC ECE Spectrum of Opportunities)

Measure Status:	**Active**			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			3	3
Annual Indicator			3	1
Numerator				
Denominator				
Data Source			State Tracking	State Tracking
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

2016-2020: 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			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			3	3
Annual Indicator			3	3
Numerator				
Denominator				
Data Source			State Tracking	State Tracking
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

2016-2020: NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
Indicators and Annual Objectives



2016-2020: NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			80.5	82	82.5
Annual Indicator		80.1	81.8	82.5	80.9
Numerator		647,060	662,516	671,363	667,982
Denominator		808,103	810,225	813,993	825,434
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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.

2016-2020: Evidence-Based or –Informed Strategy Measures

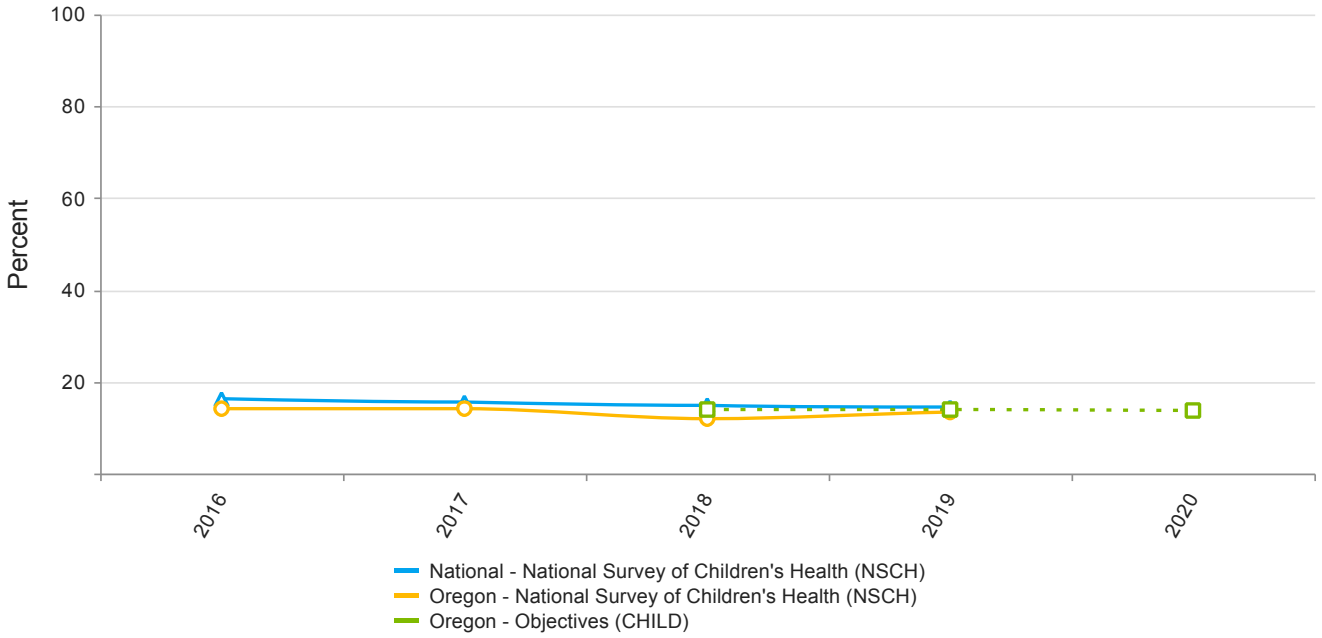
2016-2020: ESM 13.2.1 - Number of school oral health programs and Title V local grantees provided with technical assistance to enhance the quality of oral health services and increase oral health visits.

Measure Status:	Active			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	30	30	20	20
Annual Indicator	28	30	21	38
Numerator				
Denominator				
Data Source	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 13.2.3 - Number of oral health providers provided training on oral cancer and HPV.

Measure Status:	Active		
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			100
Annual Indicator			48
Numerator			
Denominator			
Data Source			Attendance sheets
Data Source Year			2020
Provisional or Final ?			Final

2016-2020: NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes
Indicators and Annual Objectives



2016-2020: NPM 14.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			14	14	13.8
Annual Indicator		14.2	14.3	12.1	13.5
Numerator		118,807	121,667	104,275	115,818
Denominator		838,336	849,982	858,440	859,186
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 14.2.5 - Number of external partners engaged in developing a policy agenda to decrease youth exposure to tobacco.

Measure Status:	**Active**		
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			5
Annual Indicator			5
Numerator			
Denominator			
Data Source			State Tracking
Data Source Year			2020
Provisional or Final ?			Final

Child physical activity report

Priority: Child Physical Activity

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 – 11 years who were physically active at least 60 minutes per day decreased from 32.8% to 30.7%, when comparing 2017/18 data to 2018/19 data. This decrease should be interpreted with caution due to the small sample size of the National Survey of Children's Health in Oregon.

Strategies:

Strategy #1: Support physical activity in childcare settings through policy, training, and workforce development.

- **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.
- **ESM:** 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)
- **Progress on ESMs:** During the reporting period, 1 of the 9 ECE Spectrum of Opportunities systems was specifically addressed through efforts and activities conducted with Title V funding.
- **Accomplishments:**
  - Provided technical assistance, policy review and support as needed related to state childcare health and safety rules and their alignment with national standards and evidence-based practices.
  - Participated in Oregon State Health Improvement Plan Obesity Priority Workgroup to promote collaboration, life course perspective awareness and consistent, shared communications across public health initiatives.
  - Participated in Oregon Safe Kids Advisory Committee, providing technical support and data interpretation for child injury areas, which include injury hospitalizations and deaths related to physical activity - including falls, pedestrian and cycle, and other conveyances, for children birth to 5.
- **Challenges/emerging issues:** The COVID-19 pandemic and other pressing priorities in the early care and education sphere made it difficult to advance this area of work. Staff across the MCH Section were deployed to the state's COVID-19 response, leaving the remaining staff to backfill and cover other staff duties. The pandemic diluted the capacity available to focus on Title V activities.

Strategy #2: Support 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.

- **ESM:**
  - 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.

- **Progress on ESMs:**
  - ESM 8.1.3: All 5 grantees were provided support and technical assistance related to their individual needs for plan implementation.

  - ESM 8.1.7: Three school districts participated in focus groups to explore challenges and opportunities to implement physical activity before, during and after school.

- **Accomplishments:**
  - Co-facilitated the Oregon Healthy Weight CollN team in partnership with Department of Education, Safe Routes to School National Partnership, and the Multnomah Educational Service District; leveraged the CollN experience and partnerships to successfully apply for the ASPHN Nutrition Capacity Grant.

  - Contributed to coordination and collaboration opportunities through active participation in:
    - Oregon Department of Education led Oregon Healthy Schools (CDC 1801 Grant) Advisory Committee. Attended bimonthly meetings.
    - Monthly Wellness in School Environment (WISE) meetings.

  - Convened local Title V partners for cross-grantee sharing of information, support, and technical assistance in core physical activity strategy areas. Provided and facilitated access to technical assistance as needed.

  - Participated in discussions with researchers from Oregon State University to support their use of BMI data available through the Oregon SMILE survey to look at the impacts of the 4-day school week model and explore the impacts of state level physical education policies on children's development.

  - Was interviewed for article about Title V children's physical activity work for the NW Public Health Bulletin.

  - Participated on Blue Ribbon Panel for annual School Wellness Award through Department of Education. The Panel solicits, reviews, and selects schools to receive wellness awards based on commitments and investments in student and staff health. Award monies are used to improve the physical environment of the schools for health and wellness.

  - Five local Title V grantees (Confederated Tribes of the Umatilla Indian Reservation, the Coquille Tribe, Jefferson County, Marion County and Wheeler County) worked in this area:
    - Marion County staff provided training, consultation, and support for the promotion of physical activity before, during and after school. Provided leadership and support for active

transportation and expansion of Safe Routes to School in neighborhoods. Provided outreach and consultation to school districts in support of physical activity.

- Jefferson County partnered with the Confederated Tribes of Warm Springs to convene the Child Health Task Force, develop outreach and engagement opportunities for families in the community, participated in transportation meetings and conducted youth engagement opportunities to understand barriers among youth to active transportation choices. In addition, Jefferson County adopted a wellness policy to support nutrition and physical activity among staff.

- Confederated Tribes of the Umatilla Indian Reservation focused on improving places and access for physical activity, and on providing intentional physical activity opportunities for the community including youth. These included in -person structured classes pre- COVID-19, and "PE at home" videos available on YouTube for families to use during COVID-19 restrictions. In addition, the Tribe's Indigenous Project LAUNCH team developed a partnership with the Department of Child and Family Services to support foster families with supplies, games and safety equipment to participate in physical activity together.

- Wheeler County expanded a yoga program started in rural schools, provided information about physical activity to providers and families at annual Health Fair.

- The Coquille Indian Tribe completed 8 safe routes walking maps for tribal and non-tribal members, young and old alike to enjoy.

- **Challenges/emerging issues:** The COVID-19 pandemic made it difficult to advance this area of work. Staff across the MCH Section were deployed to the state's COVID-19 response, leaving the remaining staff to backfill and cover other staff duties. This diluted the capacity available to focus on Title V activities. Schools across Oregon were closed at the onset of the pandemic in March/April, and focus shifted to standing up online learning, concerns about food security for families, family safety, and educational deficits caused by the pandemic. Local public health agencies and tribal health agencies caught on the front line of the COVID-19 public health emergency experienced severe capacity and community impacts, impacting the extent to which plans could be implemented.

Smoking Report (children)

Priority: Smoking (Children)

National Performance Measure: Percent of children who live in households where someone smokes.

Interpretation of national performance measure data:

The percent of children who live in a household where someone smokes increased from 12.1% to 13.5%, when comparing data from 2017-18 to data from 2018-19. This increase should be interpreted with caution due to the small sample size of the National Survey of Children's Health in Oregon.

Strategies:

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

- **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 State Health Improvement Plan - Behavioral Health.

  - 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.

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

- **Progress on ESMs:** We were able to engage 5 partners to develop a policy agenda to decrease youth exposure to tobacco and other substances during the grant year, including: Health Promotion and Chronic Disease Prevention, Injury and Violence Prevention, OHA Health Systems Division, Adolescent & School Health Unit, Alcohol and Drug Policy Commission

- **Accomplishments:**
  - A new state staff person was hired in November 2019 to be the lead for Smoking Cessation priority area activities. The current Title V coordinator oriented the new staff member to this work throughout fall 2019.

  - The staff member initiated monthly meetings with staff from the Health Promotion and Chronic Disease Prevention Program and Maternal and Child Health (MCH) Section, including those working on smoking cessation, nutrition, and physical activity. Those meetings unfortunately had to be put on hold when the COVID-19 emergency was declared in March 2020 and staff were reassigned to the state COVID-19 response.

  - Another cross-division group was formed during the grant year to coordinate Public Health Division work related to substance use disorders. Two staff from MCH regularly attend this Alcohol and Other Drug Coordinating Team. These two staff participated in the development of a collaborative framework and action plan for Division-wide AOD prevention work. MCH staff contributed a health equity and trauma-informed lens to the planning and discussion to emphasize the upstream factors (e.g., chronic stress, trauma) that may contribute to tobacco and substance misuse.

  - Finally, the new Smoking Cessation lead served as the chair for the Oregon Health Authority's State Health Improvement Plan Behavioral Health subcommittee at the beginning of this grant cycle. Goals, strategies, and activities for the SHIP were finalized in fall 2019.

- **Challenges/emerging issues:** The COVID-19 pandemic made completion of our planned activities difficult this grant cycle. Although we were able to complete many activities, we had set out to accomplish this grant cycle, progress was significantly slowed due to OHA agency staff being redirected to the state COVID-19 response.

Strategy #2: Provide technical assistance to local health agencies and tribes working on strategies to decrease tobacco use among pregnant women and children's exposure.

- **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 State Health Improvement Plan - Behavioral Health.

  - Provide necessary print, electronic, and training materials to counties and tribes to increase knowledge around tobacco cessation benefits and the Oregon Quitline.

- **ESM:** 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:** All local Title V grantees who selected smoking as a priority area received at least two technical assistance contacts with the Smoking Cessation priority lead.

- **Accomplishments:**
    - A new state staff person was hired in November 2019 to be the lead for Smoking Cessation priority area activities. The current Title V coordinator oriented the new staff member to this work throughout fall 2019.

    - The priority lead contacted all Title V grantees who selected smoking as a priority area for an initial technical assistance call as part of her onboarding. The priority lead also reviewed plans and coordinated technical assistance calls with Title V grantees during spring 2020.

    - A new Native QuitLine was developed by the Health Promotion and Chronic Disease Prevention program in partnership with Oregon Tribes. The priority lead distributed information about this new program, including materials and promotional items, to Title V grantees. Smoking cessation materials were also distributed to pregnant clients via the Oregon MothersCare program. The Smoking Cessation priority lead worked with the OHA materials distribution center to maintain smoking cessation educational materials for all Oregon MothersCare sites to use.

- **Challenges/emerging issues:** The COVID-19 pandemic made completion of our planned activities very difficult. Many local Title V staff were pulled into their community COVID-19 responses and traditional public health programs were temporarily "paused" or scaled back during the grant year. Local Title V staff lacked the capacity to participate in regular technical assistance opportunities for Title V activities.

Oral Health Report (children)

Priority: Oral Health (Children)

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

Interpretation of national performance measure data:

There has been a decrease in the percent of Oregon children ages 1 to 17 years who had a preventive dental visit in the last year, when comparing the 2016/17 rate of 81.8% to the 2017/18 rate of 80.9%. Single year data cannot be examined independently in Oregon due to small sample size. Another consequence of the small sample size is that the decrease in the rate should be interpreted with caution.

Strategies:

Strategy #1: Increase awareness and engagement within the dental community of oral cancer and HPV.

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

- **Progress on ESMs:** 48 participants attended the oral health specific presentation at the HPV Virtual Summit.

- **Accomplishments:**
    - Collaborated with the state Immunization Program to update the brochure titled, "Oral Cancer and HPV: Protect Your Family" to be more health literate. The brochure is used by dental providers to promote the HPV vaccine with adolescents and parents/caregivers.

    - Participated on the planning committee for the 2020 Statewide HPV Virtual Summit, sponsored by the American Cancer Society and state Immunization Program, that was held on August 19-20, 2020. We engaged the dental community to attend the event and had the Dean of the Dental School at Oregon Health & Science University (OHSU) present on HPV and the dental community.

- **Challenges/emerging issues:**
    - The COVID-19 pandemic limited progress in this area. Several Oral Health Unit staff members were reassigned to help with the emergency response, limiting the amount of time staff worked on oral health and title V activities.

- The pandemic did garner attention in having dentists administer vaccines. House Bill 2220 was signed into law on May 6, 2019 authorizing Oregon dentists to prescribe and administer vaccines beginning January 1, 2020. Dentists have been recruited to administer the flu and COVID-19 vaccine during the pandemic, but we hope to expand this to the HPV vaccine in the future.

Strategy #2: Provide technical assistance to school oral health programs and Title V grantees.

- **ESM:** 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:** Seventeen Title V local grantees were provided with technical assistance to promote dental visits for children and adolescents. Technical assistance was provided to 21 school dental sealant programs.

- **Accomplishments:**
  - Seventeen grantees - fifteen local health agencies and two tribes - were provided with individualized technical assistance throughout the grant year.

  - From June 2020 through August 2020, the Oral Health Unit convened a workgroup that developed draft guidelines for school oral health programs to safely provide oral health services in school settings during the COVID-19 pandemic. The workgroup included representatives from the Oregon Department of Education (ODE), PHD Adolescent & School Health, and certified school dental sealant programs. Two guidance documents were created that were finalized by Oregon's emergency response Team in September 2020:
    - OHA Guidance on Resumption of Dental Services in School Settings
    - OHA Guidance for Certified School Dental Sealant Programs

  - The Oral Health Unit conducted a virtual clinical training for school dental sealant programs on August 7, 11 & 13, 2020 that included infection control practices during the COVID-19 pandemic.

  - Before schools were closed due to the COVID-19 pandemic in mid-March 2020, site visits were conducted with 19 out of 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.

- **Challenges/emerging issues:**
  - The COVID-19 pandemic limited progress in this area. Several Oral Health Unit staff members were reassigned to help with the emergency response, limiting the amount of time staff worked on oral health and title V activities. Local public health agencies and tribes also reassigned staff to help with the pandemic, limiting the time being spent on Title V activities.

  - Schools in Oregon were closed to in-person instruction on March 16, 2020 and remained closed for the remainder of the 2019-2020 academic year. School oral health programs were not allowed to operate.

Strategy #3: Increase oral health surveillance in Oregon.

Planned Activities:

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

- **Progress on ESMs:** Seven data sets in the OOHSS can be analyzed for oral health disparities.

- **Accomplishments:**
  - Seven data sources were identified within the Oregon Oral Health Surveillance System (OOHSS) can be analyzed by race, ethnicity, language, and disability (REALD).

  - Pulled together a workgroup to look at REALD for the 2022 Oregon Smile & Healthy Growth Survey.

- The Oral Health Unit piloted a voluntary REALD questionnaire that was included with parent permission forms provided to elementary and middle schools served by the statewide OHA School-based Dental Sealant Program.

- **Challenges/emerging issues:**
  - The COVID-19 pandemic limited progress in this area. Several Oral Health Unit staff members were reassigned to help with the emergency response, limiting the amount of time staff worked on oral health and title V activities. Since the pandemic has highlighted the need for REALD, we anticipate future policy changes in this area.

Strategy #4: Provide oral health preventive services or education and referral/case management services through Oregon's Home Visiting System.

- **Accomplishments:**
  - Benton, Jefferson, Jackson, Lake, Linn, Malheur, and Morrow Counties provided oral health education and referrals for dental care during home visits.
  - Benton and Jefferson Counties had all home visiting staff take the national, online Smiles for Life training.

- **Challenges/emerging issues:**
  - The COVID-19 pandemic limited progress in this area. Local public health agencies and tribes reassigned staff to help with the pandemic, limiting the time being spent on Title V activities. Beginning in mid-March 2020, in-person nurse home visiting services were discontinued. Those that provided virtual appointments were limited to providing oral health education and referral services.

  - Dental referrals became even more challenging during the pandemic. Dental clinics were only allowed to provide emergency services from mid-March until May 2020. Many dental clinics closed entirely during this time and were slow to open. It was challenging for a lot of clinics to meet the reopening guidelines due to staffing challenges and PPE shortages.

Strategy #5: Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health and the importance of dental visits.

- **Accomplishments:**
  - Clackamas County worked on scheduling and intake processes to increase the number of WIC clients and young children receiving preventive oral health services as part of their Healthy Smiles Program.

  - Columbia County provided oral health education and referral services to children in their home visiting and WIC programs.

  - Cow Creek Band of Umpqua Tribe of Indians provided children with oral health education and dental care kits at least twice a year. Cow Creek Health & Wellness primary care and pediatric care staff received training on how to provide oral health screenings to children and adolescents during physicals.

  - Hood River County collaborated with Advantage Dental to provide monthly oral health screenings and preventive services for children in their WIC program.

  - Jefferson County Public Health provided oral health education, fluoride varnish and dental care referrals for children through WIC follow-up appointments.

  - Josephine County collaborated with Siskiyou Dental to provide oral health education and fluoride varnish to low-income children participating in their WIC and public health programs.

  - Klamath County collaborated with the Klamath Basin Oral Health Coalition and Cascade Health Alliance CCO to develop oral health education materials for adolescents and parents/caregivers around HPV and oral cancer.

  - Lake County collaborated with Advantage Dental to provide oral health assessments, education, and

fluoride varnish to children in their WIC program.

- Morrow County collaborated with Advantage Dental to provide oral health education and screenings in the schools and assisted with getting parent permission for needed follow-up dental care.
- Polk County partnered with Capitol Dental Community Outreach to provide onsite dental services for children and families at Polk County Health Services.
- Wheeler County distributed the Bright Futures Oral Health pocket guide to parents/caregivers who came to the clinic for WIC services.

- **Challenges/emerging issues:**
  - The COVID-19 pandemic limited progress in this area. Local public health agencies and tribes reassigned staff to help with the pandemic, limiting the time being spent on Title V activities. Beginning in mid-March 2020, in-person programs such as WIC and nurse home visiting were discontinued. Those programs that provided virtual appointments were limited to providing oral health education and referral services.
  - Dental referrals became even more challenging during the pandemic. Dental clinics were only allowed to provide emergency services from mid-March until May 2020. Many dental clinics closed entirely during this time and were slow to open. It was challenging for a lot of clinics to meet the reopening guidelines due to staffing challenges and PPE shortages.

Other Title V Work in this Domain

Title V's work in child health focused 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.

In addition to priority specific activities, state Title V staff provided leadership, technical and analytic expertise for multiple programs, surveillance systems and initiatives for improved child health in the following areas:

- Leadership and analytic expertise to support the development and implementation of the ECHO (3-year follow back survey to PRAMS);
- Leadership and analytic expertise to support the day to day programmatic activities of the EHDI (early hearing detection and intervention) program, including capacity to apply for CARES Act funding to support telehealth and anti-racism approaches to support EHDI systems;
- Leadership and analytic expertise to support data collection, analysis, and capacity to apply for future federal funding to support Oregon's Birth Anomalies Surveillance System (BASS);
- Technical expertise for analysis of legislative bills impacting children and youth in Oregon;
- Leadership and subject matter expertise in Oregon's State Child Fatality Review Team and in providing technical assistance to county child fatality teams;
- Leadership representing public health for Oregon's Initiative for Inclusive Child Care for Children with Special Health Needs, led by the Oregon Department of Education;
- Leadership and subject matter expertise in reviewing Oregon Coordinated Care Organization's Community Health Assessments and Health Improvement Plans for maternal and child health content and alignment;
- Leadership and representation on Oregon's State Interagency Coordinating Council (SICC), convened by the Oregon Department of Education;
- Subject matter expertise and participation in Oregon's Climate Health Action Planning work;
- Participation in the Children's Healthy Weight Collaborative Improvement & Innovation Network (CHW-CoIIN) Physical Activity and Nutrition Integration workstreams, coordinated by ASPHN and designed to promote

healthy weight among all children, including those with special health care needs (see Supporting Document #3 for infographics).

- For the Physical Activity workstream, a two-pronged approach was used to increase physical activity among children – 1. conducting focus groups to examine the opportunities and barriers to implementing physical activity and education in school districts; 2. creating a Supplemental Instructional Materials Alignment Tool that organizations can use to align with Oregon state physical education content standards. An infographic describing this work is available at: https://asphn.org/wp-content/uploads/2021/06/2020-oregon-chw-coiin-pa-final.pdf
- For the Nutrition Integration workstream, public health programs and agency work across the life course was assessed using the I +PSE framework. An infographic describing this work is available at: https://asphn.org/wp-content/uploads/2021/06/2020-oregon-chw-coiin-in-FINAL.pdf

Other local Title V grantee work in child health included a focus on car seat safety by the Confederated Tribes of Warm Springs Title V program They have been purchasing, distributing, and installing car seats to Tribal families with newborns, holding car seat clinics, and providing training for staff to be certified car seat educators and installers.

Child Injury Prevention Plan

Priority: Child Injury Prevention

National Performance Measure: Rate of injury-related hospital admissions per population ages 0 through 19 years.

Strategies:

Strategy #1: Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.

- **ESMs:**
  - ESM 7.1.1: Injury death rate among children 0 - 9 years of age
  - ESM 7.1.2: Transportation injury death rate among children 0 - 9 years of age
  - ESM 7.1.3: Drowning death rate among children 0 - 9 years of age
  - ESM 7.1.4: Poisoning injury rate among children 0 - 9 years of age

- **State level activities/timeline:**
  - Review leading causes of injury hospitalizations and deaths. Select leading 1-3 causes for state policy inventory. Oct 2021-March 2022

  - Identify injury prevention policy gaps and opportunities. April-September 2022

  - Provide data and technical assistance to local Title V partners. October 2021-September 2022

- **Local level activities/timeline:**
  - Marion, Wheeler: Assess child injury prevention policy gaps.

  - Wheeler: Assess child injury data to identify leading causes in community.

Strategy #2: Strengthen workforce capacity to address child injury prevention at the state and local level.

- **ESM:**
  - ESM 7.1.5: Among local grantees who select child injury prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance

  - ESM: 7.1.7: Completed assessment of injury prevention risk assessment, education, and remediation in Oregon's public health home visiting programs

- **State level activities/timeline:**
  - Interview PHNs and review program documents re: available training and support for injury prevention in home visiting programs. Crosswalk to look for opportunities to increase consistency and identify gaps for training. October 2021-September 2022

  - Provide data and technical assistance to local Title V partners. October 2021-September 2022

- **Local level activities/timeline:**
  - Polk County: Assess and enhance integration of injury risk assessment, education, and remediation into home visits with families. Provide or arrange for staff to participate in child injury prevention trainings.

Strategy #3: Strengthen partnerships and coalitions to support child injury education, prevention plan implementation, and communication strategies.

- **State level activities/timeline:**
  - Participate in Oregon Safe Kids meetings and special projects. Work with MCH Health Educator on coordinated social media messages with Safe Kids partners. October 2021-September 2022

  - Provide technical assistance to local Title V partners. October 2021-September 2022

- **Local level activities/timeline:**
    - Benton, Columbia, Linn, Polk, Wheeler: Develop and disseminate child injury prevention messaging to the public and/or home visiting clients.
    - Crook: Provide safe storage lockboxes for clients who report unsafe storage of harmful substances.
    - Jackson County: Provide safe sleep anticipatory guidance to each family served through home visiting.
    - Marion, North Central Public Health District, Wheeler: Participate in Oregon Safe Kids Coalitions in region or county.
    - Confederated Tribes of Warm Springs: Perform or fund culturally specific health outreach and education. Conduct Back to the Board classes for infant sleep. Distribute car seats to families of newborns.

Strategy #4: Improve data collection, analysis, interpretation, and dissemination of child injury data to focus on prevention efforts.

- **ESM 7.1.6:** Percent of engaged partner groups including other state departments, local grantees, and marginalized communities, that report satisfaction with level of engagement in the development of a collaborative child injury report.
- **State level activities/timeline:**
    - Participate on State Child Fatality Review. Serve as a liaison to local fatality teams. October 2021-September 2022
    - Convene PHD staff to map available data, timelines for reporting, processes, and develop plan for child injury data report. October 2021-September 2022
    - Provide data and technical assistance to local Title V partners. October 2021-September 2022
- **Local level activities/timeline:**
    - Wheeler: Participate in local child death review team and contribute to improved reporting

Critical partnerships:

- Safe Kids Oregon members and Local Coalitions
- State Child Fatality Review Team members
- Oregon Injury and Violence Prevention Program
- Local fatality review teams

Other Title V work in this Domain

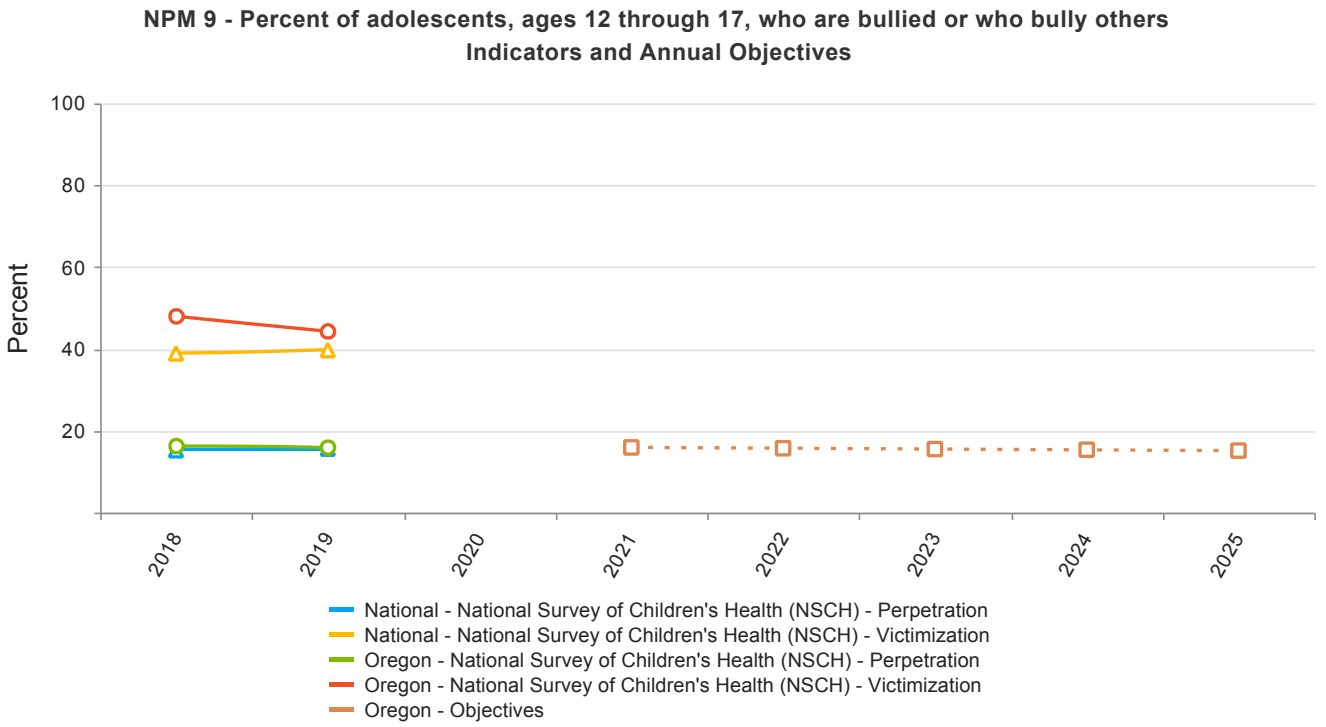
Title V's work in child health will continue to provide leadership, technical assistance and analytic expertise for the activities reported under "Other Title V work in this domain" in the preceding section; and integration of child health promotion into programs and policies across state and local agencies. Title V will also continue to support work in Oral Health for children, although it is no longer one of Oregon's selected Title V NPMs.

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-2019	27.9	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	12.2	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	16.4	NPM 9 NPM 10
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-2018_2019	13.9 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	57.2 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.6 %	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-2018_2019	12.9 %	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)	WIC-2018	14.6 %	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-2019_2020	64.1 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	74.6 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	90.2 %	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-2019	85.0 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	12.1	NPM 10

National Performance Measures



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - Perpetration		
	2019	**2020**
Annual Objective		
Annual Indicator	16.3	16.1
Numerator	44,259	44,099
Denominator	270,893	273,112
Data Source	NSCHP	NSCHP
Data Source Year	2018	2018_2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - Victimization		
	2019	**2020**
Annual Objective		
Annual Indicator	47.9	44.1
Numerator	129,756	120,491
Denominator	271,087	273,209
Data Source	NSCHV	NSCHV
Data Source Year	2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	16.0	15.8	15.6	15.4	15.2	15.0

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - Percent of 8th and 11th graders who have experienced bullying.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	24.9
Numerator	
Denominator	
Data Source	Oregon Healthy Teens Survey
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	24.0	23.0	22.0	21.0	20.0

ESM 9.2 - Percent of 8th and 11th graders who have experienced bullying due to their race or ethnicity.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	4.4
Numerator	
Denominator	
Data Source	Oregon Healthy Teens Survey
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	4.3	4.2	4.1	4.0	3.9

ESM 9.3 - Percent of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	4.7
Numerator	
Denominator	
Data Source	Oregon Healthy Teens Survey
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	4.6	4.5	4.4	4.3	4.2

ESM 9.4 - Percent of 8th and 11th graders who have experienced bullying due to a disability.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	2.0	1.9	1.8	1.7	1.6

ESM 9.5 - Among local grantees who select bullying prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	75.0	75.0	75.0	75.0

ESM 9.6 - Completion of environmental scan of youth serving agencies.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 9.7 - Number of activities completed that increase local access to bullying prevention resources.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	5.0	5.0	5.0	5.0	5.0

State Action Plan Table

State Action Plan Table (Oregon) - Adolescent Health - Entry 1	
Priority Need	
Stable and responsive relationships; resilient and connected children, youth, families and communities.	
NPM	
NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others	
Objectives	
By October 1, 2025, decrease the percentage of adolescents age 12-17 who bully others from 16.3% to 15.3%, and decrease the percentage of those who are bullied from 47.9% to 45.4%.	
Strategies	
1. Support the workforce to understand the impact of bullying on adolescent health.	
2. Support bullying prevention education in schools	
3. Determine gaps and opportunities for bullying prevention partnerships and initiatives with internal and external partners	
4. Support youth participatory action research on bullying prevention.	
ESMs	**Status**
ESM 9.1 - Percent of 8th and 11th graders who have experienced bullying.	Active
ESM 9.2 - Percent of 8th and 11th graders who have experienced bullying due to their race or ethnicity.	Active
ESM 9.3 - Percent of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity.	Active
ESM 9.4 - Percent of 8th and 11th graders who have experienced bullying due to a disability.	Active
ESM 9.5 - Among local grantees who select bullying prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance.	Active
ESM 9.6 - Completion of environmental scan of youth serving agencies.	Active
ESM 9.7 - Number of activities completed that increase local access to bullying prevention resources.	Active

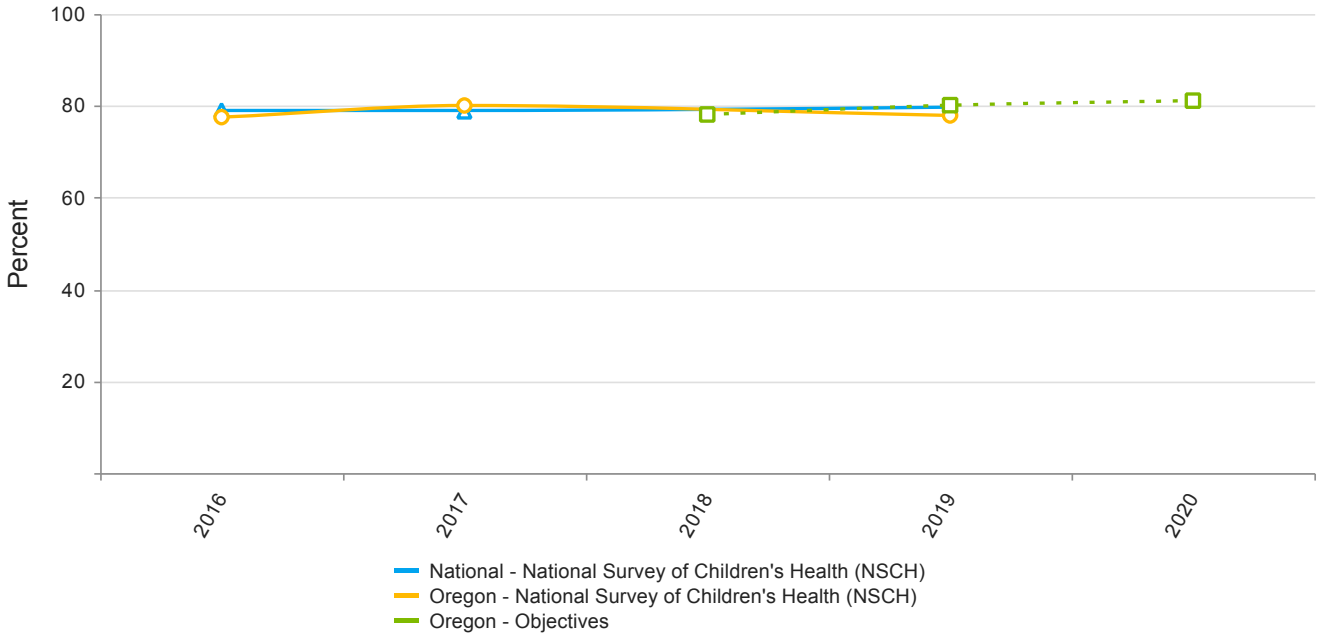
NOMs

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

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

2016-2020: National Performance Measures

2016-2020: NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			78	80	81
Annual Indicator		77.4	79.9	79.9	77.7
Numerator		227,178	230,520	230,520	216,199
Denominator		293,358	288,666	288,666	278,157
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

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.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 10.1 - Number of health professionals trained on adolescent well visits.

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				200	200
Annual Indicator	161	282	575	80	80
Numerator					
Denominator					
Data Source	Attendance sheets	Attendance sheets	Attendance sheets	Attendance sheets	Attendance sheets
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: 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**	**2019**	**2020**
Annual Objective			100	100	100
Annual Indicator	0	1,137	168	0	0
Numerator					
Denominator					
Data Source	State tracking	State tracking	State tracking	State tracking	State Tracking
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Adolescent Well Visit Report

Priority: Adolescent Well Visit (AWV)

National Performance Measure: Percent of adolescents with a preventative medical visit in the last year

Interpretation of national performance measure data:

The percent of adolescents with a preventative medical visit in the last year decreased from 79.9% in 2016/17 to 77.7% in 2019. This decrease may have been due to the discontinuation of adolescent well visits as a CCO incentive metric in Oregon.

Strategies

Strategy #1: Promote policies and practices to make youth health programs more youth friendly and youth informed.

- **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.
  - 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.
- **ESM:** 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.)
- **Progress on ESMs:** Over 80 providers/staff were trained on the promotion of youth-friendly services and/or relevant content during an adolescent well-visit.
- **Accomplishments:**
  - Snapshot of Adolescent Health was updated, and presentations were provided to multiple partners including policymakers, youth-serving agencies, and school administrators.
  - Healthcare professionals continue to have access to web-based learning and resources on the AWV through the Oregon Health Authority Transformation Center. Title V staff collaborated on the development of these resources.
  - In October 2019, over 80 School-Based Health Center (SBHC) staff from throughout the state participated in an in-person Coordinator's meeting focused on multiple issues of importance for Strategy #1, including the first updated Adolescent Health Snapshot presentation with a preview of

2019 data.

- We provided school districts and schools with data to promote, refer to, and/or deliver adolescent preventative care. The Adolescent and School Health Policy and Assessment Specialist presented to groups of educators, including state and local educational leaders. The presentations highlighted Oregon Healthy Teens data that demonstrated connections between health and educational outcomes and emphasized the benefit of the AWV.

- To improve the relevance of health surveys for schools and youth, the Policy and Assessment Specialist continued to conduct informational interviews with school administrators, youth serving organizations and youth. Information from these interviews informed the content for the new Student Health Survey (replacing Oregon Healthy Teens), scheduled to launch during the 2020-2021 school year.

- State Title V Staff supported Local Public Health Authorities that selected the AWV as a priority measure by being available for consultation and providing training resources and assuring connection with SBHCs.

- Used new Adolescent and School Health (ASH) Instagram page to promote the adolescent well visit and other youth-facing messages and further connect youth-serving agencies with the Adolescent & School Health Program.

- **Challenges/emerging issues:**
  - Adolescent and School Health Policy and Assessment Specialist (Wes Rivers) position was vacated due to a job rotation. A temporary staff person was brought on for 6 months to support the Title V work.

  - With the AWV removed from the CCO Incentive Metrics set, staff transitions, and other burgeoning issues happening at the local level, AWV promotion efforts were hampered.

  - In March 2020, school and health clinic closures due to the COVID-19 pandemic disrupted work on all Adolescent Well Visit strategies. Preventive care is not prioritized as communities respond to the pandemic.

  - The Adolescent and School Health Program in collaboration with partners is working to assure some preventive care continues. Areas of emphasis are immunizations and mental health supports. A quality well visit addresses both of those areas. Partners are being nimble, using telehealth and finding new ways to reach out to families and youth.

Strategy #2: 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.

- **Accomplishments:**
  - Adolescent and School Health Program contracted with Matchstick Consulting to
    - Provide training and technical assistance to SBHC Youth-led Project grantees on Youth Adult partnership and YPAR
    - Evaluate YPAR as a class, and YPAR as a club

  - SBHC Coordinators meetings included youth-led sessions.

  - Building momentum within the Public Health Division for additional YPAR funding in the future through collaborations with Health Systems Division and their SAMSHA Statewide Opioid Response grant.

- Local Public Health Authorities working on the AWV priority were supported to connect with their SBHCs and YACs.

- Adolescent and School Health Program contracted with the Oregon School Based Health Alliance to hold a SBHC YAC Summit and provide coaching and technical assistance to 2 SBHCs to create a YAC Coaching Model.

- **Challenges/emerging issues:**
  - Some providers and partners continue to feel that asking only adults for input is adequate community engagement.

  - Assisting providers and partners to better understand the value of youth engagement is an ongoing need.

  - Partners who are consistently using youth engagement need further support related to recruitment, activities, and sustainability.

Other Title V work in this Domain

Title V's adolescent health work strengthened policies and systems that support adolescent health in school-based health centers, schools, health systems, and communities. The program engaged youth to inform policies and programs that reflect their needs through Positive Youth Development activities including youth participatory action research.

Bullying Prevention Plan

Priority: Bullying Prevention

National Performance Measure: Percent of adolescents, ages 12 through 17 years, who are bullied

Strategies:

Strategy #1: Support the workforce to understand the impact of bullying on adolescent health.

- **ESM 9.5:**
  - Among local grantees who select bullying prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance

- **State level activities/timeline:**
  - Develop (or use existing) training module on the impact of bullying on adolescent health. Training module should be brief, and is designed to be an add-on to existing trainings and professional development gatherings. (October 2021 – January 2022)

  - Develop list of potential trainings/professional development gatherings where module can be delivered. (January 2022-March 2022)

  - Link to/collaborate with Healthy Together Oregon (HTO) State Agency Partnerships - education, criminal justice, housing, social services - to share module. (March 2022-September 2022)

Strategy #2: Support bullying prevention education in schools.

- **ESM:**
  - ESM 9.1: Percent of 8th and 11th graders who have experienced bullying

  - ESM 9.2: Percent of 8th and 11th graders who have experienced bullying due to their race or ethnicity

  - ESM 9.3: Percent of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity

  - ESM 9.4: Percent of 8th and 11th graders who have experienced bullying due to a disability

- **State level activities/timeline:**
  - Conduct an LPHA/School Relationships Scan (School, District, ESD levels) to determine "early opportunities" for local MCH staff to work with schools and share best practices among LPHAs with effective school partnerships and those who need to improve their partnerships. (March 2021 – September 2021)

  - Develop list of evidence-based bullying prevention programs to offer. (July 2022 – June 2023)

  - Align any programs/activities with health education standards and other Department of Education initiatives such as the Student Success Plan, Safe Schools Act, and Every Student Belongs. (July 2022 – June 2023)

- **Local level activities/timeline:** Lake County is the only local Title V grantee that will be implementing Bullying Prevention this grant year. Their plan is to engage youth through the development of a youth advisory council or by joining existing local youth engagement efforts to ensure youth are leading school-based bullying prevention and health education efforts. (May 2021 – ongoing)

Strategy #3: Determine gaps and opportunities for bullying prevention partnerships and initiatives with internal and external partners.

- **ESM 9.7:**
  - Number of activities completed that increase local access to bullying prevention resources.

- **State level activities/timeline:**
  - In collaboration with local level partners, develop state-level framing, points of leverage, possible funding mechanisms and policy solutions for bullying prevention in Oregon. (July 2021 – June 2022)

  - Within PHD - complete MCHB Capacity Assessment for Bullying Prevention (or similar tool) to determine partners to invite and select areas of work and alignment. https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/MCHB_ChangePkg_8-24-17_sxf.pdf (September 2021-December 2021)

  - Assess state-level efforts on the bullying of adolescents with disabilities, LGBTQAI+ youth, Black youth, non-English speaking youth, and other groups known to be at higher risk of bullying. (January 2021 – December 2021)

  - Review Student Success Plans developed through the Oregon Department of Education for solutions to bullying by Oregon students, ie. transformative justice, affinity groups, etc. (May 2021 – July 2021)

  - Collaborate with PHD to provide local level expertise to develop state-level framing, points of leverage, possible funding mechanisms and policy solutions for bullying prevention in Oregon (ongoing).

Strategy #4: Support youth participatory action research on bullying prevention.

- **ESM 9.6:**
  - Completion of environmental scan of youth serving agencies.

- **State level activities/timeline:**
  - Assess YPAR curriculum to ensure alignment with bullying prevention (ongoing, curriculum currently being evaluated).

  - Develop internal capacity to support YPAR at the local level at no cost through provision of facilitation training and curriculum (ongoing, Adolescent & School Health working on securing funding and staffing).

  - Support implementation of youth developed solutions to bullying based on YPAR (July 2022 – June 2023 if applicable).

  - Connect LPHAs/tribes with any YPAR projects happening in their community (ongoing, if applicable).

Critical partnerships:

- Oregon Department of Education is our most critical partner on the priority of Bullying. The Oregon Alliance to Prevent Suicide, Lines for Life, local public health agencies and local school districts are key allies as well. Youth engagement and partnership is also a focus of each strategy within this priority.

Other Title V work in this Domain

Title V's adolescent health work will continue to strengthen 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 Positive Youth Development activities including youth participatory action research. Specific efforts that support both bullying prevention and broader adolescent health goals include:

- School-based health centers, specifically mental health providers at the local level
- School nursing program, often the first providers young people see with symptoms related to bullying (nausea,

anxiety, headaches, etc.)
- Sexuality education programming through federal funding, currently focused on providing information and skills to young adults with intellectual and developmental disabilities in transition programs.
- Suicide prevention collaborative work connected to the Oregon Youth Suicide Prevention Plan with non-profit partners, other Oregon Health Authority staff, and schools.
- Racial Justice Student Collaborative work with partners.
- LGBTQIA2S+ Student Success Plan support and partnership.

Children with Special Health Care Needs

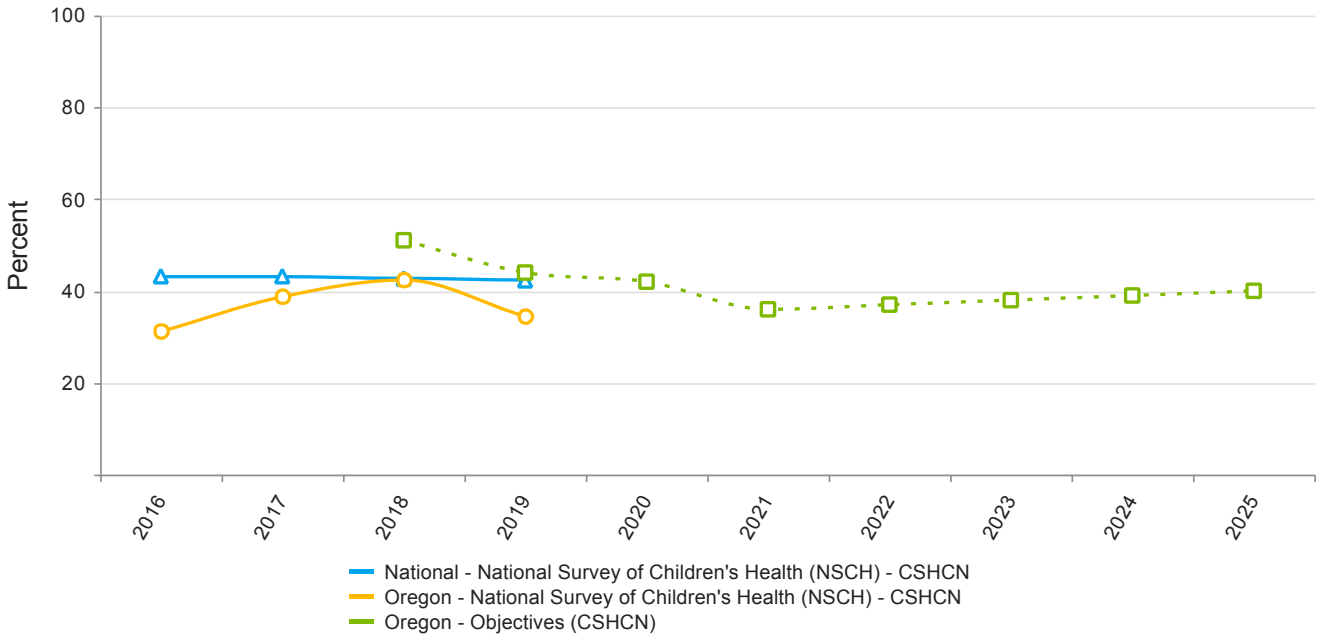
Linked National Outcome Measures

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-2018_2019	13.9 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	57.2 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	90.6 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	3.0 %	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**	**2019**	**2020**
Annual Objective			51	44	42
Annual Indicator		31.3	38.6	42.2	34.5
Numerator		49,675	61,991	70,156	60,052
Denominator		158,652	160,752	166,072	174,007
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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						
	2021	2022	2023	2024	2025	2026
Annual Objective	36.0	37.0	38.0	39.0	40.0	41.0

Evidence-Based or –Informed Strategy Measures

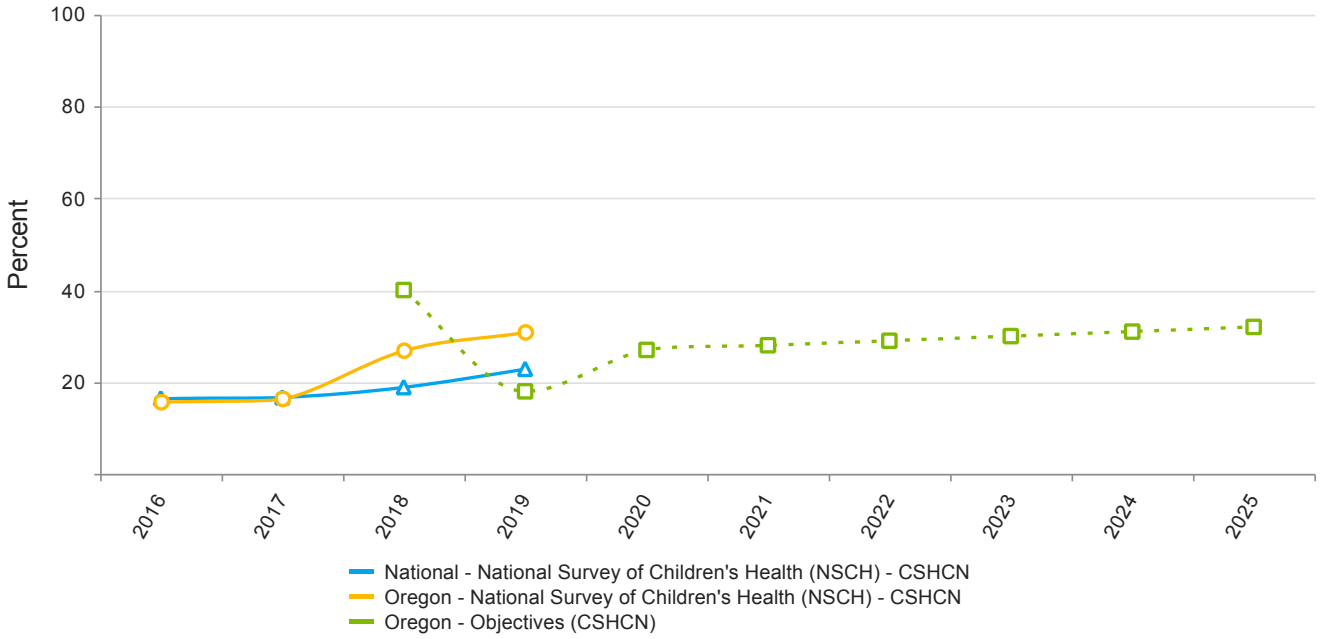
ESM 11.1 - Primary care involvement in shared care planning

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	34	26.9
Numerator	36	14
Denominator	106	52
Data Source	Shared Care Plan Information Form (SIF)	Shared Care Plan Information Form (SIF)
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	25.0	30.0	35.0	40.0	45.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition 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**	**2019**	**2020**
Annual Objective			40	18	27
Annual Indicator		15.8	16.5	26.8	30.9
Numerator		12,536	11,986	18,726	24,088
Denominator		79,458	72,528	69,860	78,055
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	28.0	29.0	30.0	31.0	32.0	33.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Young adult with medical complexity/family participation in transition preparation appointments

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	30.0	40.0	50.0	60.0	70.0

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	
By September 2025, 40% of shared care plans will have a representative of primary care help LPHAs prepare for or participate in shared care planning meetings	
Strategies	
Strategy 11.1: We will improve access to family-centered, team-based, cross-systems care coordination* for CYSHCN and their families through workforce development and financing activities.	
ESMs	**Status**
ESM 11.1 - Primary care involvement in shared care 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	
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 unable to obtain needed health care in the past 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 to prepare for the transition to adult health care

Objectives

By 2025, 60% of young adults with medical complexity (YAMC) or their families enrolled in transfer of care intervention will participate in their scheduled preparation appointments.

Strategies

Strategy 12.1. We will increase the number of YSHCN and their families who receive information about transition to adult health care from their providers through family-informed workforce development, quality improvement, systems incentives, and family awareness activities.

ESMs	Status
ESM 12.1 - Young adult with medical complexity/family participation in transition preparation appointments	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

Children and Youth with Special Health Care Needs Domain Report

Medical Home: 2020 Report

National Performance Measure 11: Percent of children with special health care needs (CYSHCN) having a medical home.

Report on Strategies and Activities October 2019– Sept 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.

Leveraging Regional Approach to Child Health (REACH) Teams

The REACH pilot project supported regional teams to identify cross-system gaps and barriers and address them through quality improvement (QI) processes. Though that pilot ended in 2018, OCCYSHN continues to leverage lessons learned from REACH to promote regional cross-systems care collaboration. Teams in Central and Southern Oregon continued REACH QI projects during this reporting period, even without OCCYSHN's financial support, as they were finding benefit in the effort.

OCCYSHN endeavored to advance the principles of the REACH concept, despite local public health resources necessarily being focused on COVID-19 and Oregon wildfires. We explored alignment opportunities with Family Connects Oregon, a new universally home visiting program for newborns and families with a focus on integration with existing efforts and resources. OCCYSHN met with OHA and national-level Family Connects staff to discuss community assets and to share lessons learned from REACH.

OCCYSHN also used the REACH pilot to inform the development of the Quality Improvement Collaboratives for CYSHCN (QuICC) framework. QuICC will ultimately support local public health authorities (LPHAs) in employing cross-sector team-building and shared care planning experiences as a foundation for integrating QI principles into their work. (See Section 11.1.1 of the Block Grant Plan).

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.

OCCYSHN continues to house and support the Oregon Family to Family Health Information Center (ORF2FHIC). In this reporting period, ORF2FHIC adapted six standard family workshops for delivery in virtual environments. We conducted 14 family trainings or listening sessions, most virtually. These were attended by 106 family members of CYSCHN, who shared their experiences with CYSHCN systems. Learnings were shared with OCCYSHN staff and external stakeholders.

Two ORF2FHIC phone lines were staffed five days a week by Parent Partners offering peer support and information to family members of CYSHCN, providing one-to-one support to more than 400 families and professionals. We also implemented a QI process for Parent Partners to improve their family support skills. We maintained Facebook pages (with over 800 followers) in both English and Spanish, regularly posting information germane to families of CYSHCN. Two Family Involvement Program (FIP) staff were certified as Family-Peer Support Specialists by OHA.

In consultation with an attorney from Family Voices, ORF2FHIC started collecting data on family support calls concerning legal issues. We expanded our data collection to capture use of the HRSA-funded Genetics Resource and Education Advocacy Tool (GREAT), which provides information and resources for families on more than 1000 genetic conditions. We worked with genetic counselors at OHSU to develop an FAQ for Parent Partners about genetic testing to better support callers. We also collaborated with OHSU, OHA, and family members of CYSHCN to develop a written resource called "Coping with a Child's Death or Life-Limiting Illness."

Early in the pandemic, ORF2FHIC led an information-gathering effort on behalf of FEMA to help them better understand the needs of families of CYSHCN. We also helped OHSU's Child Development and Rehabilitation Center (CDRC) respond to pandemic-related scheduling issues by disseminating messages to families on their behalf, using social media and list-serve channels.

Building families' capacity to care for their CYSHCN requires that ORF2FHIC has strategic relationships with other family-led organizations. ORF2FHIC collaborates extensively with local, regional, and national organizations serving families of CYSHCN to publicize our services, co-sponsor activities, collaborate on trainings, and recruit families for policy activities. In an effort to enrich the network of family organizations, the FIP Manager helped a grass-roots group organize to establish an Oregon chapter of Family Voices. The creation of a Family Voices affiliate would be

significant, as it would represent parents of medically complex children who do not experience developmental disabilities.

ORF2FHIC participated in the Statewide Family Training and Outreach Collaborative, where family trainings and other opportunities were coordinated across agencies. This effort reduced redundancies and fostered collaboration between organizations.

Strategy 11.3 Improve payer and provider responsiveness to CYSHCN by providing or supporting workforce development opportunities focused on the CYSCHN population and their care needs.

Due to COVID-19, OCCYSHN cancelled a planned two-day spring 2020 conference entitled *Building Community: Organizations Working Together to Care for CYSHCN*. National and state-level speakers were scheduled to speak on topics that included strategies for advancing systems change, team-based approaches to coordinating care, clinical updates on specific conditions, partnering with medical homes, cultural humility, and authentic partnerships with families. Invitations went to care coordination and case management professionals from public health, health care, mental health, education, and social services; nursing and social work students; family representatives and advocates; and other community partners. There were 185 registrants when we cancelled, indicating strong interest in the topics.

CaCoon

CaCoon (short for **Ca**re **Co**ordinati**on**) is OCCYSHN's public health nurse home visiting program. Across the state, CaCoon nurses help families coordinate care for CYSHCN. They also convene shared care planning teams for select CYSHCN.

In 2020, OCCYSHN contracted with 27 LPHAs to implement the CaCoon program in 29 of Oregon's 36 counties. CaCoon served 930 CYSHCN, through 4,899 public health nurse visits. Of CYSHCN served, 80% were insured through Medicaid, and 16% were transition-aged youth ≥ 12 years.

OCCYSHN provided professional development and technical support to the CaCoon workforce, and trained CaCoon nurses on Targeted Case Management (TCM) billing, increasing LPHA funding and capacity to serve CYSHCN. We developed a virtual TCM training available for home visiting staff to watch on demand.

OCCYSHN and the OHSU Department of Pediatrics collaborated on virtual Coffee Time Consultations, where experts offered virtual presentations and took questions about specific health conditions. CaCoon nurses participated regularly. The series was discontinued in 2019 due to lack of capacity within the Department of Pediatrics. OCCYSHN's Family Involvement Program (FIP) conducted a listening session for CaCoon nurses, where families of CYSHCN shared their perspectives on their experience with home visitors.

Until the pandemic, OCCYSHN offered monthly Extension for Community Healthcare Outcomes (ECHO) sessions for CaCoon nurses, consisting of didactic presentations, followed by case-based discussions. CaCoon nurses learned from each other's experiences in shared care planning and care coordination (Strategy 12.2). During the pandemic, OCCYSHN partnered with OHA to help the CaCoon workforce respond to COVID-19. Virtual meetings were held every other week for three months to provide support, answer questions, and offer updates. COVID-related materials were developed and disseminated to LPHAs. OCCYSHN also collaborated with OHA to develop virtual "Communities of Practice" to support the CaCoon workforce during the pandemic.

Assuring Comprehensive Care through Enhanced Service Systems (ACCESS)

Eight ACCESS teams were formed in Oregon from 2013-2016, using a HRSA grant. They performed community-based autism evaluations for children up to age five, providing a medical diagnosis and establishing educational eligibility for autism services. ACCESS teams reduced wait times for evaluation, decreased the need for families to travel to tertiary care centers, and ensured earlier connection to services for children.

Six ACCESS teams continued to provide evaluations during this reporting period. OCCYSHN supported those teams with a) support from increased dedicated OCCYSHN FTE; b) professional development opportunities; c) technical assistance site visits; and d) financial support. OCCYSHN adapted to the pandemic with virtual support for existing ACCESS teams and other interested providers.

OCCYSHN trained five medical providers to use the STAT autism evaluation tool, including two providers from areas of the state not previously served by ACCESS, and one provider who serves a tribal community. This aligns with our

goal to increase the capacity of health care providers to evaluate children to age 5 for autism. OCCYSHN helped spread the ACCESS model by providing technical assistance to two other states seeking to develop similar programs.

OCCYSHN's ACCESS planning and advisory teams attended an ECHO Immersion Training at the University of New Mexico. OCCYSHN used the ECHO model to provide a nine-month case-based learning collaborative for ACCESS participants. Each individual ECHO team included a caregiver of a child with ASD to ensure the family perspective was integrated. OCCYSHN's five-year strategic plan includes ongoing financial support for ACCESS teams, using ECHO, site visits, and annual meetings to support them.

Community Health Worker Curriculum

OCCYSHN's Systems & Workforce Development unit collaborated with Oregon Community Health Worker Association (ORCHWA) and Oregon State University's Center for Health Innovation to create a novel Community Health Worker (CHW) Training Program providing professional development for LPHAs' CHW workforce. This online training curriculum for CHWs focuses on family-centered, cross-systems care coordination for CYSHCN. Prior to this effort, no CYSHCN-specific or general pediatric training courses existed for Oregon CHWs.

Family-Focused Workforce Development

OCCYSHN's Family Involvement Program (FIP) staff continues to inform health and service providers about the needs and perspective of family members of CYSHCN, training OCCYSHN staff on the subject, and informing a variety of OHSU educational and clinical efforts. FIP staff served on county, state, and federal workgroups related to COVID-19.

The FIP also collaborated with OHA to review their toolkit on emergency preparedness for people with disabilities, and placed family members of CYSHCN on planning councils for Multnomah County and FEMA Region 10.

The FIP manager continued her leadership role in the Oregon Family Workforce Association, the only organization focused on advancing the field of family support. She wrote for their newsletter, and coordinated trainings on special education and telehealth during the pandemic.

The FIP manager organized a review of OCCYSHN's block grant plan by family members of CYSHCN, developing materials to make the review process more understandable for laypeople. These family representatives reviewed key sections of the block grant plan, and submitted questions and feedback. Their input was integrated it into block grant planning.

Strategy 11.4: Enhance local community infrastructure to implement child health teams by providing consultation and technical assistance to Community Connection Networks (CCN) to become self-sustaining.

OCCYSHN's Community Connections Network (CCN) program supported community-based care coordination teams before it was discontinued in 2017. The infrastructure, developed and adapted over CCN's decades of community-based collaborations, served as a foundation for the Piloting "Activate Care" for Care Coordination Teams (PACCT) project, which began in 2019.

Five LPHAs participated in PACCT, serving CYSHCN in seven counties, chosen through an RFP process. Participating LHPAs formed local cross-sector care coordination teams for CYSHCN, some employing former CCN teams as a starting point. They piloted the use of a cloud-based care coordination platform called Activate Care (formerly ACT.md), and used the ECHO model to facilitate a statewide virtual learning community. All five of the initial PACCT teams continued their work in through this reporting period.

OCCYSHN released a new PACCT RFP in August, 2020, to begin work in October 2021, focusing on use of Activate Care to respond to the pressing telehealth needs of CYSHCN during the pandemic. OCCYSHN accepted proposals from five additional LPHAs, for a total of ten PACCT project teams across the state.

OCCYSHN developed an Activate Care handbook for the initial PACCT cohort. The handbook uses a family-centered approach, and offers detailed explanations of frequently-used technical aspects of the platform. We offered individual and group trainings for PACCT participants needing help with Activate Care. Most teams participated in at least one remote training. We also developed resources to introduce Activate Care to families and professionals, including videos for both audiences.

> **ESM:** Number of PACCT standing teams with consistent primary care involvement. Our FY20 objective was 2, and there were 3 PACCT standing teams with consistent primary care involvement.

Strategy 11.5 Integrate state systems of services for CYSHCN and their families through cross-sector collaboration, workforce and system infrastructure development.

OCCYSHN recruited candidates for a new position: a Development, Quality Improvement and Innovation Manager. The position was designed to support LPHAs in enhancing systems-level cross-sector collaboration, and to help communities develop sustainable funding for their work on behalf of CYSHCN. We sought candidates experienced with feasibility studies and business plans. Recruitment was postponed due to the pandemic.

CaCoon public health nurse home visiting staff collaborated with the Babies First! home visiting program to jointly train new staff, and coordinate training and documentation for both home visiting programs. (Many public health nurses serve both programs within the same LPHA.) We participated in the Oregon Home Visiting Collaborative, and attended OHA's joint WIC and MCH quarterly meetings to foster collaboration and promote systemic efficiency.

OCCYSHN staff advocated for CYSHCN and their families on state and local level advisory boards, committees, and workgroups. We tracked statewide administrative and policy work (e.g., Oregon Health Policy Board, Early Learning Division, Oregon Department of Education, Oregon Department of Human Services, Systems of Care Advisory Council) and attended state conferences (e.g., Oregon State of Reform Health Policy Conference, Coordinated Care Organization annual conference). We disseminated data and analysis to CYSHCN-serving agencies and organizations, and gave input on policy development impacting CYSHCN, and provided oral and written testimony at the local, state and national level (See strategies 11.4 and 12.2.)

State Level Groups

- Coordinated Care Organization (CCO) 2.0 Rules Advisory Committee
- Health Home Rules Advisory Committee
- Integrated Care for Kids (InCK) state-level advisory council and regional advisory councils (Marion-Polk and Central Oregon county councils)
- Medicaid Advisory Committee and its Advancing Consumer Experience subcommittee
- Oregon Council on Developmental Disabilities
- Oregon Health Authority (OHA) Birth Anomalies Surveillance System Advisory Committee
- Oregon Home Visiting Collaborative
- OHA Early Hearing Detection and Intervention advisory board (EHDI)
- OHA Emergency Medical Services for Children Advisory Board
- OHA Patient Centered Primary Care Home Standards Advisory Committee
- OHA Safe Sleep Task Force
- Oregon Individualized Service Plan Redesign team
- Oregon Pediatric Society Board and Advocacy Committee
- Oregon State Inclusive Preschool Leadership Team
- Refugee Emotional Support Task Force
- State Interagency Coordinating Council
- State Title V – Medicaid Collaboration
- Universally Offered Newborn Home Visiting Medical Consultant

Portland Metropolitan Area

- Health Share (CCO) All:Ready Kindergarten Readiness Network (multiple subcommittees)

OHSU

- Department of Pediatrics Primary Care Pediatrics Workgroup
- Institute on Development and Disability (IDD) Diversity Task Force
- Legislative Advisory Council
- Oregon Pediatric Improvement Partnership and Steering Committees
- Pediatrics-IDD Leadership Team
- Policy Advisory Council
- School of Public Health Academic Program and Policy Committee
- Transition Task Force
- University Center for Excellence in Developmental Disability Supported Decision-Making Grand Rounds Planning Committee

Public Input

- Solicited and provided input on OHA's second round of contracts with Coordinated Care Organizations (CCO 2.0). Informed CCO 2.0 Rules Advisory Committee about care coordination and health care transition needs of CYSHCN, with technical assistance from the National Association to Advance Adolescent Health. Disseminated CCO 2.0 policy and rule changes affecting CYSHCN.
- Collaborated with a Developmental Pediatrician who sits Oregon's System of Care Advisory Council to advance Title V priorities.
- Developed a fact sheet describing the importance of licensure for genetic counselors.
- Provided input about Activate Care to the Oregon Health Leadership Council for their electronic cross-systems alignment effort (Community Information Exchange).
- Submitted a letter to the State Board of Education on Oregon Administrative Rule criteria for deaf and hard of hearing children.
- Submitted a letter on the importance of housing stability for children to the Oregon state legislature's Special Committee on COVID Response.
- Submitted input on the needs of CYSHCN for Oregon State Health Improvement Plan strategies.

Strategy 11.6: Conduct ongoing assessment of Oregon's CYSHCN by developing studies focused on subpopulations of CYSHCN.

Children with Medical Complexity in Medical Home Practices

OCCYSHN's Assessment and Evaluation (A&E) unit completed its collaboration 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. Dr. Wallace conducted 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 during the program's first four years. OCCYSHN A&E staff (Alison Martin, Shreya Roy) collaborated with Dr. Wallace to replicate these analyses for Children with Medical Complexity using the Pediatric Medical Complexity Algorithm (PMCA; Simon et al., 2014). Sara (Sally) Bachman, PhD, the Catalyst Center Principal Investigator at the time, consulted on the project. Drs. Wallace, Martin and Roy completed the analyses in FY20, and OCCYSHN developed

dissemination briefs (see Attachment 1) to inform key partners. The briefs were shared with OHA's Transformation Center Director, PCPCH Program Manager, and Integrated Care for Kids (InCK) team. The PCPCH Program Manager disseminated the one-page brief to the PCPCH statewide network. Key findings from the brief follow:

"6.8% (74,254) of Oregon children and young adults (ages 21 years and younger) experienced medical complexity.

- Of these, two in five (43%) were completely privately insured.
- Similar proportions of children living in frontier (6.1%), rural (6.7%), and urban (6.9%) areas experienced medical complexity.

Although CMC comprised only 9.5% of all those continuously insured (aged 21 years and younger) in Oregon, they were responsible for 44% of total costs for that population.

CMC cared for in a recognized PCPCH (all three tiers) showed a 10.1% reduction in overall per-person expenditures, as compared to those who received primary care in a non-PCPCH recognized practice.

- These reductions in expenditures extended across primary care, specialty care, and pharmacy costs.
- Inpatient care expenditures per user were reduced by 34.6%.
- Cost reductions for CMC were not due to decreases in service utilization.
- The probability of service use for CMC served in both PCPCHs and non-PCPCHs in rural and urban areas was largely unchanged" (Martin, Roy, Hoffman, & Wallace, 2020, p.1).

CYSHCN with Behavioral/Mental Health Conditions

Olivia Lindly, PhD, Kate Lally, MSW/MPH and Dr. Martin successfully published an analysis of CYSHCN with behavioral health conditions. The manuscript summarizes analyses using 2009-2010 NS-CSHCN data.

A Profile of Care Coordination, Missed School Days, and Unmet Needs Among Oregon Children with Special Health Care Needs with Behavioral and Mental Health Conditions. *Community Mental Health Journal, 56*(8):1571-1580. https://pubmed.ncbi.nlm.nih.gov/32239364/.

NSCH Oversample

In FY2019, Dr. Martin, Suzanne Zane, DVM, MPH (Senior MCH Epidemiologist in OHA's Maternal and Child Health Section), and Elizabeth Stuart, MPH (Child Systems Collaboration Coordinator) facilitated a group of state partners in selecting a focus for a state-level NSCH oversample. The group agreed to collect more data on children from minoritized communities, for a two-year period. The year one oversample cost was $146,183. That cost was shared equally among OHA Office of Health Analytics, Oregon Department of Human Services Reporting, Analytics, and Information, and Oregon Title V. In FY2020, Drs. Martin and Zane continued working with these agencies to pay the year two oversample cost of $148,996, with OCCYSHN serving as the contract signatory with the Census Bureau to expedite the contracting process. Oregon Title V is extremely grateful to Dr. Hirai and Mr. Albrecht for helping us develop our oversample. We are proud of the collaborative effort to develop and purchase the sample, and excited to have NSCH results that will include the oversample in 2022.

Five Year Needs Assessment

For the 2015 needs assessment, OCCYSHN developed and administered four surveys, one of which collected data from families of CYSHCN. The response was tremendous; we obtained nearly 600 usable surveys. Because the data did not adequately represent families of CYSHCN from communities of color, OCCYSHN included participatory needs assessment studies for our 2020 needs assessment. A participatory approach differs from traditional approaches in that the community "being studied" is involved in the design and implementation of the research. (Wang and Pies [2004] used a participatory needs assessment approach for Contra Costa County, California's MCH needs assessment). As described in our 2019 Block Grant Report, we identified two minoritized communities, developed and implemented an RFP, and awarded contracts to the Latino Community Association (LCA) of Central Oregon and the Sickle Cell Anemia Foundation of Oregon (SCAFO). In December 2019, AMCHP invited OCCYSHN's A&E unit to be part of a panel discussion on engaging communities in needs assessment activities as part of AMCHP's needs assessment webinar series.

In FY2020, OCCYSHN A&E staff worked with LCA and SCAFO to co-develop data collection and analysis processes. This included six hours of training on Institutional Review board protocols for our partners, which proved logistically complicated for them, leading to project delays. This was valuable information for future participatory

needs assessment efforts.

LCA and SCAFO both decided to use focus group data collection methods, and they conducted their respective focus groups. LCA completed six focus groups with 22 immigrant Latino parents of CYSHCN in Central Oregon. Winter weather, holidays, and COVID limited our ability to conduct additional groups. SCAFO completed 11 focus groups with 45 parents of Black CYSHCN in Western, Southern and Central Oregon.

In addition to our participatory needs assessment studies, we reviewed and analyzed data from the National Survey of Children's Health and the Data Resource Center. We reviewed results from National Core Indicators and Oregon Healthy Teens surveys, reports from OHA, the Oregon Secretary of State, and others describing the workforce that provides health care, education, and services to Oregon CYSHCN and their families. Our comprehensive needs assessment report summarized our findings.

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 (A&E) staff collected and analyzed shared care planning process evaluation data (Strategy 12.2).

Implementation Findings

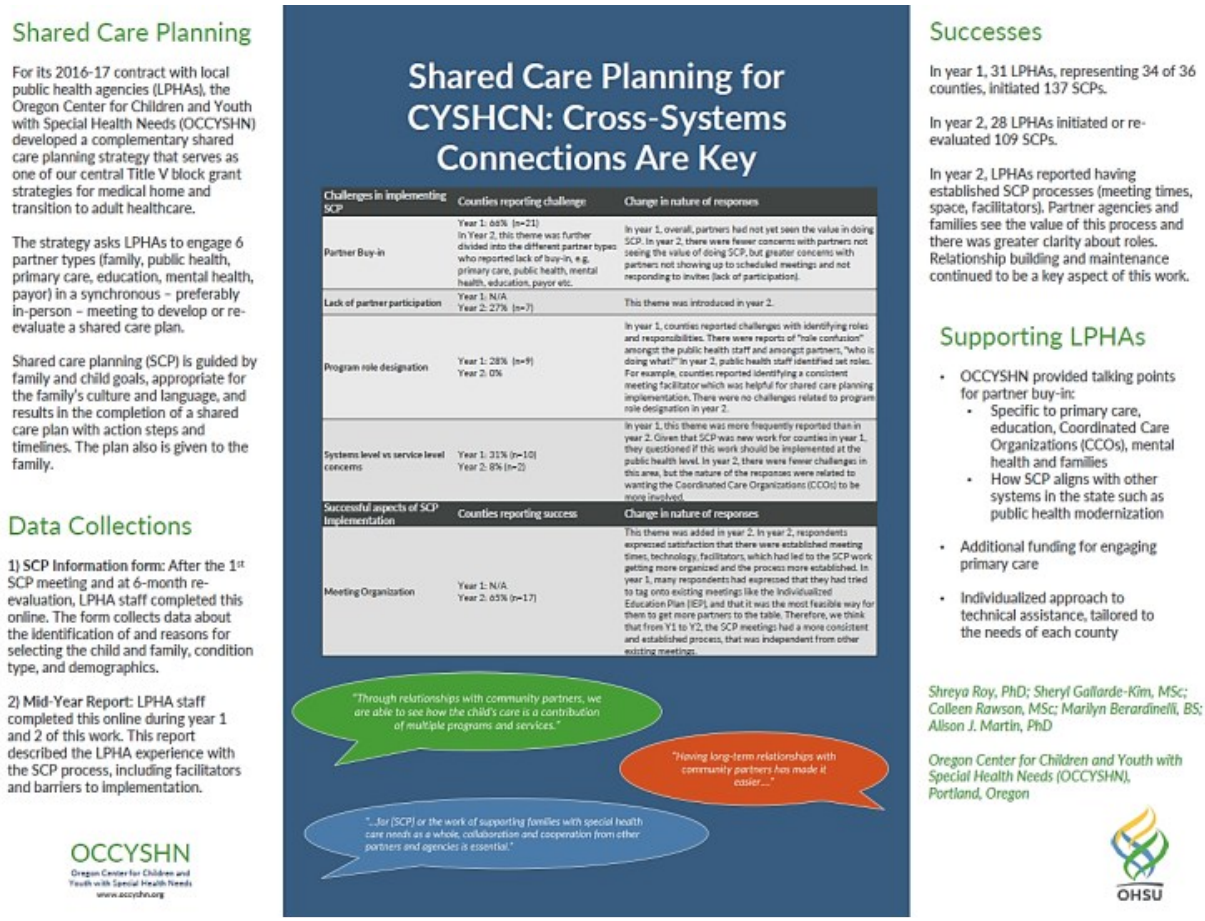
Analysis of process evaluation data showed that 27 LPHAs created or re-evaluated 52 shared care plans for Oregon CYSHCN in 2019 – 2020, with a Shared Care Plan Information Form (SIF) submitted for each meeting.

Of those:

- 33 SIFs were for children birth to 12 years.
    - 25 were new shared care plans.
    - Eight were re-evaluated shared care plans.
- 19 SIFs were for young adults 12 to ≤ 21 years.
    - 10 were new shared care plans.
    - Nine were re-evaluated shared care plans.
- 49 SIFs were for CYSHCN identified as complex (≥2 condition types-medical, behavioral, developmental, social, other).
- CaCoon public health nurses were the most frequent referral source for shared care planning.

Outcome Evaluation

A&E staff



revised its administration of the Shared Care Planning Family Survey, administering surveys electronically or by phone, according to the family's preference, due to COVID impairing our ability to mail paper surveys. A&E staff will continue these two administration methods until OHSU lifts its mandatory teleworking policy. We also offered families a text messaging option for follow-up survey reminders. A&E presented the poster below at the 2020 AMCHP Conference, to share findings from analyzing data from our first two years of Shared Care Planning Mid-Year Reports.

Health Care Transition: 2020 Report

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 2019– Sept 2020

Strategy 12.1 Increase the number of family members of Youth with Special Health Care Needs (YSHCN) who are informed about health care transition (HCT) through community conversations and resources based on Got Transition materials.

The Oregon Family to Family Health Information Center (ORF2FHIC) updated our Health Care Transition (HCT) training. We renamed it "*Moving from Pediatric to Adult Health Care,"* as the word "transition" is becoming more commonly applied to gender transition. More diverse families were depicted, activities were redesigned for virtual platforms, and a video aimed at young adults with intellectual disability was added. Drawing from consultation with pediatric providers and new materials from Got Transition, we added information for families about the differences

between pediatric and adult health care, and added or updated information on privacy rules, electronic health records, and Supported Decision Making (see below). We developed a worksheet to help families communicate with pediatric providers about transition processes.

ORF2FHIC conducted three trainings about HCT, serving 20 families. Attendees reported that the training will help them better support their child. We collaborated with Swindells Center, United Cerebral Palsy and Oregon Deafblind to plan HCT workshops for families in the upcoming program year.

ORF2FHIC promotes Supported Decision Making (SDM) for planning and implementing HCT. SDM helps people with disabilities explore and understand their options, and communicate their choices effectively. OCCYSHN's FIP manager was certified as an SDM trainer, and collaborates with OHSU's CDRC Lifespan Transition Clinic to use SDM with some of their patients, and to develop an HCT toolkit for YSHCN and their families.

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 contracted with 28 LPHAs (serving 30 counties) to provide shared care planning and home visiting services for CYSHCN. While we allowed some flexibility on LPHA scopes of work, based on community needs, capacity, and pandemic exigencies, all LPHAs were required to focus some part of their OCCYSHN-funded efforts on HCT for YSHCN.

Three of the LPHAs with whom OCCYSHN contracted initiated innovative approaches to serving YSHCN. One LPHA worked with OCCYSHN to develop a care coordination needs assessment for their area. Another initiated a care coordination collaboration with the Coordinated Care Organization (CCO) serving their area. A third LPHA convened a cross-sector meeting to discuss local efforts to support CYSHCN, including HCT efforts. The meeting included representatives from area's CCO, as well as the county's Healthy Transitions team, developmental disability services, and behavioral health program.

> **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 FY20 objective was 20%, and 37% of shared care plans created or re-evaluated 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 FY20 objective was 70%, and 42% of shared care plans addressed transition planning (see Form 10 for more detail)

Engaging local public health authorities (LPHAs) to develop shared care plans for youth with special health care needs (YSHCN) was a key strategy for building statewide capacity to promote effective health care transition (HCT). OCCYSHN supported LPHAs' CaCoon home visiting and shared care planning efforts for YSHCN (Strategy 11.3). The PACCT project (Strategy 11.4) also provided cross-sector care coordination for YSHCN, including HCT.

OCCYSHN facilitated an ECHO-based learning collaborative for public health staff who worked on shared care planning for CYSHCN in their communities. Each monthly session featured both a didactic presentation and case-based discussion, with many of the presentations and practice situations centered around HCT. The FIP manager participated to ensure family-centeredness.

Due to the pandemic, Shared Care Planning ECHO sessions were suspended beginning in March 2020. As a temporary alternative to those ECHO sessions, OCCYSHN collaborated with OHA MCH to implement monthly virtual Community of Practice meetings for all Oregon nurse home visiting program staff. These monthly meetings emphasized cross-sector care coordination, including planning for effective HCT.

In collaboration with the OHA MCH Nurse Team, OCCYSHN's Care Coordination Specialist began developing guidance for Community Health Workers (CHWs) serving the Babies First! and CaCoon Nurse Home Visiting Programs. The guidance will include role definitions and expectations, and training and certification requirements. It will also provide CHWs with guidance on how to support effective HCT.

OCCSYHN's Care Coordination Specialist began updating the CaCoon manual to be more family-centered and inclusive, and to address HCT more explicitly. She collaborated with OHA in developing and testing a new data collection tool called Tracking Home Visiting Effectiveness in Oregon (THEO). Changes to data collection will include new questions about HCT. Additionally, OCCYSHN provided tools and resources about HCT to OHA's web-based communication hub for the public health home visiting workforce.

OCCYSHN continued to consult with Jeanne McAllister, BSN, MS, MHA, a national subject matter expert on medical home and shared care planning. OCCYSHN staff participated on the OHSU Transition Taskforce, which addressed systemic efforts to integrate HCT activities into clinical practices. A Systems and Workforce Development staff member attended the Baylor Transition Conference in Texas in October 2019.

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.

Oregon's CoIIN project focuses on health care transition (HCT). FY20 overlapped with CoIIN project years three and four. OCCYSHN continued to lead an Advisory Team and an Implementation Team. We also continued collaboration with the Principal Investigator for OHSU Primary Care Pediatrics Complex Care Collaborative (Reem Hasan, MD, PhD), and an OHSU General Pediatrics and Adolescent Health Clinic nurse (Reyna Lindert, PhD, RN).

The CoIIN project's Implementation Team enrolled eligible young adults with medical complexity (YAMC), and their families, in a Quality Improvement (QI) project, consisting of a three stage process for transferring YAMC from pediatric to adult primary care. Ten YAMC enrolled between September 2019 and March 2020, when enrollment was halted due to COVID-19.

The primary finding from the first three months of enrollment was that pediatric primary care providers (PCPs) were reluctant to transfer YAMC to adult primary care. Of the eligible YAMC, PCPs declined to have the team approach 63% patients about the project. Most of those YAMC approached by the QI team did enroll. PCPs gave the following reasons for declining patient participation: feeling that the YAMC was not ready; the YAMC was experiencing active health problems; or desire to keep patient in their panel. An abstract with these findings was accepted for presentation at the Pediatric Academic Societies National Conference 2020.

While enrollment was halted due to COVID-19, the Implementation Team brainstormed ideas for revising the QI project to increase enrollment. The Implementation Team reviewed Got Transition recommendations, consulted with the Advisory Team and national experts (Jennifer Lail, MD, and Dennis Kuo, MD as part of our July 2020 two-day support visit with Boston University partners). The team decided to revise the project to begin transition preparation at an earlier age. The revised QI project was envisioned as follows: Clinical team partners would schedule an appointment with YAMC 13-15 years of age who had not had a well-child visit in the past year. During the appointment, the PCP would initiate a conversation about HCT, discussing topics like changes in healthcare at age 18, navigating the healthcare system, and medication management. The pediatrician and YAMC would collaboratively agree on a HCT-related goal, and the nurse would then follow-up on the goal with the patient in three months.

Discussion of the QI project revision led the Implementation Team to develop a vision statement on how our team wants YAMC and their families to be supported as they transition from pediatric to adult primary care, and brainstorm CoIIN project activities in the areas of payment, policy, awareness, data collection and dissemination in support of the vision. In fall 2020, key Advisory and Implementation Team members sought technical assistance from Got Transition, and began plans to promote billing and coding tools to increase provider payment for HCT activities.

Prior to COVID-19, Implementation Team members discussed expanding the QI project to OHSU's Bethany Pediatric clinic. Though there was interest from the clinic, workforce shortages made them unable to commit to the project. Implementation Team members also talked with Shriners' Children's Hospital's Transition Nurse Specialist about the possibility of collaborating on specialty care transfer for YAMC. Due to the current focus of the CoIIN project on preparing for primary care transfer, we decided to revisit this potential collaboration in the future.

Family Leaders Ana M.D. Valdez, BranDee Trejo, and Tamara Bakewell were actively engaged in Implementation Team meetings and QI project revisions, offering valuable input on the perspectives and experiences of family members of YAMC. In November 2019, Ms. Valdez and Ms. Trejo facilitated a family focus group to understand factors related to child and family quality of life and well-being, and participated in the qualitative analysis of environmental scan data. Preliminary findings from that analysis were accepted for poster presentation at the American Academy of Pediatrics National Conference and Exhibition 2020. During the July, 2020 TA visit, family leaders talked with Boston University partners about participating in the CoIIN inter-professional team. They also scored Family Voices® "Family Engagement in Systems Assessment Tool" for the CoIIN project. Our team is preparing a manuscript that describes a case example of meaningful family engagement in health care system quality improvement for families of children with medical complexity, which will submitted to a peer-reviewed academic journal.

OCCYSHN's Systems and Workforce Development unit increased provider awareness of HCT by developing HCT materials to support LPHA care coordination work. We offered technical assistance to CaCoon public health nurses on using Got Transition's readiness assessments for YSHCN, and encouraged them to share those tools with youth,

families, and providers.

Strategy 12.4 Increase pediatric provider awareness of transition services by incorporating health care transition into adolescent well visits.

OCCYSHN and OHA MCH Adolescent Health had planned to integrate transition readiness assessments into OHA's Adolescent Well Care Guide, to align with OHA Transformation Center goals. However, the CCO metric regarding adolescent well care rates was eliminated, effectively destroying the impetus for integration.

OCCYSHN supports and trains LPHAs to develop transition-related shared care plans for YSHCN (Strategy 12.2). We encourage LPHA staff to invite PCPs to participate in shared care planning on behalf of individual YSHCN, and the sharing of the plans with the PCP of any youth served. This work will be informed by the work of the CoINN noted above.

Children and Youth with Special Health Care Needs Domain Plan

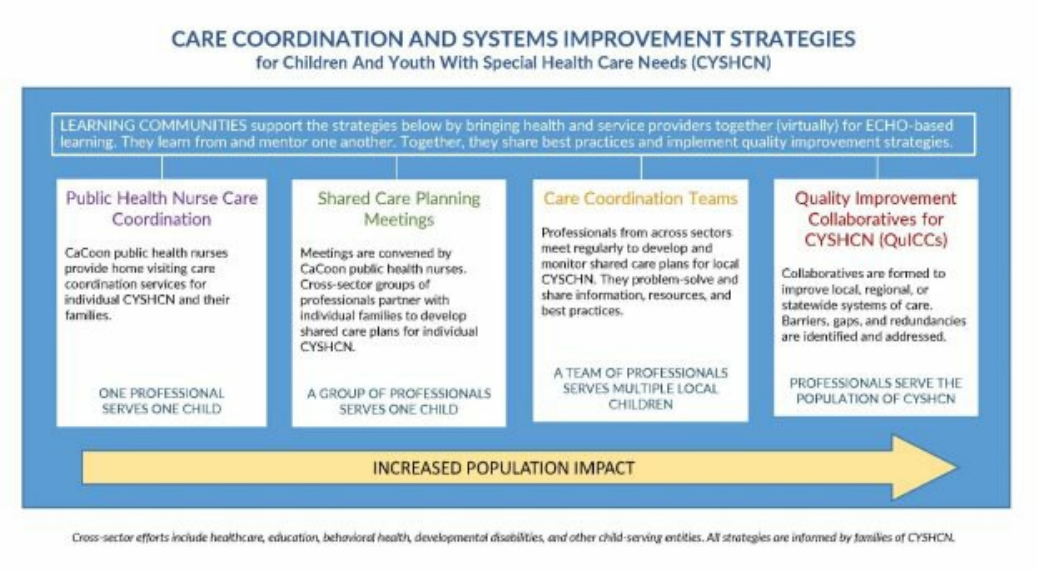
2022 Plan: NPM 11 Medical Home

National Performance Measure 11: Percent of children with special health care needs having a medical home

Planned strategies, ESMs and activities for October 2021 – September 2022

Strategy 11.1: OCCYSHN will improve access to family-centered, team-based, cross-systems care coordination for CYSHCN and their families through workforce development and financing activities.

Activity 11.1.1. Quality Improvement Collaboratives for CYSHCN (QuICC)



Overview: Regional Approach to Strengthening Cross-systems Care Coordination (REACH)
OCCYSHN will improve Oregon's workforce capacity to provide to cross-systems care coordination for CYSHCN. We will build off of lessons learned from our REACH pilot, in which community-based teams employed quality improvement methodology to address gaps and barriers in cross-systems care coordination for CYSHCN. This learning is the foundation for developing Quality Improvement Collaboratives for CYSHCN (QuICCs).

QuICC is a framework for addressing systems improvement, providing flexibility to accommodate differences in local priorities and capacity, allowing collaboration and innovation. OCCYSHN will endeavor to align QuICC implementation with Family Connects Oregon (the new, universally-offered nurse home visiting program for families with newborns), as that program will also draw on local public health authority (LPHA) capacity. QuICCs will leverage existing LPHA shared care planning efforts (see Strategy 11.1.3), and the Piloting "Activate Care" for Care Coordination Teams project (PACCT) project (see Strategy 11.1.2).

OCCYSHN will introduce QuICCs to LPHAs as their capacity allows. Existing innovative collaborations by LPHAs in Umatilla, Lane and Josephine counties may serve as foundations for QuICCs in those areas. Umatilla focused on conducting a local needs assessment of the families of CYSHCN, with the intent to innovate cross-systems care

coordination. Lane County is improving cross-systems care coordination for transition-aged youth with special health care needs, and Josephine County is developing community-based care coordination teams for CYSCHN. Each of these projects brings innovation to cross-systems care coordination, and applying quality improvement methods should advance their efforts.

11.1.1.1. Family Involvement

OCCYSHN's Family Involvement Program (FIP) will consult with QuICCs as they evolve, and provide resources, training, and technical assistance on integrating the family perspective into systems improvement. The FIP will leverage connections with family organizations and leaders statewide to help QuICCs recruit diverse family members of CYSHCN to lend their expertise.

11.1.1.2. Equity

OCCYSHN will prioritize health equity, diversity, and inclusion in the evolution of QuICCs. We will encourage QuICCs to invite culturally specific service organizations to inform their work. We acknowledge that racism and other forms of discrimination affect the health of Oregon CYSHCN, and we will be accountable to BIPOC communities and other underserved populations.

11.1.1.3. Systems and Policy

To inform our quality improvement collaboratives, we will track the phased roll-out of Family Connects Oregon. The systems alignment component will likely occur in the last stages of local implementation. OCCYSHN's Director serves as the Medical Director for Oregon Family Connects, which will support a smooth integration of OCCYSHN's efforts with theirs.

OCCYSHN's Systems and Workforce Development unit (S&W) will also monitor the components of public health modernization efforts impacting systems of care for CYSHCN. We will track policy development, acting on opportunities to promote shared care planning, PACCT, and QuICC. OCCSYSHN will provide public comment and testimony on policy relevant to CYSHCN and systems alignment.

OCCYSHN's Director will continue serving on Oregon's Patient-Centered Primary Care Home (PCPCH) Advisory Committee. The PCPCH program advances the medical home model in Oregon, setting standards, and incentives for medical practices in Oregon to achieve a PCPCH designation. We will ensure that the needs of children, especially CYSHCN, are considered in advancing PCPCHs statewide. OCCYSHN will promote community engagement in the evolution of PCPCH policy.

11.1.1.4. Evaluation

OCCYSHN's Assessment and Evaluation and Systems and Workforce Development unit will collaborate on a formative evaluation plan for QuICC, and a database to track technical assistance activities.

11.1.1.5. Communication

OCCYSHN will promote health literacy best practices in QuICC communications. We will develop and promote accessible, inclusive dissemination products. We will develop a strategic communications plan to share our findings and learning about QuICC with local, state, and national audiences.

Activity 11.1.2. Piloting "Activate Care" for Care Coordination Teams (PACCT)

OCCYSHN will continue the Piloting Activate Care for Care Coordination Team (PACCT) project with select LPHA shared care planning teams. Activate Care (formerly ACT.md) is a cloud-based care coordination platform where

care plans can be collaboratively created, shared, managed, and tracked. We will add new teams to the pilot based on LPHA interest.

OCCYSHN has a contract with Activate Care through 2023. Eleven LPHAs have access to the platform, and are receiving TA from OCCYSHN. We will explore the feasibility engaging more LPHAs, to further promote cross-systems care coordination. We will work with LPHAs to strengthen local partnerships with primary care providers and/or Coordinated Care Organizations (CCO) in use of the platform. We will assess the potential for such partnerships to fund Activate Care licenses after the PACCT project ends.

To promote sustainability for community-based care coordination teams, OCCYSHN will work with PACCT teams to seek local, sustainable funding sources. We will help participating PCPs identify reimbursement strategies for their work, in collaboration with associated CCOs.

11.1.2.1. Family Involvement

The Family Involvement Program will provide PACCT participants with resources and technical assistance, bringing the perspective of family members of CYSHCN. We will leverage connections with key family organizations and leaders to recruit diverse family members to participate in PACCT activities.

11.1.2.2. Equity

OCCYSHN will prioritize health equity, diversity, and inclusion in the evolution of PACCT, and the use of Activate Care. We will engage culturally responsive service organizations to develop materials (e.g., curricula, Transformation Center video, etc.) for LPHA workforce development. OCCYSHN acknowledges that racism and other forms of discrimination affect the health of Oregon CYSHCN, and we will be accountable to BIPOC communities and other underserved populations.

11.1.2.3. Systems and Policy

The Oregon Health Leadership Council is a collaborative seeking solutions to high health care costs. This group is researching use of health information technology (HIT) around the state. OCCYSHN will inform the Council with lessons learned from using Activate Care for PACCT, including insight into issues surrounding family/youth access to care plans.

OCCYSHN will track the implementation of Connect Oregon, a network of health and social care providers sharing a new technology platform. We will disseminate information on Connect Oregon to shared care planning and PACCT partners.

LPHAs have reported that primary care providers' (PCP) participation in PACCT is limited, in part because payment for shared care planning activities is inadequate. OCCYSHN will research coding and billing mechanisms, including novel financing options for supporting PCP engagement, and disseminate the information to our partners statewide.

11.1.2.4. Evaluation

OCCYSHN's Assessment and Evaluation (A&E) unit will continue to:

- **Collect and analyze End of Year Reports on PACCT activities.** The purpose of the data collection is to learn about LPHA implementation of PACCT. LPHA staff complete this annual electronic report in the fourth quarter of each block grant year.
- **Collect and analyze PACCT partner survey data.** The survey asks a short series of questions about communication with other partner types when coordinating care for CYSHCN. We administer the survey at

baseline (inception of local PACCT effort) and at the end of the first year.

- **Analyze Activate Care secondary data**. Activate Care provides us with de-identified administrative data from individual shared care plans. A&E staff currently are assessing the data files to determine whether we can use them for our intended purposes (e.g., date of shared care plan initiation, frequency of partner type use of Activate Care, average length of time to complete assigned actions). This work will continue into FY2022.
- **Analyze PACCT technical assistance (TA) data.** When S&W provides TA to PACCT members, they record with whom they met, the purpose of the contact, and the method (phone, video, webinar, etc.), and information about implementation facilitators and barriers that may have arisen during the TA contact. A&E and S&W will use these results to determine the focus of future analyses of activity tracking data.
- **Collect and analyze Family Survey data.** The survey collects data describing family empowerment, experience with shared care planning, and demographic data. Families who participate in PACCT also are asked an additional set of questions about their experience using Activate Care. We administer an electronic survey to all families who have participated in a shared care planning meeting (see Section 11.1.3.4).

A&E will develop methods for interviewing families who participate in shared care planning (see Section 11.1.3.4) and PACCT, to gather more in-depth data on their experiences. Our hope is that these interviews will allow us to collect data on unanticipated outcomes and challenges beyond the information we currently gather from our family survey. A&E will collaborate with Systems and Workforce Development to disseminate findings.

11.1.2.5. Communication

OCCYSHN will develop technical support products for PACCT participants, including accessible, inclusive resources for families and communities, employing health literacy best practices. We will share PACCT findings and learning with local, state, and national audiences.

Activity 11.1.3. Shared Care Planning

LPHAs will continue integrating shared care planning into their CaCoon work. CaCoon is OCCYSHN's statewide public health nurse home visiting program (see Strategy 11.1.4). CaCoon nurses identify individual CYSHCN who would benefit from shared care planning, and convene the family of those CYHSCN and the professionals who serve them, to collaboratively develop a family-centered shared care plan. The CYSHCN's primary care provider is invited, as are other health, education and community service providers. We will continue to provide technical assistance for shared care planning (including support for quality improvement efforts) to LPHAs and other participating partners (e.g., primary care practices, Education Service Districts, and Coordinated Care Organizations (CCOs)).

We will support the burgeoning integration of Community Health Workers (CHW) into LPHAs. In collaboration with Oregon State University, we will finalize an online course for CHWs, focusing on the foundations of cross-systems care coordination for CYSHCN. OCCYSHN will provide financial support to LPHAs for training CHWs to support CaCoon nurses' work with CYSHCN. Based on what we learn when this initial CYSHCN-related CHW training is implemented, we hope to expand its use to organizations outside of public health that employ CHWs (e.g., primary care practices, CCOs, and community-based organizations).

OCCYSHN will develop a self-assessment tool for the CaCoon workforce and their partners, to identify and strengthen their capacity to offer family-centered, team-based care. The tool will be based on National Care Coordination Standards. We will pilot the tool with a few LPHAs, modify it as needed, then disseminate to other LPHAs statewide.

The OCCYSHN Care Coordination Tier Level Assessment is a tool that was developed in 2012 to help care coordinators assess the types and intensity of family service needs. We will update this tool to make it more family- and equity-centered, with the goal of creating an assessment tool that is useful to both the CaCoon program and to other CYSCHN care coordination efforts.

11.1.3.1. Family Involvement

The Family Involvement Program will support shared care planning with resources and technical assistance, leveraging connections with family organizations to recruit diverse family members of CYSHCN to inform and support shared care planning workforce development.

11.1.3.2. Equity

OCCYSHN will promote health equity, diversity, and inclusion in our care coordination efforts, and in our collaboration with Oregon's Integrated Care for Kids project (see Section 11.1.3.3). We will ensure shared care planning services are culturally sensitive and responsive, including to the needs of LGBTQ+ CYSHCN and their families. OCCYSHN acknowledges that racism and other forms of discrimination affect the health of Oregon CYSHCN, and we will be accountable to BIPOC communities and other underserved populations.

11.1.3.3. Systems and Policy

The CMS-funded Integrated Care for Kids (InCK) project is working in two regions of the state—Central Oregon and Marion-Polk counties to support family-centered, integrated care. OCCYSHN will collaborate with InCK to promote shared care planning in these areas and offer shared care planning learning and tools to inform their efforts.

In January 2020, the state increased requirements for Coordinated Care Organizations (CCOs) around care coordination. New contracts require intensive care coordination and care planning for prioritized populations, including children aged 0-5, and children with complex or high health needs or multiple chronic conditions. OCCYSHN will continue to build and nurture relationships with CCOs to support shared care planning on behalf of this population. We will look for opportunities to partner with CCOs on shared care planning pilot projects and strategies for improving health care provider participation. We will also explore collaborating with commercial insurers on care coordination for CYSHCN.

OCCYSHN will monitor the work of Oregon's Medicaid Advisory Committee, and the Advancing Consumer Experiences subcommittee, for recommendations related to care coordination. We will provide input on CYSCHN as needed.

11.1.3.4. Evaluation

In addition to the End of Year Reports, S&W Technical Assistance data, and Family Survey data described in Section 11.1.2.5, OCCYSHN's A&E unit will continue to collect, analyze, monitor and track Shared Care Planning Information Form (SIF) data. This form collects data that include the date of the shared care planning meeting, demographic data about the child for whom shared care planning was conducted, the reasons for shared care planning for the child, etc. LPHA staff complete this electronic form after shared care planning meetings. A&E analyze these data on a monthly basis, and provide results to S&W for tracking shared care planning implementation. The interview data collection described in Section 11.1.2.5 also will be used for families who participate in shared care planning.

11.1.3.5. Communication

OCCYSHN will develop a strategic communications plan to share our findings and learning about shared care planning with local, state, and national audiences. We will develop accessible, inclusive dissemination products for

use with families, and we will promote health literacy best practices.

Activity 11.1.4. Care Coordination (CaCoon) Public Health Nurse Home Visiting
OCCYSHN will continue to contract with LPHAs to provide public health nurse home visiting services focused on care coordination for CYSHCN. CaCoon nurses will implement shared care planning for CYSCHN as appropriate (see Section 11.1.3). CaCoon is part of the systems improvement continuum described in the graphic shown atop Strategy 11.1.

OCCYSHN will monitor the process of Public Health Modernization in Oregon. We will identify opportunities to align our systems-improvement work with LPHA modernization and provide training and resources to the CaCoon workforce on the topic. We will assess the feasibility of hosting a statewide conference on cross-systems care coordination. If it is not feasible, we will offer virtual learning opportunities.

11.1.4.1. Family Involvement
The FIP will provide support and technical assistance to the CaCoon program, leveraging relationships with family organizations as needed. We will offer listening session(s) with family members of CYSHCN for nurse home visiting program administrators, including CaCoon. We will engage family leaders to participate in training and developing materials for CaCoon.

11.1.4.2. Equity
OCCSYHN will prioritize health equity, diversity, and inclusion in public health modernization efforts. We will encourage LPHAs to employ a CHW workforce that aligns with the cultural and linguistic make-up of their communities. We will contribute to CHW trainings, incorporating CLAS topics. We will integrate input from an expert data equity consultant into CaCoon data collection. We will partner with OHSU's Transgender Health Program and other subject matter experts to train the CaCoon workforce on providing inclusive and affirming health care to LGBTQ+ youth. OCCYSHN acknowledges that racism and other forms of discrimination affect the health of Oregon CYSHCN, and we will be accountable to BIPOC communities and other underserved populations (see State Priority Section 2.1.1 for plans to improve CLAS through workforce development).

11.1.4.3. Systems & Policy
OCCYSHN will partner with OHA's MCH nurse team to develop a combined nurse home visiting manual, incorporating culturally sensitive, responsive, and linguistically appropriate services standards. Additionally, OHA and OCCYSHN will create a combined CaCoon and Babies First! orientation, which will include the Oregon Home Visiting Core Competencies and the 2018 Quad Council Coalition Community/Public Health Nursing Competencies. The orientation will include training specific to the CaCoon program.

OCCYSHN anticipates getting CaCoon referrals directly from Family Connects Oregon, the universally-offered nurse home visiting program for families with newborns and will continue work with OHA to align these efforts. We will offer input on Family Connects guidelines. OCCYSHN's Care Coordination Specialist is a member of the State Interagency Coordinating Council (SICC), along with an FIP Parent Partner. They will offer input to the yearly SICC Governor's Report. The report summarizes the ongoing development of quality statewide services for young children receiving Early Intervention/Early Childhood Special Education Services and their families.

11.1.4.4. Evaluation
OCCYSHN's Assessment and Evaluation unit will continue to get CaCoon data from ORCHIDS via OHA, and analyze these data on a triannual basis for program monitoring purposes. With the Systems and Workforce

Development unit, we will offer input into the development of THEO data collection forms and procedures. We will pilot a survey in four counties with family members of CYSHCN served by CaCoon. The purpose of the survey is similar to those for activities 11.1.2.4 and 11.1.3.4. We will work with LPHA staff to finalize the survey content.

11.1.4.5. Communication

As noted in 11.1.4.3, we will develop a combined public nurse home visiting manual. OCCYSHN will develop, accessible, inclusive dissemination products, and promote health literacy best practices. We will share CaCoon findings and learning with local, state, and national audiences.

Activity 11.1.5. Emergency Medical Systems for Children (EMSC) Registry for CYSHCN

In 2020, OCCYSHN collaborated with OHA's EMSC program and others to develop the Health Emergency Ready Oregon (HERO) Kids registry. The registry allows families of CYSHCN to record information about their child for first responders and Emergency Department providers to access in an emergency. In FY2022, the FIP will solicit family input on HERO Kids project development. Because discussing children's life-threatening conditions and injuries can be traumatizing for families, and in keeping with State Strategy 1.1 to promote trauma-informed care, HERO Kids will seek technical assistance from Trauma Informed Oregon on how best to recruit families to register. The FIP manager will serve as a liaison to the EMSC Advisory Committee, and will collaborate with CYSHCN stakeholder groups to spread awareness of the registry. She will also consult with from bilingual family leaders on outreach to the Latinx and other communities where English is not the primary language.

Activity 11.1.6. Leverage the Oregon Family-to-Family Health Information Center (ORF2FHIC)

The ORF2FHIC is funded through May 2022. We will continue employing Parent Partners to provide peer phone support in English and Spanish, and maintain our comprehensive family resource website and social media presence. We will develop and disseminate family-centered toolkits, tip-sheets and other resources, and publish family newsletters in both English and Spanish. We will conduct family trainings and listening sessions (renamed Table Talks in 2021). Our trainings and family gathering topics will include medical home, health care transition, parent-professional partnerships, community-based services, and telemedicine. We will collaborate with other family-led organizations on training, outreach, referrals, and quality improvement. We will host information tables in patient waiting areas at OHSU's Spina Bifida and Maternal Fetal Medicine clinics, and approach other hospitals serving CYSHCN about promoting our services. We will consult with public health home visiting nurses statewide to share family-oriented information and resources, and to spread awareness of the peer support we can offer their clients.

11.1.6.1. Equity

ORF2FHIC's Bilingual Outreach/Training Coordinator will ensure that Latinx families get equitable services via Familia a Familia, ORF2FHIC's Spanish-language program. We will re-launch a Spanish-language Facebook page, build our listserve, and attend events for Latinx families of CYSHCN. We will engage Latinx family leaders to evaluate the Spanish-language section of the ORF2FHIC website, and make recommendations. We will continue collaborating with the African Youth Community Organization, African Family Holistic Health Organization and Lutheran Community Services Northwest, consult with them about the needs of their clients, and offer coaching, training, and resources. We will make ORF2FHIC materials available for them to adapt and translate as needed, and pay for that translation. We will explore potential for similar collaborations with Asian Family Services and Russian Oregon Social Services.

11.1.6.2. Systems & Policy

The FIP manager will provide technical assistance on using the “Planning for Meaningful Family Involvement” worksheet she developed for professionals. She will leverage ORF2FHIC’s statewide connections to recruit family members of CYSHCN to participate in systems-level work. She will serve as Family Faculty to OHSU’s Leadership Education in Neurodevelopmental and Related Disorders (LEND) program, where she will train a clinical cohort on the principals and practice of family-centered care. ORF2FHIC staff will participate on the State Interagency Coordinating Council, the Medicaid Advisory Committee, Durable Medical Equipment and Insurance Legislation workgroups, and the Ombudsman’s Advisory Committee. The FIP will facilitate OCCYSHN’s annual family review of block grant activities.

11.1.6.3. Evaluation

OCCYSHN A&E staff will collect and analyze data for ORF2FHIC reporting. We also will analyze data from the 211 Information Center, to monitor their referrals to ORF2FHIC.

11.1.6.4. Communications

ORF2FHIC will share findings and learning with local, state, and national audiences. We will maintain our comprehensive family resource website. We will develop accessible, inclusive dissemination products, and we will promote health literacy best practices.

Activity 11.1.7. Policy

OCCYSHN will identify systems issues impacting social determinants of health for low-income CYSHCN, and inform the policy agendas of the Oregon Health Authority, community-based organizations, and advocacy groups. We also will advise and inform the Oregon Legislature, Oregon Health and Science University, Oregon Law Center, Oregon Pediatric Society, Oregon Medical Association, and the Health Share All:Ready Network.

We will continue to work with OHA MCH and Oregon Medicaid leaders through our Title V-Medicaid memorandum of understanding. Our group identified EPSDT as a priority, specifically for children with autism spectrum disorder and behavioral health diagnoses. We also will use our MOU setting to inform Oregon’s application for an 1115 waiver to CMS, focused on improving systems and resources for CYSHCN. Additionally, we will work with Oregon Medicaid and the Health Evidence Review Committee on addressing disparities relevant to children, youth and young adults on the Medicaid Prioritized List of Health Services.

OCCYSHN’s Director will continue to serve in leadership roles with potential to impact the health of children in general, and CYSHCN specifically:

- Universally Offered Newborn Home Visiting - State Medical Director
- Oregon Patient Centered Primary Care Home Advisory Committee
- Oregon Commission on Developmental Disabilities
- Oregon Individualized Service Plan Redesign Team
- Oregon State Inclusive Preschool Leadership Team
- Oregon Pediatric Society Board and Advocacy Committee
- OHSU Policy Advisory Council

OCCYSHN will collaborate with OHA and Oregon Pediatric Improvement Partnership on the CMS-funded InCK project (see Section 11.1.3.3). We will also advise the pediatric representative to Oregon’s System of Care Workgroup. OCCYSHN will partner with OHSU Government Affairs and OHA MCH to provide input and education on state legislation relevant to CYSHCN.

OCCYSHN's Director and staff will participate in the Health Share CCO All:Ready Kindergarten Readiness network, which focuses on antiracism and ableism. We will further OHSU's mission to become an antiracist organization by partnering with the Department of Pediatrics Vice Chair for Equity, Diversity and Inclusion to address systems-level change.

Activity 11.1.8. Assessment

OCCYSHN will continue conducting ongoing needs assessment activities in FY22. Our intent is to regularly communicate the needs of the CYSHCN population to decision-makers, and to prepare for our next five-year needs assessment in 2025. Needs assessment data collections will seek to describe medical home/care coordination, transition to adult health care, access to care, and access to culturally responsive care. Next year, we will:

- Review updated National Survey of Children's Health (NSCH) results and begin preparing data "snapshots" summarizing NSCH results across years (e.g., 2016-2017 compared to 2018-2019, compared to 2020-2021, etc.). These will be available on our website and disseminated to relevant decision-makers.
- Continue working with OHA MCH and other state partners on the NSCH oversample of children from minoritized racial and ethnic communities. Oregon purchased an oversample, the data for which were collected in FY20 and FY21. The results will be available in FY22. We will begin analyzing these data, disaggregating CYSHCN survey results by race/ethnicity.
- Implement a Photovoice project with young adults with behavioral or mental health conditions.
- Plan for participatory needs assessment activities to better understand the needs of specific populations of CYSHCN for whom state-level data are not available (e.g., Asian, Native Hawaiian/Pacific Islander, Native American/Alaska Native, those living in foster care, or who experience behavioral/mental health conditions). This work will be based on OCCYSHN's 2020 participatory needs assessments with the Latino Community Association (Latino CYSHCN in Central Oregon) and Sickle Cell Anemia Foundation of Oregon (Black CYSHCN throughout Oregon).
- Resume conversations with the Patient Centered Primary Care Home program about updating 2010 – 2014 All Payer All Claims (APAC) data for children with medical complexity (see Report Section 11.6).
- Collect data that describe barriers to accessing specific care and data describing wait times for specific care and services (see State Strategy 3.1.1).

Critical Partnerships

- County Local Public Health Authorities
- Culturally-Specific Organizations (AYCO, IRCO, LCSNW, Open Doors, Unete, AFHHO)
- Family Voices/LFPP
- Health Share, All:Ready Systems Alignment Workgroup
- Latino Community Association
- LEND trainees and training coordinators
- OHA Early Hearing Detection & Intervention (EHDI) Advisory Council
- OHA Patient-Centered Primary Care Home (PCPCH) Advisory Committee
- OHSU Care Management
- OHSU Doernbecher Gender Clinic
- OHSU Maternal-Fetal Medicine Clinic
- OHSU IDD/CDRC and CDRC Eugene
- OHSU Language Services
- OHSU NICU
- OHSU Social Work, Women and Children's Services
- Oregon Council on Developmental Disabilities (OCDD)
- Oregon Department of Consumer Business Services (Insurance Regulative Authority)
- Oregon Emergency Medical Services for Children
- Oregon Family Networks and Organizations (25)
- Oregon Health Authority Birth Anomalies Surveillance System
- Oregon Law Center
- Oregon Office on Disability and Health (OODH) at OHSU
- Oregon Pediatric Improvement Project (OPIP)
- Oregon Rural Practice Research Network (ORPRN)
- Oregon State University, Professional and Continuing Education (PACE)
- Sickle Cell Anemia Foundation of Oregon
- State Interagency Coordinating Council
- University of Oregon, College of Education
- Washington County Health and Human Services, Behavioral Health

2022 Plan: NPM 12 Health Care Transition

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 2021 – September 2022

Strategy 12.1: We will increase the number of Youth with Special Health Care Needs (YSHCN) and their families who receive information about transition to adult health care from their providers through family-informed workforce development, quality improvement, systems incentives, and family awareness activities.

Activity 12.1.1. Workforce Development

OCCSYHN will improve health care transition (HCT) for youth with special health care needs (YSHCN). We will integrate HCT into all our cross-systems care coordination efforts, including QuICCs, PACCT, shared care planning, CaCoon, and CHW training. We will offer LPHAs technical assistance, training, and support for HCT quality improvement with LPHAs. We will help LPHAs implement innovative approaches to coordinating care for YSHCN, and plan for HCT. We will explore partnering with CCOs, primary care practices, and education systems to promote care coordination and HCT planning for YSHCN.

OCCYSHN will resume ECHO virtual learning communities with LPHAs, which were paused during the pandemic. They were a valuable tool for teaching and learning about HCT. We will also resume annual regional meetings, with cross-systems care coordination and HCT topics included.

12.1.1.1. Family Involvement

The FIP will invite professionals who serve CYSHCN to participate in family workshops on HCT, to increase professional insight into issues faced by YSHCN and their families. We will recruit health and community service providers to co-sponsor ORF2FHIC trainings on HCT. We will seek opportunities to present to professionals on the family experience of HCT. We will leverage our connections with other family-serving organizations to include HCT topics in their conferences and events.

12.1.1.2. Equity

OCCYSHN will prioritize health equity, diversity, and inclusion in our efforts to improve HCT for YSCHN. We acknowledge that racism and other forms of discrimination affect the health of Oregon YSHCN, and will be accountable to BIPOC communities and other underserved populations. The FIP will seek family members of YSHCN from minoritized communities to contribute to OCCYSHN's workforce development efforts.

12.1.1.3. Systems and Policy.

OCCYSHN will monitor Oregon health and education system efforts to address HCT. We will increase awareness and understanding by presenting on HCT at conferences, and provide guidance on HCT to the InCK project (see Section 11.1.3.3). We will approach education partners about integrating HCT planning into Individual Education Plans. We will train the LPHA workforce, including CHWs, about supporting effective HCT.

12.1.1.4. Evaluation

Evaluation activities for our medical home activities (see Section 11.1) will incorporate focus on HCT.

12.1.1.5. Communication

OCCYSHN will offer the LPHA workforce HCT training and resources. We will develop accessible, inclusive dissemination products, promote health literacy best practices, and share HCT findings and learning with local, state, and national audiences.

Activity 12.1.2. Continuation of Oregon's CMC CoIIN Project

OCCYSHN will continue our CMC CoIIN project to improve the transition from pediatric to adult primary care for young adults with medical complexity (YAMC). Our project's problem statement is that "young adults with medical complexity and their families are not adequately prepared for, or supported in, the transition from pediatric to adult healthcare" (Martin et al., 2019). We have identified root causes that span clinical, family, and policy realms, and will continue interventions in each of those settings.

Our CoIIN Implementation Team is composed of family leaders, OHSU General Pediatrics and Adolescent Health clinical partners, and OCCYSHN staff. In FY2021, the team will meet regularly to refine our pediatric provider transition education seminar, and disseminate it to OHSU pediatricians. We will also seek opportunities to educate non-OHSU pediatricians. We will oversee QI efforts with OHSU General Pediatrics and expand our clinical QI work to practices outside of OHSU.

12.1.2.1. Family Involvement

The CoIIN Implementation Team will develop a public awareness campaign to increase young adult and family

awareness about the importance of HCT, particularly for YAMC. We have learned from our work that families lack knowledge about HCT and its purpose. In collaboration with family leaders, we will use social marketing tools to raise awareness, and we will review and disseminate existing materials for families.

12.1.2.2. Equity

In the spirit of *"nothing about us, without us,"* we will recruit two youth leaders to sit on the CoIIN Implementation Team. We will consult with a trusted YAMC and with OHSU's University Center for Excellence in Developmental Disabilities about how best to support this effort.

In FY2021, our Implementation Team used Malawa and colleagues' (2021) Racism as a Root Cause (RRC) framework to evaluate the extent to which our project activities contribute to dismantling racism. Our review identified opportunities for improvement. We will collaborate with culturally specific service organizations to modify our clinical intervention to improve cultural responsivity. Our goal is to improve our intervention on at least one of the four RRC criteria.

12.1.2.3. Systems and Policy

Our root cause analysis identified that a lack of payment to providers or clinics for time spent on HCT as a barrier. We will continue our work with Got Transition and Oregon's InCK staff to identify value-based or other alternative payment methods to support HCT. The CCO Incentive Metric program is an important component of Oregon's health care transformation, employing incentive metrics to reward CCOs for achieving certain benchmarks. OCCYSHN will explore proposing an HCT incentive metric to induce CCOs and their provider networks to pay increased attention to HCT.

12.1.2.4. Evaluation

We will explore avenues for improving our survey response rate, including revision and shortening of the CoIIN family questionnaire. We will collect and analyze data from clinical staff participating in the QI project using the current in-person survey instrument. We will consider collecting survey data from YAMC participants. Finally, we will develop an evaluation plan for the family-focused public awareness campaign.

12.1.2.5. Communication

OCCYSHN will share HCT findings and learning with local, state, and national audiences by preparing manuscripts for peer-reviewed journals, and by disseminating a CoIIN impact statement. We will promote and develop accessible, inclusive dissemination products, and we will promote health literacy best practices.

Activity 12.1.3. Leverage Family-to-Family Health Information Center Grant

The ORF2FHIC will raise awareness among families and youth about the importance of planning for HCT. We will offer small group trainings on HCT, use social media, and disseminate materials and guidance from Got Transition. Parent Partners will be trained on the subject so they can coach families on HCT. We will train families to proactively assess their youth's readiness for HCT, and to support YSHCN to manage their own adult health care as much as possible. We will educate families on the process of HCT so they are better prepared to coordinate care, address legal matters, and ensure insurance coverage.

We will collaborate with OHSU's Child Development and Rehabilitation Center Lifespan Transition Clinic to complete and disseminate a workbook on HCT. We will collaborate with the Child Neurology Foundation on an HCT training for youth with intensive medical needs requiring multiple specialists. We will develop a tip sheet with key questions for families to ask pediatric providers to ensure effective HCT. We will consult with CoIIN and the Lifespan

Transition Clinic upon request, and promote their HCT efforts.

ORF2FHIC will recruit and train a young adult with special health care needs to fine-tune, promote, and co-lead our "Moving from Pediatric to Adult Health Care" training. We will also adapt the training and outreach for teens and their families who attend together. We will explore collaborating with School Based Health Centers on outreach and dissemination.
ORF2FHIC will offer Table Talks (formerly called Listening Sessions) on the subject of HCT for family members of YSHCN, offering stipends for participation. The insights, experiences, and concerns we glean from these sessions will inform OCCYSHN's planning and quality improvement.

ORF2FHIC's HCT training materials were reviewed by a workgroup of Black family members of CYSHCN in 2018. They have not been reviewed by Latinx family members of CYSHCN. We will finish translating the existing HCT training materials into Spanish, and recruit a workgroup of Latinx family members of CYSHCN to review them and make recommendations, paying workgroup members for their time and expertise. We will offer our HCT training and materials to our partners in culturally-specific organization (see Section 11.1.6.1).

Activity 12.1.4. Assessment

OCCYSHN's Assessment and Evaluation unit will incorporate HCT into Strategy 11.1.8 assessment activities.

Critical Partnerships

- County Local Public Health Authorities
- Family Organizations (25)
- Health Share, All:Ready Systems Alignment Workgroup
- Latino Community Association
- LEND trainees and training coordinators
- Metropolitan Pediatrics
- National Alliance for Advancing Adolescent Health (NAAAH), Got Transition
- OHA Early Hearing Detection & Intervention (EHDI) Advisory Council
- OHA Transformation Center
- OHSU Doernbecher Gender Clinic
- DCH General Pediatrics and Adolescent Health Clinic (Reem Hasan, MD, PhD; Danielle Sullivan, RN)
- OHSU Language Services
- OHSU Social Work, Women and Children's Services
- OHSU IDD/CDRC and CDRC Eugene
- OHSU IDD Lifespan Transition Clinic
- Oregon Council on Developmental Disabilities (OCDD)
- Oregon Law Center
- Oregon Office on Disability and Health at OHSU
- Oregon Pediatric Improvement Project (OODH) (OPIP)
- Oregon Rural Practice Research Network
- Oregon State University, Professional and Continuing Education (PACE)
- Sickle Cell Anemia Foundation of Oregon
- State Interagency Coordinating Council
- The Arc Oregon
- University of Oregon, College of Education
- Washington County Health and Human Services, Behavioral Health
- Youth ERA
- Department of Education Youth Transition Programs
- YSHCN and YSHCN families

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Percentage of new mothers who experienced stressful life events before or during pregnancy

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		43	41	43	43
Annual Indicator	43.9	41.3	44.8	44.8	43
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2017	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	42.5	42.0	41.5	41.0	40.5	40.0

SPM 2 - Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		90.7	94.6	93.5	94.2
Annual Indicator	90.5	94.4	93.3	94	93.8
Numerator					
Denominator					
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2011/12	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	93.9	94.0	94.1	94.2	94.3	94.4

SPM 3 - Percent of children living in a household that received food or cash assistance

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	42.3	43.3
Numerator		
Denominator		
Data Source	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	43.2	43.1	43.0	42.9	42.8	42.7

State Action Plan Table

State Action Plan Table (Oregon) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Stable and responsive relationships; resilient and connected children, youth, families and communities.
SPM
SPM 1 - Percentage of new mothers who experienced stressful life events before or during pregnancy
Objectives
By October 1, 2025 decrease the percentage of new mothers who experienced stressful life events before and during pregnancy from 44.8% to 38.0%.
Strategies
OCCYSHN will promote trauma-informed care for CYSHCN and their families by incorporating a family-informed, trauma-informed lens to workforce development activities.
MCAH Foundations - community, individual and family capacity: Support/fund programs - such as home visiting - that engage families and build parent capabilities, resilience, supportive/nurturing relationships, and children's social-emotional competence
MCAH Foundations - community, individual and family capacity: Build community capacity for improved health, resilience, social/cultural connection and equity.
MCAH Foundations - assessment & evaluation: Engage families and communities in all phases of MCAH assessment, surveillance, and epidemiology, including interpretation and dissemination of findings.

State Action Plan Table (Oregon) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Enhanced equity and reduced MCAH health disparities.

SPM

SPM 2 - Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs

Objectives

By October 1, 2025 increase the percentage of children age 0-17 who have a healthcare provider sensitive to their family's values and customs from 94.0% to 95.2%.

Strategies

OCCYSHN will improve CYSHCN and their families' access to culturally sensitive and responsive care through workforce development.

MCAH Foundations - policy & systems: Strengthen economic supports for families through policy development and implementation.

MCAH Foundations - policy & systems: Develop and/or strengthen systems and partnerships to address food security and barriers to accessing food resources.

MCAH Foundations - policy & systems: Foster cross-system coordination and integration to ensure screening and referral for SDOH, and equitable access to needed services for the MCAH population.

MCAH Foundations - policy & systems: Develop and implement systems that actively promote equitable, anti-racist, and trauma-informed workplaces, institutions, and services.

MCAH Foundations - policy & systems: Strengthen policies and systems that provide equitable access to safe, stable and affordable housing for the MCAH population.

MCAH Foundations - workforce capacity & effectiveness: Advance the skills and abilities of the workforce to deliver equitable, trauma informed, and culturally and linguistically responsive services.

MCAH Foundations - workforce capacity & effectiveness: Implement standards for workforce development that address bias and improve delivery of equitable, trauma-informed, and culturally and linguistically responsive services.

MCAH Foundations - workforce capacity & effectiveness: Ensure all Title V priority areas include a racial/ethnic and health equity focus including performance measurement and evaluation to identify and address disparities.

MCAH Foundations - assessment & evaluation: Ensure all Title V priority areas include a racial/ethnic and health equity focus including performance measurement and evaluation to identify and address disparities.

State Action Plan Table (Oregon) - Cross-Cutting/Systems Building - Entry 3

Priority Need

Enhanced social determinants of health

SPM

SPM 3 - Percent of children living in a household that received food or cash assistance

Objectives

By October 1, 2025, decrease the percentage of households with children that receive food or cash assistance from 42.3% to 41.3%.

Strategies

OCCYSHN will increase access to needed care and supports through investigation of barriers that inhibit CYSHCN and their families' timely access, and develop family-informed activities to reduce or eliminate the barriers.

Foundations - policy & systems: Strengthen economic supports for families through policy development and implementation.

Foundations - policy & systems: Develop and/or strengthen systems and partnerships to address food security and barriers to accessing food resources.

Foundations - policy & systems: Foster cross-system coordination and integration to ensure screening and referral for SDOH, and equitable access to needed services for the MCAH population.

Foundations - policy & systems: Develop and implement systems that actively promote equitable, anti-racist, and trauma-informed workplaces, institutions, and services.

Foundations - policy & systems: Strengthen policies and systems that provide equitable access to safe, stable and affordable housing for the MCAH population.

Foundations - assessment & evaluation: Conduct continuous needs assessment and/or exploratory analysis to add to the SDOH, Equity, CLAS, and Trauma/ACEs knowledge base and improve effectiveness of Title V foundational interventions and innovations.

2016-2020: State Performance Measures

2016-2020: 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**	**2019**	**2020**
Annual Objective		15.9	14.1	12.8	12.6
Annual Indicator	16.1	16.1	12.9	11.1	9.8
Numerator					
Denominator					
Data Source	USDA	USDA	USDA	USDA	USDA
Data Source Year	2013-15	2014-16	2015-17	2016-18	2017-19
Provisional or Final ?	Final	Final	Final	Final	Final

Toxic stress/ACEs Report

Priority: Toxic Stress/ACEs

State Performance Measure:

- Percentage of new mothers who experienced stressful life events before or during pregnancy;
- Percentage of mothers of 2-year-olds who have adequate social support.

Interpretation of performance measure data:

- From 2017 to 2019, the percent of new mothers who experienced at least 2 types of prenatal stress decreased from 44.8% to 42.8%. Due to data lag of the PRAMS survey, it will be at least two years before the impact of COVID-19 on stress before and during pregnancy can be observed.
- Updated data was not available for the percent of mothers of 2-year-olds with sufficient social support. In 2017, 92.5% of mothers of 2-year-olds had adequate social support. (Data for this measure is from PRAMS, and 2017 data is the most current that has been analyzed and released to date.)

Strategies:

Strategy #1: Provide technical assistance to local Title V Grantees implementing toxic stress, ACEs, and resilience work in their communities.

- **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 (neurobiology, epigenetics, ACEs and resilience), 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.
- **Accomplishments:**
  - A new state staff person was hired in November 2019 to be the lead for local level Toxic stress/ACEs priority area activities. The current Title V coordinator and former lead for this priority area oriented the new staff member to this work throughout fall 2019.
  - The new staff member coordinated needs assessment and local grantee technical assistance efforts, though efforts were interrupted when the COVID-19 emergency was declared in March 2020 and both state and local efforts to address COVID-19 reduced capacity to focus on non-emergent needs. The priority lead reviewed plans and coordinated technical assistance calls with Title V grantees as needed throughout the remainder of the grant year.
- **Challenges/emerging issues:** The COVID-19 pandemic made completion of our planned activities very difficult. Many local Title V staff were pulled into their community COVID-19 responses and traditional public health programs were temporarily "paused" or scaled back during the grant year. Local Title V staff lacked the capacity to participate in regular technical assistance for Title V activities.

Strategy #2: Promote family friendly policies that decrease stress and adversity for all parents, increase economic stability, and/or promote health.

- **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.

- **Accomplishments:**
  - The SDOH CoIIN digital stories were posted on the MCH website and used in a variety of policy and decision-making settings prior to COVID-19. A community film showing and storyteller panel was scheduled for April 2020, but had to be postponed due to the pandemic.
  - MCH staff participated in the development of an OHA trauma-informed policy alongside representatives from divisions across the agency. This trauma-informed policy workgroup continued to meet during the COVID-19 pandemic and was on track to present the draft policy to agency leadership by fall 2020.
  - The Title V program continued to strengthen partnerships with several organizations working 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 supported the continued development and implementation of legislation and programming for Oregon's Universally offered home visiting program.
- **Challenges/emerging issues:** The COVID-19 pandemic presents both challenges and opportunities related to the establishment of policies to prevent and/or mediate ACEs and trauma for children and families. The increased stresses on parents and families – especially in disenfranchised communities – are exacerbating both need and disparities. Although some short-term funding and policies to support families are being implemented, there are disparities in the reach and implementation of those policies, and the longer term policy solutions remain in doubt.

Strategy #3: Provide outreach and education to increase understanding of NEAR (neurobiology, epigenetics, ACEs, and resilience) science, and the impact of childhood adversity on lifelong health.

- **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.
- **Accomplishments:**
  - Information on toxic stress/trauma and its impact on lifelong health was provided to partners state and local partners as requested throughout the grant year.

- The MCH Section's Health Equity and trauma work group sponsored workplace educational programs throughout the grant year to increase the state public health workforce understanding of NEAR science, racism, and the impact of childhood adversity on lifelong health.

- The state Title V program presented and disseminated information on Trauma and ACEs to policy makers, state and community partners including state early childhood partners and local Title V grantees.

- Jackson County Health Department engaged a variety of partners, including Southern Oregon Early Learning Hub, Healthy Families Oregon, and Early Head Start on trauma-informed initiatives during the grant period. Jackson County's Nurse Family Partnership program coordinated quarterly meetings with these partners to provide training on trauma-informed topics.

- Lincoln County purchased the video *Broken Places* so staff could do a group viewing and discussion. Unfortunately, due to COVID-19, staff were unable to watch together but the film became available through the local public broadcasting station and staff were able to watch independently. Lincoln County then lent their copy to Deschutes County for viewing.

- **Challenges/emerging issues:**
  - Challenges related to this strategy included the variability 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.

  - Jackson County reported challenges with completing activities due to staff being diverted to local COVID-19 response. Jackson County was also impacted by unprecedented wildfires in September 2020, which displaced thousands and impacted local public health operations. As described below, Jackson County nurses implemented NEAR skills with clients and colleagues in both COVID-19 and wildfire responses.

Strategy #4: Engage partners to build capacity for safe, connected, equitable and resilient communities.

- **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.

- **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 MCH population within their work – especially as it relates to food security and community cohesion.

- 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. These programs build safe and connected communities by identifying children and families who are experiencing stress and adversity and refer them to appropriate supports and care.

- **Challenges/emerging issues:**
  As with other areas of this work the COVID-19 pandemic created challenges, illuminated disparities, and also created opportunities. The diversion of MCH staff at both the state and local level to COVID-19 response work was a huge challenge, but at the same time, new relationships with community-based organizations and new systems for funding disenfranchised communities around the state hold promise for this strategy in the coming years.

Strategy #5: Conduct assessment, surveillance, and epidemiological research. Use data and NEAR science to drive policy decisions.

- **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 ECHO 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.

- **Accomplishments:** Oregon's Title V program funded the inclusion of the ACEs module in Oregon's BRFSS, and supported the PRAMS and PRAMS 2 (now ECHO) surveys which include critical questions related to trauma, toxic stress, social support and resilience among pregnant women and mothers of 3-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 ECHO 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.
  - Title V staff partnered with other state agencies to fund and implement a National Survey of Children's Health oversample for Oregon, beginning in 2020.

- **Challenges/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. The NSCH oversample will help to address some of the data limitations.

Strategy #6: Develop a trauma-informed workforce, workplaces, systems, and services.

- **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.
- **Accomplishments:**
  - The integrated state MCH trauma-informed care and health equity work group continued development of internal systems and policies to ensure that the links between toxic stress and adversity, and racism and health equity are recognized and interwoven throughout our work.
  - Work on trauma-informed workplace systems and supports shifted with the pandemic to support for telework and COVID-related stressors on MCH staff and their families. These included ensuring that staff had flexible schedules, understood how to access emergency leave and childcare supports, and had ways to integrate self-care and wellness into their new work settings.
  - Benton County continued to build upon previous work to develop trauma-informed workplace and services. MCH home visiting RN's attended additional training to support their development and education about ACE's, Trauma Informed Care, Motivational Interviewing, and Postpartum Support. The MCH HV RN's attended a two-day remote training provided by Wendy Davis, PhD, PMH-C of Postpartum Support International, in partnership with Lincoln County who included Benton & Linn Counties to attend. Topics covered included pregnancy & postpartum mental health, depression during pregnancy & postpartum, anxiety during pregnancy & postpartum, postpartum PTSD & PMS as risk factors, and support and outreach resources. This training enabled the MCH RN's to expand understanding and offer more education, support, and resources to MCH clients with more confidence.
  - Deschutes County continued efforts to implement the Sanctuary Model. They were able to have all modules updated and ready for training by June 2020 and have subsequently finished training on all 10 modules. They reported spending more time than initially anticipated on these trainings because Zoom technology and remote work made it easier for staff to participate in training sessions.
  - Lane County intended to provide ongoing training in NEAR science to home visiting staff, however, was unable to complete large employee trainings due to COVID-19 capacity limitations. Lane County instead focused on providing one-on-one support to home visitors on NEAR science and trauma-informed practice implementation.
  - Washington County held multiple trauma-informed trainings over the year. All staff participated in Dr. Amy Stoeber' s Building Resiliency workshop. Maternal Child & Reproductive Health (MCRH) and Department

of Health and Human Services (HHS) leadership implemented a vigorous work environment assessment to increase organizational approach to trauma-informed care and encourage application of trauma-informed principles. The environmental scan resulted in some changes that require budget approval and Washington County will be working on including in the HHS budget over the next several years.

- **Challenges/emerging issues:**
  Challenges related to this strategy at both the state and local levels included the COVID-related changes in workplaces and all of the trauma-informed adjustments that those necessitated. Additionally, it is an ongoing challenge to address the complexity of developing trauma-informed systems and services, which span both how our MCH systems treat employees and workforce, as well as how we address trauma and racism and their impacts on health.

  At the local level, all grantees expressed challenges related to the COVID-19 pandemic. Many Title V grantee staff were diverted to their local COVID-19 response. Some trainings were postponed, and others were cancelled. Although previous training and professional developing in trauma-informed workplace principles helped Title V grantees to address staff trauma and toxic stress, some grantees reported that no one was fully prepared to meet the challenges of the complex trauma brought on by COVID-19 and regional wildfires during this grant cycle – both for staff and the clients they serve. This continues to be a challenge that will face Title V grantees in the future.

  Several grantees also noted the challenges with remote work, including fewer opportunities for staff to connect and build resilience. Washington County noted that staff seemed to be energized by the ability to incorporate trauma-informed approaches. The County has also supported staff to engage in various affinity groups and anti-racism discussions.

Strategy #7 Support programs that strengthen protective factors for individuals and families (build parent capabilities, social emotional competence, supportive/nurturing relationships; and foster connection to community, culture, and spirituality).

- **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.

- **Accomplishments:**
  - Benton County adopted telehealth to provide remote home visiting services for clients during the COVID-19 pandemic. The county worked to apply trauma-informed care principles to this practice but experienced some challenges in the implementation of this new technology.

  - Jackson County Health Department engaged a trainer to provide NEAR science training for home visiting staff. Staff also participated in a trauma-informed care for caregivers science of hope and healing training in fall 2019. NEAR skills trainings were placed as monthly agenda item for nurse meetings. Activities included NEAR skills games, and “Facilitating Attuned Interactions” (FAN) training. A November 2019 retreat included sessions focused on trauma-informed topics. All nurses completed NEAR @ Home training and 6-month integration. The team also watched the documentary film, Paper Tigers. Nurses integrated skills from training into client interactions, including how to talk with clients about ACEs and the impacts of trauma, using ACEs cards and games.

  - Lane County continued to implement the NEAR @ Home model for home visiting clients, building upon previous work in this area. Home visits were provided via telehealth after the start of the COVID-19 pandemic.

  - Linn County continued to screen for safety, support system and environment and refer to community supports based on individual family need.

- **Challenges/emerging issues:**
  All grantees expressed challenges related to the COVID-19 pandemic. Many Title V grantee staff were diverted to their local COVID-19 response or experienced staff turnover. Although previous training and professional developing in trauma-informed care principles helped Title V grantees to address client and staff trauma and toxic stress, some grantees reported that no one was fully prepared to meet the challenges of the

complex trauma brought on by COVID-19 and regional wildfires during this grant cycle. This continues to be a challenge that Title V grantees will work to address in the future.

Benton County reported challenges adopting telehealth for home visits, including lack of internet access, and difficulty identifying appropriate technology for each client. Some solutions were identified, however, including using doxy.me for Android devices and Facetime for Apple devices.

Lane County reported challenges with implementing NEAR @ Home model via remote visits. Visits during the COVID-19 pandemic were provided over the phone, which impacted the ability of home visitors to connect with clients. Lane County also reported some staff challenges related to documentation and implementation of the NEAR model. They switched to one-on-one coaching, so training can be tailored to specific staff needs.

Food Insecurity Report

Priority: Food Insecurity

State Performance Measure:

- Percent of households experiencing food insecurity;
- Percent of households with children under 18 years of age experiencing food insecurity.
    - SPM 2A: % households experiencing food insecurity; 9.8% (data from 2017-19)
    - SPM 2B: % household with children experiencing food insecurity; 19.2% (data has not been updated, still from 2003-11)

Interpretation of performance measure data: Oregon's food insecurity rate through 2017-2019 has steadily decreased since 2013-2015 due to many factors including a strong system of food supports, with greater outreach and participation in federal nutrition assistance programs. However, with COVID-19 food insecurity rates have spiked upwards as indicated by different data sources and is not reflected in the USDA dataset. New data for SPM 2B is not available from USDA.

Strategies:

Strategy #1: 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.

- **Accomplishments:** State work initially focused on updating resources in the Food Insecurity Implementation Toolkit that was shared with all grantees along with the recommended validated screening questions, and individual TA was provided to grantees. When COVID-19 emerged, the priority shifted at state and local level to provide information about accessing food resources and flexibilities implemented across nutrition assistance programs. Information was widely shared with partners statewide and highlighted on the OHA COVID-19 resources page.

- **Challenges/emerging issues:** At state and local levels responding to COVID-19 took precedence for every grantee. Local grantees were not able to implement some of their initial plans and focused on publicizing and increasing access to food resources in their community. The MCH staff lead for this priority was deployed to the state COVID-19 emergency management team overseeing contact tracing response in May through the end of grant cycle.

Strategy #2: 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.

- **Accomplishments:** Josephine, Lane, and North Central Public Health District (NCPHD) conducted food insecurity screening and referral. Two grantees (Josephine and Lane counties) reported 2,603 clients were screened for food insecurity in home visiting and WIC programs. This is an undercount of actual food insecurity screening that occurred as Josephine County stopped using paper screening forms during the pandemic but they continued screening clients during the pandemic; screening data was entered into the database used by WIC however staff had no way of accessing the data (which is why they used paper surveys). North Central Public Health District reported that they screened for food insecurity throughout the year but did not report any data.

  Clients who screened positive were referred to food resources. Josephine County conducts screening with paper surveys, limiting screening to just a few months before the pandemic. They kept their community resource guide updated. Lane County has worked on this activity over the past few years, building screening and referral into their clinic operations and charting systems, and getting good performance data so they will be able to continue activity in future years without dedicating funding to this strategy. Their community has an established referral network. NCPHD trained 6 home visiting and WIC staff about food insecurity screening and referral resources. Screening and referral data were not submitted however they reported that screening has continued in their programs. Their strong community partnerships enabled them to quickly pivot to address COVID-19 related food insecurity needs.

- **Challenges/emerging issues:** Umatilla County was unable to conduct screening and referral as the principle staff person went on unexpected leave early in the grant cycle and has since retired. Other staff were dedicated to COVID-19. NCPHD did not submit any data about screening and referral; reporting occurred during pandemic response. Josephine relied on paper surveys and when the pandemic hit there were no in-person visits to gather the data. While food insecurity screening was captured in the WIC program data system, there is no capability to run a report to capture screening and referral numbers.

Strategy #3: Support or provide food security education.

- **Activities – Local Level:** Josephine and Umatilla counties will address food insecurity through education of clients and community.

- **Accomplishments:** Umatilla was able to conduct four key informant interviews with partners, and the faith community, to guide their food insecurity work (there was a plan to conduct many more). Josephine was able to educate 1057 clients and community members, initially through in-person classes and cooking events and later online during the pandemic. Online education through WIC Health and the WIC shopper app were promoted to help educate families about cooking and resources like Oregon's FoodHero.org developed by SNAP-Ed.

- **Challenges/emerging issues:** Umatilla did not have a staff member to continue the key informant interviews and implement the subsequent plan. Josephine's onsite classes were more poorly attended than expected, though with a combination of onsite and virtual classes they were able to educate 1,057 clients and community members.

Strategy #4: 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.

- **Accomplishments:** The PHD Prevention Specialist, WIC Coordinator and VISTA have participated in the Gorge Grown Food Coalition. Sharing resources and participation in planning meetings occurred due to a strong community network. When COVID-19 emerged the coalition paused, and it was a seamless transition with communication to support the coalition's work and regional food bank in increasing food access for the community.

- **Challenges/emerging issues:** With COVID-19, NCPHD did not work to develop new partnerships within their coalition.

Culturally and Linguistically Responsive Services (CLAS) – OHA MCAH Report

Priority: Culturally and Linguistically Responsive Services (CLAS)

State Performance Measure:

- Percent of children age 0-17 years who have a healthcare provider who is sensitive to their family's values and customs.
- Percent of new mothers who have ever experienced discrimination while getting any type of health or medical care.

Interpretation of performance measure data:

From 2018 to 2019, the percent of children with a healthcare provider who is sensitive to their family's values and customs decreased from 94% to 93.8%. This decrease should be interpreted with caution due to the small sample size of the National Survey of Children's Health in Oregon.

From 2017 to 2018, the percent of new mothers who ever experienced discrimination while getting any type of health or medical care decreased from 10.9% to 9.7%. While this decrease cannot be linked directly to Title V efforts, it does represent an improvement in the health care experiences of women in Oregon, including among marginalized communities.

Strategies:

Strategy #1: 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.

- **Accomplishments:**
  - State Level: We continued to provide TA to local grantees, specifically Coos County. We supported their professional development efforts through a site visit in October 2019 that included a day long cultural humility training hosted by Celebrate Diversity!, an equity and inclusion consulting agency.
  - During the COVID-19 pandemic, our state team re-evaluated how our Health Equity Workgroup operates. The workgroup accomplished a lot over the last several years; and we also needed to examine where we may have fell short, staff burnout, and what equity and trauma-informed work meant for MCAH moving forward. Some changes we implemented included:
    - Inviting everyone in MCH to join the meetings as often as they could.
    - Shifting group goals to have connection and conversation around current events; challenges faced in work settings; understanding collective trauma, sharing equity initiatives from various

MCH teams, and overall working towards developing a culture of belonging where all colleagues feel safe to participate as their full selves in our work.
    - During the summer of 2020, we reached out to Engage to Change (a team of consultants who work with agencies on equity and trauma informed work) to establish a long-term consulting relationship. Our goal in working with them is to deepen our commitment to racial equity and engage all MCH staff in the work in meaningful, trauma-informed ways.

- From April through September of 2020, our MCH equity lead joined the COVID-19 response efforts as co-leader of the Equity and Community Engagement Team. Over 30 weeks, we helped lead weekly COVID-19 Community Engagement webinars and Community Listening Sessions. The focus of these sessions was to identify experiences of disproportionately impacted populations and make recommendations to address these disparate experiences.

- Local Level:
    - Multnomah County: The Transition Team community of practice worked hard to improve communication, expectations, and goals for racial equity work on the county level. The results of these team efforts have formed into an implementation plan to be carried out in subsequent grant cycles.
    - Coos County: Coos County Public Health successfully hed three full day trainings on inclusion and diversity with Celebrate Diversity!, a local EDI training organization. The Title V program staff were all in attendance, as well as the rest of the small county public health department. This was an excellent example of leveraging Title V CLAS resources to implement training and education to a wide array of staff who work with our communities at all different levels.

- **Challenges/emerging issues:**
    - State Level:
        - We have struggled to prioritize updating the Racial Equity/Trauma components of our public facing webpages. We have focused more internally on restructuring our work, and this is an area that continues to need attention in the next cycle.
        - COVID-19 impacted our work in a variety of ways, and most notably in the number of MCH staff that stepped up to help with the emergency response that the pandemic required from the public health department. Staff shortages and the rapid changing to remote work required a great deal of flexibility from all of us.

- Local Level:
    - Multnomah County: Multnomah County worked for a few years to get a Community Health Worker (CHW) program off the ground for Immigrant and Refugee Families using Title V funding (in collaboration with other funding sources/agencies). The We Are Home Project included some refugee led organizations that hired and trained CHWs for their communities. Each organization has a work plan to support families in their communities with children 0-3. The targets and measures were not reported on because the requests for data were unmet. Various funding sources backed out sooner than predicted, which added a lot of strain to the program. However, moving forward, the African Family Holistic Health Organization will work in direct collaboration with another part of Multnomah County Health District to support MCH services for African families.

Strategy #2: 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 Fetal Alcohol Spectrum Disorder 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 who 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.

- Confederated Tribes of 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 wooden board or frame to which an infant is secured with blankets or straps. Cradleboards are used for infant transport and sleep. This traditional practice was a cultural protective factor in the past, and this approach provides an opportunity to return to culturally specific American Indian infant care practices. 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.

- **Accomplishments:**
  - Local Level:
    - Multnomah County's Future Generations Collaborative Program was successful in implementing several opportunities for Native American/Alaska Native communities to improve knowledge and understanding of reproductive health topics, substance use, and cultural traditions. Various education modes were implemented to successfully increase male participation in these events (storytelling, slam poetry, Pow-Wows, Wellness Day events, support circles, etc.). One ongoing partnership the FGC continues to maintain is with Strong Men, Strong Community, and this last year focused primarily on understanding trauma.

    - Confederated Tribes of Warm Springs: Even despite having to cancel in person classes due to COVID-19, Confederated Tribes of Warm Springs saw an increase in participation in this project, seeing over 20 baby boards made with 41 mothers and supportive persons in attendance.

    - Lincoln County: Hired a bicultural/bilingual CHW in April 2020, and quickly her responsibilities expanded to other programs due to needs based on COVID-19.

- **Challenges/emerging issues:** In Lincoln County it took a long time to find the right candidate to fulfill the CHW role.

Culturally and Linguistically Responsive Services (CLAS) – OCCYSHN Report

Strategy: Develop a set of evidence-informed state and local level strategies and resources for addressing CLAS Standards

- OCCYSHN established a CLAS workgroup in October 2019, to monitor progress on CLAS objectives, and to integrate CLAS principles more consistently across all OCCYSHN's efforts. Because addressing inequity and disparity requires change at both the personal and systems levels, the workgroup also serves as a resource for OCCYSHN staff professional development of OCCYSHN staff through regular discussions and sharing of resources that examine the impacts of racism more generally. According to the *Racial Equity Stages* developed by Dismantling Racism (www.dismantlingracism.org), internal growth is an important phase of racial equity practice that informs any subsequent external efforts. Thus, the CLAS workgroup was renamed the Equity Workgroup.

- Discussion topics included the historical impact of Native American boarding schools, inclusive language, and gender equity for CYSHCN. The Equity Workgroup committed to presenting about CLAS and/or equity topics quarterly at OCCYSHN staff meetings. For example, in September 2020, the workgroup led a staff discussion about OHSU's accountability on anti-racism efforts.

- In January 2020, the equity workgroup organized OCCYSHN staff participation in an in-person lecture on OHSU's campus focused on combatting racism by renowned scholar on racism, Dr. Camara Phyllis Jones. OCCYSHN's journal club devoted a session to discussion of her article "The Gardener's Tale," which offers a framework for describing levels of racism. The journal club decided to focus future meetings on articles about the impacts of racism on CYSHCN.

- OCCYSHN developed and adopted an Equity Commitment Statement, detailing ways in which we will identify and address discrimination and its impacts on CYSHCN and their families. We posted the Equity Commitment on the front page of our website in August 2020. We also offered input on OHA's Title V Equity Commitment Statement. In Fall 2020, we changed our block grant tracking tools to include CLAS in every strategy, to integrate CLAS principles into progress on all block grant priorities.

- To align CLAS principals and program practices, OCCYSHN established a goal to include unconscious bias and other anti-racism training in the onboarding of new staff, and to include OCCYSHN's Equity Commitment Statement into OCCYSHN's Aid to Navigation (ATON), or our new employee resource guide. In October 2019, we revised hiring materials to include inclusive pronouns, and to offer candidates options for disclosing pronouns in the interview process. Additionally, we developed a new Systems Quality Improvement and Innovation Manager position which includes a leadership role supporting community-based projects focused on health equity. Largely due to COVID-19, that position has not been filled.

- OCCYSHN collaborated with other OHSU programs and departments on equity issues, which influence systems capacity to provide CLAS. In October 2019, we developed talking points for the University Center for Excellence on Developmental Disabilities (UCEDD) on a proposed federal "public charge rule," which stood to impact CYSHCN of color disproportionately. OCCYSHN's Director, who serves as OHSU's Department of Pediatrics Vice-Chair for Community Health and Advocacy, helped the Department of Pediatrics create, develop and recruit a new Vice-Chair position for Equity, Diversity, and Inclusion, and helped form the department's first formal equity committee. Given the influence of OHSU statewide, these Department of Pediatrics changes have important potential to promote change.

- The Oregon Family to Family Health Information Center addressed CLAS with language and culture-based efforts. A newly-established Spanish-language program component entitled "Familia a Familia" employed a bilingual outreach specialist to offer CYSHCN family support, develop materials, and conduct listening sessions in Spanish. Additionally, ORF2FHIC collaborated with Family Voices to plan a telehealth coach project for families of CYSHCN in the Portland area's underserved African immigrant community. (See Strategy 11.2.)

- OCCYSHN's Systems and Workforce Development team integrated CLAS into several significant projects. We began collaborating on efforts to train and integrate Community/Traditional Health Workers serving CYSHCN into the public health workforce, with a focus on culturally representative CHWs. We also addressed cultural and linguistic diversity in shared care planning and nurse home visiting. We collaborated with OHA on using Basecamp, a cloud-based productivity resource, for public health nurses, providing access to resources and materials in multiple languages; our shared care planning templates are available in five languages. We also translated our Activate Care orientation video into Spanish, and worked on making the platform more accessible to non-English-speaking families of CYSHCN. (See Strategies 11.1, 11.3, 11.5, 12.2.)

- As part of the 2020 Need Assessment, OCCYSHN established relationships with community-based organizations serving communities of color. OCCYSHN contracted with the Sickle Cell Anemia Foundation of Oregon and the Latino Community Association in Central Oregon to collect data from families of Black CYSHCN and families of Latino CYSHCN (See Strategies 11.6 and 12.1).

OCCYSHN Critical Partnerships for CLAS:

- African Youth Community Organization
- Family Voices
- Immigrant and Refugee Community Organization
- Latino Community Association
- Local Public Health Authority grantees workforce

- Lutheran Community Services Northwest
- OHA Office of Equity and Inclusion
- OHA MCAH Internal equity workgroups
- OHSU Center for Diversity & Inclusion
- OHSU UCEDD
- Oregon Community Health Worker Association
- Oregon State University
- Parent/Family Groups
- Sickle Cell Anemia Foundation of Oregon

Cross-cutting/Systems Building Domain Plans

As described in the introduction to this section, the plans for this domain reflect the different ways that OHA MCAH and OCCYSHCN are approaching the state-specific cross-cutting work during the coming year.

- Title V MCAH has developed an integrated approach to the 3 new state-specific priorities: toxic stress/trauma/ACES/resilience, CLAS and SDOH-E. Recognizing the interwoven nature of work on these 3 upstream priorities, the Title V MCAH program is approaching them as an integrated "Foundations of MCAH" priority. Work on the Foundations of MCAH, including strategies and activities at the state and local level are divided into 4 areas: policy & systems; workforce capacity & effectiveness; community, individual & family capacity; and assessment & evaluation.
- OCCYSHN will continue to work on CLAS and has added work for SDOH-E and Toxic stress.
- Other Title V efforts and investments which cut across priorities and domains and are described at the end of the cross-cutting section, for both the OHA MCAH and OCCYSHCN branches of the Oregon Title V program.

State Performance Measures:

- **SPM 1:** Percentage of new mothers who experienced stressful life events before or during pregnancy
- **SPM 2:** Percent of children age 0-17 years who have a healthcare provider who is sensitive to their family's values and custom
- **SPM 3:** The percentage of children living in a household that received food or cash assistance

Foundations – Policy & Systems Plan

Priority: Foundations – Policy and Systems

Strategy #1: Strengthen economic supports for families through policy development and implementation.

State level activities/timeline:

- Assess, develop, and implement family friendly policies for OHA/PHD employees (e.g., paid family leave, flexible scheduling, etc.)
- Conduct an environmental scan to assess, identify roles and coordinate MCH economic supports program and policy work.
- Continue to articulate MCH role in economic drivers for families, such as childcare and Earned Income Tax Credit ((EITC). Develop partnerships and policy priorities based on environmental scan to advance MCH role in economic support policies and initiatives.

Strategy #2: Develop and/or strengthen systems and partnerships to address food security and barriers to accessing food resources.

State level activities/timeline:

- Partner with state-level organizations to support cross-collaboration with food security initiatives:
  - SNAP-Ed Advisory Council through attendance at quarterly meetings and exploring opportunities through new cultural food work groups representing different racial/ethnic populations
  - Connect with OHA Healthier Together Oregon Housing and Food work group
  - Nutrition Council of Oregon to support nutrition security initiatives and collaborations through bi-monthly meetings
  - PHD Environmental Health Climate Change program around resilient food systems report

engagement

- Facilitate Childhood Hunger Coalition quarterly meetings to collaborate across represented organizations

- Develop new partnerships to address food security initiatives
  - Participate in SHARE (Supporting Health for All through REinvestment) Initiative cross-agency workgroup to support connections between Title V and CCO work in SDOH-E
  - Work with OHA Health Policy and Analytics to learn about implementation of SDOH & food security metrics within CCOs
  - Develop partnership with Partners for a Hunger Free Oregon and learn about their community food insecurity listening sessions and plan
  - Explore potential new partnership with OPIP (Oregon Pediatric Improvement Partnership) and InCK (Integrated Care for Kids)

Local level activities/timeline:

- Support local health agencies, tribes and community partners with healthy food system planning, policies and strategies that strengthen community food systems and food sovereignty

- Support 6 local public health agencies and Cow Creek Band of the Umpqua Tribe of Indians who selected food insecurity strategy to engage with community partners

- Support the local grantees to implement and strengthen food security screening and referral systems

Strategy #3: Foster cross-system coordination and integration to ensure screening and referral for SDOH, and equitable access to needed services for the MCAH population.

- **State level activities/timeline:**
  - Assess opportunities for MCH participation in state level, cross-system efforts to screen for SDOH needs and refer to social safety net supports, including local Title V representation in Community Information Exchange (CIE) networks.

  - Support local partners to build capacity in trauma-informed SDOH needs screening implementation.

- **Local level activities/timeline:**
  - Develop culturally and linguistically competent systems to screen for trauma and SDOH needs in clinical and community settings. (Clackamas, Columbia)

  - Deepen relationships with local partners to build a strong, culturally competent and trauma-informed local referral network (Clackamas, Marion, Confederated Tribes of Umatilla Indian Reservation)

  - Partner with CCOs and other community partners to integrate local LPHA and tribal MCAH programs into CIE networks. (Clackamas, Columbia)

Strategy #4: Develop and implement systems that actively promote equitable, anti-racist, and trauma-informed workplaces, institutions, and services.

State level activities/timeline:

- Our state MCAH office will prepare and present TA opportunities on these topics for Title V grantees (e.g. Health Literacy Training, trauma-informed approaches, implicit bias, hiring practices) throughout the grant cycle.

- Through our health equity workgroup, we will provide monthly professional development opportunities on SDOH Foundational Topics for all MCAH staff.

- Based on the monthly topics, we will compile list of anti-racism/trauma-informed trainings and resources

(detailing format, knowledge gain, and where they fit in a selected framework) and how selected opportunities will be implemented into the program. This list will also be shared with local grantees. In addition to anti-racism and trauma-informed trainings and resources, we will also update food insecurity education resources and promote these with our community partners and local grantees.

Local level activities/timeline:

- Lane County will build off their previous health equity work to develop more action-oriented plans to address our structural components that create barriers for the BIPOC community. Title V will support Lane County to hire a consultant to help leadership adopt these practices, and then include home visitors and support staff to improve capacity in this area.

- Linn County became more aware the significant need to address health disparities, including the need for equitable anti-racist care for people of color, while working with their community through COVID-19. Additionally, they identified need for improved trauma informed care for their clients and trauma informed workplace policies for their agency.
    - Title V will support Linn County to assess and develop organizational readiness for anti-racist and trauma informed practices and policies.

Strategy #5: Strengthen policies and systems that provide equitable access to safe, stable, and affordable housing for the MCAH population.

- **State level activities/timeline:**
    - Develop partnerships with Oregon Housing and Community Services (OHCS) and other state/community-based programs and agencies to explore opportunities for MCH Title V to support housing stability and equitable access to healthy affordable homes for all Oregon families. Timeline: October 2021 – September 2022

    - Research the barriers, disparities, upstream causes and health impacts of housing instability and inequity on Oregon's MCH population. Timeline: October 2021 – September 2022

Critical partnerships:

- Strategy 1: Local Public Health Authorities, Tribes, CCOs, Early Learning Division, Early Learning Hubs, Oregon Department of Human Services, OHA Transformation Center, OHA Office of Health Information Technology, Trauma Informed Oregon, Connect Oregon (UniteUS), Help Me Grow, Aunt Bertha, Oregon Primary Care Association (SDOH screening), 211, OHA Social Determinants of Health workgroup, Healthy Families Employee Resource Group.
- Strategy 2: Public Health Division – other programs including Director's Office (SHIP work), WIC program, Environmental Health, Health Promotion and Chronic Disease Prevention; Injury and Violence Prevention; OHA Health Policy and Analytics, OHA Health Services Division, Oregon Department of Human Services, Oregon State University Extension SNAP-Ed, Oregon Department of Education, Child Nutrition Programs, Moore Institute, Oregon Food Bank, Nutrition Council of Oregon members, Childhood Hunger Coalition members (including health system representatives), Association of State Public Health Nutritionist, Local grantees and tribes working on this strategy
- Strategy 3: Local Public Health Authorities, Tribes, CCOs, Early Learning Division, Early Learning Hubs, Oregon Department of Human Services, OHA Transformation Center, OHA Office of Health Information Technology, Trauma Informed Oregon, Connect Oregon (UniteUS), Help Me Grow, Aunt Bertha, Oregon Primary Care Association (SDoH screening), 211, OHA Social Determinants of Health workgroup, Healthy Families Employee Resource Group.
- Strategy 5: Oregon Housing and Community Services, Oregon Dept of Human Services, Healthier Together Oregon, Community agencies working on housing for families, Oregon Early Childhood Division, Oregon Coordinated Care Organizations

Foundations – Workforce Capacity & Effectivess plan

Priority: Foundations – Workforce Capacity & Effectiveness

Strategies:

Strategy #1: Advance the skills and abilities of the workforce to deliver equitable, trauma informed, and culturally and linguistically responsive services.

- **State level activities/timeline:**
  - Prepare and present TA opportunities on these topics for Title V grantees (eg Health Literacy Training, trauma-informed approaches, implicit bias, hiring practices). This will be ongoing through the grant cycle in response to individual grantee needs.
  - State MCH Professional Development on Foundational Topics -Monthly topic sessions. Beginning in August, there will be monthly topical discussions on anti-racism and trauma informed work. This will align with our contractual work with Engage to Change (noted in the next activity area).
  - Compile list of available Anti-Racism trainings (detailing format, knowledge gain, and where they fit in a selected framework) and how selected opportunities will be implemented into the program. Will be included on our MCH Racial Equity web page as a resource for our community partners and local grantees, and related to monthly topical discussions through grant cycle
  - Identify/revise food insecurity education resources and promote with partners; support or provide training about food insecurity.
- **Local level activities/timeline:**
  - Participate in TA opportunities to improve knowledge and skills in equity, trauma/ACEs, and CLAS (including home visiting staff)
  - Douglas County United Community Action Network (UCAN): UCAN will provide professional development activities and continue training public health staff on anti-racist and trauma-informed service delivery. They will utilize resources and information from a recent 6-week course that staff attended on perinatal health and racism. As their work develops, they will partner with WIC staff and nurse home visiting programs to improve the baseline knowledge through all the programs that work with families during the perinatal and postpartum periods.
  - Washington County: Washington County will implement required professional development for their MCAH team, focusing on holistic, client centered and culturally responsive service delivery.
  - Benton County: Benton County will work with Trauma Informed Oregon to connect training to build upon ACEs and TIC trainings that Title V and nurse home visiting staff have already completed.
  - North Central Public Health District:
    - NCPHD will focus on workforce professional development to improve onboarding and staff retention. They have previously completed an equity assessment and will identify and provide opportunities for staff to deepen their commitment to eliminate disparities and improving culturally responsive service delivery.
    - Provide training and education for perinatal providers and community partners including anti-racism trainings and other SDOH areas
  - Coquille Indian Tribe: Title V will support the tribe in providing training opportunities for all public health programs that are part of the CIT Health and Human Services department. Special considerations will be made to find appropriate trainers/trainings who are able to account for historical and current racism and trauma experienced by Native Americans in Oregon. The Coquille Indian Tribe is also leveraging this work with PH modernization dollars to improve staff knowledge and service delivery in SDOH areas.

Strategy #2: Implement standards for workforce development that address bias and improve delivery of equitable, trauma-informed, and culturally and linguistically responsive services.

- **State level activities/timeline:**
  - All MCH Staff will have 10% of their time allocated for equity work. Related activities include manager

–support, accountability through professional development plans. Title V staff will support managers and consultants to develop plan and implement this policy

- Work closely with MCH leadership to determine measures of accountability and appropriate activities to fulfill this requirement.

- Develop standards for best practices for hiring and trauma informed services (over the 5-year plan, work with CHLO to include in PEs)

- Work with the PHD Health Equity Work Group (HEWG) and PHD Leadership to adopt hiring and retention guidelines and systems of accountability for MCH and other sections of public health.

- Research potential gaps in support for MCH priority communities with a special emphasis on SDoH.

- Create a Culture of belonging to help retain staff and skills as well as provide space for lived experience. Identify standards, activities that lead to a more inclusive, safer culture and staff retention.

- **Local level activities/timeline:**
  - Assess standards currently in place, determine best practices and develop action plan for equitable workforce development and trauma informed, culturally responsive services
    - Multnomah County: An initial baseline assessment was performed in three sections: team culture, the experience of trust and inclusion at work, and knowledge, skills, and abilities. The follow-up assessment will identify, and measure culture shifts in these areas.
    - Josephine County: Will undergo an organizational assessment for equity (tool TBD) to better prioritize their racial equity and trauma work moving forward over this grant cycle and future cycles.

  - Develop and implement a hiring and retention plan using trauma informed principles and an equity lens
    - Yamhill County: A draft Hiring and Retention Plan for Equity has been developed, and will be tested this cycle, incorporating best practices for professional development and staff retention.
    - Coos County:
      - One or more PH staff will participate in the Regional Equity Coalition
      - PH staff will be trained to recognize and respond to issues of diversity, equity, and inclusion in public health work.
      - Implement the agency's new Health Equity Policy to establish equitable practices in hiring, retention, workforce development and provision of services.

Critical partnerships:

- Healthy Start (Douglas County)
- Regional Health Equity Coalitions (statewide)
- Public Health Nurse Home Visiting Programs
- State and Local WIC programs
- Engage to Change

Foundations – Community, Individual, and Family Capacity

Priority: Foundations – Community, Individual, and Family Capacity

Strategies:

Strategy #1: Support/fund programs, such as home visiting, that engage families and build parent capabilities, resilience, supportive/nurturing relationships, and children's social-emotional competence.

- **State level activities/timeline:**
  - In collaboration with the Family Connects Oregon and MCH Nurse Team, support implementation of Family Connects Oregon, an evidence-based home visiting program that will eventually be offered to all families of newborns in Oregon. This will be critical in assessing the needs of families during the period of adjustment around 3 weeks of life and building local systems of care to support families with newborns. State level efforts include developing clinical guidelines, coordinating training and technical

assistance as well as developing a system to bill commercial payers and Medicaid for reimbursement.

- In collaboration with the MCH Nurse team, provide training, 1:1 reflective supervision, monthly community of practice meetings, technical assistance, and oversight to the Babies First! and Nurse Family Partnership Nurse Home Visiting programs.

- **Local level activities/timeline:**
  - Marion, Washington, Linn, Lincoln, and Jefferson counties will use Title V funding to support the implementation of the Family Connects Program. Home visiting services are just ramping up and staff are new, so they will be building capacity for increased home visiting services to all families. Partnerships are being developed with the Early Learning HUBs, other home visiting programs such as Early Head Start and Healthy Families Oregon, and health/hospital systems. A multi-County approach is being used in some regions requiring alignment among multiple Counties.

  - Jackson and Lane County are using Title V funding to support nurse home visiting programs. The Title V funding is a critical complement to other funding sources. By focusing on caseloads, and the details of referrals, enrollment by demographics, race and ethnicity, they will be able to provide services to the people in the community who need our services the most regardless of who they are and where (rural/urban) they live. This effort should also help our outreach planning and family retention in the future. Jackson nurse home visiting programs are a cornerstone for building family protective factors.

  - Multnomah County will enhance access to parenting education by supporting a new partnership with the Healthy Birth Initiatives (HBI) program which focuses on ensuring better maternal and infant birth outcomes in the African American Community. HBI has not been able to serve the African, non-English speaking community because of language barriers. Collaborating and funding a new partnership with the African Family Holistic Health Organization (AFHHO) will allow for more robust education and support.

Strategy #2: Build community capacity for improved health, resilience, social/cultural connection, and equity.

- **State level activities/timeline:**
  - Engage with inter-agency collaborations and cross-systems initiatives that work to prevent/address trauma and ACEs and promote resilience.

  - Explore opportunities within MCH, CP&HP and OHA/PHD to directly fund community-based organizations to build resilient, trauma-informed communities.

  - Work across MCH to build systems and programs that enhance community capacity and are accountable to the people they serve, particularly communities of color.

- **Local level activities/timeline:**
  - Convene coalitions, inter-agency collaborations, and cross-systems initiatives to prevent/address trauma and promote resilience. (Jefferson, Multnomah, Cow Creek Band of the Umpqua Tribe of Indians)

Critical partnerships:

- Strategy 1: MIECHV, MCH Nurse Team, Family Connects Oregon, Family Connects International, Early Learning Division/Early Learning Hubs
- Strategy 2: Critical partners for this work include: Local Public Health Authorities, Tribes, MCH Health Equity Workgroup, Engage to Change consultants, PHD Community Engagement Community of Practice, community-based organizations, PHD Director's Office, Trauma-Informed Oregon, OHA Trauma-Informed Policy workgroup, Injury and Violence Prevention Section, Adolescent Genetics and Reproductive Health Section, Health Promotion and Chronic Disease Prevention Section, fiscal staff, community members.

Foundations – Assessment & Evaluation plan

Priority: Foundations – Assessment & Evaluation

Strategies:

Strategy #1: Ensure all Title V priority areas include a racial/ethnic and health equity focus including performance measurement and evaluation to identify and address disparities.

- **State level activities/timeline:** Where possible, report Title V performance measures by race and ethnicity, disability, gender, age, sexual orientation, socioeconomic status, nationality, and geographic location.
    - Review Title V national performance measures, state performance measures, national outcome measures, and evidence based/informed strategy measures for disparities, and produce report of relevant findings for use by priority areas leads to improve program delivery. (October 2021 to December 2021)

    - Review all Title V programming to ensure that Oregon Health Authority REAL D protocols for data collection are used wherever possible, or that there is a plan in place to transition to use of the protocols. (March 2022 – September 2022)

    - Participate in Babies First/CaCoon data collection workgroup. The workgroup is partnering with service providers, community partners, and expert consultants to improve Title V funded home visiting data collection, to increase the culturally and linguistically responsiveness of the questions and collection methods, and to frame the data collection using a trauma informed lens. (October 2021 – September 2022)

    - Expand the use of a rigorous evaluation framework and continuous quality improvement across social determinants of health, equity, culturally and linguistically appropriate services, and trauma, toxic stress, and resilience strategies.
        - Review evaluation protocol of Title V funded programs (October 2021 – September 2022)

    - Evaluate food insecurity strategies and outcomes of Title V food insecurity priority at the state and local level for 2015-2020; develop brief and success stories from evaluation. (October 2021 – June 2022)

    - Scan existing state and national data sources for food security with focus on equity data; identify data gaps. (October 2021 – June 2022)

- **Local level activities/timeline:**
    - Monthly meetings held by Lincoln county to provide training on social determinants of health interviewing with an emphasis on empathetic inquiry and community awareness and collaboration. Attendees will include community members to inform staff on access needs of clients; particularly on differing access based on language. The meetings will allow for conversations on sensitive topics, particularly racism, with both staff and community members, including from communities of color. These meetings will be used as an opportunity to assess what improvements are needed to facilitate program access for non-English-speaking clients and other marginalized clients. This information will then be used to determine quality improvement activities. (October 2021 – June 2022)

    - Conduct local level evaluation of Title V efforts that engages end users, (e.g. consumer satisfaction surveys) particularly among marginalized communities such as BIPOC, LGBTQ+, homeless families, etc.

- Conduct satisfaction surveys among home visiting clients and community partners to evaluate services to marginalized communities, and to develop capacity of staff where necessary. (October 2021 – June 2022)

Strategy #2: Conduct continuous needs assessment and/or exploratory analysis to add to the SDOH, Equity, CLAS, and Trauma/ACEs knowledge base and improve effectiveness of Title V foundational interventions and innovations.

- **State level activities/timeline:**
  - In partnership with CSTE/CDC Applied Epidemiology Fellow and MCH Epidemiologist (CDC Assignee), publish manuscript on the association between adverse childhood events and cognitive disability in a peer reviewed publication. (October 2021 – December 2021)

  - Update brief fact sheet on adverse childhood events in Oregon for public release (October 2021 – December 2021)

  - Attend monthly policy team meetings to provide data consultation and produce data briefs as necessary (October 2021 – September 2022)

Strategy #3: Engage families and communities in all phases of MCAH assessment, surveillance, and epidemiology, including interpretation and dissemination of findings

- **State level activities/timeline:**
  - Reengage with original recipients of needs assessment community voices grants, to report on priority selection and to explore future partnership in strategy development and program delivery. (October 2021 – January 2022)

  - Continue needs assessment community voices project by partnering with American Indian/Alaska Native, Asian, and Pacific Islander communities or community specific agencies to assess maternal and child health needs within these communities. (January 2022 – September 2022)

Critical partnerships:

- CSTE/CDC Applied Epidemiology Fellowship
- Community voices mini grant recipients:
  - Casa Latinos Unidos de Benton County
  - Coos County Health & Wellness
  - Multnomah County Health Department, Healthy Birth Initiative
  - Klamath County Public Health
  - Klamath Tribal Health and Family Services
  - Oregon Health and Science University, Transgender Health Program, Doernbecher Gender Clinic
  - Spect-Actors Collective, Doulas Latinas International
- Lane County Public Health
- Lincoln County Public Health
- CDC MCH Epidemiology Program Sponsored Assignee to Oregon
- Association of State Public Health Nutritionists
- Culturally specific organizations that serve American Indian, Asian, and Pacific Islander communities

OCCYSHN Toxic Stress, Trauma, ACEs and Resilience 2022 Plan

Strategies:

Strategy 1.1. We will promote trauma-informed care for CYSHCN and their families by incorporating a family-informed, trauma-informed lens into our workforce development activities.

- **Activity 1.1.1. Develop OCCYSHN Internal Capacity:**
  - OCCYSHN will investigate curricula and best practices regarding developing trauma-informed approaches to care coordination. Once we have identified promising materials, we will begin the process of integrating training for appropriate staff, and subsequently into our work with local public health authorities.

- **CYSHCN ESM for SPM1.1:** The percentage of OCCYSHN staff who complete at least one training about trauma-informed care.

- **Objective:** By 2025, all OCCYSHN staff will complete at least one training about trauma-informed care.

- **Progress:** At baseline (FY2020), 47% (8) of OCCYSHN's 17 staff had participated in at least one training about trauma-informed care. As of May 31, 2021, 50% (9) of OCCYSHN's 18 staff had participated in at least one.

- **Activity 1.1.2. Develop expertise on Pediatric Medical Trauma and CYSHCN:**
  - OCCYSHN will gather information about pediatric medical trauma. The National Child Traumatic Stress Network defines pediatric medical trauma as a "set of psychological and physiological responses of children and their families to pain, injury, serious illness, medical procedures, and invasive or frightening treatment experiences that may occur as a response to a single or multiple medical events." We will employ OHSU's Research Engagement Librarian to perform a literature search on pediatric medical trauma, with a focus on disparities treating pain in Black children. We will convene four or five directors of other F2FHICs to discuss medical trauma for CYSHCN and their families. OHSU has a number of nationally recognized experts in trauma associated with pain (Drs. Anna Wilson and Amy Holley), and we will collaborate to disseminate resources to families and providers, with the goal of reducing trauma in medical settings.

- **Activity 1.1.3. Workforce development:**
  - OCCYSHN will review and modify cross-systems care coordination processes to align with principles of trauma-informed care. We will review and modify our materials, products, trainings, and technical assistance to ensure they are consistent with principles of trauma-informed care and establish a trauma-informed approach to engaging family voices to inform our work.

OCCYSHN Culturally and Linguistically Responsive Services (CLAS) 2022 Plan

Strategies:

Strategy 2.1. We will improve CYSHCN and their families' access to culturally sensitive and responsive care through workforce development.

- **Activity 2.1.1. Workforce Development:**
  - OCCYSHN will partner with culturally-responsive community-based organizations to review and inform our cross-systems care coordination and health care transition workforce development activities. Our goal is that these services be sensitive and responsive to the needs of all CYSHCN and families. (See Sections 11.1 and 12.1.)

- **CYSHCN ESM for SPM1.1:** Culturally-specific community-based organizations reviewed our cross-systems care coordination strategies, and OCCYSHN modified strategies based on organization feedback (Yes/No).

- **Objective:** By 2025, we will have adapted or modified our cross-systems care coordination strategies on the basis of feedback from at least two culturally-specific community-based organizations.

- **Progress:**
  - We will begin recruiting culturally-specific community-based organizations for this review during FY2022.

  - OCCYSHN will provide resources and learning opportunities on these topics to the CaCoon public health nurse workforce. (See Section 11.1.4.) We will incorporate culturally sensitive, responsive, and linguistically appropriate service objectives in the forthcoming CaCoon program manual update.

  - Our new state-level data collection system, Tracking Home Visiting Effectiveness in Oregon (THEO), currently is under development, and will reflect feedback from a Data Equity Workgroup. Data collection will focus on equity, and employ a strength-based approach, as we strive to improve equity outcomes in the CaCoon program. The goal is to ensure data collection aligns with community needs and can foster program evaluation opportunities. We will continue to partner in its development and disseminate state and county level data to key stakeholders, including current and potential CaCoon clients.

  - OCCYSHN will offer technical assistance to PACCT care coordination unit members on ways to help families engage with Activate Care, the on-line care coordination platform used in this project that are both culturally sensitive and responsive. (See Section 11.1.2.) We will work with our Activate Care business partners to improve the platform's orientation towards cultural sensitivity and responsiveness.

- **Activity 2.1.2. Promotion of Culturally Appropriate Health Care:**
  - OCCYSHN will promote culturally sensitive and responsive health care through our local public health authority partners around the state. (See Section 11.1.) We will update shared care planning and Activate Care forms to include inclusive personal pronouns. We will continue to host trainings for public health nurses on serving gender diverse and LGBTQ+ clients, and we will provide them with links to additional training, information, and resources on these topics.

  - OCCYSHN's Assessment and Evaluation unit manager (Alison Martin, PhD) served as research mentor to Mr. Charles Smith, MSW, during his 2020-2021 Leadership Education in Neurodevelopmental and Related Disabilities (LEND) fellowship. OCCYSHN will contract with Mr. Smith to continue the work he began with Dr. Martin during this fellowship, to identify a clinic-level assessment tool responsive to the needs of Black CYSHCN and their families. The goal for FY2022 will be to create or modify an existing assessment tool, and to test the tool in one or two pediatric medical homes. This work will address our five-year goal to identify pediatric providers that provide culturally responsive care to Black CYSHCN and their families, and to disseminate those culturally responsive practices.

- **Activity 2.1.3. Multicultural Organizations:**
  - In 2019, staff from the Oregon Family to Family Health Information Center (ORF2FHIC) met with representatives from Washington's Open Doors for Multicultural Families to learn about their origins, goals, and programming. Although we determined that ORF2FHIC does not have the resources to replicate such a program, the Family Involvement Program will explore contracting with Open Doors to provide trainings, workshops and listening sessions for Oregon families.

  - ORF2FHIC will continue to partner with both African Youth and Community Organization's (AYCO) Bridge program, and Lutheran Community Services Northwest (LCSNW). We will work with their clinicians and social workers to modify existing ORF2FHIC trainings to make them more culturally appropriate. Family trainings will be held in languages other than English, and ORF2FHIC will provide simultaneous translation ensuring that trainers and trainees can communicate more effectively. AYCO and LCSNW will translate selected ORF2FHIC materials, and the ORF2FHIC Resource Specialist will offer AYCO and LCSNW help building CYSHCN-specific resource pages for their websites.

- **Activity 2.1.4. OCCYSHN Equity Workgroup:**
  - The OCCYSHN Equity Workgroup was developed to inform and monitor CLAS efforts and has grown into a broader initiative. In 2020 the workgroup expanded its focus to include other equity-related issues affecting CYSHCN, with the understanding that learning about equity is an ongoing process requiring both internal and external effort. The workgroup will regularly present on equity topics at OCCYSHN staff meetings and discuss the impacts of inequities on CYSHCN and their families. The

workgroup will educate OCCYSHN staff and share learning with community partners. We will monitor and support OCCYSHN's CLAS activities using a tracking tool developed for that purpose, and report progress on CLAS activities regularly, to inform the efforts of the Equity Workgroup. The process will ensure consistent attention is paid to integrating CLAS into all OCCYSHN efforts.

- **Activity 2.1.5. Policy:**
  - OCCYSHN's Director, in his role as Vice Chair for Community Health and Advocacy for OHSU's Department of Pediatrics, was successful in establishing a Departmental Vice Chair position in Equity, Diversity and Inclusion. He meets regularly with this Vice Chair to coordinate work. OCCYSHN will work closely with that leader to establish programs, policies, and systems changes for a more diverse, equitable and inclusive workplace. We will also collaborate on professional development opportunities to enhance knowledge, skills and attitudes around equity, anti-racism, and social justice.

  - OCCYSHN will continue working with the All:Ready Network, whose mission is to transform early childhood by mitigating poverty, racism and ableism. We have expanded our relationship with the Oregon Law Center and will continue to align our health equity work with theirs. OCCYSHN staff will continue to track policy relevant to our Title V Block Grant strategies. We will provide testimony, public comment, and guidance as appropriate. We will develop, strengthen, and leverage strategic partnerships with colleagues in support of State and National Performance Measure strategies.

- **Activity 2.1.6. Assessment:**
  - In addition to the assessment and evaluation efforts detailed in Section 11.1.8., OCCYSHN's Assessment & Evaluation manager will work with the managers of our Systems & Workforce Development and Family Involvement units to assess our strategies using *Racism as a Root Cause Approach: A New Framework* (Malawa et al., 2021).

OCCYSHN Social Determinants of Health and Equity 2022 Plan

Strategies:

Strategy 3.1. We will increase access to care and supports by investigating barriers that inhibit CYSHCN and their families' timely access, and we will develop family-informed activities to reduce or eliminate the barriers.

Using an equity lens, we will work with our state and county partners to identify systemic disparities in health care access. We will leverage our partnerships with local public health authorities, OHA, and other state-level systems to collaboratively develop and implement interventions that mitigate those disparities.

- **Activity 3.1.1. Barriers to Receipt of Care:**
  - Diagnostic evaluation for autism spectrum disorder continues to be complex and difficult for Oregon families to access. We will continue to develop and support community-based joint medical/educational autism evaluation teams. (See Section 3.2.) ACCESS teams perform comprehensive, high quality evaluations in communities where children live, obviating the need to travel to tertiary care centers, and significantly reducing the wait time for evaluation. We will use the ECHO model to support a virtual learning community among these teams, allowing for peer-mentorship and shared learning.

  - We will complete our review of challenges faced by Oregon families trying to access durable medical equipment (DME). We will use this information to populate a fishbone diagram. The diagram is a quality improvement tool that OCCYSHN has used previously with success. We will also leverage our partnership with the Oregon Law Center to employ legal remedy for systems-level issues in DME services for CYSHCN and their families. (See Section 3.1.2).

- **CYSHCN ESM for SPM3.1:** We will complete root cause analyses for (a) DME by December 2021, (b) Autism Evaluation by June 2022, and (c) Respite care by June 2023 (Yes/No).

- **Objective:** By 2025, we will have completed root cause analyses of the barriers that inhibit CYSHCN and their families from timely access to DME, autism evaluation, and respite care.

- **Progress:** DME root cause analysis work is underway.

- **Activity 3.1.2. Systems and Policy:**
    - OCCYSHN's director is working with the OHSU Department of Pediatrics to establish a Medical Legal Partnership (MLP) in OHSU's neonatal intensive care unit (NICU). This will be the first MLP in the US focused on serving infants and families from the prenatal to the postnatal period. Caregivers of all infants admitted to the NICU at OHSU complete a screening tool regarding social determinants of health, and then meet with a social worker to review. The social worker meets regularly with MLP staff (two physician champions and two MLP attorneys) to identify clients. Since poverty is the leading risk factor for premature birth, patients often face issues with housing, employment, insurance, immigration status, and domestic violence. In the coming year, the MLP will expand services to include Maternal Fetal Medicine, which serves mothers whose pregnancy is complicated by a significant health condition of their fetus. Working with this population will allow the MLP to address issues prenatally, moving farther upstream to prevent toxic stress and potential adverse childhood events.

    - OCCYSHN also contracts with the Oregon Law Center (OLC), a non-profit legal aid agency with a focus on addressing systems-level issues impacting children and families. We will collaborate to investigate barriers to accessing health care and related services, especially as they relate to Early and Periodic Screening, Diagnostics and Treatment. OCCYSHN will convene regular meetings between the MLP and OLC to ensure work is aligned. Because MLP focuses on the interface of families and the health care system, and OLC works at a broader systems level, we anticipate that this work will support synergistic approaches to mitigating social determinants of health.

- **Activity 3.1.3. Strengthen and Leverage Existing Relationships:**
    - OCCYSHN has actively pursued opportunities to collaborate on cross-sector, systems-level issues affecting CYSHCN. We will continue to work with Coordinated Care Organizations (CCOs) statewide to address payment and coverage issues. We will also continue our involvement on OHA's Patient-Centered Primary Care Home Advisory Committee. We have been working with state Medicaid leaders to address disparities and inequities that impact children. This includes participation in the development of an application to CMS for an 1115 Waiver allowing Oregon to maintain a prioritized list of covered services and eliminating some requirements of Early Periodic Screening Diagnosis and Treatment (EPSDT). OCCYSHN's input will focus on equity for all children, especially CYSHCN, as the waiver of EPSDT requirements impacts only children. We will collaborate with health care providers and local public health authorities to enhance the quality of pediatric medical homes. We will promote training for health care professionals to strengthen the workforce that serves CYSHCN, with a focus on culturally and linguistically appropriate services.

Strategy 3.2. OCCYSHN will increase access to community-based autism diagnostic services through implementation of community-based autism evaluation teams.

The goals of the Assuring Comprehensive Care through Enhanced Service Systems (ACCESS) project are to: a) provide earlier access to evaluations for autism spectrum disorders and other developmental disabilities for children 0-5; b) eliminate confusion between a medical diagnosis and eligibility for educational services; and c) connect families to local care and services for their child. Community-based ACCESS teams are comprised of physicians and educational autism specialists who do either joint or sequential evaluations.

OCCSYHN will continue to support six community-based ACCESS teams across the state, and endeavor to establish a seventh. By supporting and developing ACCESS teams, we expand statewide capacity to evaluate children for ASD, and, ultimately, increase the number of Oregon children receiving a timely, local evaluation.

- **CYSHCN ESM for SPM3.2:** Change in number of teams over time.

- **Objective:** By 2025, we will expand the number Autism Evaluation Teams by 5%.

- **Progress:**
    - During FY2020, we had six Autism Evaluation Teams operating in Oregon. The pandemic limited our expansion efforts in FY2021. We currently are in discussions with partners in Tillamook County about starting a seventh team there.

    - Technical assistance and training for ACCESS teams will include site visits, an ECHO virtual learning community, phone consultations, and an annual meeting. OCCYSHN will help teams seek sustainable funding through coding and billing, braided funding among partners, including community benefit dollars, and other OCCYSHN policy work. We will encourage teams to recruit and retain a diverse

group of providers. The ECHO series will integrate topics and resources addressing systemic inequities in our communities and care systems. We will engage OHSU providers to share their expertise with ACCESS participants through technical assistance and ECHO trainings. OCCYSHN will share tools and resources on ASD screening and diagnosis with educators and health care providers to increase workforce capacity.

- **Activity 3.2.1. Family Involvement:**
  - The Family Involvement Program manager (who is the parent of a person with ASD) will serve as a panelist for ACCESS ECHOs and will recruit other family members. She will share family resources with participating providers and will participate in project planning meetings to advise and support Parent Partners serving on ACCESS teams.

- **Activity 3.2.2. Equity:**
  - We will promote health equity, diversity, and inclusion in the ACCESS program by supporting diversity on evaluation teams, and by providing training on CLAS-related topics. OCCYSHN acknowledges that racism and other forms of discrimination affect the health of Oregon CYSHCN, and we will be accountable to BIPOC communities and other underserved populations.

- **Activity 3.2.3. Systems & Policy:**
  - The ACCESS project planning team will disseminate information on the program to broaden the project's reach, align it with other systems of care, and integrate it with other services for CYSHCN. For example, we will offer to present on the project to Oregon's State Interagency Coordinating Council. We will continue to advocate for a coordinated and unified statewide process for autism diagnosis and eligibility.

Strategy 3.3. We will improve agencies' knowledge of and ability to respond to CYSHCN and their families during an emergency or disaster response.

OCCYSHN will conduct a listening session with families to learn about their experiences and needs related to emergency planning. OCCYSHN will track local public health authorities' work on Emergency/Disaster Preparedness for CYSHCN and look for opportunities to support those efforts, and provide them information, technical assistance, and training about emergency preparedness for CYSHCN. We will continue to inform OHA's web-based *Preparedness Tools for Oregonians*, which was updated to include disproportionately affected populations, including CSYCHN. We will disseminate links to the *Preparedness Tools* through our programs and projects. We will participate on regional and state level workgroups for emergency preparedness planning.

- **CYSHCN ESM for SPM3.3:** Number of hospital, county, and regional emergency preparedness plans that integrate the needs of CYSHCN and their families.

- **Objective:** By 2025, five hospital, county, or regional emergency preparedness plans, which previously did not integrate the needs of CYSHCN and their families, will do so.

- **Progress:** At baseline (FY2020), we had no knowledge of any hospital, county, or regional emergency preparedness plans that integrated the needs of CYSHCN and their families. During FY2021, COVID-19 limited our ability to collaborate with local partners to address emergency planning. To our knowledge, no emergency preparedness plans incorporated CYSHCN and their families' needs.

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:** OCCYSHN advocates for systems-level improvements for CYSHCN at every level. We increase awareness about the challenges facing Oregon CYSHCN, their families, and their care providers. Our staff sits on state and local level advisory boards, committees, and workgroups to ensure the needs of CYSHCN and their families are represented. We also play an active role in OHSU's efforts to serve CYSHCN. OCCYSHN staff tracks the work of state and regional committees (e.g., Oregon Health Policy Board, Early Learning Division, Oregon Department of Education, Oregon Department of Human Services, Systems of Care Advisory council) and attend state conferences (e.g., Oregon State of Reform Health Policy Conference, Coordinated Care Organization annual conference) to inform strategic advocacy. We provide input on policy development with potential to impact CYSHCN, and we offer oral and written testimony at local, state, and national levels. We disseminate information critical to CYSHCN-serving agencies and organizations through our website and Facebook pages. (See strategies 11.4, 11.5, and 12.2 for details.)

  OCCYSHN's Systems and Workforce Development unit tracks and reviews systems and policy developments and identifies opportunities to inform change. Participating in policy workgroups is essential to promoting integrated systems for CYSHCN. OCCYSHN will continue to seek such opportunities in 2021-22.

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:** OCCYSHN's Communications Coordinator collaborates with staff to ensure strategic and effective communication. The Coordinator develops and disseminates OCCYSHN program guidance and products. She manages OCCSYHN's web and social media presence, and edits written public input. The Coordinator promotes health literacy standards both internally and with LPHA partners. OCCYSHN's

Assessment and Evaluation unit and Family Involvement Program engage families of CYSCHN to help inform OCCYSHN's work with family perspective.

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, ECHO, BRFSS, Oregon Student Health Survey, 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. The work of the SSDI program as well as other MCH Data work is described in detail in section III.E2.b.iii.

- **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 research associates and one research assistant. A&E is responsible for conducting ongoing and five-year assessment of the needs of Oregon CYSHCN and their families, monitoring and 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 employs 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, to provide input to Title policy and program decision-making at many levels. MCAH assessment data, priorities, strategies and performance measures, trends, and outcomes are regularly presented and reviewed by stakeholders and Title V implementing partners across Oregon. The Title V program 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 to inform 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.

Oregon Public Health Division MCAH Public Input Process

Throughout the grant year, the Title V program actively sought stakeholder and public input into the development of the strategies, activities, and measures that are included in this grant application, and are being implemented as part of the new five-year grant cycle. Additionally, Title V participated in the public input process for implementation of Healthier Together Oregon (HTO) - the new State Health Improvement Plan - which has important MCAH components. The development of HTO strategic agenda had significant state and local level public input which Title V supported. This input was also used to align new Title V strategies and activities to HTO. Methods used to solicit both public and stakeholder input this year have included: presentations and dialogue at virtual partner meetings, webinars, surveys, focus groups, postings 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 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 regular SB770 state – tribal meetings.

The Title V State leads conducted webinars on each Title V priority in February 2021 These webinars were used to deliver TA on the new Title V Annual Plan priorities, as well as to solicit input about implementation issues, strategies, activities, and 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 ongoing Title V Block Grant Needs Assessment

Following the 2020 Needs Assessment, we had anticipated further expanding our solicitation of input on the needs of under-represented communities through a continuation of our Community Voices Grant process. However, due to the COVID-19 pandemic, neither state level staff or community agencies had the capacity to focus on that type of research, so it has been put on hold until state and local partner capacity allows for it.

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 #4).

Given the close alignment with the MCH strategic plan priorities, Title V also supports and benefits from ongoing community input and engagement in the State Health Improvement Plan (HTO) implementation process. MCH priorities feature prominently in the HTO 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 can also use the website for timely MCH updates, apply for special funding opportunities, and to contact MCAH staff with any concerns or input.

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 over 100 followers on Facebook. We have posted over 300 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 1,700 times (this means that have "liked" something, commented on a story, or clicked on a link provided). We began building a content library by creating graphics which will be used on an Instagram page next year to increase our reach with younger individuals.

Clearly the COVID-19 pandemic has shifted the ways we receive ongoing input into the Title V program. The shift from in-person to all virtual methods has many limitations, but it has also opened up opportunities to hear from communities and areas of the state that are often missed. The increase in community engagement for COVID-19 is an opportunity to listen and hear more from communities around the state about all MCH issues, and we are taking advantage of those opportunities wherever they arise. Title V staff serve in numerous outreach and communications capacities for the emergency response, ensuring that the needs of MCH populations are being considered and listening for anything we can learn to support Oregonians with COVID-19 related services.

Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) Public Input Process

OCCYSHN obtained input from essential stakeholder groups to develop its 2020-2021/2025 strategic plan. These groups included family members of CYSHCN, local public health authorities (LPHAs) and their community partners, and Children with Medical Complexity CoIIN Advisory and Implementation Team members. OCCYSHN also maintains a website and a general mailbox where people can submit feedback to OCCYSHN. A description of other input processes follows.

Families

The Oregon Family to Family Health Information Center (ORF2FHIC), in partnership with OCCYSHN, conducts family listening sessions around the state to learn about family experiences with health services, delivery, gaps, and access. Between October 1, 2019 and September 30, 2020, two family listening sessions were conducted in person in rural communities, and seven more were held virtually due to COVID-19 restrictions. Themes included health care barriers and challenges, pandemic needs, telehealth, and remote special education. One session was conducted in Spanish. One was with parents who also experience disability. Two were conducted in rural communities, and one was for parents of children who are deaf or who experience hearing loss. ORF2FHIC Parent Partner facilitators prompted families to answer specific questions, then encouraged discussion. Pre-pandemic, question prompts were general, and focused on health care systems broadly. During the pandemic, questions focused on COVID-19. Sample questions included: "What kinds of supplies, medications, or health care are harder to get due to the pandemic?," and "What challenges has your child faced related to the pandemic?" Responses were compiled and shared at three OCCYSHN staff meetings. OCCYSHN leadership used the information gathered from families of CYSHCN to inform its strategic planning.

OCCYSHN held a virtual meeting with six parents of CYSHCN in spring, 2020 to provide input on the 2021 plan. In addition to ORF2FHIC Parent Partners, participants included three parents whose children are medically complex and/or experience intellectual disabilities. Families were given context and background about the Block Grant

process before they read the plan. They gave input on the plan using a customized form. Their comments were shared with OCCYSHN staff. The families' insights on the subject of shared care planning helped guide implementation of OCCYSHN's pilot of the Activate Care platform. (Activate Care is the online care coordination platform previously called Act.md.) Families expressed support for OCCYSHN's activities, and interest in being part of the review team again in 2021.

Local Public Health Authorities and other Community-Based Partners

Each year OCCYHSN holds regional meetings with contracted local public health authorities (LPHAs). OCCYSHN's 2020 Regional Meetings were to be integrated into a statewide conference that was planned for spring 2020. Due to the pandemic, we cancelled this conference (see section 11.3), and the 2020 Regional Meetings did not occur. As a temporary alternative, OCCYSHN joined efforts with OHA MCH to implement a monthly virtual Community of Practice for Oregon nurse home visiting program staff. Meetings focused on topics specific to CYSHCN and home visiting, with an emphasis on cross-sector care coordination. The sessions served as an opportunity for shared learning. They also served as a mechanism for hearing about barriers to home visiting during the pandemic, which allowed for a coordinated response to the workforce needs. Topics were initially geared toward modifying home visiting practices during the pandemic.

OCCYSHN's Care Coordination Specialist collaborated with ORF2FHIC to conduct a listening session with parents of CYSHCN to hear about their experiences with home visiting and learn more about the care coordination needs of their CYSHCN. This information was collected and shared with CaCoon nurses.

Children with Medical Complexity (CMC) Collaborative Improvement and Innovation Network (CoIIN) Team Members

The CMC CoIIN Advisory Team consists of three family members of CYSHCN (including OCCYSHN's Family Involvement Program Manager), a Shriners' Hospital pediatric surgeon, a Doernbecher Children's Hospital General Pediatrics and Adolescent Health Clinic pediatrician, the Children's Health Alliance/Children's Health Foundation Executive Director, and three OCCYSHN staff. The Implementation Team consists of the same three family representatives, an OHSU internal medicine/pediatric physician, Doernbecher Children's Hospital General Pediatrics clinic nurse, and four OCCYSHN staff. These stakeholders informed the root cause analysis for our problem statement, and prioritized causes on which to focus our quality improvement (QI) project. The Implementation Team continues to advise, co-develop, and co-monitor our QI project. This work directly informed OCCYSHN's strategic planning.

Needs Assessment and Prioritization

OCCYSHN's efforts are guided by our 2020 and 2015 needs assessment results. The 2020 needs assessment engaged two culturally-specific community based organizations: the Latino Community Association (LCA) and the Sickle Cell Anemia Foundation of Oregon (SCAFO) to collect data from Latino and Black families of CYSHCN in Oregon. The 2020 needs assessment also collected data from other families of CYSHCN, and from LPHA nursing staff statewide. These results informed our strategic planning.

III.G. Technical Assistance

Title: Data support to local Title V grantees
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. Title V MCAH and CYSHCN will explore collaboration for this technical assistance.
Performance Measure: all
Proposed TA source: TBD
Estimated Budget: TBD
Estimated Dates: TBD

Title: Photovoice Training
Brief description: To conduct needs assessments, Title V grantees 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 as 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 National Survey of Children's Health analyses that we conducted in partnership with Dr. Olivia Lindly, which we are 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 other subpopulations of CYSHCN. OCCYSHN's Assessment & Evaluation (A&E) Coordinator and a 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*:* 11/2022

Title: 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 CYSHCN 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. Training will also focus on the intersection of trauma and racism and the need to move anti-racism and trauma-informed approaches forward in an integrated manner.
Performance Measure: State Toxic stress, trauma, and ACEs performance measure
Proposed TA source: TBD
Estimated Budget: TBD
Estimated Dates: TBD

Title: Anti-White Supremacy training for State Title V staff
Brief description: Hire a contractor with experience in anti-white supremacy training and public health, to provide Oregon's Title V staff with training to use a anti-white supremacy lens to develop a plan to critically address internal processes and power structures in order to address racial disparities in Oregon.
Performance measure: State performance measures 1-3 (Toxic stress/trauma/ACEs, Culturally and linguistically accessible services, and social determinants of health and equity)
Proposed TA source: TBD – possibly Futures without Violence or Engage to Change
Estimated Budget: TBD

Estimated Dates: Sept 2021-June 2022.

Title: Anti-racism workshop series with Nurturely
Brief description: Provide a multi-session training opportunity to state and local MCH staff focused on anti-racism, systems of oppression and increasing cultural humility and responsiveness for MCH populations. Would include live speakers and facilitated discussion sessions, as well as supplementary articles and resources to support learning to action. All sessions would be recorded and made available asynchronously.
Performance measure: all
Proposed TA source: Nurturely
Estimated Budget: TBD - likely $10K+
Estimated Dates: 2021-2022

Title: Technical Assistance to support alignment and integration of injury work across PHD sections
Brief description: Receive a technical assessment to understand and improve organizational efforts across infrastructure, data and surveillance, and policy and program strategies to align and integrate MCH injury prevention work across the PHD
Performance measure: NPM 7
Proposed TA source: Safe States Alliance
Estimated Budget: TBD
Estimated Dates: 2021-2022

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_SupplementalDoc_1.pdf

Supporting Document #02 - OCCYSHN_SupplementalDoc_2.pdf

Supporting Document #03 - SD 3_NA and other Title V Products.pdf

Supporting Document #04 - SD 4_MCAH guiding docs.pdf

Supporting Document #05 - SD 5_Local Title V MCAH Grantee Info.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - BG2022_Combined OCCYSHN and OHA Org Chart August 2021.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Oregon

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,091,610	
A. Preventive and Primary Care for Children	$ 2,596,195	(42.6%)
B. Children with Special Health Care Needs	$ 1,827,483	(30%)
C. Title V Administrative Costs	$ 609,161	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,032,839	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 22,291,675	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 6,377,931	
5. OTHER FUNDS (Item 18e of SF-424)	$ 10,108,921	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 38,778,527	
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)	$ 44,870,137	
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)	$ 36,324,636	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 81,194,773	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 775,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 8,386,057
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,222,871
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 22,687,894
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 1,970,509
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 239,805
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > American Rescue Plan Act	$ 387,500

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,178,818		$ 6,091,610	
A. Preventive and Primary Care for Children	$ 2,673,152	(43.3%)	$ 2,596,195	(42.6%)
B. Children with Special Health Care Needs	$ 1,853,646	(30%)	$ 1,827,483	(30%)
C. Title V Administrative Costs	$ 617,881	(10%)	$ 609,161	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,144,679		$ 5,032,839	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 10,720,618		$ 21,856,666	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 5,594,165		$ 6,377,931	
5. OTHER FUNDS (Item 18e of SF-424)	$ 8,527,525		$ 10,176,807	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 24,842,308		$ 38,411,404	
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		$ 44,503,014	
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		$ 33,784,920	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 70,904,012		$ 78,287,934	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 620,991	$ 239,805
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 154,192	$ 144,780
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 195,980	$ 114,449
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 178,576	$ 145,872
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 381,191	$ 582,280
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	$ 379,841
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	$ 7,151,835
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 83,853	$ 104,565
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 206,968	$ 231,633
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 644,943	$ 779,095
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,662,185	$ 1,222,871
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 25,203,280	$ 22,687,894

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: This is based on the FFY 20 Notice of Award (NOA).	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2022**
	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 FFY 2022.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: This is based on the FFY 20 Notice of Award (NOA).	
9.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: 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 FFY 2020.	
10.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2020**
	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.	
11.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: FY 20 projected budget is based on FY 19 expenditures at the time the 2020 Block Grant application was prepared. FY 20 expenditures included the general funds for the Universal Home Visiting and Family Planning. .	
12.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: FY 20 projected budget is based on FY 19 expenditures at the time the 2020 Block Grant application was prepared.	
13.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: FY 20 projected budget is based on FY 19 expenditures. Increase in public health lab screening fees FY 20 expenditures..	

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 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 560,047	$ 560,047
2. Infants < 1 year	$ 260,597	$ 260,597
3. Children 1 through 21 Years	$ 2,596,195	$ 2,596,195
4. CSHCN	$ 1,827,483	$ 1,827,483
5. All Others	$ 238,127	$ 238,127
Federal Total of Individuals Served	$ 5,482,449	$ 5,482,449

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 723,266	$ 723,266
2. Infants < 1 year	$ 10,819,926	$ 10,490,357
3. Children 1 through 21 Years	$ 21,371,780	$ 21,371,780
4. CSHCN	$ 1,388,925	$ 1,851,371
5. All Others	$ 4,474,631	$ 4,474,631
Non-Federal Total of Individuals Served	$ 38,778,528	$ 38,911,405
Federal State MCH Block Grant Partnership Total	$ 44,260,977	$ 44,393,854

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:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2020 actual expenditures at the time the 2022 Block Grant Application was prepared.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2020 actual expenditures at the time the 2022 Block Grant Application was prepared.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2020 actual expenditures at the time the 2022 Block Grant Application was prepared.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2022**
	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:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2020 actual expenditures at the time the 2022 Block Grant Application was prepared.	
6.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**

	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2020 actual expenditures at the time the 2022 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:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2020 actual expenditures at the time the 2022 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:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2020 actual expenditures at the time the 2022 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:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: The Oregon Center for Children with Special Health Care Needs budget includes the OCCYSHN matching State General funds.	
10.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2020 actual expenditures at the time the 2022 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:	**2020**
	Column Name:	**Annual Report Expended**

	Field Note: Expenditures are based on the actual expenditures at the time the 2022 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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2022 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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2022 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:	**2020**
	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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2022 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:	**2020**
	Column Name:	**Annual Report Expended**

	Field Note: Expenditures are based on the actual expenditures at the time the 2022 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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2022 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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2022 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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The Oregon Center for Children with Special Health Care Needs expenditures includes the OCCYSHN matching state General funds.	
20.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2022 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 22 Application Budgeted	FY 20 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	$ 2,199,130	$ 2,199,130
3. Public Health Services and Systems	$ 3,892,480	$ 3,892,480
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	$ 6,091,610	$ 6,091,610

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 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	$ 31,067,410	$ 31,534,545
3. Public Health Services and Systems	$ 7,711,118	$ 6,876,860
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	$ 38,778,528	$ 38,411,405

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:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2022**
	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:	**2020**
	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:	**2020**
	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:	**2020**
	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:	**2020**
	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:	**2020**
	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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: 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:	**2020**
	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.	
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:	**2020**
	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:	**2020**
	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:	**2020**
	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:	**2020**
	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.	
24.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2020**
	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.	

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Oregon

Total Births by Occurrence: 40,370 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	40,194 (99.6%)	1,457	84	84 (100.0%)

Program Name(s)				
Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Cystic Fibrosis
Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Mucopolysaccharidosis Type 1
Primary Congenital Hypothyroidism	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Short-chain acyl-CoA dehydrogenase deficiency	40,194 (99.6%)	0	0	0 (0%)
Gaucher	40,194 (99.6%)	56	0	0 (0%)
Fabry	40,194 (99.6%)	194	0	0 (0%)
2-methybutyryl-CoA dehydrogenase deficiency	40,194 (99.6%)	1	1	1 (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 2020

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	3,534	55.0	0.0	17.8	17.9	9.3
2. Infants < 1 Year of Age	1,131	0.0	55.5	6.1	1.0	37.4
3. Children 1 through 21 Years of Age	40,707	49.1	1.5	20.4	11.0	18.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	10,781	58.2	0.0	40.0	0.1	1.7
4. Others	19,783	20.4	0.0	16.9	61.5	1.2
Total	65,155					

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	41,858	Yes	41,858	85.6	35,830	3,534
2. Infants < 1 Year of Age	42,288	Yes	42,288	100.0	42,288	1,131
3. Children 1 through 21 Years of Age	1,023,359	Yes	1,023,359	12.3	125,873	40,707
3a. Children with Special Health Care Needs 0 through 21 years of age^	213,334	Yes	213,334	45.0	96,000	10,781
4. Others	3,151,066	Yes	3,151,066	0.7	22,057	19,783

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**

Field Note:
Pregnant individuals served by Maternity Case Management (MCM), Babies First! (BF!) and Oregon Mother's Care (OMC).

MCM is a nurse home visiting program that promotes positive pregnancy outcomes through education and support during pregnancy. MCM nurses provide support throughout pregnancy and for the first 2 months of an infant's life. MCM nurses help support development and give new parents reassurance, and the program is free and voluntary.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems.

OMC seeks to improve access to prenatal care for all people in Oregon. The program connects pregnant individuals to pregnancy and prenatal information, help and services. OMC services are provided at Access Sites, typically local clinics or public health agencies. OMC Access Sites help connect pregnant people to the services they need for a healthy pregnancy. OMC sites provide these services to all clients free of charge.

In 2020, MCM and BF! combined served a total of 1,106 pregnant individuals, and OMC served 2,428 pregnant individuals.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**

Field Note:
Infant served by Babies First! (BF!). BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2020, BF! served 1,131 infants.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
Children served by School Based Health Centers (SBHCs), Babies First! (BF!), family planning for females <22 years of age delivered by the Reproductive Health Program (RHP), and Title V funded dental sealant programs.

SBHCs are a vital community tool with a youth-centered model that supports young people's health and well-being. Oregon SBHCs are in schools or on school grounds and provide medical care, behavioral health services and, often, dental services. SBHCs provide easy access to health care. SBHCs reduce barriers such as cost, transportation and concerns about confidentiality that keep parents and students from seeking the health services students need. In the 2019 to 2020 school year, SBHCs served 29,356 children.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2020, BF! served 1,046 children ages 1 to 4.

The RHP receives funding from three different sources to provide reproductive health services to people in Oregon. It is dedicated to ensuring all people in Oregon have access to high-quality, culturally-responsive reproductive and sexual health services, knowledge, and resources through partnerships with clinics, community organizations, and policy makers. In 2020, the RHP served 9,876 individuals below the age of 22.

The OHA School Dental Sealant Program prevents cavities among children, by serving 1st to 7th graders. Services are offered to all students in the targeted grades, regardless of insurance status, race/ethnicity, or income. Schools are eligible if at least 40% of the students are eligible for Free-and-Reduced Lunch (FRL) Program. In 2020, 429 students were screened, and of these, 213 received sealants.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
CYSHCN served in FY20 through direct and enabling services: CaCoon program, Shared care planning initiative, Zetosch Charitable Gift Fund, 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:	**2020**

Field Note:
Family planning delivered by the Reproductive Health Program (RHP) for reproductive aged women (22 to 54 years of age), and non-pregnant adult caregivers served by Babies First.

The RHP receives funding from three different sources to provide reproductive health services to people in Oregon. It is dedicated to ensuring all people in Oregon have access to high-quality, culturally-responsive reproductive and sexual health services, knowledge, and resources through partnerships with clinics, community organizations, and policy makers. The RHP commits to working towards racial equity by addressing racism and implicit bias, and reducing systemic barriers to care. In 2020, the RHP served 19,177 individuals 22 years or older.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2020, BF! served 606 non-pregnant adult caregivers.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**

Field Note:
Percentage includes pregnant individuals served by Maternity Case Management (MCM); Babies First! (BF!); Maternal, Infant, and Early Childhood Home Visiting (MIECHV); Oregon Mothers Care (OMC); and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

MCM is a nurse home visiting program that promotes positive pregnancy outcomes through education and support from pregnancy to 2 years postpartum. BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2020, MCM and BF! combined served a total of 1,106 pregnant individuals

OMC seeks to improve access to prenatal care for all people in Oregon. The program connects pregnant individuals to pregnancy and prenatal information, help and services. In 2020, OMC served 2,428 pregnant individuals.

MIECHV serves pregnant people and families with young children to improve health outcomes for parents and children, encourage positive child development and school readiness, and enhance family well-being. In Oregon, MIECHV funds the following evidence-based home visiting models: Early Head Start, Healthy Families America, and Nurse Family Partnership. In 2020, MIECHV served 625 pregnant individuals.

WIC serves lower-income pregnant, postpartum and breastfeeding women, infants and children under age 5 who have health or nutrition risks. The WIC program aims to safeguard the health of low-income women, infants, and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care. In 2020, WIC served 31,673 women.

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**

Field Note:
Percentage includes infants served by The Northwest Regional Newborn Bloodspot Screening (NWRNBS) Program, the Early Hearing Detection & Intervention (EHDI) Program, and Babies First (BF!).

NWRNBS screens newborns for endocrine, hemoglobin, cystic fibrosis, and metabolic conditions and identifies those who need immediate treatment. If a baby tests positive for one of these conditions, staff will follow up to ensure they receive appropriate medical care. These screening tests can prevent developmental problems, mental retardation or death. In 2020, 40,194 babies were screened by NWRNBS.

The goal of EHDI is to assure that all Oregon newborns receive a hearing screening by one month of age, infants who refer on newborn screening receive diagnostic evaluation by three months of age and infants diagnosed with loss are enrolled into early intervention services by six months of age. The first months of life are a critical period for developing speech and language skills. Hearing loss is the most common birth defect, occurring at a rate of three in every 1,000 children. Early identification of a hearing loss and appropriate intervention enhances a child's potential for speech and language development. In 2020, EHDI screened 39,569 infants for hearing loss.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2020, BF! served 1,131 infants.

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
Percentage includes non-pregnant caregivers served by the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), family planning delivered by the Reproductive Health Program (RHP) for reproductive aged women (22 to 54 years of age), and non-pregnant adult caregivers served by Babies First! (BF!).

MIECHV is a voluntary service for pregnant people and families with young children designed to improve health outcomes for parents and children, encourage positive child development and school readiness, and enhance family well-being. Home Visitors meet with families to share information and connect families to other services and supports, promote positive parent/child relationships and to support families in achieving their goals. In Oregon, MIECHV funds the following evidence-based home visiting models: Early Head Start, Healthy Families America, and Nurse Family Partnership. In 2020, MIECHV served 1,135 non-pregnant caregivers.

The RHP receives funding from three different sources to provide reproductive health services to people in Oregon. It is dedicated to ensuring all people in Oregon have access to high-quality, culturally-responsive reproductive and sexual health services, knowledge, and resources through partnerships with clinics, community organizations, and policy makers. The RHP commits to working towards racial equity by addressing racism and implicit bias, and reducing systemic barriers to care. In 2020, the RHP served 19,177 individuals 22 years or older.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2020, BF! served 606 non-pregnant adult caregivers.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
We categorized OCCYSHN's strategy activities into the tiers of the MCH pyramid. Although we ultimately hope that the following activities will influence private insurer's coverage and policies, public comment on Oregon Health Care Transformation efforts and service on the Medicaid Advisory Council will have direct influence on CYSHCN who have public insurance. According to the National Survey of Children's Health (NSCH) 2018-2019, approximately 63,500 (37%) CYSHCN are publically insured (CAHMI, 2021). Needs assessment activities included examination of children with medical complexity (CMC) from birth through age 21 using Oregon All Payers All Claims data from 2010 Quarter 4 through 2014 Quarter 3. Results identified that 32,100 children in this group were privately insured. Therefore, we add 32,100 to 63,500 to generate our numerator.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**

Field Note:
Percentage includes non-pregnant caregivers served by the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), family planning delivered by the Reproductive Health Program (RHP) for reproductive aged women (22 to 54 years of age), and non-pregnant adult caregivers served by Babies First! (BF!).

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BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2020, BF! served 606 non-pregnant adult caregivers.

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Oregon

Annual Report Year 2020

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	40,194	25,774	958	7,705	354	2,126	267	1,516	1,494
Title V Served	3,563	2,576	171	360	62	57	18	0	319
Eligible for Title XIX	16,729	9,296	636	5,023	229	438	201	765	141
2. Total Infants in State	40,194	25,774	958	7,705	354	2,126	267	1,516	1,494
Title V Served	1,728	908	171	603	17	29	0	0	0
Eligible for Title XIX	16,729	9,296	636	5,023	229	438	201	765	141

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2020**
	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.

MCM is a nurse home visiting program that promotes positive pregnancy outcomes through education and support during pregnancy. MCM nurses provide support throughout pregnancy and for the first 2 months of an infant's life. MCM nurses help support development and give new parents reassurance, and the program is free and voluntary.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems.

OMC seeks to improve access to prenatal care for all people in Oregon. The program connects pregnant individuals to pregnancy and prenatal information, help and services. OMC services are provided at Access Sites, typically local clinics or public health agencies. OMC Access Sites help connect pregnant people to the services they need for a healthy pregnancy. OMC sites provide these services to all clients free of charge.

2.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**

Field Note:
Infant served by Babies First! (BF!). BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Oregon

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 211-0000	5034940865
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"		16,310

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	211Info	211info
2. Number of Calls on Other Toll-Free "Hotlines"		141,582
3. State Title V Program Website Address	www.211info.org	www.211info.org
4. Number of Hits to the State Title V Program Website		325,559
5. State Title V Social Media Websites	facebook.com/211info; twitter.com/211info; https://www.instagram.com/211info	facebook.com/211info; twitter.com/211info; www.instagram.com/211info
6. Number of Hits to the State Title V Program Social Media Websites		26,379

Form Notes for Form 7:

Oregon's MCH warm line operates through our 211 information and referral system. The actual phone # is 211, the additional digits were added to accomodate TVIS data entry requirements. Reporting year line 5 includes all callers identified as pregnant or having children under age 18. Reporting line 5 is lower than in previous years reflecting th eCOVID-19 pandemic. Overall call volumes were higher, but staff asked the demographic questions less frequently to adequately manage service levels and wait times.

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
Address 2	
City/State/Zip	Portland / OR / 97232
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 St
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 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Safe and supportive environments	New
2.	Stable and responsive relationships; resilient and connected children, youth, families and communities.	Revised
3.	Improved lifelong nutrition	Revised
4.	Enhanced equity and reduced MCAH health disparities.	Continued
5.	Enhanced social determinants of health	New
6.	High quality, culturally responsive preconception, prenatal and inter-conception services	Continued
7.	High quality, family-centered, coordinated systems of care for children and youth with special health care needs	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Safe and supportive environments	New
2.	Stable and responsive relationships; resilient and connected children, youth, families and communities.	Revised
3.	Improved lifelong nutrition	Revised
4.	Improved health equity and reduced MCAH disparities	Continued
5.	Enhanced social determinants of health	New
6.	High quality, culturally responsive preconception, prenatal and inter-conception services	Continued
7.	High quality, family-centered, coordinated systems of care for children and youth with special health care needs	Continued

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
2019	82.9 %	0.2 %	34,565	41,683
2018	82.4 %	0.2 %	34,500	41,870
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
2018	67.0	4.1	268	39,976
2017	66.7	4.1	274	41,051
2016	61.6	3.8	261	42,344
2015	67.3	4.6	215	31,962
2014	63.7	3.9	267	41,888
2013	65.4	4.0	266	40,657
2012	56.9	3.8	232	40,766
2011	50.4	3.5	213	42,264
2010	50.0	3.4	215	42,981
2009	50.3	3.4	225	44,735
2008	46.6	3.2	215	46,167

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	10.1	2.1	22	218,867
2014_2018	10.8	2.2	24	222,565

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - 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
2019	6.7 %	0.1 %	2,801	41,841
2018	6.7 %	0.1 %	2,826	42,179
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
2019	8.3 %	0.1 %	3,470	41,842
2018	7.8 %	0.1 %	3,304	42,170
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**
2019	23.6 %	0.2 %	9,881	41,842
2018	23.0 %	0.2 %	9,690	42,170
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
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
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:

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
2018	4.7	0.3	198	42,292
2017	5.8	0.4	254	43,752
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
2018	4.2	0.3	178	42,188
2017	5.3	0.4	233	43,631
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
2018	2.7	0.3	112	42,188
2017	3.6	0.3	158	43,631
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
2018	1.6	0.2	66	42,188
2017	1.7	0.2	75	43,631
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
2018	137.5	18.1	58	42,188
2017	183.4	20.5	80	43,631
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 - 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
2018	94.8	15.0	40	42,188
2017	77.9	13.4	34	43,631
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 - Percent of women who drink alcohol 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 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	5.7	0.4	228	40,074
2017	6.0	0.4	247	40,978
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
2018_2019	12.9 %	1.5 %	106,464	828,406
2017_2018	12.7 %	1.7 %	104,322	818,895
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**
2019	11.2	1.6	48	426,951
2018	11.8	1.7	51	431,530
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
2019	27.9	2.4	138	495,217
2018	31.0	2.5	154	496,049
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
2017_2019	12.2	1.3	90	739,739
2016_2018	9.9	1.2	73	739,962
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
2017_2019	16.4	1.5	121	739,739
2016_2018	15.7	1.5	116	739,962
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
2018_2019	20.0 %	1.6 %	174,007	869,102
2017_2018	19.1 %	1.7 %	166,072	867,432
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
2018_2019	13.9 %	3.1 %	24,149	174,007
2017_2018	15.9 %	3.8 %	26,447	166,072
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
2018_2019	3.3 %	0.8 %	24,253	729,710
2017_2018	3.0 %	0.9 %	21,720	712,398
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
2018_2019	8.6 %	1.2 %	62,779	728,568
2017_2018	9.4 %	1.4 %	66,599	711,121
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
2018_2019	57.2 %	5.2 %	62,619	109,518
2017_2018	56.1 %	6.1 %	61,438	109,453
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
2018_2019	90.6 %	1.3 %	786,368	867,625
2017_2018	90.6 %	1.3 %	783,649	864,786
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
2018	14.6 %	0.2 %	4,960	33,899
2016	14.7 %	0.2 %	5,079	34,485
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 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate 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
2018_2019	12.9 %	2.3 %	48,478	376,608
2017_2018	11.7 %	2.4 %	41,225	353,254
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
2019	4.1 %	0.4 %	35,030	862,749
2018	3.8 %	0.4 %	33,420	871,296
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 who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	67.5 %	5.0 %	31,000	46,000
2015	67.7 %	3.9 %	31,000	46,000
2014	58.9 %	3.7 %	27,000	46,000
2013	67.5 %	4.1 %	32,000	47,000
2012	58.7 %	4.3 %	28,000	47,000
2011	58.5 %	3.9 %	27,000	46,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable 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
2019_2020	64.1 %	1.6 %	521,089	812,931
2018_2019	61.0 %	2.1 %	501,301	822,074
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 because the relative standard error is >0.3.

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
2019	74.6 %	3.3 %	183,342	245,918
2018	75.3 %	3.1 %	184,364	244,776
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 width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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
2019	90.2 %	2.2 %	221,809	245,918
2018	86.1 %	2.5 %	210,725	244,776
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 width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable 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
2019	85.0 %	2.7 %	209,017	245,918
2018	83.0 %	2.6 %	203,158	244,776
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 width/estimate >1.2

Estimates with 95% confidence interval widths > 20 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
2019	12.1	0.3	1,451	119,931
2018	13.3	0.3	1,598	120,144
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
2019	12.7 %	1.1 %	4,986	39,104
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 unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	3.0 %	0.6 %	25,945	858,779
2017_2018	3.4 %	0.8 %	29,535	858,722
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**	**2019**	**2020**
Annual Objective					71
Annual Indicator				70.8	72.0
Numerator				517,099	529,410
Denominator				730,360	735,342
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	73.0	74.0	75.0	76.0	77.0	78.0

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**	**2019**	**2020**
Annual Objective	93.6	93.8	94	89.6	93.6
Annual Indicator	92.5	93.2	89.4	93.5	93.2
Numerator	37,456	44,505	38,219	35,799	35,964
Denominator	40,509	47,759	42,729	38,275	38,600
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	93.4	93.6	93.8	94.0	94.2	94.4

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**	**2019**	**2020**
Annual Objective	34	35	39	34	31.8
Annual Indicator	30.6	38.3	33.4	31.6	35.6
Numerator	11,501	17,140	13,911	11,640	13,431
Denominator	37,583	44,757	41,664	36,894	37,678
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	35.8	36.0	36.2	36.4	36.6	36.8

Field Level Notes for Form 10 NPMs:

None

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2019	**2020**
Annual Objective		
Annual Indicator	127.1	122.1
Numerator	609	582
Denominator	479,233	476,789
Data Source	SID-CHILD	SID-CHILD
Data Source Year	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	121.0	120.0	119.0	118.0	117.0	116.0

Field Level Notes for Form 10 NPMs:

None

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - Perpetration		
	2019	**2020**
Annual Objective		
Annual Indicator	16.3	16.1
Numerator	44,259	44,099
Denominator	270,893	273,112
Data Source	NSCHP	NSCHP
Data Source Year	2018	2018_2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - Victimization		
	2019	**2020**
Annual Objective		
Annual Indicator	47.9	44.1
Numerator	129,756	120,491
Denominator	271,087	273,209
Data Source	NSCHV	NSCHV
Data Source Year	2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	16.0	15.8	15.6	15.4	15.2	15.0

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**	**2019**	**2020**
Annual Objective			51	44	42
Annual Indicator		31.3	38.6	42.2	34.5
Numerator		49,675	61,991	70,156	60,052
Denominator		158,652	160,752	166,072	174,007
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	36.0	37.0	38.0	39.0	40.0	41.0

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 to prepare for the transition 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**	**2019**	**2020**
Annual Objective			40	18	27
Annual Indicator		15.8	16.5	26.8	30.9
Numerator		12,536	11,986	18,726	24,088
Denominator		79,458	72,528	69,860	78,055
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	28.0	29.0	30.0	31.0	32.0	33.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Oregon

2016-2020: 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**	**2019**	**2020**
Annual Objective			30	31	32
Annual Indicator		29.7	30.9	32.8	30.7
Numerator		88,810	91,445	98,353	97,318
Denominator		298,807	296,257	299,920	317,301
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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.

Field Level Notes for Form 10 NPMs:

None

2016-2020: 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**	**2019**	**2020**
Annual Objective			78	80	81
Annual Indicator		77.4	79.9	79.9	77.7
Numerator		227,178	230,520	230,520	216,199
Denominator		293,358	288,666	288,666	278,157
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

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.

Field Level Notes for Form 10 NPMs:

None

2016-2020: 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**	**2019**	**2020**
Annual Objective	62	63	54	54	55
Annual Indicator	57.0	53.5	53.5	53.5	50.6
Numerator	24,297	22,955	22,955	22,955	19,941
Denominator	42,656	42,925	42,925	42,925	39,412
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2015	2015	2019

Field Level Notes for Form 10 NPMs:

None

2016-2020: 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**	**2019**	**2020**
Annual Objective			80.5	82	82.5
Annual Indicator		80.1	81.8	82.5	80.9
Numerator		647,060	662,516	671,363	667,982
Denominator		808,103	810,225	813,993	825,434
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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.

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	9.6	9.3	9.2	8.8	8.6
Annual Indicator	9.9	9.5	8.9	8.4	7.5
Numerator	4,517	4,326	3,880	3,523	3,113
Denominator	45,489	45,405	43,455	42,041	41,722
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

Field Level Notes for Form 10 NPMs:

None

2016-2020: 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**	**2019**	**2020**
Annual Objective			14	14	13.8
Annual Indicator		14.2	14.3	12.1	13.5
Numerator		118,807	121,667	104,275	115,818
Denominator		838,336	849,982	858,440	859,186
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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.

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Oregon

SPM 1 - Percentage of new mothers who experienced stressful life events before or during pregnancy

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		43	41	43	43
Annual Indicator	43.9	41.3	44.8	44.8	43
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2017	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	42.5	42.0	41.5	41.0	40.5	40.0

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		90.7	94.6	93.5	94.2
Annual Indicator	90.5	94.4	93.3	94	93.8
Numerator					
Denominator					
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2011/12	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	93.9	94.0	94.1	94.2	94.3	94.4

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Percent of children living in a household that received food or cash assistance

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	42.3	43.3
Numerator		
Denominator		
Data Source	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	43.2	43.1	43.0	42.9	42.8	42.7

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: 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**	**2019**	**2020**
Annual Objective		15.9	14.1	12.8	12.6
Annual Indicator	16.1	16.1	12.9	11.1	9.8
Numerator					
Denominator					
Data Source	USDA	USDA	USDA	USDA	USDA
Data Source Year	2013-15	2014-16	2015-17	2016-18	2017-19
Provisional or Final ?	Final	Final	Final	Final	Final

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%	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Updated data is not available for SPM 2B. SPM 2B: Percentage of households with children < 18 years of age experiencing food insecurity. 2019 Annual Objective: 19% 2019 Annual Indicator: 19.2% Numerator: Not available Denominator: Not available Data Source: USDA Data Source Year: 2003-11 Provisional or Final? Final	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Updated data is not available for SPM 2B.

SPM 2B: Percentage of households with children < 18 years of age experiencing food insecurity.
2020 Annual Objective: 19%
2020 Annual Indicator: 19.2%
Numerator: Not available
Denominator: Not available
Data Source: USDA
Data Source Year: 2003-11
Provisional or Final? Final

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Oregon

ESM 1.1 - Percent of new mothers who have had a postpartum checkup.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	89.5
Numerator	
Denominator	
Data Source	PRAMS
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	90.0	90.5	91.0	91.5	92.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.2 - Among local grantees who select well woman care, percent who report improved knowledge, skills, or policies based on provided technical assistance.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - Completion of environmental scan of organizations and partners for increasing diversity in the perinatal workforce.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

ESM 1.4 - Number of OHA Office of Equity and Inclusion Certified Community Health Workers.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	604
Numerator	
Denominator	
Data Source	OEI
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	610.0	620.0	630.0	640.0	650.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.5 - Completion of environmental scan to determine role of Title V in perinatal behavioral health.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Breastfeeding initiation among Non-Hispanic Black mothers.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	93
Numerator	
Denominator	
Data Source	Vital statistics
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	93.2	93.4	93.6	93.8	94.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.2 - Breastfeeding initiation among Non-Hispanic American Indian/Alaska Native mothers.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	89
Numerator	
Denominator	
Data Source	Vital statistics
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	89.2	89.4	89.6	89.8	90.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.3 - Exclusive breastfeeding at 6 months among Non-Hispanic Black mothers.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	57
Numerator	
Denominator	
Data Source	PRAMS-2
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	57.5	58.0	58.5	59.0	59.5

Field Level Notes for Form 10 ESMs:

None

ESM 4.4 - Exclusive breastfeeding at 6 months among Non-Hispanic American Indian/Alaska Native mothers.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	67
Numerator	
Denominator	
Data Source	PRAMS-2
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	67.5	68.0	68.5	69.0	69.5

Field Level Notes for Form 10 ESMs:

None

ESM 4.5 - Among local grantees who select breastfeeding, percent who report improved knowledge, skills, or policies based on provided technical assistance.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.6 - Completion of environmental scan of organizations and partners for increasing diversity in the perinatal workforce.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

ESM 4.7 - Number of OHA Office of Equity and Inclusion Certified Community Health Workers.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	604
Numerator	
Denominator	
Data Source	OEI
Data Source Year	2020
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	610.0	620.0	630.0	640.0	650.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.8 - Number of providers engaged in anti-racism or cultural humility training.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	30.0	30.0	30.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.1 - Injury death rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	6.3
Numerator	87
Denominator	1,385,268
Data Source	Vital statistics and census
Data Source Year	2018-20
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	6.2	6.1	6.0	5.9	5.8

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.2 - Transportation injury death rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	2.2
Numerator	31
Denominator	1,385,268
Data Source	Vital statistics and census
Data Source Year	2018-20
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	2.1	2.0	1.9	1.8	1.7

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.3 - Drowning death rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	0.9
Numerator	20
Denominator	2,335,113
Data Source	Vital statistics and census
Data Source Year	2016-20
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.9	0.9	0.8	0.8	0.7

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.4 - Poisoning injury rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	26.1
Numerator	362
Denominator	1,385,268
Data Source	Vital statistics and hospitalization data
Data Source Year	2018-20
Provisional or Final ?	Provisional

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	25.9	25.7	25.5	25.3	25.1

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.5 - Among local grantees who select child injury prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.6 - Percent of engaged partner groups including other state departments, local grantees, and affected communities, that report satisfaction with level of engagement in the development of a collaborative child injury report.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	80.0	80.0	80.0	80.0	80.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.7 - Completed assessment of injury prevention risk assessment, education, and remediation in Oregon's public health home visiting programs.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

ESM 9.1 - Percent of 8th and 11th graders who have experienced bullying.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	24.9
Numerator	
Denominator	
Data Source	Oregon Healthy Teens Survey
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	24.0	23.0	22.0	21.0	20.0

Field Level Notes for Form 10 ESMs:

None

ESM 9.2 - Percent of 8th and 11th graders who have experienced bullying due to their race or ethnicity.

Measure Status:	Active
State Provided Data	
	2020
Annual Objective	
Annual Indicator	4.4
Numerator	
Denominator	
Data Source	Oregon Healthy Teens Survey
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2022	**2023**	**2024**	**2025**	**2026**
Annual Objective	4.3	4.2	4.1	4.0	3.9

Field Level Notes for Form 10 ESMs:

None

ESM 9.3 - Percent of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity.

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	4.7
Numerator	
Denominator	
Data Source	Oregon Healthy Teens Survey
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	4.6	4.5	4.4	4.3	4.2

Field Level Notes for Form 10 ESMs:

None

ESM 9.4 - Percent of 8th and 11th graders who have experienced bullying due to a disability.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	2.0	1.9	1.8	1.7	1.6

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Objectives are based on 2020 preliminary, unweighted data, and may be changed once finalized weighted data is available.	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Objectives are based on 2020 preliminary, unweighted data, and may be changed once finalized weighted data is available.	
3.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: Objectives are based on 2020 preliminary, unweighted data, and may be changed once finalized weighted data is available.	
4.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Objectives are based on 2020 preliminary, unweighted data, and may be changed once finalized weighted data is available.	
5.	**Field Name:**	**2026**
	Column Name:	**Annual Objective**
	Field Note: Objectives are based on 2020 preliminary, unweighted data, and may be changed once finalized weighted data is available.	

ESM 9.5 - Among local grantees who select bullying prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	75.0	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 9.6 - Completion of environmental scan of youth serving agencies.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

ESM 9.7 - Number of activities completed that increase local access to bullying prevention resources.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	5.0	5.0	5.0	5.0	5.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Primary care involvement in shared care planning

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	34	26.9
Numerator	36	14
Denominator	106	52
Data Source	Shared Care Plan Information Form (SIF)	Shared Care Plan Information Form (SIF)
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	25.0	30.0	35.0	40.0	45.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: We consider these to be baseline data. Data source: Shared Care Plan Information Form (SIF) Item: How did the team member [Primary Care Provider] participate in shared care planning? In person, by phone, by video, and written comment.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: We consider these to be baseline data. The decline in volume of shared care planning meetings is reflective of LPHAs reassigning their nursing staff to respond to COVID. We've included 2019 results as an additional year of baseline data to understand what shared care planning looked like prior to COVID. Data source: Shared Care Plan Information Form (SIF) Item: How did the team member [Primary Care Provider] participate in shared care planning? In person, by phone, by video, and written comment.	

ESM 12.1 - Young adult with medical complexity/family participation in transition preparation appointments

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	30.0	40.0	50.0	60.0	70.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: 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**	**2019**	**2020**
Annual Objective		500	600	700	800
Annual Indicator	0	0	0	2,085	2,000
Numerator					
Denominator					
Data Source	Log of brochures distributed, social media views/l	Unable to track this year	Unable to track this year	Outreach tracking	County tracking
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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.	

2016-2020: 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**	**2019**	**2020**
Annual Objective	100	100	100	100
Annual Indicator	100	100	100	100
Numerator	11	9	11	15
Denominator	11	9	11	15
Data Source	Minutes from TA trainings and phone calls	Minutes from TA trainings and phone calls	Minutes from TA trainings	Minutes from TA trainings
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: 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		
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			15
Annual Indicator		38	9
Numerator			
Denominator			
Data Source		State Tracking	State Tracking
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 4.3 - Number of health care providers trained in breastfeeding support

Measure Status:	Active			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective		50	50	50
Annual Indicator	112	50	11	39
Numerator				
Denominator				
Data Source	Grantee annual report on strategy measures	Grantee annual report on strategy measures	Grantee annual report on strategy measures	Grantee annual report on strategy measures
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 4.4 - Percent of local grantees who have met their target for breastfeeding education among pregnant and postpartum women

Measure Status:	Active		
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			60
Annual Indicator		62.5	44.4
Numerator		5	4
Denominator		8	9
Data Source		Local reporting databse	Local reporting database
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: 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**	**2019**	**2020**
Annual Objective	100	100	100	100
Annual Indicator	100	100	100	100
Numerator	5	5	6	5
Denominator	5	5	6	5
Data Source	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: 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			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			3	3
Annual Indicator			3	1
Numerator				
Denominator				
Data Source			State Tracking	State Tracking
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: 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			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			3	3
Annual Indicator			3	3
Numerator				
Denominator				
Data Source			State Tracking	State Tracking
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 10.1 - Number of health professionals trained on adolescent well visits.

Measure Status:	Active				
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective				200	200
Annual Indicator	161	282	575	80	80
Numerator					
Denominator					
Data Source	Attendance sheets	Attendance sheets	Attendance sheets	Attendance sheets	Attendance sheets
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: 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**	**2019**	**2020**
Annual Objective			100	100	100
Annual Indicator	0	1,137	168	0	0
Numerator					
Denominator					
Data Source	State tracking	State tracking	State tracking	State tracking	State Tracking
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: There was no specific training offered to providers for moving beyond the sports physical this reporting period. The need for this type of training has decreased as Title V has concentrated on this need for the past three years. We are finding that providers are willing to complete annual AWVs in place of sports physicals. Efforts in this reporting period, especially at the local level, have been on setting up systems to make it easier for providers to offer AWVs.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: There was no specific training offered to providers for moving beyond the sports physical this reporting period. The need for this type of training has decreased as Title V has concentrated on this need for the past three years. We are finding that providers are willing to complete annual AWVs in place of sports physicals. Efforts in this reporting period, especially at the local level, have been on setting up systems to make it easier for providers to offer AWVs.	

2016-2020: ESM 11.2 - Number of PACCT (Piloting ACT.md for Care Coordination Team) standing teams with consistent primary care involvement.

Measure Status:	Active		
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			2
Annual Indicator	0	1	3
Numerator			
Denominator			
Data Source	Shared Care Planning End of Year Report	Shared Care Planning End of Year Report	Shared Care Planning End of Year Report
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: PACCT teams had not yet been established in the 2018 reporting year.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 1 PACCT team reported on the 2019 Shared Care Planning End of Year Report that their team's primary care representative attended more than half of their standing team meetings this year.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 3 PACCT teams reported on the 2020 End of Year Report that their team's primary care representative attended more than half of their standing team meetings this year.	

2016-2020: 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**	**2019**	**2020**
Annual Objective		10	15	20	20
Annual Indicator	0	25.5	19.3	19.8	36.5
Numerator		35	21	21	19
Denominator		137	109	106	52
Data Source	SPOC Information Form	SPOC Information Form	SPOC Information Form	SPOC Information Form	SPOC Information Form
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2018-2019 was the third contract year for county public health departments (LPHAs) to implement shared care planning. For year 3, LPHAs initiated or re-evaluated 106 SPOC, of those 21 were for transition-aged youth.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2019-2020 was the fourth contract year for county public health departments (LPHAs) to implement shared care planning. For year 4, LPHAs initiated or re-evaluated 52 SPOC, of those 19 were for transition-aged youth.	

2016-2020: 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**	**2019**	**2020**
Annual Objective		80	85	68	70
Annual Indicator	0	45.7	66.7	42.9	42.1
Numerator		16	14	9	8
Denominator		35	21	21	19
Data Source	SPOC Information Form	SPOC Information Form	SPOC Information Form	SPOC Information Form	SPOC Information Form
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: 2018-2019 was the third contract year for county public health departments (LPHAs) to implement shared care planning. Of the SPOCs initiated or re-evaluated for transition-aged youth (21), 9 addressed transition planning.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2019-2020 was the fourth contract year for county public health departments (LPHAs) to implement shared care planning. Of the SPOCs initiated or re-evaluated for transition-aged youth (19), 8 addressed transition planning.	

2016-2020: 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			
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			7	7
Annual Indicator			7	7
Numerator				
Denominator				
Data Source			State Tracking	State Tracking
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: 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**	**2019**	**2020**
Annual Objective	30	30	20	20
Annual Indicator	28	30	21	38
Numerator				
Denominator				
Data Source	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 13.2.3 - Number of oral health providers provided training on oral cancer and HPV.

Measure Status:	Active		
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			100
Annual Indicator			48
Numerator			
Denominator			
Data Source			Attendance sheets
Data Source Year			2020
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: 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**	**2019**	**2020**
Annual Objective	75	75	75	75
Annual Indicator	50	100	71.4	100
Numerator	5	10	5	7
Denominator	10	10	7	7
Data Source	Local grantee reports	Local grantee reports	Local grantee reports	Local grantee reports
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: 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**	**2019**	**2020**
Annual Objective	80	80	80	80
Annual Indicator	90.9	100	100	100
Numerator	10	10	7	7
Denominator	11	10	7	7
Data Source	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 14.2.5 - Number of external partners engaged in developing a policy agenda to decrease youth exposure to tobacco.

Measure Status:	Active		
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			5
Annual Indicator			5
Numerator			
Denominator			
Data Source			State Tracking
Data Source Year			2020
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Oregon

SPM 1 - Percentage of new mothers who experienced stressful life events before or during pregnancy
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To reduce the experience of chronic stress before and during pregnancy</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>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</td></tr>
<tr><td>Denominator:</td><td>Number of new mothers</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Pregnancy Risk Assessment Monitoring System (PRAMS)</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

SPM 2 - Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To improve the cultural sensitivity and responsiveness of healthcare providers who serve children < 18 years of age</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>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</td></tr>
<tr><td>Denominator:</td><td>Number of children age 0 - 17 years</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>National Survey of Children's Health (NSCH)</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

SPM 3 - Percent of children living in a household that received food or cash assistance
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To reduce poverty among families
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children living in households that received food or cash assistance **Denominator:** Number of households with children < 18
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)
Significance:	Women and children are particularly vulnerable and overrepresented among those impacted by poverty, homelessness, unhealthy housing, employment instability, family and community violence, and other social determinants of health (SDOH). These factors amplify the impacts of adversity and inequity on women and children's health throughout the lifespan. Among SDOH, housing concerns consistently rank at or near the top of family and community concerns (including housing affordability and homelessness, health and safety of existing housing, and the neighborhood and physical environment). Recent studies show strong correlations between housing stability and child outcomes. Multiple aspects of housing quality and the social and physical environment of the home impact women and children's health. These include air quality, home safety, presence of mold, asbestos and lead. Poor-quality housing is associated with various negative health outcomes, including chronic disease and injury and poor mental health. A focus on SDOH is increasingly recognized as essential to improving the health of families and communities, achieving successful health systems transformation, and improving health equity in Oregon.

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: 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:	**Unit Type:** Percentage **Unit Number:** 100 **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
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.

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 1.1 - Percent of new mothers who have had a postpartum checkup.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the percent of women, particularly in marginalized communities, who access postpartum care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of new mothers who have had a postpartum checkup **Denominator:** Number of new mothers
Data Sources and Data Issues:	Pregnancy Risk Assessment Monitoring System (PRAMS)
Evidence-based/informed strategy:	Ensure access to culturally responsive preventive clinical care for low income and undocumented women.
Significance:	Postpartum care is important in the management of chronic health conditions, the facilitation of women's access to contraceptives, the early identification of postpartum health concerns, and as a connection point to increase utilization of well woman care.

ESM 1.2 - Among local grantees who select well woman care, percent who report improved knowledge, skills, or policies based on provided technical assistance.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To provide technical assistance to local grantees that leads to an increase in well woman care utilization.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of local grantees that report improvements following state technical assistance **Denominator:** Number of local grantees that selected well woman care as a priority
Data Sources and Data Issues:	Local grantee reports
Evidence-based/informed strategy:	Support advanced training, coaching and quality improvement activities for home visitors related to well woman care.
Significance:	A crucial component of state level efforts to increase women's access to well woman care is to support local grantees, by providing technical assistance and resources.

ESM 1.3 - Completion of environmental scan of organizations and partners for increasing diversity in the perinatal workforce.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase diversity of the workforce that serves perinatal populations.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Support efforts to improve diversity in the workforce.
Significance:	Before activities to increase diversity in the perinatal workforce can be undertaken, an inventory of organizations and partners that can act as collaborators in the work needs to be completed.

ESM 1.4 - Number of OHA Office of Equity and Inclusion Certified Community Health Workers.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase diversity of the workforce that serves perinatal populations.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of OHA Office of Equity and Inclusion Certified Community Health Workers. **Denominator:**
Data Sources and Data Issues:	OHA Office of Equity and Inclusion Tracking
Evidence-based/informed strategy:	Support efforts to improve diversity in the workforce
Significance:	The certification of community/traditional health workers is a key strategy towards increasing the diversity of the workforce that serves perinatal populations.

ESM 1.5 - Completion of environmental scan to determine role of Title V in perinatal behavioral health.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To determine where Title V can best impact perinatal behavioral health.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Strengthen early identification of and supports for women's behavioral health needs.
Significance:	Behavioral health is a key component of perinatal wellbeing, however Title V's role in this area is not well defined. In order to support perinatal behavioral health without duplication of efforts, an environmental scan will be completed of current partner efforts and opportunities to: be involved in development of new policies and implementation of policy changes; participate in state level initiatives to address perinatal behavioral health; and opportunities to attend meetings with partners relevant to perinatal behavioral health

ESM 4.1 - Breastfeeding initiation among Non-Hispanic Black mothers.
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 among marginalized communities.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Non-Hispanic Black mothers that initiate breastfeeding **Denominator:** Number of Non-Hispanic Black mothers
Data Sources and Data Issues:	Vital statistics
Evidence-based/informed strategy:	Promote & support laws and policies for pregnant & breastfeeding people in the workplace. Focus on populations with additional barriers.
Significance:	While Oregon has a consistently high rate of breastfeeding initiation, racial/ethnic disparities in this rate persist. Examining the breastfeeding rate among marginalized communities will facilitate the evaluation of the effectiveness of laws and policies that support breastfeeding individuals.

ESM 4.2 - Breastfeeding initiation among Non-Hispanic American Indian/Alaska Native mothers.
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 among marginalized communities.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of Non-Hispanic American Indian/Alaska Native mothers that initiate breastfeeding</td></tr><tr><td>**Denominator:**</td><td>Number of Non-Hispanic American Indian/Alaska Native mothers</td></tr></table>
Data Sources and Data Issues:	Vital statistics
Evidence-based/informed strategy:	Promote & support laws and policies for pregnant & breastfeeding people in the workplace. Focus on populations with additional barriers.
Significance:	While Oregon has a consistently high rate of breastfeeding initiation, racial/ethnic disparities in this rate persist. Examining the breastfeeding rate among marginalized communities will facilitate the evaluation of the effectiveness of laws and policies that support breastfeeding individuals.

ESM 4.3 - Exclusive breastfeeding at 6 months among Non-Hispanic Black mothers.
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 among marginalized communities.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Non-Hispanic Black mothers that exclusively breastfeed for 6 months postpartum **Denominator:** Number of Non-Hispanic Black mothers
Data Sources and Data Issues:	PRAMS-2/ECHO
Evidence-based/informed strategy:	Promote & support laws and policies for pregnant & breastfeeding people in the workplace. Focus on populations with additional barriers.
Significance:	While Oregon has a consistently high rate of breastfeeding exclusivity at 6 months postpartum, racial/ethnic disparities in this rate persist. Examining the breastfeeding rate among marginalized communities will facilitate the evaluation of the effectiveness of laws and policies that support breastfeeding individuals.

ESM 4.4 - Exclusive breastfeeding at 6 months among Non-Hispanic American Indian/Alaska Native mothers. 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 among marginalized communities.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of Non-Hispanic American Indian/Alaska Native mothers that exclusively breastfeed for 6 months postpartum</td></tr><tr><td>**Denominator:**</td><td>Number of Non-Hispanic American Indian/Alaska Native mothers</td></tr></table>
Data Sources and Data Issues:	PRAMS-2ECHO
Evidence-based/informed strategy:	Promote & support laws and policies for pregnant & breastfeeding people in the workplace. Focus on populations with additional barriers.
Significance:	While Oregon has a consistently high rate of breastfeeding exclusivity at 6 months postpartum, racial/ethnic disparities in this rate persist. Examining the breastfeeding rate among marginalized communities will facilitate the evaluation of the effectiveness of laws and policies that support breastfeeding individuals.

ESM 4.5 - Among local grantees who select breastfeeding, percent who report improved knowledge, skills, or policies based on provided technical assistance.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To provide technical assistance to local grantees that leads to an increase in breastfeeding.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of local grantees that report improvements following state technical assistance **Denominator:** Number of local grantees that selected breastfeeding as a priority
Data Sources and Data Issues:	Local grantee reports
Evidence-based/informed strategy:	Support advanced training, coaching and quality improvement activities for home visitors related to breastfeeding.
Significance:	A crucial component of state level efforts to increase breastfeeding rates is to support local grantees, by providing technical assistance and resources.

ESM 4.6 - Completion of environmental scan of organizations and partners for increasing diversity in the perinatal workforce.
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 diversity of the workforce that serves perinatal populations.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Support efforts to improve diversity in the workforce
Significance:	Before activities to increase diversity in the perinatal workforce can be undertaken, an inventory of organizations and partners that can act as collaborators in the work needs to be completed.

ESM 4.7 - Number of OHA Office of Equity and Inclusion Certified Community Health Workers.
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 diversity of the workforce that serves perinatal populations.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of OHA Office of Equity and Inclusion Certified Community Health Workers. **Denominator:**
Data Sources and Data Issues:	OHA Office of Equity and Inclusion Tracking
Evidence-based/informed strategy:	Support efforts to improve diversity in the workforce
Significance:	The certification of community/traditional health workers is a key strategy towards increasing the diversity of the workforce that serves perinatal populations.

ESM 4.8 - Number of providers engaged in anti-racism or cultural humility training.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To improves access to culturally responsive care for marginalized communities.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of providers engaged in anti-racism or cultural humility training. **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Ensure that providers who serve tribal members have training in culturally specific approaches to breastfeeding promotion and support.
Significance:	As part of an increased focus of addressing health equity and racial/ethnic disparities in breastfeeding rates, perinatal providers will be engaged in anti-racism and cultural humility training.

ESM 7.1.1 - Injury death rate among children 0 - 9 years of age
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
ESM Subgroup(s):	Children 0 through 9
Goal:	To prevent deaths due to injury among children ages 0 - 9
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of deaths due to injury among children 0 - 9 years of age **Denominator:** Per 100,000 population of children ages 0 - 9
Data Sources and Data Issues:	Vital statistics and census
Evidence-based/informed strategy:	Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.
Significance:	Unintentional injuries are largely preventable, and yet unintentional injury is the leading cause of death, hospitalizations and emergency department visits for infants, children and adolescents. In Oregon, unintentional injury is the leading cause of death for children and youth over age 1. This measure is intended to complement the National Performance Measure for injury hospitalizations.

ESM 7.1.2 - Transportation injury death rate among children 0 - 9 years of age
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
ESM Subgroup(s):	Children 0 through 9
Goal:	To prevent transportation injury deaths among children ages 0 - 9
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of deaths due to transportation injury among children 0 - 9 years of age **Denominator:** Per 100,000 population of children ages 0 - 9
Data Sources and Data Issues:	Vital statistics and census
Evidence-based/informed strategy:	Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.
Significance:	Motor vehicle/transportation is the leading cause of injury death for children 1-19 years old, and the 3rd leading cause of hospitalization for children 1-9 years old. Transportation related injuries and deaths are preventable through policy changes, education and safer environments.

ESM 7.1.3 - Drowning death rate among children 0 - 9 years of age
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
ESM Subgroup(s):	Children 0 through 9
Goal:	To prevent drowning deaths among children 0 - 9 years of age
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of drowning deaths among children 0 - 9 years of age **Denominator:** Per 100,000 population of children ages 0 - 9
Data Sources and Data Issues:	Vital statistics
Evidence-based/informed strategy:	Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.
Significance:	Drowning is the second leading cause of death for children birth to 9, and a leading cause of death for children 10-19 years of age. Drowning is preventable through policy changes, education and safer environments.

ESM 7.1.4 - Poisoning injury rate among children 0 - 9 years of age
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
ESM Subgroup(s):	Children 0 through 9
Goal:	To prevent poisoning injuries among children 0 - 9 years of age
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of hospitalizations due to poisoning among children 0 - 9 years of age **Denominator:** Per 100,000 population of children ages 0 - 9
Data Sources and Data Issues:	Hospitalization Data and Census Data
Evidence-based/informed strategy:	Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.
Significance:	Poisoning is the leading cause of injury hospitalization for all ages, 0-19, and the 6th cause of death for children 1-4 years old. Poisoning is preventable through policy changes, education and safer environments.

ESM 7.1.5 - Among local grantees who select child injury prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
ESM Subgroup(s):	Children 0 through 9
Goal:	To provide technical assistance to local grantees in the prevention of child injury.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of local grantees that report improvements following state technical assistance **Denominator:** Number of local grantees that selected child injury prevention as a priority
Data Sources and Data Issues:	Local grantee reports
Evidence-based/informed strategy:	Strengthen workforce capacity to address child injury prevention at the state and local level.
Significance:	A crucial component of state level efforts to prevent child injury is to support local grantees, by providing technical assistance and resources.

ESM 7.1.6 - Percent of engaged partner groups including other state departments, local grantees, and affected communities, that report satisfaction with level of engagement in the development of a collaborative child injury report.
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>ESM Subgroup(s):</td><td>Children 0 through 9</td></tr>
<tr><td>Goal:</td><td>To create a comprehensive statewide child injury report</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of engaged partner groups including other state departments, local grantees, and affected communities, that report satisfaction with level of engagement in the development of a collaborative child injury report</td></tr>
<tr><td>Denominator:</td><td>Number of partner groups engaged in the development of a collaborative child injury report</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>State tracking</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Improve data collection, analysis, interpretation and dissemination of child injury data to focus on prevention efforts.</td></tr>
<tr><td>Significance:</td><td>An important piece in the development of a statewide injury report is the engagement of partners, to avoid duplication of efforts, and to ensure that all voices are heard, including those of marginalized communities.</td></tr>
</table>

ESM 7.1.7 - Completed assessment of injury prevention risk assessment, education, and remediation in Oregon's public health home visiting programs.
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
ESM Subgroup(s):	Children 0 through 9
Goal:	To assess injury prevention efforts in Oregon's home visiting programs.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Strengthen workforce capacity to address child injury prevention at the state and local level.
Significance:	In order to better provide technical assistance in the prevention of child injury to the home visiting workforce, Title V first needs to examine what currents efforts are, and where improvements can be made in education or referral services.

ESM 9.1 - Percent of 8th and 11th graders who have experienced bullying.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To decrease bullying.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 8th and 11th graders who have experienced bullying **Denominator:** Number of 8th and 11th graders
Data Sources and Data Issues:	2019 data from the Oregon Healthy Teens Survey. 2020 data and beyond from the Student Health Survey.
Evidence-based/informed strategy:	Support bullying prevention education in schools.
Significance:	While the Title V National Performance Measure for bullying prevention uses data from the National Survey of Children's Health, the sample size is quite small in Oregon, and disaggregation of this data in order to examine disparities is not always reliable. The Oregon based Student Health Survey has a larger sample size and can be more reliably disaggregated. The Student Health Survey also has the advantage of being asked of youth themselves, rather than relying on parent report. The results of this survey will be used to examine the rate of bullying among all students, and among specific marginalized communities of youth.

ESM 9.2 - Percent of 8th and 11th graders who have experienced bullying due to their race or ethnicity.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To decrease bullying among marginalized communities.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of 8th and 11th graders who have experienced bullying due to their race or ethnicity</td></tr><tr><td>**Denominator:**</td><td>Number of 8th and 11th graders</td></tr></table>
Data Sources and Data Issues:	2019 data from the Oregon Healthy Teens Survey. 2020 data and beyond from the Student Health Survey.
Evidence-based/informed strategy:	Support bullying prevention education in schools.
Significance:	While the Title V National Performance Measure for bullying prevention uses data from the National Survey of Children's Health, the sample size is quite small in Oregon, and disaggregation of this data in order to examine disparities is not always reliable. The Oregon based Student Health Survey has a larger sample size and can be more reliably disaggregated. The Student Health Survey also has the advantage of being asked of youth themselves, rather than relying on parent report. The results of this survey will be used to examine the rate of bullying among all students, and among specific marginalized communities of youth.

ESM 9.3 - Percent of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To decrease bullying among marginalized communities.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity **Denominator:** Number of 8th and 11th graders
Data Sources and Data Issues:	2019 data from the Oregon Healthy Teens Survey. 2020 data and beyond from the Student Health Survey.
Evidence-based/informed strategy:	Support bullying prevention education in schools.
Significance:	While the Title V National Performance Measure for bullying prevention uses data from the National Survey of Children's Health, the sample size is quite small in Oregon, and disaggregation of this data in order to examine disparities is not always reliable. The Oregon based Student Health Survey has a larger sample size and can be more reliably disaggregated. The Student Health Survey also has the advantage of being asked of youth themselves, rather than relying on parent report. The results of this survey will be used to examine the rate of bullying among all students, and among specific marginalized communities of youth.

ESM 9.4 - Percent of 8th and 11th graders who have experienced bullying due to a disability.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To decrease bullying among marginalized communities.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of 8th and 11th graders who have experienced bullying due to a disability</td></tr><tr><td>**Denominator:**</td><td>Number of 8th and 11th graders</td></tr></table>
Data Sources and Data Issues:	Bullying due to disability was not listed on the Oregon Healthy Teens Survey, so the first available data will be 2020 data from the Student Health Survey.
Evidence-based/informed strategy:	Support bullying prevention education in schools.
Significance:	While the Title V National Performance Measure for bullying prevention uses data from the National Survey of Children's Health, the sample size is quite small in Oregon, and disaggregation of this data in order to examine disparities is not always reliable. The Oregon based Student Health Survey has a larger sample size and can be more reliably disaggregated. The Student Health Survey also has the advantage of being asked of youth themselves, rather than relying on parent report. The results of this survey will be used to examine the rate of bullying among all students, and among specific marginalized communities of youth.

ESM 9.5 - Among local grantees who select bullying prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To provide technical assistance to local grantees in the prevention of bullying.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of local grantees that report improvements following state technical assistance</td></tr><tr><td>**Denominator:**</td><td>Number of local grantees that selected bullying prevention as a priority</td></tr></table>
Data Sources and Data Issues:	Local grantee reports
Evidence-based/informed strategy:	Support the workforce to understand the impact of bullying on adolescent health.
Significance:	A crucial component of state level efforts to prevent bullying is to support local grantees, by providing technical assistance and resources.

ESM 9.6 - Completion of environmental scan of youth serving agencies.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To facilitate Title V youth engagement in bullying prevention activities.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Support youth participatory action research on bullying prevention.
Significance:	A key focus of the Title V bullying prevention efforts is to ensure that youth are engaged in all components of the work. In order to access youth, Title V will partner with youth serving agencies, which will be identified through this environmental scan.

ESM 9.7 - Number of activities completed that increase local access to bullying prevention resources.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To support local access to resources that decrease bullying.
Definition:	**Unit Type:** Count **Unit Number:** 20 **Numerator:** Number of activities completed that increase local access to bullying prevention resources **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Determine gaps and opportunities for bullying prevention partnerships and initiatives with internal and external partners.
Significance:	Activities will be completed to increase local access to bullying prevention resources. In order to optimize the efficacy of these resources, gaps and opportunities where they can best be leveraged by local agencies will be identified.

ESM 11.1 - Primary care involvement in shared care planning
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	By September 2025, 40% of shared care plans will have a representative of primary care help LPHAs prepare for or participate in shared care planning meetings.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of shared care plans with a primary care representative assisting the LPHA to prepare for, or participating in, a new or re-evaluation shared care planning meeting in a given year. **Denominator:** Number of shared care plans in the same year.
Data Sources and Data Issues:	The data source for this ESM is the Shared care plan Information Form (SIF), which is a data collection administered by OCCYSHN. LPHAs complete a SIF after each shared care planning meeting. OCCYSHN contracts require LPHA participation in this data collection and request that LPHAs complete their SIF within two weeks of a shared care planning meeting. For 2019 and 2020 baseline data, we report data from this SIF item, “How did the team member [Primary Care Provider] participate in shared care planning?” - In person, by phone, by video, and written comment. A limitation of using this item for baseline results is that it only captures part of the new ESM indicator for 2021-2025. That is, baseline results reflect primary care provider meeting participation but do not reflect primary care provider assistance to LPHAs for meeting preparation. We established objectives in June 2020. We are still learning how COVID-19 is affecting LPHAs ability to implement shared care planning and, as a result, may have to adjust our objectives in the future.
Evidence-based/informed strategy:	This ESM measures evidence-based/informed strategy 11.1, OCCYSHN will improve access to family-centered, team-based, cross-systems care coordination for CYSHCN and their families through workforce development and financing activities (see CYSHCN State Action Plan Narrative, NPM 11, Activity 11.1.3). The National Standards for Systems of Care for CYSHCN, the National Care Coordination Standards and McAllister’s (2014) shared care planning white paper informed the development of this strategy.
Significance:	The National Standards for Systems of Care for CYSHCN identify pediatric primary care as the locus for care coordination for CYSHCN, although recognize that teams of professional and family partners provide care to CYSHCN. Not all Oregon primary care clinics well provide care coordination for CYSHCN and their families, and not all primary care-based care coordinators well coordinate care across systems. Given their community connections, local public health authorities can support primary care practices in cross-systems care coordination but need primary care to engage in the team-based work. This measure helps us monitor whether and how primary care engages in one of our cross-systems care coordination strategies.

ESM 12.1 - Young adult with medical complexity/family participation in transition preparation appointments
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	By 2025, 60% of young adults with medical complexity (YAMC) or their families enrolled in transfer of care intervention will participate in their scheduled preparation appointments.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of enrolled YAMC patients/their families who participate in at least one of their preparation-to-transfer appointments. **Denominator:** Number of enrolled YAMC patients/their families.
Data Sources and Data Issues:	The data source for this ESM is the Children with Medical Complexity (CMC) CoIIN project process tracking form. We established objectives in June 2020. We are still learning how COVID-19 is affecting our partner's ability to implement our CMC CoIIN quality improvement primary care clinical project and, as a result, may have to adjust our objectives in the future.
Evidence-based/informed strategy:	This ESM measures evidence-based/informed strategy 12.1, OCCYSHN will increase the number of Youth with Special Health Care Needs (YSHCN) and their families who receive information about transition to adult health care from their providers through family-informed workforce development, quality improvement, systems incentives, and family awareness activities (see CYSHCN State Action Plan Narrative, NPM 12, Activity 12.1.2). OCCYSHN accessed evidence on this strategy from Got Transition and the Georgetown University Maternal and Child Health MCH Evidence Center.
Significance:	Patient/family engagement is an implementation characteristic that will affect the success of the intervention. This measure tracks patient/family engagement in the transition intervention. We are using a quality improvement framework for this work. Therefore, if patients/families are not engaging in our intervention, we will take steps to modify the intervention to increase its acceptability to them.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To expand public education and decrease stigma about preconception and well-woman care through the use of traditional and social media.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10,000</td></tr>
<tr><td>Numerator:</td><td>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.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

2016-2020: 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Provide technical assistance (TA) to support implementation of routine pregnancy intention screening local public health programs.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of local health departments receiving technical assistance to support implementation of the well woman care priority area</td></tr>
<tr><td>Denominator:</td><td>Number of local health departments that choose Well-Woman Care as a priority for their Title V work.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Minutes from TA trainings and phone calls</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

2016-2020: 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:	**Unit Type:** Count **Unit Number:** 50 **Numerator:** Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services. **Denominator:**
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.

2016-2020: 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:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>200</td></tr><tr><td>**Numerator:**</td><td>Number of health care providers such as community health workers, nurses, dietitians, physicians, trained in breastfeeding support</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
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.

2016-2020: 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:	**Unit Type:** Percentage **Unit Number:** 100 **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
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.

2016-2020: 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.
2016-2020: 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:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>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</td></tr><tr><td>**Denominator:**</td><td>Number of local grantees that selected the child physical activity priority area</td></tr></table>
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.

2016-2020: 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)
2016-2020: 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:	**Unit Type:** Count **Unit Number:** 10 **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:**
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.

2016-2020: 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
2016-2020: 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:	**Unit Type:** Count **Unit Number:** 10 **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:**
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.

2016-2020: ESM 10.1 - Number of health professionals trained on adolescent well visits.
2016-2020: NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To promote policies and practices to make health care more youth friendly through provider and health professional training.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>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.)</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Attendance sheets of all professionals attending training.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

2016-2020: ESM 10.2 - The number of health professionals trained and informed to promote the practice of going beyond the sports physical
2016-2020: NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To promote practice of going beyond sports physicals.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>2,000</td></tr>
<tr><td>Numerator:</td><td>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 (</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>State tracking</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

2016-2020: 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
Goal:	We seek to track the progress that PACCT teams make towards involving primary care in piloting ACT.md for care coordination.
Definition:	**Unit Type:** Count **Unit Number:** 5 **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:**
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.

2016-2020: 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 to prepare for the transition 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:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>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.</td></tr><tr><td>**Denominator:**</td><td>The total number of SPOC that county public health staff initiated or re-evaluated.</td></tr></table>
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.

2016-2020: 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 to prepare for the transition 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:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Of the total number of SPOC that county public health staff initiated or re-evaluated for youth 12 years of age and older, the number of SPOC that address transition planning.</td></tr><tr><td>**Denominator:**</td><td>The total number of SPOC that county public health staff initiated or re-evaluated for youth 12 years of age and older.</td></tr></table>
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.

2016-2020: ESM 13.1.2 - Number of data sets in the Oregon Oral Health Surveillance System (OOHSS) that can be analyzed for oral health disparities
2016-2020: 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:	**Unit Type:** Count **Unit Number:** 20 **Numerator:** Number of data sets analyzed for oral health disparities **Denominator:**
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.

2016-2020: 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.
2016-2020: 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:	**Unit Type:** Count **Unit Number:** 40 **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:**
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.

2016-2020: ESM 13.2.3 - Number of oral health providers provided training on oral cancer and HPV.
2016-2020: 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 increase awareness of oral cancer and HPV in order to increase HPV vaccination rates among adolescents.
Definition:	**Unit Type:** Count **Unit Number:** 200 **Numerator:** Number of oral health providers provided with training on oral cancer and HPV. **Denominator:**
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.

2016-2020: 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.
2016-2020: NPM 14.1 – Percent of women who smoke during pregnancy

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To identify pregnant women who smoke and provide them with best practice interventions to quit.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of local Title V grantees who have selected smoking as a priority area who are implementing the 5A's with their clients.</td></tr>
<tr><td>Denominator:</td><td>Number of local Title V grantees who have selected smoking as a priority area.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Local grantee report</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

2016-2020: 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.
2016-2020: 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:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of local Title V grantees who have selected smoking as a priority area who have at least two technical assistance contacts.</td></tr><tr><td>**Denominator:**</td><td>Number of local Title V grantees who have selected smoking as a priority area.</td></tr></table>
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.

2016-2020: ESM 14.2.5 - Number of external partners engaged in developing a policy agenda to decrease youth exposure to tobacco.
2016-2020: NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
Goal:	To decrease youth exposure to tobacco
Definition:	**Unit Type:** Count **Unit Number:** 20 **Numerator:** Number of external partners engaged in developing a policy agenda to decrease youth exposure to tobacco **Denominator:**
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

Form 12
MCH Data Access and Linkages

State: Oregon

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	More often than monthly	0		
2) Vital Records Death	Yes	Yes	More often than monthly	0	Yes	
3) Medicaid	Yes	Yes	More often than monthly	3	No	
4) WIC	Yes	Yes	More often than monthly	0	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	0	No	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	0	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	3	No	
8) PRAMS or PRAMS-like	Yes	Yes	More often than monthly	12	Yes	

Form Notes for Form 12:

None