Maternal and Child Health Services Title V Block Grant

Oregon

FY 2021 Application/ FY 2019 Annual Report

Created on 7/22/2020 at 1:44 PM

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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

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July 9, 2020

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

Dear Ms. Lawler:

Enclosed are the FY 2021 Maternal & Child Health (MCH) Title V Block Grant Application and FY 2019 Annual Report for the State of Oregon.

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

Thank you for your consideration of this application.

Sincerely,

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

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

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

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Oregon's Title V framework and leadership role

Oregon's Title V program relies on shared leadership between the Oregon Health Authority (OHA) Public Health Division (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. 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 the local level Title V grantees (public health and tribal). Title V also has a tribal liaison who supports/oversees the work of the tribal Title V grantees. The state priority leads, Title V coordinator, Title V MCAH and CYSHCN research analysts and Title V tribal liaison coordinate work across populations/domains.

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

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

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

Oregon's 2020 Maternal Child and Adolescent Health (MCAH) Title V Needs Assessment identified six national priorities and three state-specific priorities for 2021-2025. They are: well woman care, breastfeeding, child injury, 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 MCAH Title 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 being implemented at the state level and by local grantees include: case-management and use of the postpartum health care visit to improve utilization of well-woman care; marketing to educate the population and promote well-woman care; training of health care providers, support for access through Family Planning Clinics.

Perinatal/Infant Health

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

Child Health

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

Needs/priorities

Based on the 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 for the upcoming five-year cycle are still in development. Strategies will focus on evidence bases/informed approaches to address upstream risk and protective factors including ACEs and social determinants of health and equity. Injury work will be addressed in a cross-cutting manner with a wide range of partners, and will be designed to impact a variety of injury outcomes across MCAH populations.

Adolescent Health

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

Needs/priorities

Based on the 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/positive youth development strategies for the upcoming five-year cycle are still in development. Strategies will focus on evidence based/informed approaches to address upstream risk and protective factors including ACEs and social determinants of health and equity. Approaches will be cross-cutting, involving a wide range of partners, and will be designed to impact a variety of injury prevention and positive youth development outcomes.

Children and Youth with Special Health Needs (CYSHCN)

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 children and youth with special health needs, increasing health care equity, 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; promoting regional and state level infrastructure development to support CSCC; and building an evidence base to describe the effectiveness of these strategies.

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

Life course and Cross-cutting/systems

Oregon's Title V program uses a life course focus and equity lens to maximize investment in policies, systems and programs that support lifelong health. Cross-cutting/systems work includes work on upstream on both national performance measures and state-specific priorities; and investment in foundational capabilities such as

epidemiology, communications, and leadership.

Needs/priorities

Based on the 2020 needs assessment, Oregon's MCAH needs with cross-cutting/systems implications 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 Title V program is developing a new structure and strategies to address these upstream cross-cutting needs during the coming five-year cycle including: integrated state-level staff teams, re-structured strategies and logic models, and new supports for local Title V grantees – particularly in relation to the upstream state-specific Title V priorities. Work on strategies related to continuing priorities will proceed as outlined below, while the new framework and strategies related to social determinants of health and equity strategies is developed.

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

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

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 4A: breastfeeding initiation. NPMs that have improved moderately include 8.1: child physical activity, 13.2: child dental visits, 14.1: smoking during pregnancy, and 14.2: household smoking. NPMs that have worsened slightly but are still consistently about national averages are 4B: exclusive breastfeeding at 6 months and 13.1: dental visits during pregnancy. An NPM that showed substantial worsening is 10: adolescent well visits. Moderate increases and decreases in NPMs are small and should be interpreted with caution.

According to the 2016-17 National Survey of Children's Health (NSCH), 39% of CYSHCN have a medical home (NPM 11). The estimate remained the same for 2018. Seventeen percent of YSHCN received services necessary to make transitions to adult health care (NPM 12); state-level estimates are not available for 2018.

Updated data is only available for two of the six SPMs, and both of these showed improvement; 2A: food insecurity, and 3A: children with a healthcare provider who is sensitive to their family's values and customs.

Title V partnerships and stakeholder engagement

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

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

Title V funds complement and support overall state MCAH efforts. The 30% of funding that goes to OCCYSHN provides capacity for work with partners and local grantees on medical home transition initiatives 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.

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

III.A.3. MCH Success Story

Two of Oregon's Title V success stories are highlighted below.

Oregon Title V collaborated with OHA Office of Health Analytics and Oregon's Department of Human Services Reporting, Analytics, and Information to purchase an NSCH oversample. Each entity paid one-third of the cost for additional data to be collected from households with children of non-White race/ethnicity. OHA PHD and OCCYSHN co-facilitated a state-level partner group to provide input on the sampling method. We are extremely grateful to MCHB and Census for their assistance.

Title V funding and staff have been critical to all aspects of Oregon's COVID-19 response from the beginning, using the flexibility of Title V funding to meet rapidly changing needs. Title V staff have stepped up – epidemiologists, nurses, health educators, managers, program and support staff – all working to "do what needs to be done". Title V staff provide leadership in the incident management structure, as well as for continuation of operations across the agency. This includes leading work in: epidemiology and surveillance, planning and cross-agency liaisons, contact tracing, communications with disproportionately impacted communities, and more. This is in addition to supporting local grantees to transition Title V supports to families and respond to emerging needs; continuing critical MCH work, and supporting state staff's transition to working at home while coping with caregiving and other stresses brought on by the pandemic.

III.B. Overview of the State

Oregon's demographics, geography, economy and urbanization

Demographics and urbanization

Oregon's population of 4 million makes it 27th in population among US states. Oregon has large rural and frontier areas, resulting in an overall population density of 40 people per square mile. Approximately 84 % of Oregonians live in urban areas, while 16 % live in rural and frontier areas. Population density ranges from about 4,228 persons per square mile in Portland to 7 persons per square mile in frontier areas and 23 persons per square mile in areas with 50,000 or less population (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 72,000 Native Americans and Alaska Natives living in Oregon. The Portland area has the 9th largest urban Native American population in the US, and 43-member tribes participate in the Northwest Portland Area Indian Health Board.

Oregon is becoming increasingly diverse. In the 2010 Census, 83.6% reported as White only, a drop from 90.1% in 2008. Hispanics make up the largest minority population at 11.7%, a 64% increase since the 2000 Census. Other races have remained about the same, with Asians at 3.7%, African Americans at 1.8%, and American Indian/Alaska Natives at 1.4%. Approximately 16% of Oregonians speak a language other than English at home (American Community Survey, 2018).

Oregon's birth rate is declining, with 66 births per 1,000 women ages 15-44 compared to the national average of 69.2 (Oregon Vital Statistics, 2017). In 2018, Oregon had less than 43,000 births, of which 67% were White, followed by 19% Hispanic, 6% Asian, 4% mixed race, 2.3% African American, and less than 2% Native American (OVS, 2018). In 2019, about 6% of the population was under 5 years of age, and 21% was under the age of 18 (USCB, 2019). Overall the median age of Oregonians is 39.6 years, and as of 2017 the median age of mothers for all births is 29 (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 to delivering and accessing health services, and issues related to workforce capacity and training needs varying vastly in different regions of the state.

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.

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). In 2017, Oregon's population grew by 64,700 people, 56,800 of those due to in-migration.

Prior to the COVID-19 outbreak, Oregon's seasonally adjusted unemployment rate had peaked in May 2009 at 11.6%. 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 was unevenly experienced around the state, with county level unemployment rates ranging from 2.8% to 6.3% and 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, with estimates that unemployment rates could climb past 20%.

Oregon's median household income was $59,393 in 2018, placing it 27th among US states (ACS, 2018). The American Community Survey for 2018 estimated poverty at 14.1%, with 15.4% under age 18 living below poverty. 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). Twenty-eight percent of CYSHCN ≤18 years live in households with incomes less than 100% of the Federal poverty level, although this estimate should be interpreted with caution due to small sample size (NSCH, 2016-17).

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 as those impacts are just beginning to be felt and due to limited time and knowledge only briefly touches on issues that will have large long-lasting impacts. The topics addressed below reflect primarily issues that preceded the COVID-19 pandemic.

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 42% of Medicaid and CHIP population as of the last reporting period in January 2020. CCOs are responsible for providing care for people covered by Medicaid. Despite Oregon's healthcare transformation rollout

with its commitment to the Triple Aim, families and partners across the state still report considerable unmet needs for the CYSHCN population. Families experience confusion about who is responsible for coordinating care for CYSHCN across multiple systems. Patient-Centered Primary Care Home standards and CCO incentive metrics do not adequately incentivize primary care providers to prioritize CYSHCN within their practices. Additionally, there are no consistent policies across CCOs regarding the type and amount of services covered, except for the Applied Behavioral Analysis (ABA) mandate for children with Autism Spectrum Disorder.

Education

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

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

Oregon has 197 public school districts, 1,246 public schools, and 582,661 students enrolled from kindergarten through grade 12. Among K-12 public school students in Oregon, 39% are students of color; 47% qualify for free or reduced lunches; 14% are in special education, and 9% are English Language Learners. Oregon's 4-year high school graduation rate is 83.7%, a significant increase over the past several years (Oregon Department of Education, 2019).

Every child in Oregon identified as needing special education has at least one of the disabilities defined in the IDEA. In Oregon, children must have 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 2018, 89,125 Oregon children (age 3 – 21 years), were in special education, and 4,388 children age 0 – 3 years, received EI services (Oregon Department of Education).

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

Early learning system transformation

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

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

- The P-3 Alignment initiative which 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. Title V was a key partner in its development, and now in its implementation.

Transformation of the early learning system continued and included alignment with other child-serving systems. These efforts have been particularly relevant to CYSHCN. Early Learning Hubs have led or participated in efforts to systematize screenings and risk assessments in their regions. Some Hub regions mapped pathways or developed resources to guide high-quality programming for children whose screenings indicated need. The linkages to programs that effectively meet the needs of different families and populations of children with high needs are aimed at ensuring kindergarten readiness.

Patient-Centered Primary Care Home (PCPCH) Program

The PCPCH Program is Oregon's realization of the patient-centered medical home concept. The program's goal is to accomplish the Triple Aim of health care. OHA established a set of recognition criteria, a technical assistance guide, and a self-assessment tool to aid practices in applying for PCPCH recognition. Initially the program consisted of 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 system. The changes focus on the need to achieve sustainable and measurable improvements in population health; continue to protect individuals from injury and disease; and be fully prepared to respond to public health threats. A Public Health Modernization manual has been developed, along with a Modernization Plan based on assessment of the capacity and gaps in the governmental public health structure across Oregon. Phase one funding of $5 million was spent to enhance 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

The American Community Survey estimates that Oregon has nearly 1.8 million housing units (ACS, 2018). 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 $1,050 for renters, $1,647 for mortgaged owners, and $519 for other owners. 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 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

OHA is the central agency that oversees health transformation in Oregon, guided by the Triple Aim of: improving the lifelong health of Oregonians; increasing the quality, reliability, and availability of care for all Oregonians; and lowering or containing the cost of care so it's affordable to everyone. Title V's prevention and health promotion work supports the Triple Aim through interventions with vulnerable populations at critical stages of the life course. Section 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 within the Department of Pediatrics at OHSU 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 face the onset of disabling conditions. They 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 this year with new 2020-24 priorities. The new SHIP priorities include: Institutional bias; Adversity, trauma and toxic stress; Economic drivers of health; Access to equitable preventive health care; and Behavioral health. Title V is a critical partner whose work is threaded across all the new SHIP priorities.

CCO Community Health Improvement Plans and Outcome Metrics

Title V work also aligns with and supports the community health improvement plans of the CCO's, as well as their performance metrics. Each of the 16 CCOs has developed a community health improvement plan (CHIP) which details their commitment to improving population health, and is required to report on those plans annually. The CCOs are also being measured and receive enhanced payment on 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. Newly signed contracts also charged CCOs with addressing social determinants of health. Title V works with the CCOs as a provider of: 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 the age of 18 (USCB, 2019). Fifteen percent of Oregonians under age 18 live below the federal poverty level.

The 2016-17 National Survey for Children's Health (NSCH) estimated that 18.7% of Oregon children 0 to 18 years have special health care needs. These CYSHCN were mostly White, non-Hispanic. About 20.5% were of Hispanic ethnicity and 13.5% identified as other, non-Hispanic.

Nearly 67.5% of Oregon CYSHCN have a condition that affects their daily activities and over 32.6% experience two or more difficulties related to functionality (NSCH, 2016-17). According to the most recent state-level prevalence rates, 2.7% of Oregon children age 3 – 17 have Autism Spectrum Disorder (ASD), compared to 3.1% nationally (NSCH, 2017). In 2018, about 10,971 Oregon youth age 3 – 21 who received special education had ASD (Oregon Department of Education [ODE], 2018).

Significant advances in science and technology have reduced the risk of mortality for CYSHCN, resulting in an increase in morbidity due to chronic illness and disability. Of children under age 18 insured through Oregon Medicaid in 2015-2016, 6.1% of children met criteria for having complex chronic disease. Of those, 6.7% were Black/African American, 5.6% were Native American, and 5.6% were multiracial (OPIP, OHA, DHS, 2018). Eighteen percent were categorized as having non-complex chronic disease. Of those, 19.2% were Black/African American, 17.8% were multiracial, and 17.6% were Native American (OPIP, OHA, DHS, 2018). Youth and young adults with special health care needs (YSHCN) are living longer and assuming productive lives. However, only 51% of Oregon YSHCN graduated from high school in 2014 (NCES, 2013-14). NSCH (2016-17) estimates suggest that less than 19.6% 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 needs, and other social factors.

Oregon's Birth Anomalies (birth defects) Surveillance System (BASS) tracks prevalence of select birth anomalies using birth certificate, hospital discharge, and Medicaid data. Children who get home-visiting public health nursing care coordination services through OCCYSHN's CaCoon program are tracked through a statewide database. The most frequent risk factors and conditions cited for CaCoon recipients during FY2019 were developmental delay, other chronic conditions, Autism Spectrum Disorder, and behavioral or mental health disorder. Children can have more than one risk factor recorded. In FY2019, 66% of children in the CaCoon program had multiple risk factors.

Health services infrastructure

Primary care and safety net health services are available through private 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 148 designations for 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. 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**: A large portion of the uninsured were eligible for OHP. The top three reasons Oregonians cited for not being covered by OHP were: concerned about high costs of coverage (44 percent); not eligible, make too much money (36 percent); and concerned about quality of care (21 percent).

Oregon has expanded Medicaid coverage (Oregon Health Plan – or OHP), to cover adults whose income is 133% of the Federal Poverty Level (FPL). Pregnant women are covered to 185% FPL, and children to 300%. OHP pays for medical, dental and mental health services for low-income Oregonians. Since ACA implementation, OHP enrollment has grown by 557,000 people, and OHP now covers nearly 1 million Oregonians. OHP pays for 53% of Oregon births, including prenatal and delivery coverage for approximately 3100 undocumented women covered through the state-funded prenatal expansion program and Citizen Alien Waived Emergent Medical (CAWEM) program. About 20% of all Medicaid enrollees are Hispanic, 3% African American, 1.5% American Indian/Alaskan Native, 3% Asian or Pacific Islander, 58.5% Caucasian, and 14% "Other" or "Unknown". More than one-third (36%) of Oregon CYSHCN < 18 years were insured through Medicaid (NSCH 2016-2017).

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

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

State revenues and budgets

Over 90% of the state's general fund support core functions in three areas: education, health and human services, and public safety. Oregon does not have a sales tax, and recent attempts to increase corporate taxes through ballot measures have failed to pass. Furthermore, state law mandates a "kicker" refund to taxpayers in any year in which state revenues exceed projected by more than 2%. Consequently, even with robust employment and income tax, the state continues to face budget shortfalls.

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

State statutes with relevance to Title V

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

- **ORS 413** defines to the Oregon Health Authority (OHA) and the Oregon Health Policy Board, which were created by the Oregon Legislature in 2009. Most health-related programs in the state are under the OHA including Public Health, Medicaid, Addictions and Mental Health, the Public Employees and Oregon Education Benefit Boards. OHA is overseen by the Oregon Health Policy Board.
- **ORS 431.375** governs the policy on local public health services; local public health authority, and the provision of maternal and child public health services by tribal governing council.
- **HB 3650,** passed in 2011, sets the framework for health system transformation and the CCOs which are a cornerstone of Oregon health system transformation and provide care to Oregon's Medicaid (OHP).
- **HB 3100,** passed In July 2015, implements the recommendations made by the *Task Force on the Future of Public Health Services* and sets forth a path to modernize Oregon's public health system so that it can more proactively meet the needs of Oregonians. Legislation to expand support for Public Health modernization is being considered in the current session.
- **ORS 326.425** establishes the Early Learning Council, which oversees the Oregon Early Learning System.
- **ORS 444.010, 444.020 and 444.030**, the Oregon Health and Science University (OHSU) is designated to administer a program to extend and improve services for CYSHCN, including the administration of federal funds made available to Oregon for services for children with disabilities and CYSHCN.
- Oregon is one of 39 states that passed ASD mandates that require health insurers to provide the behavioral therapy Applied Behavior Analysis (ABA) to children with ASD and other developmental disorders under 18 years old who have health insurance.
- **HB 4133**, passed in 2018, created Oregon's Maternal Mortality and Morbidity Review Committee (MMRC).
- **SB 526 (2019),** passed universally offered home visiting for Oregon newborns.

III.C. 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 CoIIN 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%20T
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 8th and 11th 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 CoIIN 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 CoIIN 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 CoIIN, Infant Mortality CoIIN; Children's Healthy Weight CoIIN, 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 (CoIIN) 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

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

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,198,272	$6,129,512	$6,150,471	$6,178,818
State Funds	$8,482,655	$10,163,564	$8,888,929	$9,068,855
Local Funds	$6,299,075	$7,003,170	$6,026,893	$5,594,166
Other Funds	$7,136,279	$7,468,578	$7,236,918	$7,531,186
Program Funds	$0	$0	$0	$0
SubTotal	$28,116,281	$30,764,824	$28,303,211	$28,373,025
Other Federal Funds	$36,772,879	$35,420,484	$38,871,933	$39,324,236
Total	$64,889,160	$66,185,308	$67,175,144	$67,697,261

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,129,512	$6,172,689	$6,178,818	
State Funds	$10,116,862	$11,960,373	$10,720,618	
Local Funds	$7,003,170	$9,707,490	$5,594,165	
Other Funds	$7,684,389	$9,783,913	$8,527,525	
Program Funds	$0	$0	$0	
SubTotal	$30,933,933	$37,624,465	$31,021,126	
Other Federal Funds	$37,139,702	$44,501,432	$39,882,886	
Total	$68,073,635	$82,125,897	$70,904,012	

	2021	
	Budgeted	Expended
Federal Allocation	$6,172,689	
State Funds	$13,276,271	
Local Funds	$9,707,490	
Other Funds	$11,838,611	
Program Funds	$0	
SubTotal	$40,995,061	
Other Federal Funds	$43,526,340	
Total	$84,521,401	

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 MCAH Title V Partnership and leadership roles

Oregon's Title V program relies on shared leadership between the Public Health Division's Maternal and Child Section, 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 (Jessica Duke), 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. 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 leadership team and priority leads participate in external and internal work teams and committees to provide MCAH leadership and ensure that Title V work is represented by appropriate subject matter experts and integrated into related work within the agency, across state agencies, and with external partners. Key policy and system development initiatives which Title V MCAH staff either convene or contribute to include the: Governor's Children's Cabinet, Health Aspects of Kindergarten Readiness metrics work group, Reach Out & Read Advisory Committee, Social Determinants of Health CoIIN, Childhood Obesity CoIIN, Early Learning Council and its committees, OHA Health Disparities Advisory Committee, CCO Metrics and Scoring Committee, Oregon Pediatric Improvement Project, State Health Improvement Plan 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.

Key policy and system development initiatives that Title V CYSHCN staff contribute to include: OHA's Early Hearing and Detection Intervention Program Advisory Committee, OHA's Emergency Medical Services for Children (EMSC) Advisory Committee, Health Share of Oregon (CCO) All:Ready Network, Medicaid Advisory Committee, the Oregon Council on Developmental Disabilities, OHA's Patient-Centered Primary Care Home (PCPCH) Advisory Committee, Oregon Pediatric Improvement Partnership, OHA's State Health Assessment, and the State Interagency Coordinating Council.

MCAH Program Purpose and Design

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 on four domains: policy and systems; workforce capacity and effectiveness; assessment, surveillance and epidemiology; and community & family capacity. Each domain has a goal and several strategic priorities (see Supporting Document #4), and Title V's work is integrated across all of these.

Title V's Adolescent Health work sits within the Adolescent & School Health Unit, with a mission of supporting the health of all youth in Oregon through evidence-based and data driven policies, practices, and programs. The Unit's work is comprised of four program areas: policy and assessment; school-based health centers, school nursing, and youth sexual health.

Oregon's state and local public health system is undergoing extensive re-structuring to ensure capacity and focus on core public health functions. This initiative is called Public Health Modernization, and the Title V program is providing leadership for the MCAH community's participation in this effort. Public Health Modernization legislation currently passed in June 2019 allocates $25 million to enhance state and local public health modernization efforts. Title V strategies and activities, mapped out in Title V priority-specific logic models, demonstrate foundational public health capabilities in practice across the Title V program (see Supporting Document #5).

OCCYSHN Program Purpose & Design

Mission, Vision, and Priorities

OCCYSHN improves the health, development, and well-being of Oregon's children and youth with special health care needs (CYSHCN). OCCYSHN's 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 appropriate. OCCYSHN provides subject matter expertise, data, and provider and family perspective to policymakers and administrators, LPHAs and families. The *Standards for Systems of Care for CYSHCN*, the Title V block grant national and state priorities for CYSHCN, Oregon's health care transformation efforts, and the contract with OHA all shape OCCYSHN's work. Partnership with families, community-based providers, OHSU Institute for Development & Disability, and policymakers is foundational to addressing the needs of Oregon CYSHCN and their families.

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

Family Involvement

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

OCCYSHN administers an annual distribution of the Oregon Community Foundation's Sidney and Lillian Zetosch Fund to purchase adaptive educational equipment, such as computers and tablets, for CYSHCN from low-income families. In 2019, OCCYSHN purchased educational equipment for 93 CYSHCN.

Systems & Workforce Development (S&W)

OCCYSHN provides resources and technical assistance to partners across the state to improve local systems of care, and to increase local capacity to serve CYSHCN. S&W's primary effort is supporting a continuum of care coordination and systems improvement efforts for CYSHCN. ECHO-based virtual learning communities allow providers across the state (at any level on the continuum) to share learning with one another, and to improve both individual practice and systems of care for CYSHCN.

This community-based care coordination continuum starts with CaCoon public health nurse home visiting. CaCoon nurses share resources and care coordination expertise with families, building family capacity to coordinate the complex care and service needs of their CYSHCN. OCCYSHN provides training and guidance to the nurses.

CaCoon nurses also implement shared care planning for specific CYSCHN in need of additional support. Nurses convene a cross-sector team of professionals with the child's family. The team develops and monitors an actionable care plan to achieve family goals. Professionals share accountability and build connections. Shared care planning strengthens local systems of care while improving the well-being of CYSHCN and families.

Next, OCCYSHN supports Piloting ACT.md for Care Coordination Teams (PACCT). These cross-sector teams meet regularly to provide shared care planning as described above, and to monitor and revise plans over time for a cohort of CYSCHN. They are also piloting the use of an online platform (previously ACT.md, now called Activate Care) that fosters collaboration and accountability in shared care planning.

The REACH pilot concluded in September 2019. REACH convened local and regional decision-makers from various systems that serve CYSCHN. These teams employed QI methodology to identify shared goals, address issues in regional systems of care, and coordinate for greater efficiency and effectiveness on behalf of CYSHCN. Lessons learned from REACH will inform the development of further collaboratives across the state that address systems issues on behalf of CYSHCN.

Assessment & Evaluation (A&E)

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

III.E.2.b. Supportive Administrative Systems and Processes

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

MCAH Staff Development and Capacity

Overview of Oregon's MCAH Workforce strengths and capacity

Oregon's MCAH workforce strengths include an experienced and dedicated workforce that continually demonstrates creativity and flexibility in the face of changing systems and funding. 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.

Staff training and workforce development

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

- State MCAH staff have individual employee development plans and attend conferences, trainings, university courses, or other development opportunities to meet the goals of those plans. State staff participate in a state government leadership academy, as well as the Northwest Center for Public Health Leadership Institute's year-long fellowship program.
- Title V sponsors or supports a variety of workforce development activities throughout the year, which are available to both state and local MCAH staff. Current areas of focus include:
    - Training to enhance capacity for trauma-informed and equitable workforce and workplace are a major focus of MCAH workforce development. All MCH staff completed the Intercultural Development Inventory this year, and results were used at the individual, work group, and section levels. This work with state and local MCAH workforce aligns with Oregon's state-specific priorities and strategies, as well as Public Health Division and OHA priorities.
    - The state MCAH program is active in mentoring MCAH students and new professionals. This year, Title V supported expanded our traditional mentoring to include hosting two interns from a local high school.

- Local MCAH programs receive ongoing technical assistance and training through state MCAH nurse consultants, program, policy, and research staff, and nutrition consultants. Title V has been working to build grantee capacity in: assessment, priority selection, and planning and measures development in alignment with the BG 3.0. This year, grantees participated in webinars and conference calls with colleagues around the state working on shared priorities to build skills in the above topics.
- A critical and ongoing consultation/workforce development activity is the training of new MCH supervisors and staff in local health departments around the state. Training is conducted through a combination of state public health orientation trainings and individualized consultation delivered on site or by phone.
- The Oregon MothersCare (OMC) program provides quarterly training and ongoing technical assistance to local OMC coordinators and supervisors across the state to facilitate enrollment in Oregon Health Plan (OHP) and other forms of health insurance, and access to prenatal services.
- Local MCAH programs serve as field placement sites for nursing students as well as high school, undergraduate and graduate students – providing critical exposure to public health career opportunities.

Recruitment and Retention

- The MCH Section and Title V program have focused extensively over the past year on the implementation of a

racial equity policy statement and instituting new policies and practices to ensure recruitment and retention of a diverse and trauma informed workforce. The policy and guidelines are included in Supporting Document #4.

- The MCH Section has piloted the use of the new recruitment and hiring practices targeted at increasing equity in hiring and retention.

Innovations in staffing structure and workforce financing

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

OCCYSHN Staff Development and Capacity

OCCYSHN operates with a staff of 16. OCCYSHN increased capacity this year by hiring an Assessment and Evaluation Research Assistant. OCCYSHN is also actively recruiting a Systems Quality Improvement & Innovation Manager to join the Systems & Workforce Development unit. In addition, OCCYSHN is recruiting a part-time Office Assistant to increase administrative support. OCCYSHN's Title V funds partially support the FTE of 13 clinical staff within CDRC. Efforts continue to shift Title V resources away from direct services provided by OHSU to systems building, population health related efforts, in alignment with BG 3.0.

Actions to Build CYSHCN Workforce Capacity

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

OCCYSHN partners with IDD/CDRC to improve health care for CYSHCN. This partnership prioritizes care coordination, behavioral health, medical consultation, feeding and nutrition, genetics, and high-risk infant care and follow-up. CDRC provides direct services to Oregon CYSHCN and their families in Portland, Eugene, and at outreach clinics. Services offer a family-centered, team based, interdisciplinary care model. Multiple specialists evaluate a child on the same day, and develop holistic, integrated diagnostic summary and family recommendations. CDRC's approach helps families "pull the pieces together" for their children 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 OCCYSHN's capacity to address the workforce's needs related to CYSHCN and their families. OCCYSHN partners with UCEDD and LEND to educate pre-service students and community service providers. OCCYSHN also collaborates with UCEDD and OODH on shared priorities, such as health care transition for YSHCN.

One of OCCYSHN's primary foci is to enhance the LPHA workforce through strategy 11.1 of OCCYSHN's state action plan. One piece of this strategy builds the LPHA workforce's cross-systems communication and coordination skills. We include LPHA partners in TA activities, which provides an opportunity to spread interdisciplinary skill building to other systems.

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

MCAH Family Partnership

Oregon's MCAH program is committed to building the capacity of women, children, and youth, including those with special health care needs to partner in decision making for the Title V program. Special efforts are made in assessment, planning, policy development, and program implementation to include representatives of communities experiencing disparities – and to engage families and consumers in ways that are culturally and linguistically accessible.

State and local efforts to build and strengthen family/consumer partnerships include:

- Oregon's work on the AMCHP-led Social Determinants of Health CoIIN is focused on ensuring that the voice and needs of traditionally under-represented families are elevated in policy and program decisions related to caregiving in the first year of life. This year the CoIIN team contracted with StoryCenter to deliver a 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 next step for the CoIIN will be to partner with the storytellers to find ways to use their stories to reach policy makers.
- Oregon's 2020 MCAH Title V Needs Assessment has a strong family/community partnership component, including 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.
- Local Title V programs are administered through local health departments and tribes in each county in Oregon, and all have unique approaches to engage families/consumers to meet the specific needs of their communities. Consumers are engaged in needs assessment, program development and quality assurance in local Title V programs through community meetings, advisory boards, surveys, etc.
- State level Title V staff partner with a wide range of community agencies, as well as local public health agencies and tribes to ensure family and consumer voice informs program and policy decisions, and community programs such as the Healthy Birth Initiative Community Action Network that help ensure consumer voice in our program planning and implementation.
- Oregon Early Hearing Detection and Intervention program (EHDI) engages families of infants with hearing loss in all aspects of the program, including:
  - Contracting with Oregon Hands & Voices to provide informational and emotional support to families of infants newly diagnosed with hearing loss;
  - Actively recruiting parent members for the legislatively mandated EHDI Advisory Committee;
  - Surveying parents about their experiences, system successes and program opportunities for improvement;
  - Soliciting parent review of parent/caregiver communications.

- The Adolescent and School Health (A&SH) Unit has a focus on engaging youth in the development and implementation of their policies and programs. This is achieved through youth participatory action research curriculum implemented through SBHC youth advisory councils across the state.
- The Public Health Division also has multiple advisory groups which rely on community and consumer representatives to develop policies and programs. These include the WIC Advisory Committee, Oregon Partners to Immunize Children, Immunization Advisory Committee, Genetics Advisory Committee, Teen Pregnancy Task Force, the Youth Sexual Health Partnership, and the Marijuana Communications Committee.

OCCYSHN Family Partnership

OCCYSHN ensures family partnership through a robust Family Involvement Program (FIP). Oregon's Family to Family Health Information Center is housed within the FIP, which is staffed by the FIP Manager, the ORF2FHIC Bilingual Outreach and Training Specialist, the Parent Partner/Resource Specialist and three community-based Parent Partners (PPs). The FIP Manager supervises the training of PPs on health care financing, systems advocacy, medical home, transition, screening, and other topics affecting CYSHCN. ORF2FHIC supports families navigating health care and community service systems, and maintains a large, up-to-date clearinghouse of Oregon CYSHCN resources. PPs model advocacy skills and present options for solving care and service system challenges. In addition, FIP holds listening sessions around the state where families communicate their experiences, concerns, and questions. These experiences inform OCCYSHN's work.

PPs create content for the ORF2FHIC website, tip sheets/resource guides, and social media. FIP seeks partnerships with professionals to create accurate, up-to-date, plain-language materials for families. To support non-English-speaking families of CYSHCN, interpretation services are hired, as needed, through a variety of community-based services (such as the Immigration and Refugee Community Organization language line). The ORF2FHIC Bilingual Outreach/Training Specialist translates family tip sheets, trainings, and other resources into Spanish and disseminates through Latino community organizations.

PPs and other Oregon family support programs provide OCCYSHN with perspective, information, and context about the experiences of families. The FIP Manager regularly recruits family members of CYSHCN to serve on committees, boards, and workgroups. She coaches programs on how to integrate family experience into their work, using the "Planning for Meaningful Family Involvement" tool that was deemed a "cutting edge" practice by AMCHP's Innovation Station in 2019. Oregon parents serve on OHA Rules Advisory Committees, CCO Consumer Advisory Councils, State Interagency Coordinating Council, Medicaid Advisory Committee, Early Learning Council, and the Emergency Medical Services for Children Advisory Board. The FIP Manager is a member of OCCYCHN's block grant writing team, and arranges each year for families to review Oregon's Block Grant application. She is also the Family Delegate for Oregon to AMCHP.

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

FIP is represented at OCCYSHN's regional meetings and web-based trainings. In addition to contributing to the policy-tracking efforts of OCCYSHN's Systems and Workforce Development pillar, it contributes significantly to the CoIIN, the ACCESS project, and other OCCYSHN activities.

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

The Oregon State Systems Development Initiative (SSDI) program develops, enhances, and expands Oregon's Title V Maternal and Child Health (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.

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

In prior fiscal years, Oregon's SSDI program supported efforts to obtain access, and make available, the minimum and core data sets. As a result of these efforts, all 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.

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

Over the course of FY19, the SSDI program worked to identify and gather key stakeholders for the work to migrate and support Title V data collection on a new home visiting database. The legacy database was to begin sunsetting in FY20 and it was known that many local agencies leverage the system for data collection and reporting on Title V-related measures. This stakeholder group was critical in establishing state-level needs as well as coordinating with local partners in the upcoming migration work to maintain data collection efforts. However, due to priority response needs for COVID-19 across both the State and local level, the transition between the legacy database and the new home visiting database was largely delayed, and much of the transition work was deferred until FY21.

OCCYSHN provides block grant funding annually to OHA PHD to support collection and cleaning of home visiting data entered by LPHA public health nurses. OCCYSHN S&W and A&E staff have contributed thought and time into the development of the state data system (THEO) that will eventually replace its current data system (ORCHIDS). As

described in Section III.E.2.c NPM 11 Strategy 11.6, OCCYSHN's A&E Manager co-facilitated with MCH staff a group of state partners to purchase an oversample of non-dominant ethnic/racial households for the National Survey of Children's Health (NSCH). OCCYSHN A&E also continues to maintain data systems for monitoring and evaluating LPHA implementation of its shared care planning activities (report sections 11.4 and 12.2).

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

Overview of Health Reform in Oregon

Oregon's health system transformation is guided by the Triple Aim of better health, better care, and lower costs, and has been underway since 2011. The Oregon Health Authority, within which the MCAH Title V program is housed, is the key agency tasked with responsibility for implementing federal health reform, as well as Oregon's health system transformation. Title V is a partner in supporting key elements of Health Reform in Oregon including: Medicaid expansion, rollout of Oregon's Coordinated Care Organizations and Transformation Center, integration of physical, behavioral and oral health, coordination of services for children and youth with special health care needs, as well as enrollment in insurance coverage through the Oregon ONE Eligibility portal.

Oregon's Medicaid Expansion

Oregon is one of 33 states to accept federal funding, expanding access to the Oregon Health Plan (OHP), the state's Medicaid program. Oregon also received a waiver from the Centers for Medicare and Medicaid Services (CMS) that allowed for "fast-track" enrollment, through which OHA pre-screened and recruited Medicaid-qualified participants of the Supplemental Nutrition Assistance Program (SNAP) and parents of children enrolled in the OHP. More than 375,000 people have enrolled in OHP as a part of Medicaid Expansion.

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

Oregon's Health Insurance Exchange

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

Coordinated Care model

Coordinated Care Organizations (CCOs) are at the center of Oregon's health system transformation. Sixteen CCOs were established since 2012, and one closed, leaving fifteen operating. The CCOs coordinate physical, mental, and dental health care for Medicaid clients with a focus on prevention and management of chronic disease, as well as increased health equity. The CCO model is designed to provide person-centered and coordinated care. CCOs are accountable for improving the health of their entire population and have a global budget that grows at a fixed rate. Quarterly progress towards defined benchmarks, including 17 incentive metrics, is measured and shared publicly. In addition, each CCO has a community advisory council (with at least 51% of membership being OHP members or family members), a transformation plan, and a community health improvement plan which extends impacts beyond the OHP population. Local Title V agencies are active partners with their CCOs in assessment, community prevention, and MCAH service delivery. The newly revised CCO incentive metrics demonstrate the increasing

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

Since 2012 Oregon's Medicaid reforms and the CCO model have saved taxpayers an estimated $2.2 billion. CCOs are also making progress on quality. The latest metrics report shows improvements in several areas including: effective contraceptive use, follow-up after hospitalization for mental illness, and in applying dental sealants for kids. The new five-year CCO contract began in January of 2020, with 11 CCOs receiving 5 year contracts and 4 receiving one year contracts (CCO 2.0). Governor Kate Brown has asked that the Oregon Health Policy Board, which oversees OHA's work, focus improvements in four areas: sustainable cost growth, value-based payments that pay for performance, social determinants of health and equity, and the behavioral health system.

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

Title V MOU with Medicaid

In addition to the broader Medicaid and health systems transformation work described above, Title V works to ensure access and coordinate systems of care for MCAH populations on Medicaid includes linking women to prenatal care (Oregon MothersCare, 211info, etc.); anticipatory guidance and referrals for women and children through home visiting, childcare and schools; and policy and system development work on both the state and local levels.

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

Other Health System reforms impacting MCAH

Implementation of several key pieces of legislation passed in the last legislative session is currently being integrated into Oregon health and other systems supporting the MCAH populations. These include:

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

Additional health systems reforms that are being driven by the COVID-19 pandemic, including expanded use of telehealth and various Medicaid reforms are also in process and will be reported on in future years.

Health Care Delivery for CYSHCN

The ORF2FHIC Parent Partners provide one-to-one coaching to families on navigating both public and private insurance. It regularly trains its Parent Partners to understand how insurance works, how to access state and federal protections for consumers, and how to help families pursue appeals and grievances. It also offers training to families through its popular workshop "*Health Care Advocacy."* Topics include health care record keeping, advocacy techniques, systems navigation, and basic insurance information. ORF2FHIC resources include tip sheets, appeal and grievance tool-kits, and web-based materials from the Oregon Insurance Division Consumer and Business Services.

OCCYSHN's Children with Medical Complexity (CMC) CoIIN project focuses on improving the transfer from pediatric to adult primary care for young adults with medical complexity (YAMC) (see Section III.E.2.c NPM 12 Strategy 12.3). OCCYSHN partners with OHSU's General Pediatrics and Adolescent Health Clinic and Family Representatives to develop and test a quality improvement project. OCCYSHN also partners with the clinic and Children's Health Alliance to explore financing options to pay providers for their time in transfer of care activities. OCCYSHN's intention is to share this learning with other Oregon health care systems to improve the health care transfer experience for the population of Oregon YAMC and their families. Additionally, the public comment letters on Oregon CCO 2.0 and committee participation (e.g., Medicaid Advisory Committee, Patient-Center Primary Care Home Advisory Committee) described in Section III.E.2.c NPM 11 Strategy 11.3 seek to raise awareness about systems changes needed to provide improved health care for CYSHCN.

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

Women/Maternal Health

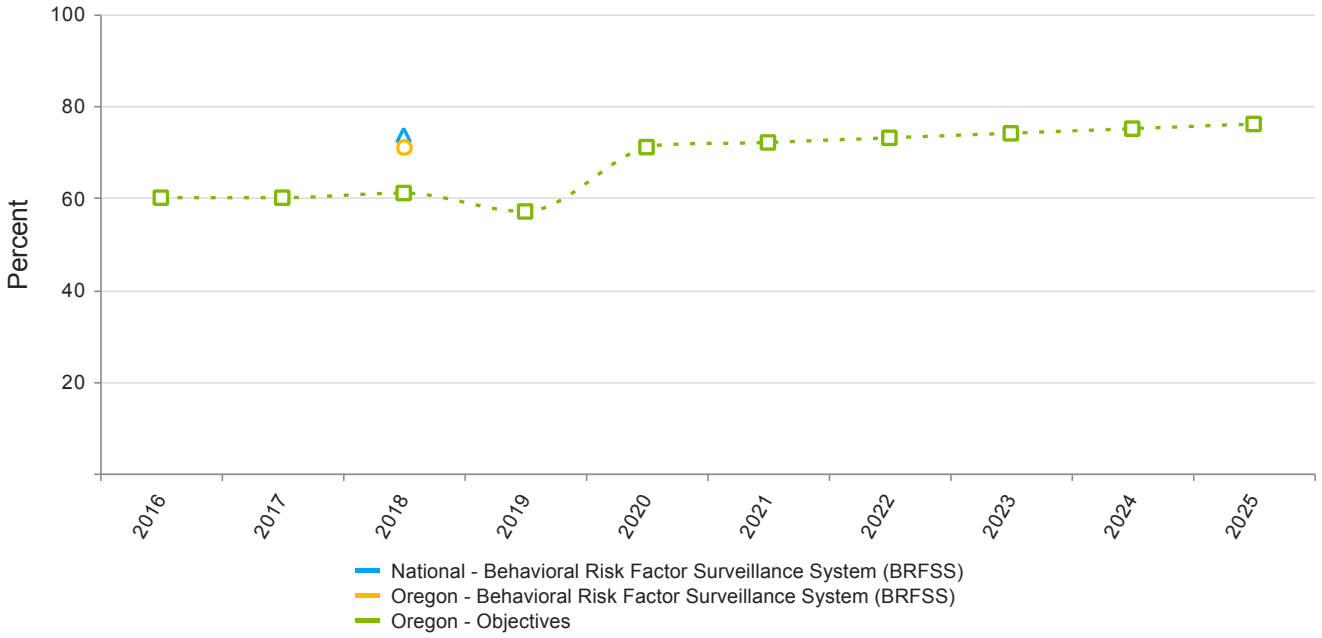
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2017	64.6	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	10.8	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	6.7 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	7.8 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	23.0 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	5.8	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	5.3	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	3.6	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	1.7	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	183.4	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	77.9	NPM 14.1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	11.6 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2017	6.0	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2017_2018	12.7 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	90.6 %	NPM 13.1 NPM 14.1

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	13.3	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	9.7 %	NPM 1

National Performance Measures

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



Federally Available Data				
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	60	60	61	57
Annual Indicator	58.0	59.2	56.5	70.8
Numerator	394,235	409,007	391,780	517,099
Denominator	680,107	691,064	693,242	730,360
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	71.0	72.0	73.0	74.0	75.0	76.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - 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
Annual Objective		500	600	700
Annual Indicator	0	0	0	2,085
Numerator				
Denominator				
Data Source	Log of brochures distributed, social media views/l	Unable to track this year	Unable to track this year	Outreach tracking
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	800.0	900.0	1,000.0	1,000.0	1,000.0	1,000.0

ESM 1.2 - 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
Annual Objective	100	100	100
Annual Indicator	100	100	100
Numerator	11	9	11
Denominator	11	9	11
Data Source	Minutes from TA trainings and phone calls	Minutes from TA trainings and phone calls	Minutes from TA trainings
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

ESM 1.3 - 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
Annual Objective		
Annual Indicator		38
Numerator		
Denominator		
Data Source		State Tracking
Data Source Year		2019
Provisional or Final ?		Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	15.0	15.0	15.0	15.0	15.0	15.0

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

By 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

Provide case management to improve utilization of well woman care
Use traditional and social marketing to educate the population and promote well woman care
Provide education/training on preconception/inter-conception and well woman care for health care providers.
Support access to well woman care through Family Planning Clinics
Promote use of the postpartum health care visit to increase utilization of well-woman visits

ESMs	Status
ESM 1.1 - Number of women reached using traditional and social marketing campaigns such as CDC Show Your Love brochures, social media including Facebook and Twitter, attendance at health fairs and community meetings, and public service announcements.	Active
ESM 1.2 - Percent of local health departments receiving technical assistance to support implementation of the well woman care priority area.	Active
ESM 1.3 - Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services.	Active

NOMs

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

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

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

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

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

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

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

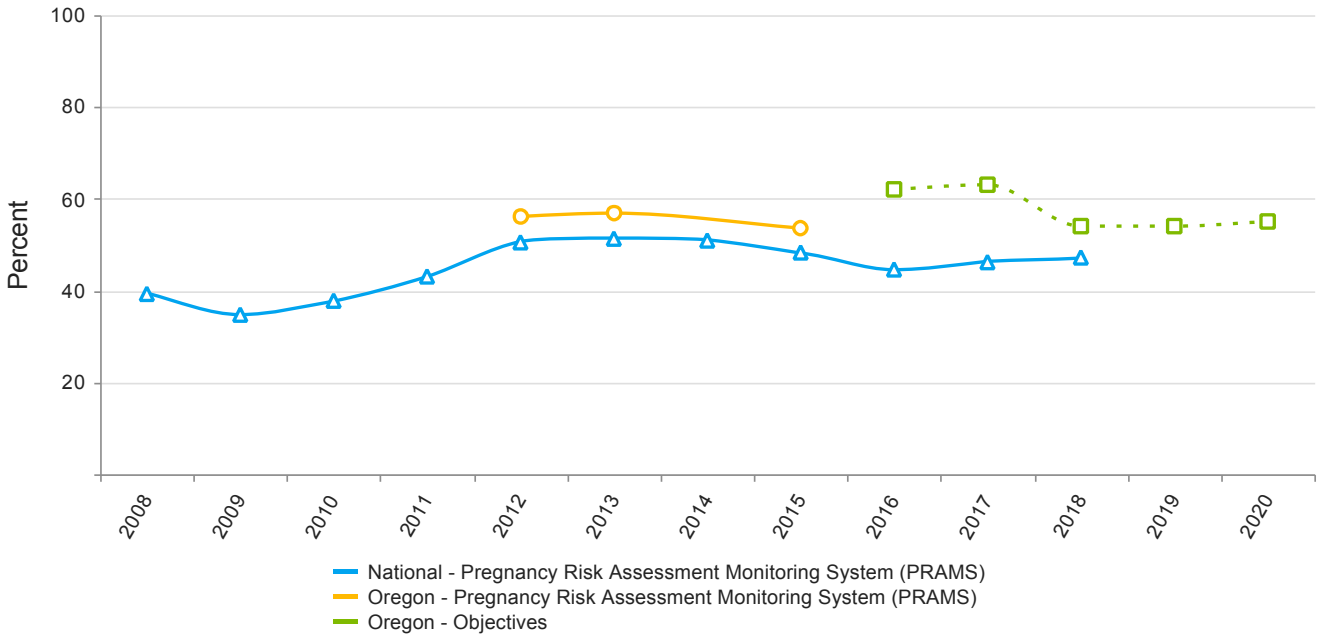
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

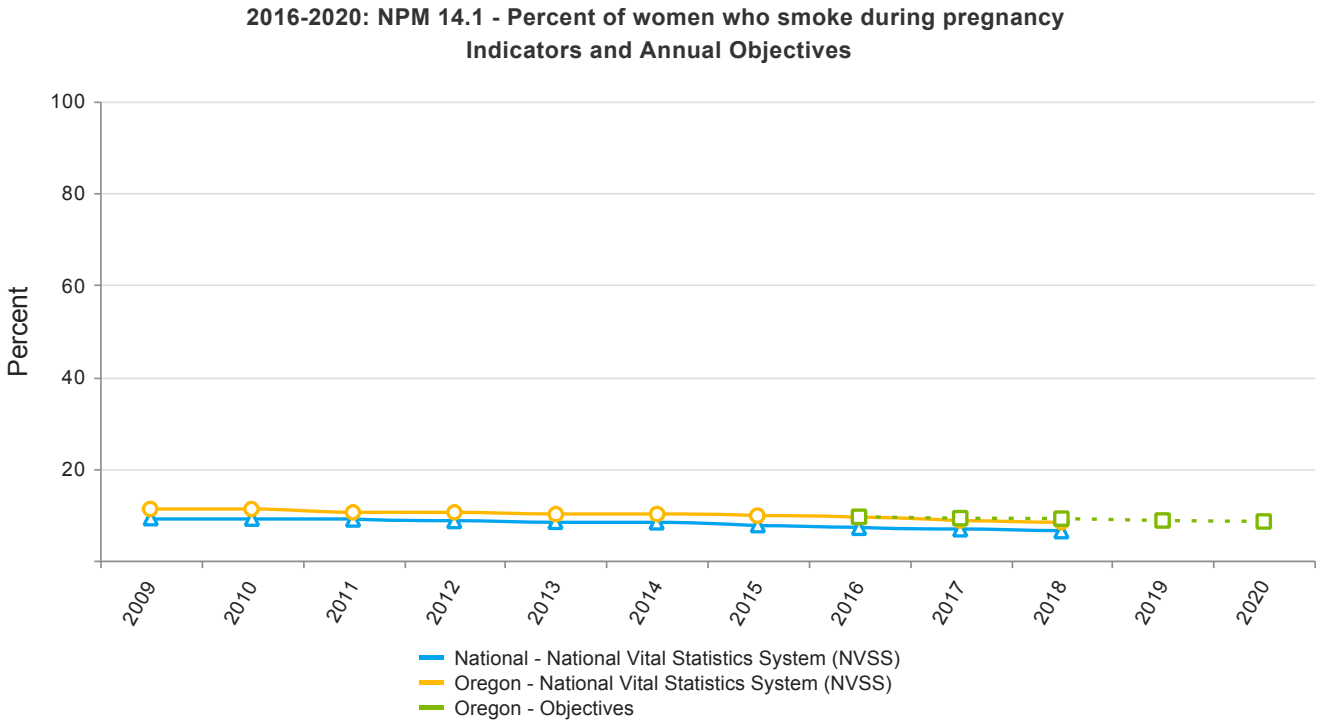


Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	62	63	54	54
Annual Indicator	57.0	53.5	53.5	53.5
Numerator	24,297	22,955	22,955	22,955
Denominator	42,656	42,925	42,925	42,925
Data Source	PRAMS	PRAMS	PRAMS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

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**
Annual Objective			7
Annual Indicator			7
Numerator			
Denominator			
Data Source			State Tracking
Data Source Year			2019
Provisional or Final ?			Final



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

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**
Annual Objective	75	75	75
Annual Indicator	50	100	71.4
Numerator	5	10	5
Denominator	10	10	7
Data Source	Local grantee reports	Local grantee reports	Local grantee reports
Data Source Year	2017	2018	2019
Provisional or 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**
Annual Objective	80	80	80
Annual Indicator	90.9	100	100
Numerator	10	10	7
Denominator	11	10	7
Data Source	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

DOMAIN – Women and Maternal Health

2019 Annual Report

Well-Woman Care 2019 Report

National Performance Measure (#1)
Percent of women with a past year preventive visit.

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

Strategies and Activities

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

Accomplishments

State Level

- The program manual for Oregon's MCH Nurse Home Visiting Program (Babies First!) was updated in January 2019. The updated manual includes a revised protocol on Reproductive Life Planning that has been implemented by programs statewide. Reproductive life planning has been identified as a key program outcome for the Babies First! Program.
- State staff supported training and technical assistance, data collection, and quality improvement activities for the MCH Nurse Home Visiting and MIECHV-funded Home Visiting programs. A key activity of the home visiting programs is to provide case management to assist women in establishing a medical home and accessing preventive care.

Local Level

- Coos County collaborated with Maternal Child Health home visiting programs and WIC to implement a strategy for increasing awareness of the importance of and supporting access to appropriate well-women and pre/inter-conception care among clients.
- Coos County was able to add the One Key Question to the workflows of Reproductive Health Clinic, WIC, and home visiting activities. 100% of eligible clients were screened in both the clinic and home visits, while WIC had 76% of the eligible clients screened, averaging to above the goal of 50%.
- Crook County increased access to the Nurse Practitioner from three times a month to four days a week, increasing utilization of care.
- Deschutes County mandated the One Key Question to be asked of all female home visiting clients yearly.
- Klamath Tribes utilized check-off lists that required participants to see an OB at least four times during their pregnancy, testing for health and wellness of mother and child, taking prenatal vitamins, at least one visit to the dentist, regular phone calls to patients to ensure adequate resources, and a six-week postpartum visit.
- Klamath Tribes report having had increase utilization of the MCH program, which facilitated the clients making well woman appointments and follow ups with their providers.
- Malheur County successfully implemented a plan to educate 100% of MCH home visiting adult female clients on the importance of well women and preconception care and provide referrals as needed.
- Malheur County originally planned to educate MCH home visiting clients on the importance of well woman and preconception care and was able to expand to all Healthy Families home visiting clients. They coordinated with insurance assisters to educate on the well woman care being covered by CCOs or insurance providers.
- Washington County, working in conjunction with Washington County Public Health Division's reproductive health program educator, developed a plan to implement a pregnancy screening process by the Washington County Maternal Child Health home-visiting team.

Challenges/emerging issues

- Deschutes County noted difficulty motivating staff to ask the One Key Question of non-pregnant or postpartum

clients and they were unable to separate the data to just pregnant and post-partum clients.
- Klamath Tribes reported having issues with the mothers completing the checklists and losing them.
- Washington County had difficulties separating out the target population precisely. Also, they had planned on engaging with One Key Question in the pregnancy intention screening, but it was cost prohibitive.

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

ESM (1.2): Number of women reached using traditional and social marketing campaigns such as CDC Show Your Love brochures, social media including Facebook and Twitter, attendance at health fairs and community meetings, and public service announcements. (Objective: 700)

Accomplishments

State Level
- Supported shared learning of best practices and lessons learned through Well Woman Care learning collaborative meetings that included Title V grantees and partners.
- Established a committee to plan for outreach activities including a Governor's proclamation for Women's Health Week 2020.

Local Level
- The Confederated Tribes of Umatilla Indian Reservation developed an all-encompassing, culturally appropriate women's health brochure to be distributed throughout Yellowhawk Tribal Health Center.
- The Confederated Tribes of Umatilla Indian Reservation developed a women's health event that promoted the woman's traditional role historically within CTUIR and tied it to the importance of the health and wellbeing within the community, which reached 2,000 people.
- The Confederated Tribes of Umatilla Indian Reservation developed a digital story focused on traditional/medicinal plants that women historically gathered to incorporate into modern-day preventative care.
- The Confederated Tribes of Umatilla Indian Reservation – Yellowhawk, in October 2018, successfully implemented an Indigenous Pink Breast Cancer Awareness campaign, including Breast Cancer Walks weekly and an event "Light Up the Night" walk with 75 participants. They promoted American Indian/Alaska Natives breast cancer statistics in the local newspaper and social media outlets and encourage patients to participate in the Yellowhawk mammogram screening. In October the local tribal radio station, KCUW, promoted "Turn Up the Pink" music to rally against breast cancer. Yellowhawk also developed a breastfeeding campaign with breastfeeding statistics, health benefits, and local resources, including offering four breastfeeding classes, with photos of mothers breastfeeding to normalize breastfeeding in the community.
- Malheur County developed informational slides on the well woman care that were shared on the TV in the waiting room for clinic services and WIC.
- Marion County built a well woman social media campaign using the hashtag wellwomanwednesday#. They were able to grow their followers from 1500 to 2300.
- Marion County participated in a health fair at the local Teen Parent Program. Thirty-five teens stopped by the booth and received educational materials about Well Woman Care and Reproductive Life Planning.

Challenges/emerging issues

The resources and expertise it takes to build a robust and meaningful public awareness campaign remains a challenge. It is also difficult to measure the impact of public awareness campaigns. Some local grantees described difficulty engaging clinical providers in their efforts.

Progress on ESMs

At least 2085 women were 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. ESM will remain in place. We were able to track outreach in some areas but need to work on improved methods for tracking reach for social media campaigns.

Strategy #3: Provide education/training on preconception/ interconception and well woman care for health care providers.

ESM (1.3): Percent of local health departments receiving technical assistance to support implementation of the well woman care priority area. (Objective: 100)

Accomplishments

State Level

- Facilitated well woman care learning collaborative meetings for grantees and partners.
- Technical assistance offered to all grantees.

Local Level

- Crook County sent 4 WIC/Family Planning staff to training update for One Key Question /Power to Decide and then were able to train all MCH home visiting workers.
- Marion County provided leadership to a local Maternal Child Health Coalition that selected reproductive life planning as one of four priority areas. They worked on creating and planning for a survey for local providers/agencies that will be used to drive messaging and campaigns moving forward.
- Marion County completed four different education-based trainings, 2 for providers and 2 for the community. At each training Well Woman Care messaging and Reproductive Life Planning materials were shared.
- All local grantees were given the opportunity for technical assistance and shared learning through learning collaborative meetings. Local grantees were able to train their staff and engage in training and community efforts with other providers of MCH services.

Challenges/emerging issues

- Family Building Block home visitors shared that reproductive health messaging would be difficult for them to deliver because they do not give medical advice.
- It is difficult to measure the impact of reproductive health messaging on behavior change.
- Transitioning away from use of the One Key Question due to training cost concerns.
- Crook County had challenges with staff turnover impacting ability to collect data on utilization of the One Key Question/Power to Decide metric and providers who did not like the One Key Question and felt it was insensitive for some groups.

Progress on ESMs

100% of local health departments received some amount of technical assistance. ESM will continue next year.

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

ESM (1.5): Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services. (Objective: 15)

Accomplishments

State Level

- Coordinated and collaborated with state Reproductive Health Program to integrate support for well woman care in family planning clinics.

Local Level

- Baker County utilized EHR recall to remind women that they are due for an annual exam and outreach to the Hispanic population through collaboration with school district.
- Baker County engaged with the Baker 5J School District Hispanic Interpreter to increase and improve outreach to the Hispanic population. Through this partnership, Baker County was able to provide a mother-daughter education class at the high school that included Spanish interpretation. Participants were given gift bags with hygiene products, and outreach materials promoting well woman exams at the Baker County Health Department.
- Union County developed a plan to implement pregnancy intention screening via the One Key Question among women of reproductive age who were clients of the STD clinic. This included educating clients on the importance of well-woman visits, pre/interconception care and providing appropriate referrals.
- Washington County in conjunction with Washington County Public Health Division's reproductive health program educator, established the Reproductive Health Coalition of Washington County, to determine collective goals and strategies to promote reproductive health and well woman care within the community.
- Washington County through the newly established Reproductive Health Coalition of Washington County, successfully brought the three reproductive health service providers in the county together to work collectively on improving access to reproductive health services. They planned and implemented a "Youth Access Ambassadors" event, which focused on training youth to share information about accessing reproductive

health services with their friends, families, and community; reaching over 50 youth. Also, they presented information to the Washington County Board of Commissioners on reproductive health issues and concerns.

Challenges/emerging issues

- Effective contraceptive use will no longer be an incentive measure for Oregon's Coordinated Care Organizations.
- Baker County had difficulties with provider illness which inhibited its ability to provide family planning appointments, during June 2018 – June 2019, which made providing well woman exams difficult.
- Union County did not reach their goal of 100% but made gains. There is difficulty in documenting that the One Key Question is asked so that it is recorded on the reports. The question is asked on the intake form but there is a recording /reporting issue.
- Washington County had difficulty keeping community partners engagement up. Most meetings were well attended but a couple had low turnout.

Progress on ESMs

38 local partners were identified. Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services. (Objective: 15)

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

Accomplishments

State Level

- Partnered with the OHA Transformation Center to develop a guidance document and host a 6-part Postpartum Care online learning series for Oregon's Coordinated Care Organizations (CCOs). Postpartum Care became a CCO incentive metric beginning in 2019. The learning series and other supports provided were intended to assist CCOs in meeting their metric targets while enhancing engagement of women in postpartum and perinatal care through strategies that can be applied at the system and clinic levels, and which support collaboration and partnership between various entities serving pregnant and postpartum women.
- Continued to build relationships with Oregon's CCOs.
- Supported MCH Nurse Home Visiting programs in quality improvement activities to improve attendance at postpartum care visits.

Local Level

- The Confederated Tribes of Warm Springs implemented a plan for the MCH nurse to facilitate scheduling a postpartum check with a provider during the postpartum home visit.
- The Confederate Tribes of Warm Springs reported that their postpartum mothers were very receptive to the MCH nursing making appointments for them. This also allowed the nurse to follow up on the appointment to remind clients and facilitate rides or assist with other issues. MCH worked with WIC to try to schedule appoints on the same day as postpartum appointments to decrease the number of trips to the clinic.

Challenges/emerging issues

- The postpartum metric for the CCOs doesn't align with the 2018 guidance from ACOG on post-partum care.
- The Confederated Tribes of Warm Springs had challenges with staff turnover, specifically the Director of Nursing position was vacant, and the interim staff were reluctant to make changes to how postpartum appointments were scheduled. The MCH nurse position was vacant for five months.

Oral Health (Women) 2019 Report

National Performance Measure (#13)

Percent of women who had a dental visit during pregnancy.

Interpretation of Data

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

pregnancy from 2016 to 2017.

Strategies and Activities

Strategy #1: Integrate oral health into state Maternal and Child Health (MCH), Health Promotion, and Chronic Disease Prevention Programs.

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

Accomplishments

- Developed monthly oral health messages that were posted on the MCH and Public Health Division's Twitter and Facebook accounts.
- Developed presentation and fact sheets for the Oregon MothersCare Program and 211 Info to assist their staff in educating clients on the importance of oral health and making dental referrals.
- Hosted a site visit with Tim Ricks, DMD, MPH, Rear Admiral, Assistant Surgeon General on September 23, 2019. Activities included:
    - Dr. Ricks met with senior leadership where oral health integration efforts into Oregon's system of care were highlighted.
    - Live streamed a presentation where the public could learn about the upcoming Surgeon General's Report on Oral Health, and successes and challenges of oral health integration nationally and in Oregon.
    - Toured Multnomah County Health Department's Northeast Dental Clinic as an example of successful oral health integration and reducing opioid prescriptions by dental providers.
- The Oral Health Unit presented posters and exhibited at the 2018 Oregon Rural Health Conference in October 2018, Oregon Oral Health Coalition's (OrOHC) 2018 Fall Conference in November 2018, and the WIC Statewide Meeting in May 2019. The posters utilized described the link between oral health and chronic diseases and how oral health can be integrated into chronic disease systems of care. Oral health educational materials were disseminated at the conferences.

Challenges/emerging issues

The Oral Health Unit intended to collaborate with the Health Promotion and Chronic Disease Prevention Section but did not have enough capacity to establish this relationship. Funding outside of Title V is necessary to support their grantees, and no grant opportunities were available during the grant period.

Progress on ESMs

Two fact sheets, three posters, and three presentations were developed.

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

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

Accomplishments

- Eleven grantees – ten local health agencies and one tribe – were provided with individualized technical assistance throughout the grant year.

- Held the training, *"Introduction to Health Literacy, Plan Language and Design"*, on March 19, 2019 for Title V MCH grantees and school dental sealant programs. Participants learned how to better communicate with the communities we serve. The examples used during the training were oral health related.
- The Oral Health Unit collaborated with the Oregon Oral Health Coalition to promote the Maternity: Teeth for Two training program with grantees. The Maternity: Teeth for Two curriculum informs pregnant women and medical professionals, such as public health nurses, on the importance of oral health during pregnancy. It trains health professionals on how to integrate oral health education and referrals into primary and prenatal care.

Challenges/emerging issues
No challenges to report

Progress on ESMs
Eleven Title V local grantees were provided with technical assistance to promote dental visits for pregnant women.

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.

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

Challenges/emerging issues
The Oral Health Unit would like to increase its capacity to decrease oral health racial and ethnic disparities in Oregon. In 2018, the Unit applied for a 2018 Dental Trade Alliance (DTA) Foundation grant titled, *"Understanding Barriers to Optimal Oral Health in Oregon's Minority Communities,*" but did not receive funding. The grant would have supported conducting a panel survey with Hispanic/Latino, Black/African American, and American Indian/Alaska Native racial and ethnic groups. The findings would have been used to develop a health equity communications plan; test oral health messages with partners in the specific racial and ethnic communities; and develop social media content and materials targeted to each specific racial/ethnic population.

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

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

Accomplishments
- Benton, Linn, and Lincoln Counties provided oral health education and referrals for dental care in their home visiting programs (Babies First! and Maternity Case Management). They also provided First Tooth and Maternity: Teeth for Two trainings for home visiting staff.
- Morrow County provided oral health education and referral case management for their home visiting clients in the CaCoon and NFP programs.

Challenges/emerging issues
Some public health nurses are hesitant to apply fluoride varnish during home visits. Counties intend to provide regular oral health and fluoride varnish training so that staff become more comfortable.

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

Accomplishments
- Benton, Linn, and Lincoln Counties provided culturally appropriate oral health education to all clients (e.g. WIC, home visiting, etc.).
- Clackamas County incorporated oral health education and referral services into all programs administered such as WIC, school-based health centers and the federally qualified health center (FQHC).
- Douglas County collaborated with Advantage Dental to provide oral health education and preventive services at two community baby showers, a well-child clinic hosted by a local family practice, and the Douglas County fair. They also worked with the WIC program to provide xylitol kits and oral health education to 125 pregnant and postpartum women as part of an “Oral Health for Pregnant Women Project”.
- Hood River County provided oral health education and referrals to dental care for home visit and WIC clients.
- Klamath County facilitated the Klamath Basin Oral Health Coalition and developed a three-year strategic plan, which included specific strategies for pregnant and postpartum women.

Challenges/emerging issues
Counties have done a good job in referring clients for dental care, but it is difficult to track whether those clients followed through on the referral. It is challenging to build a system that tracks closed-loop dental referrals.

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

Accomplishments
- Jackson County developed a training and outreach plan to incorporate ACOG oral health recommendations for pregnant women into the medical community.
- Jackson County attended an OB/GYN Section meeting for Joint Medical OB Staff Providers (Asante and Providence Medford Medical Center) and gained providers support to provide oral health education in their offices and through home visitors.

Challenges/emerging issues
Jackson County had difficulties gaining access to specific OBGYN offices in their area. They plan to work with their Coordinated Care Organization (Medicaid) on future partnerships.

Smoking (Women) 2019 Report

National Performance Measure (#14A)
Percent of women who smoke during pregnancy

Interpretation of Data
The rate of smoking during pregnancy has steadily decreased in Oregon, from 11.3% in 2010 to 9.3% in 2017. This has mirrored a steady decline nationally, although Oregon values in this performance measure are consistently higher than the national average.

Strategies and Activities
Strategy #1: 5As Intervention and Quit Line Referral (or other customized Evidence-Informed Program) within MCH Programs including Home Visiting, Oregon MothersCare, Family Planning, and WIC (if applicable).

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.

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

Local Level

- In Columbia County, 84% of home visiting clients who smoke received a 5As intervention and 84% also received a referral to the Quit Line, provider, or local tobacco cessation specialist. This process was made easier by incorporating smoking cessation resources into home visiting handouts.
- The Confederated Tribes of the Umatilla Indian Reservation provided 5As intervention during visits at the Yellowhawk clinic for 20% of women ages 13-44 who smoke tobacco.
- The Coquille Indian Tribe worked with multiple partners to improve the tribal clinic's policies and procedures related to commercial tobacco screening and intervention. Updates were made to the clinic's EHR to enable providers to document tobacco use, intervention and follow-up at each visit.
- Harney County worked to develop a policy agenda to decrease youth exposure to tobacco products and decrease the likelihood of initiation and use. As part of this effort, staff provided presentations at local schools, reaching over 380 youth. Staff also continued work to make all county properties tobacco free, including the county fairgrounds.
- In Lane County, 53% of home visiting clients who smoke received a 5As intervention and 100% received education on tobacco cessation benefits. Oregon MothersCare (OMC) clients also received information on tobacco cessation benefits. The local Quit Tobacco In Pregnancy (QTIP) program provides support and incentives to quit tobacco.
- Tillamook County's home visiting program worked to use 5As screening, education and referral for pregnant clients who smoke, referred clients to the Quit Line, and enrolled pregnant people in the tobacco cessation incentive program with Columbia Pacific Coordinated Care Organization. As a result of the incentive program, 10 clients quit tobacco completely and 5 cut down on their tobacco use during pregnancy.
- Yamhill County implemented the Healthy Futures smoking cessation program in partnership with a Behaviorist at Valley Women's Health prenatal care practice. Thirty percent of pregnant clients continued to be tobacco free at their 3-month postpartum visit.

Challenges/emerging issues

Local Level

- The MCH Program has a focus on home visiting and is therefore not able to see all pregnant people who smoke. The result is that not all clients receive referrals to providers and may miss getting interventions. Grantees have reported challenges getting pregnant clients to accept referrals either because they are resistant or because they have already received a referral from their primary care provider. Training in motivational interviewing and trauma-informed practices may support grantees to provide these services to pregnant clients.

- Several local grantees also reported challenges with staff turnover, which hindered implementation of smoking cessation efforts.

State Level
The lead for the Smoking priority at the State Maternal & Child Health program retired in spring 2019. Her replacement was not hired until mid-October 2019. Unfortunately, this gap in coverage impacted our ability to complete some of the State level activities we had planned for this grant cycle.

Progress on ESMs
Five out of seven (71%) Title V grantees who selected smoking as a priority implemented 5As with their clients.

All Title V grantees who selected smoking as a priority area (100%) received at least two technical assistance contacts with the State Title V program.

Strategy #2: Promote health insurance coverage benefits for pregnant and postpartum women and promote their utilization.

Accomplishments
Local Level
- The Title V-funded MCH Program, Oregon MothersCare (OMC), a patient navigation program for pregnant people, is conducted at the local level by Smoking Priority county programs as well as those who have not chosen the Smoking Priority. Some Smoking Priority Counties have incorporated OMC into their Title V work plans. However, all OMC Programs are required to provide screening and intervention for their pregnant clients who smoke. Nearly 350 pregnant people received smoking cessation education and referral from an OMC site during the reporting period.

Challenges/emerging issues
The lead for the Smoking priority at the State Maternal & Child Health program retired in spring 2019. Her replacement was not hired until mid-October 2019. Unfortunately, this gap in coverage impacted our ability to complete some of the State level activities we had planned for this grant cycle.

DOMAIN – Women and Maternal Health

2021 Application Year

Well-Woman Care 2021 Plan

National Performance Measure (#1)
Percent of women with a past year preventive visit.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Note also: due to COVID-19, submission of local Title V annual plans has been delayed, so we do not know which local grantees will select this priority and are unable to write about specific local level activities planned for the upcoming year at this time.

Planned strategies, ESMs, and activities for October 2020 – September 2021
Strategy #1: Case-management to improve utilization of well-woman care

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities - State Level

- Provide training and technical assistance, data collection, and quality improvement activities for the MCH Nurse Home Visiting and MIECHV-funded Home Visiting programs. A key activity of the home visiting programs is to provide case management to assist women in establishing a medical home and accessing preventive care.
- Explore opportunities to collaborate with Oregon Mother's Care program on case management activities.

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

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Support shared learning of best practices and lessons learned through Well Woman Care learning collaborative meetings that included Title V grantees and partners.
- Work with a committee to plan for outreach activities for Women's Health Week 2021.
- Seek out guidance and partnership with agencies communications team.

ESM: 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. (Objective: 1000)

Strategy #3: Provide education/training on preconception/ interconception and well woman care for health care providers.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Explore interest in continuation of learning collaborative meetings.
- Provide technical assistance and support to local grantees.
- Participate in the Oregon Perinatal Collaborative and pursue shared activities.

ESM: Percent of local health departments receiving technical assistance to support implementation of the well woman care priority area. (Objective: 100)

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

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Coordination and collaboration with the state Reproductive Health Program.

ESM: Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services. (Objective: 20)

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

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Provide support and expertise to developing and implementing recommendations from Oregon's Maternal Mortality and Morbidity Review Committee.
- Provide training and technical assistance to Oregon's MCH Nurse Home Visiting Programs.
- Provide technical assistance to Oregon's CCOs around the post-partum care incentive metric.
- Provide subject matter expertise to surveillance activities through participation in PRAMS team.

Critical Partnerships

- Local grantees
- The Oregon Perinatal Collaborative
- Oregon's Healthy Start programs
- Other public health programs including reproductive health, WIC, MIECHV and MCH Nurse Home Visiting, the Maternal Mortality and Morbidity Committee, PRAMS and Oregon Mothers Care

Perinatal/Infant Health

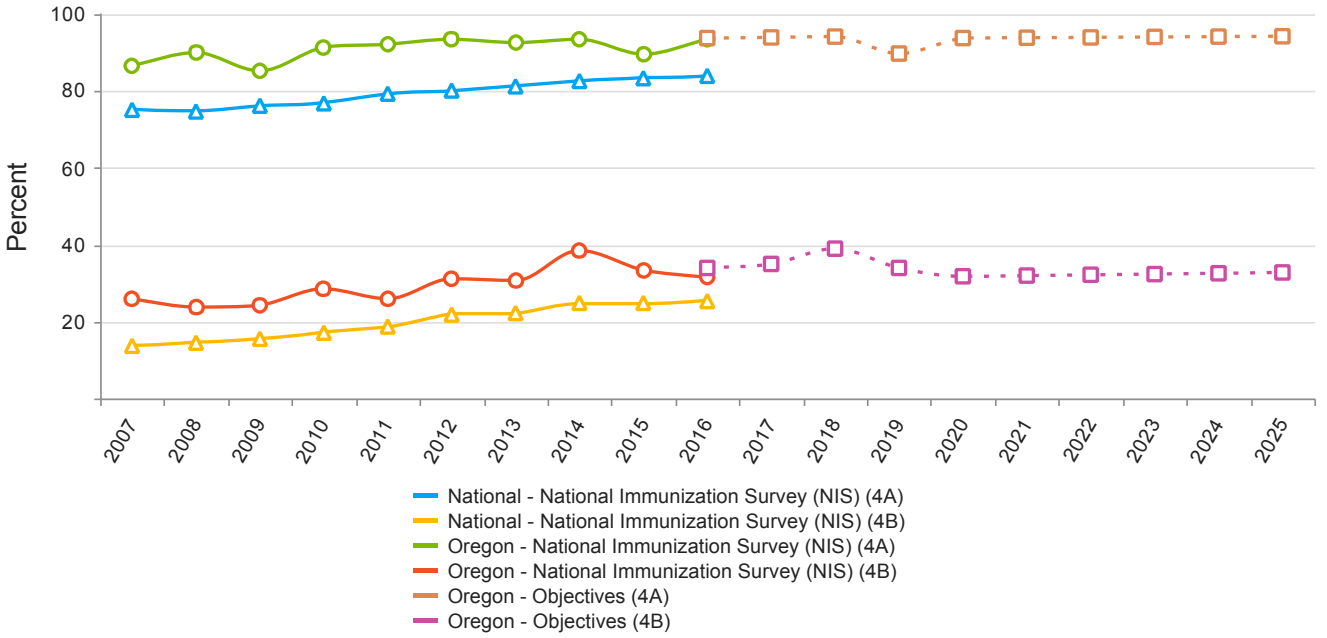
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	5.3	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	1.7	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	77.9	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**
Annual Objective	93.6	93.8	94	89.6
Annual Indicator	92.5	93.2	89.4	93.5
Numerator	37,456	44,505	38,219	35,799
Denominator	40,509	47,759	42,729	38,275
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	93.6	93.7	93.8	93.9	94.0	94.1

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

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

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	31.8	32.0	32.2	32.4	32.6	32.8

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Number of health care providers trained in breastfeeding support

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective		50	50
Annual Indicator	112	50	11
Numerator			
Denominator			
Data Source	Grantee annual report on strategy measures	Grantee annual report on strategy measures	Grantee annual report on strategy measures
Data Source Year	2017	2018	2091
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

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
Evaluate breastfeeding evidence-informed strategies for policy, system and environmental change impact
Provide technical assistance to local Title V grantees implementing strategies to support breastfeeding in their communities.
Increase the number of fathers, non-nursing partner and family members, especially grandmothers, who learn about the importance of breastfeeding.
Fill unmet needs for peer support of breastfeeding.
Educate pregnant women about breastfeeding.
Increase workforce support for breastfeeding through training and access to high quality services.
Increase access to workplace breastfeeding support.
Increase the support of breastfeeding at childcare settings through policy, training and workforce development.

ESMs	Status
ESM 4.1 - Number of health care providers trained in breastfeeding support	Active

NOMs

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

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

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

2016-2020: National Performance Measures

DOMAIN – Perinatal and Infant Health

2019 Annual Report

Breastfeeding 2019 Report

National Performance Measure (#4)

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

Interpretation of Data

A) The rate of breastfeeding initiation in Oregon has consistently surpassed the national average from 89.4% in 2015 to 94% in 2016.
B) The rate of exclusive breastfeeding through 6 months in Oregon has also consistently surpassed the national average. Although this rate has slightly decreased over past two years, and from 33.4% in 2015 to 32% in 2016, there has been an overall upward trend since 2010. Oregon continues to have state policies and practices in place that support breastfeeding.

Strategies and Activities

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

Accomplishments

- Clatsop County – held two community-wide baby showers, engaging more than 8 community partners in planning and hosting events.
- Coos County – produced 6 breastfeeding videos engaging childcare and healthcare providers, dads, grandparents and peer mothers. Shared on social media and with community providers. Developed a breastfeeding basics booklet in both English and Spanish that addresses concerns identified in a community survey.

Challenges/emerging issues

Data collection proved to be challenging across the board. Clatsop County was not able to get data determining class attendance of pregnant and breastfeeding family members as classes were provided by a doula outside of the health department.

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

Accomplishments

- Clackamas County – exceeded goal of offering at least 30 prenatal peer support groups for a total of 30 in English and 18 in Spanish. Twelve staff received training and developed promotional “elevator speeches” for Breastfeeding Peer Counselor program. This led to an update of the counties’ breastfeeding webpage.
- Jackson County – met goal to hold peer support group classes for non-WIC eligible moms for total of 17 sessions. Partners who promoted classes included the CCO and primary care providers.
- Multnomah County – after much staff turnover hired an African American/Black (AA/B) Breastfeeding Peer Counselor; increased moms receiving AA/B culturally specific lactation services by 4%. Strengthened partnerships resulting in 3 written partner agreements. Implemented county Babies at Work policy.
- Cow Creek Tribe – partnered with another department and was instrumental in coordination of breastfeeding support follow-up activities with mothers of babies born within tribal service area. Came close to goal-reached 70% of families (80% goal). Worked with Blue Zones Umpqua to draft a breastfeeding policy for staff and patients.

Challenges/emerging issues
Staff turnover and data system issues were consistent challenges. Clackamas County's rate for prenatal classes continues to be low at 60%; continue to strategize how to increase prenatal class participation. Jackson County's class attendance was challenging during part of the year due to staff turnover. Multnomah County dealt with staff turnover and leave across programs, which continues to be challenging; turnover impacts program caseloads. Cow Creek Tribe had significant staff turnover (three coordinators in one year), which greatly impacted ability to consistently track interactions with new mothers in tribal service area. They don't have a robust data system that would allow outcome measures to be meaningful and accurate. They lost some breastfeeding data as migration to new EHR platform occurred.

Strategy #3: Educate pregnant women about breastfeeding.

Accomplishments
- Clackamas County – developed plan for offering breastfeeding education that assures every mom can find an option ranging from in-person groups and classes to online education.
- Clatsop County – more pregnant women in community are being educated about breastfeeding, and discussions in local breastfeeding coalition have resulted in a doula providing education classes at the hospital.
- Columbia County – increased breastfeeding discussions and interventions with home visiting clients from 62% to 94% of clients.
- Grant County – worked with community partners to set up breastfeeding collaboration to help new moms with lactation; created brochure for community partner "new mom" packets, and warm hand-offs are provided by community health workers.
- Harney County – Babies First nurse was trained to provide breastfeeding education.
- Tillamook County – every pregnant woman through Maternity Case Management received breastfeeding education resulting in most women breastfeeding their infants. Formal agreements were implemented with partners supporting breastfeeding education and messages.
- Washington County – staff completed a training on breastfeeding during emergency situations.
- Warm Springs Tribe – despite being without an MCH nurse for 5 months, the number infants fully breastfed at least 6 months held steady at 41%. Community partners were engaged to provide breastfeeding education while we continued to provide breastfeeding supplies to clients. After being hired, the new nurse connected with parents individually and gave incentives based on months fully breastfeeding which was a good opportunity for relationship building.

Challenges/emerging issues
The time needed to develop partnerships, data system issues, and staff turnover were consistent challenges. Clackamas County's class enrollment for breastfeeding classes continues to be low and continue to strategize ways to increase class participation. Clatsop County struggled with the time it takes to engage partners about providing streamlined breastfeeding education and support. Columbia County found getting accurate data in database challenging. Grant County struggled to establish a written formal agreement with hospital for provision of lactation services; some difficulty with working with some community partners on collaborative efforts. Harney County had staff turnover as Babies First nurse quit before education of pregnant moms could be provided and Babies First program had to be discontinued altogether. Washington County saw that 60% of MCH clients received breastfeeding education which did not meet goal of 100%. Challenge is to help staff understand the importance of breastfeeding promotion while still supporting mothers in whatever feeding decision they make. One possible reason for a lower than expected number is related to an issue with electronic medical record system. Warm Springs Tribe saw that the 6-month breastfeeding club was sparsely attended despite incentives and healthy snacks for participants. This was even more challenging when the MCH nurse retired and attendance never recovered when new MCH nurse was hired.

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

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

Accomplishments

State Level

11 health care providers received advanced training in breastfeeding support: 3 achieved IBCLC certification, 2 achieved CLC certification, 1 achieved CLE certification, and 5 attended an in-depth clinical breastfeeding course, IBALE formerly Breastfeeding Champions.

Local Level

- Clatsop County – One nurse received training and support to obtain her IBCLC credential.
- Columbia County – One home visit nurse earned Certified Lactation Counselor credential and 1 WIC staff earned Certified Lactation Educator credential. None of the staff completed the IBCLC requirements. Since WIC shares an office with Nurse Home Visiting and is often consulted on breastfeeding issues for home visiting client, she was supported for the CLE.
- Douglas County – One nurse became IBCLC credentialed, and one IBCLC staff is mentoring the local hospital labor and delivery nurses. WIC partner is preparing a staff member who currently has a CLC to become an IBCLC. 11 of 16 staff members meet minimum competency in breastfeeding.
- Jackson County – One home visit nurse obtained IBCLC with mentoring support from the WIC IBCLC. Another nurse obtained CLC certification in breastfeeding; the goal was for both nurses to obtain IBCLC but one of them moved so the new nurse was able to get her CLC instead.
- Yamhill County – Five of six nurse staff completed advanced breastfeeding training (IBALE – formerly Breastfeeding Champions). Working with other home visiting programs to develop shared messaging strategies.

Challenges/emerging issues

Challenges include staff turnover and training time. State Level issues included local level staff capacity did not allow Breastfeeding Champion trainings beyond one region. Staff turnover across counties highlight need for access to continuous high-quality training in lactation care for home visit nurses. Columbia County did not meet goal of home visit nurse to become an IBCLC (switched to CLC instead). It was challenging to find training time in busy schedule of home visit nurse, and there was high staff turnover. In order to provide high quality lactation training in the county, support of community partners and local providers is essential. Douglas County saw continued turnover of staff in partner agencies who have been certified as educators and counselors (CLE & CLC). Jackson County also struggled with staff turnover. Yamhill County had one nurse on vacation during advanced breastfeeding training; working to get her trained online.

Progress on ESMs

Eleven health care providers in local health agencies received advanced training in breastfeeding support, which includes three who obtained IBCLC credential.

Strategy #5: Increase access to workplace breastfeeding support.

ESM (4.1 and 4.2):

- Number of government agencies partnered with to implement breastfeeding support policy
- Number of hits to state intranet website with policy on breastfeeding in the workplace.

Accomplishments

State Level

Provided technical assistance to business and agency requests about implementation of breastfeeding workplace support laws and policies.

Local Level

Josephine County – In partnership with WIC and local breastfeeding coalition, information about breastfeeding laws and lactation services guidance was provided to health insurance company to provide breast pumps for women returning to work, as well as how to refer clients needing assistance. A policy for workplace breastfeeding support is in process for one local company.

Challenges/emerging issues

Main challenge was staff capacity. At the state level, cross-agency health improvement plan group was disbanded and programs implementing workplace support policy have not had capacity to further the dissemination of tools or evaluate guidance and implementation of the policy. For ESM, unable to obtain website data as another agency

manages this and web platform has changed. At the local level, due to loss of the Healthy Start grant for 2018-2019, Josephine County did not have capacity to reach out individually to business human resource departments like initially planned to support developing breastfeeding workplace support policies.

Progress on ESMs

4.1 remains the same as previous years. 4.2 Unable to obtain website data as another agency manages this and web platform has changed.

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

Accomplishments

- Clackamas County – Leveraging highly skilled WIC staff with childcare and breastfeeding expertise to develop a survey about childcare breastfeeding policies and practices and collaborating with the Early Learning Hub to advise and inform survey development, implementation and next steps. Online survey was sent to 156 childcare providers.
- Josephine County – The public health RD worked with OSU Extension RD by providing up-to-date resources for the childcare provider training on developmentally appropriate feeding practices. Through these resources and additional community partnerships, training was provided at the Southern Oregon Childhood Educators Conference in Feb 2019.

Challenges/emerging issues

Staff turnover was the biggest challenge. Clackamas County had limited staffing and capacity, which proved challenging. A low survey response of 7% and not being able to get on the Early Learning Hub agenda due to competing priorities were also issues. In Josephine County, due to loss of Healthy Start grant during 2018-2019 training was not able to be provided directly to childcare providers. This limitation was addressed by collaborating with additional community partners to provide training through other venues. However, fewer local businesses and childcare providers within Josephine County were reached but a much broader audience throughout Southern Oregon was reached instead.

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

Accomplishments

Technical assistance was provided to all grantees. Individual TA was provided when requested by the agency. Resources and tools were shared with all grantees such as online lactation training opportunities, webinars on breastfeeding in the community, and safe sleep and breastfeeding. The Public Health Division breastfeeding webpages underwent a comprehensive review and update.

Challenges/emerging issues

Getting consistent data for similar strategies across agencies remains challenging. Continuing work in this area to improve the ability to quantify data for some of the strategies.

DOMAIN – Perinatal and Infant Health

2021 Application Year

Breastfeeding 2021 Plan

National Performance Measure (#4)

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

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Note also: due to COVID-19, submission of local Title V annual plans has been delayed, so we do not know which local grantees will select this priority and are unable to write about specific local level activities planned for the upcoming year at this time.

Planned strategies, ESMs, and activities for October 2020 – September 2021

Strategy #1: Evaluate breastfeeding evidence-informed strategies for policy, system and environmental change impact.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Develop evaluation plan of state and local breastfeeding strategies over past five years

Strategy #2: Provide technical assistance to local Title V Grantees implementing strategies to support breastfeeding in their communities.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Assess grantee needs related to technical assistance and networking.
- Update breastfeeding brief to include current data and strategy evidence.
- Identify or develop resources, including developing or strengthening community partnerships, for dissemination to local grantees.
- Provide and/or facilitate access to technical assistance for local grantees.

Strategy #3: Increase the number of fathers, non-nursing partner and family members, especially grandmothers, who learn about the importance of breastfeeding.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Share resources among grantees that address this strategy.

Strategy #4: Fill unmet needs for peer support of breastfeeding.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Share resources among grantees that address this strategy.

Strategy #5: Educate pregnant women about breastfeeding.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Share resources among grantees that address this strategy.

Strategy #6: Increase workforce support for breastfeeding through training and access to high quality servicers.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Share resources among grantees that address this strategy.
- Promote breastfeeding training opportunities to increase minimum competencies for lactation care with public health partners, including home visiting programs.

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

Strategy #7: Increase access to workplace breastfeeding support.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Share resources among grantees that address this strategy.
- Update online web resources as needed to support implementation of Oregon workplace breastfeeding support laws among grantees and public health partners.

Strategy #8: Increase the support of breastfeeding at childcare settings through policy, training and workforce development.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Share resources among grantees that address this strategy.
- Partner with Early Learning Division programs to support breastfeeding in childcare settings through workforce training and policy.

Critical Partnerships

- Oregon WIC program
- Oregon home visiting programs (including Oregon Family Connects, Nurse Family Partnership, and MIECHV)
- OHA Health Systems Division
- Oregon Medical Assistance Program
- CCO Innovator Agents
- Coordinated Care Organizations
- Early Learning Division
- NW Portland Area Indian Health Board
- Nutrition Council of Oregon
- SNAP-Ed Advisory Council

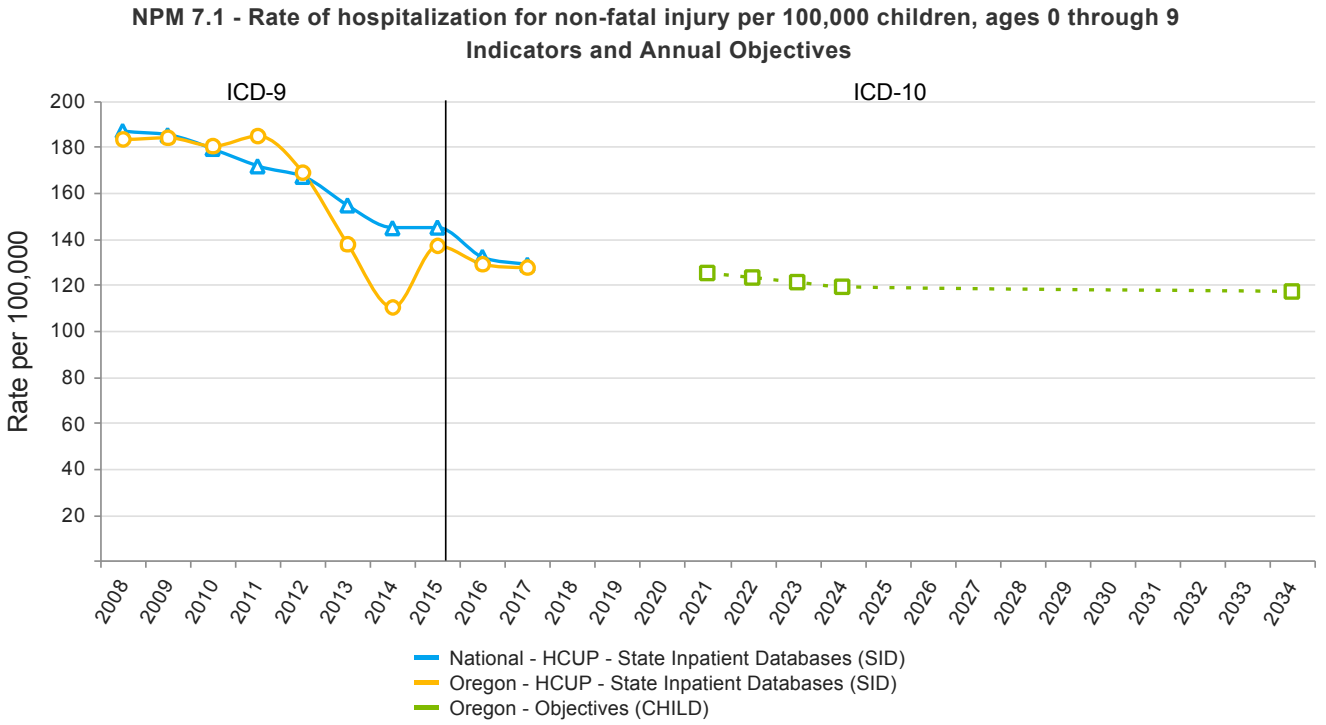
Child Health

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-2017	64.6	NPM 14.2
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	10.8	NPM 14.2
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	6.7 %	NPM 14.2
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	7.8 %	NPM 14.2
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	23.0 %	NPM 14.2
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	5.8	NPM 14.2
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	5.3	NPM 14.2
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	3.6	NPM 14.2
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	1.7	NPM 14.2
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	183.4	NPM 14.2
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	77.9	NPM 14.2
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2017_2018	12.7 %	NPM 13.2
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2018	11.8	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	31.0	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	9.9	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	15.7	NPM 7.1

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	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-2017_2018	11.7 %	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-2016	14.7 %	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
Annual Objective	
Annual Indicator	127.1
Numerator	609
Denominator	479,233
Data Source	SID-CHILD
Data Source Year	2017

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	125.0	123.0	121.0	119.0	117.0

Evidence-Based or –Informed Strategy Measures

ESM 7.1.1 - The number of strategies developed to address injury prevention among children across the spectrum of prevention

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	6.0	6.0	6.0	6.0	6.0

ESM 7.1.2 - The number of critical partners engaged in the development of upstream strategies to address child injury

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	8.0	8.0	8.0	8.0	8.0

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
Develop a cross-cutting injury prevention team to address upstream drivers of child injury, and link to work across population domains.
Develop evidence-based/informed strategies and measures for Oregon's Title V child injury work - including strategies that address upstream drivers of maternal, child and adolescent health. Engage local Title V grantees and family and community representatives in the process.
Develop and adopt a logic model for Oregon's cross-cutting child injury prevention Title V work.
Begin implementation and tracking of state level strategies for child injury prevention.
Provide technical assistance to Title V grantees on injury prevention strategies and measures, to inform local level Title V priority selection and planning.
Review local grantee annual plans and provide TA on implementing injury prevention strategies beginning July 2021..
Begin implementation of local level injury prevention strategies and tracking of outcomes.

ESMs	Status
ESM 7.1.1 - The number of strategies developed to address injury prevention among children across the spectrum of prevention	Active
ESM 7.1.2 - The number of critical partners engaged in the development of upstream strategies to address child injury	Active

NOMs

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

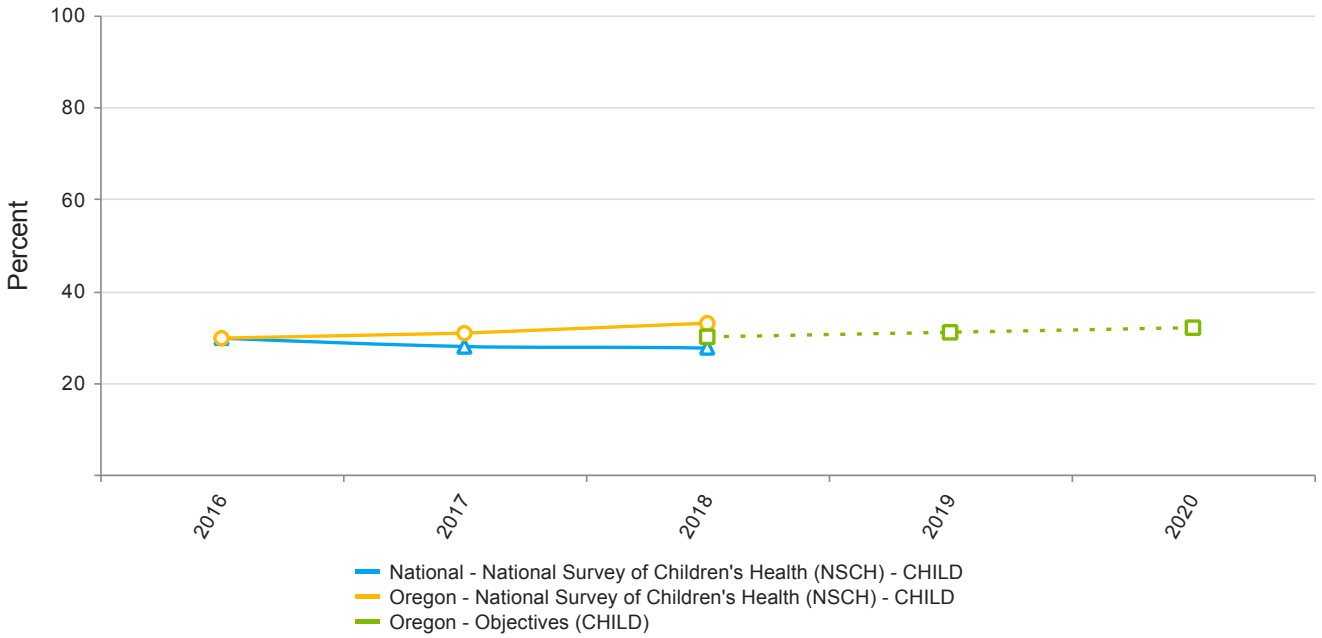
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

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**
Annual Objective			30	31
Annual Indicator		29.7	30.9	32.8
Numerator		88,810	91,445	98,353
Denominator		298,807	296,257	299,920
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018

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

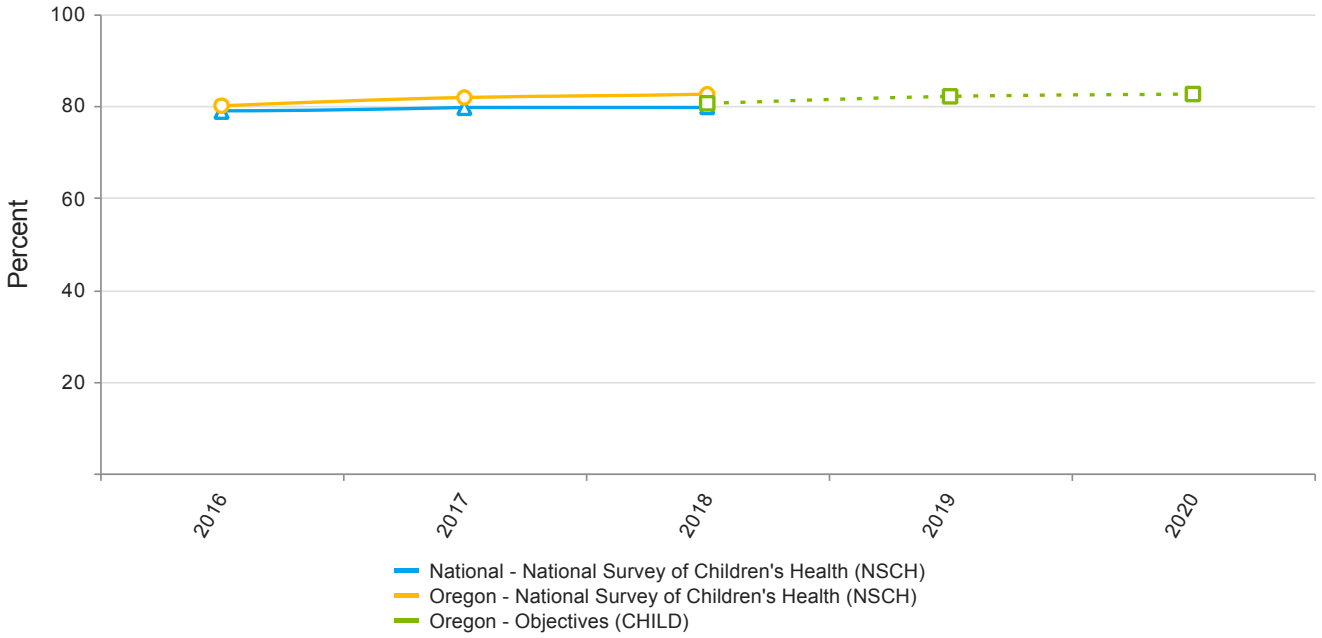
2016-2020: ESM 8.1.6 - Number of state early care and education systems addressed or influenced by Title V physical activity efforts during the grant year (CDC ECE Spectrum of Opportunities)

Measure Status:		**Active**	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			3
Annual Indicator			3
Numerator			
Denominator			
Data Source			State Tracking
Data Source Year			2019
Provisional or 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**
Annual Objective			3
Annual Indicator			3
Numerator			
Denominator			
Data Source			State Tracking
Data Source Year			2019
Provisional or 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**
Annual Objective			80.5	82
Annual Indicator		80.1	81.8	82.5
Numerator		647,060	662,516	671,363
Denominator		808,103	810,225	813,993
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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.

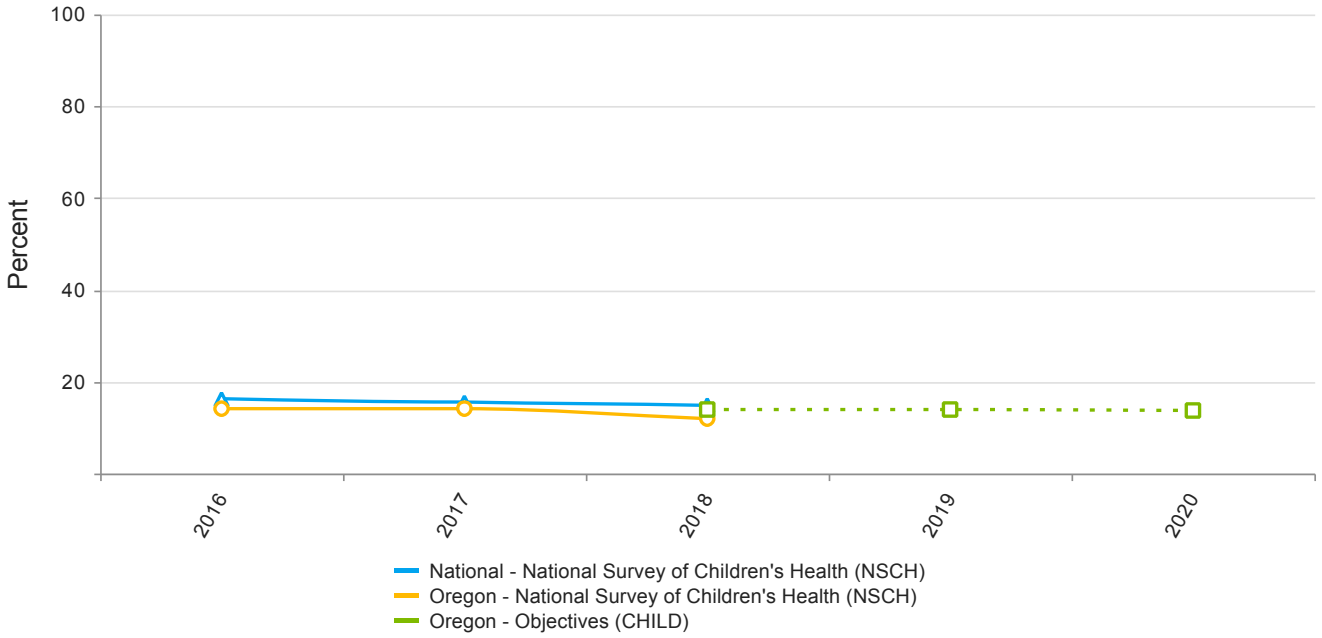
Measure Status:		**Active**	
State Provided Data			
	2017	**2018**	**2019**
Annual Objective	30	30	20
Annual Indicator	28	30	21
Numerator			
Denominator			
Data Source	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017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

Baseline data was not available/provided.

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**
Annual Objective			14	14
Annual Indicator		14.2	14.3	12.1
Numerator		118,807	121,667	104,275
Denominator		838,336	849,982	858,440
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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

Baseline data was not available/provided.

DOMAIN – Child Health

2019 Annual Report

Physical Activity for Children 2019 Report

National Performance Measure (#8)
Percent of children ages 6 through 11 years who are physically active at least 60 minutes per day.

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

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

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

Accomplishments
- Continued to provide 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.
- Continued to participate in Oregon State Health Improvement Plan Obesity priority workgroup to promote collaboration, life course perspective awareness and consistent, shared communications.

Challenges/emerging issues
Challenges related to advancing physical activity in childcare settings are primarily state level capacity limitations and difficulties influencing change in the early learning and education sectors. The early learning and education sectors are very focused on their own priorities, such as childcare quality, addressing sleep related deaths in care, academic readiness of children, issues of equity and supporting childcare providers in the field. Among the many other competing priorities, it is difficult to see improvement in healthy weight practices in childcare settings.

Progress on ESMs: 3 of 9

During this funding cycle, Oregon Title V has primarily focused on 3 of the 9 components of the Spectrum of Opportunities: improving licensing standards, increasing participation and retention in the Child and Adult Care Food Program, and supporting the development and availability of obesity prevention trainings in professional development systems. Title V has been an invested stakeholder and participant in efforts to update standards in Oregon's Quality Rating Improvement System, with little effect.

Strategy #2: Support physical activity before, during and after school.

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.

Accomplishments

State-Level

- Continued to co-lead Children's Healthy Weight CoIIN through the Association of State Public Health Nutritionists (ASPHN) in partnership with the Oregon Department of Education, Safe Routes to School National Partnership, and the Multnomah Education Service District. The team meets monthly to advance project components focused on understanding and addressing the challenges to meeting the state's physical education and activity law (Senate Bill 4). As part of this project, Title V staff helped craft a presentation abstract submitted to the Annual Oregon Conference of School Administrators, and developed a poster presented at the Association of State Public Health Nutritionists Annual Conference in June 2019 describing our efforts to date. In addition, Title V staff participated in planning the Oregon Healthy Schools Pro-Bowl training in July 2019 where school administrators, physical education teachers and nutrition directors joined for a day of intensive training and learning together.
- Participated in monthly Wellness in School Environments (WISE) coalition meetings.
- Provided technical assistance and support to local Title V partners to strengthen and improve school and district wellness policies.
- Participated with other PHD colleagues (1305 funded staff, Title V, WIC) in monthly meetings and coordinated efforts of State Health Improvement Plan Obesity team.
- Engaged in exploratory conversations with researchers and academics in Oregon and across the US to address CoIIN-identified gaps related to behavioral health and inclusive physical education and physical activity for children
- 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.

Local-Level

- Klamath County participated in community outreach events, participated with Blue Zones Partnership, supported schools and districts in adopting physical activity policies, and supported growth of walking school buses and other Safe Routes activities.
- Marion County developed and supported expansion of Safe Routes to School in neighborhoods, presentations and outreach to schools and districts.
- Polk County collaborated with community wide 5-2-1-0 campaign, partnered in outreach events at a local university and free clinic for physical activity promotion, promoted via social media.
- Jefferson County partnered with Warm Springs Tribe to convene Child Health Task Force, develop outreach and engagement opportunities for families in the community, participated in transportation meetings and conducted youth engagement to understand barriers among youth to active transportation choices.
- Confederated Tribes of the Umatilla Indian Reservation focused on improving places and access for physical activity, as well as conducting a broad tribal multi-sector community engagement event to learn from community members about visions for healthy spaces for youth.
- Wheeler County expanded yoga program started in rural schools, provided information about physical activity to providers and families at annual Health Fair.

Challenges/emerging issues

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

Through the Healthy Weight CoIIN project, our team has identified a potential gap in the research, teacher preparation, and training related to students with behavioral issues and dysregulation due to trauma, adversity and mental health issues being equitably served with physical education and activity. These children and youth may be unable to participate in physical education and activity due to their own traumatic experiences and can disrupt learning and participation for other students. Teachers need training and support to engage these students in appropriate and responsive ways that do not retraumatize, nor sideline students, but instead support equitable access. The team began formative work to identify an expert in inclusive physical activity/education and behavioral health who could provide training, technical assistance and consultation in Oregon. We attempted to craft a Title V Technical Assistance request for consultation and training to improve inclusive practices, but have not successfully found the right trainer/consultant, nor been able to adapt the need to the parameters of TA requests.

Progress on ESMs: 3 school districts – large urban, rural, and suburban

Strategy #3: Improve the physical environment for physical activity.

Accomplishments

State-Level

- Partnered with Jefferson County to support their efforts to create and convene listening sessions for youth engagement related to active transportation, built environment and physical activity; engaged Oregon Dairy and Nutrition Council and other state experts in participatory research to contribute their perspectives and suggestions to Jefferson County staff.
- Co-authored poster for Safe Kids PrevCon describing rates of child injuries and fatalities in Oregon over time, including pedestrian, bicycle, other wheeled conveyances, and sports-related injuries, which are impacted by the physical and built environment.
- Annual participation as member of Oregon School Wellness Awards Blue Ribbon Panel which solicits, reviews and selects schools to receive wellness awards based on commitments and investments in student and staff health. Award money is typically used to improve the physical environments of the schools for physical activity and wellness.

Local-Level

- Marion County continues to be a leader in active transportation promotion and built environment improvements to support health. During the reporting year, they engaged with local partners to continue long term planning for traffic calming and bike/pedestrian infrastructure, as well as supporting local schools and districts in applying for funding for infrastructure projects.

Challenges/emerging issues
Nothing to report.

Strategy #4: Increase safe and active transportation options.

Accomplishments

- Marion County continues to be a leader in active transportation promotion and built environment improvements to support health. During the reporting year, they engaged with local partners to continue long term planning for traffic calming and bike/pedestrian infrastructure, as well as supporting local schools and districts in applying for funding for infrastructure projects.
- Jefferson County actively participated in local transportation and planning meetings, used data to identify hazardous zones where pedestrians and cyclists were exposed to vehicles moving at excess speeds, surveyed youth to better understand the culture around physical activity and active transportation in their community, and performed walkability assessments.

Challenges/emerging issues
Nothing to report.

Strategy #5: Provide technical assistance to local health agencies working on strategies to promote physical activity.

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

Accomplishments

- 100% of grantees were offered and received training and support related to school wellness policies, collaboration opportunities with school districts, and safe routes to schools during a webinar training held in March 2019.

Challenges/emerging issues
Nothing to report.

Progress on ESMs: 100%

Oral Health (Children) 2019 Report

National Performance Measure (#13)

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

Interpretation of Data

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

Strategies and Activities

Strategy #1: Integrate oral health into state Maternal and Child Health (MCH), Health Promotion, and Chronic Disease Prevention Programs.

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

Accomplishments

- Developed monthly oral health messages that were posted on the MCH and Public Health Division's Twitter and Facebook accounts.
- Developed and posted bi-weekly oral health messages on Facebook and Twitter to promote Children's Dental Health Month in February 2019. Topics included oral hygiene techniques, access to dental care, dental sealants, fluoride, mouth guards, etc. A resource table was staffed for the entire month in the lobby of the Public Health Division.
- Hosted a site visit with Tim Ricks, DMD, MPH, Rear Admiral, Assistant Surgeon General on September 23, 2019. Activities included:
    - Dr. Ricks met with senior leadership where oral health integration efforts into Oregon's system of

care were highlighted.
    - Live streamed a presentation where the public could learn about the upcoming Surgeon General's Report on Oral Health, and successes and challenges of oral health integration nationally and in Oregon.
    - Toured Multnomah County Health Department's Northeast Dental Clinic as an example of successful oral health integration within a FQHC.
- Participated on the planning committee for the 2019 Statewide HPV Summit, sponsored by the American Cancer Society and state Immunization Program. We engaged the dental community to attend the event and have two presentations specifically on oropharyngeal cancer and HPV.
- The Oral Health Unit presented posters and exhibited at the 2018 Oregon Rural Health Conference in October 2018, Oregon Oral Health Coalition's (OrOHC) 2018 Fall Conference in November 2018, and the WIC Statewide Meeting in May 2019. The posters utilized described the link between oral health and chronic diseases and how oral health can be integrated into chronic disease systems of care. Oral health educational materials were disseminated at the conferences.

Challenges/emerging issues
The Oral Health Unit intended to collaborate with the Health Promotion and Chronic Disease Prevention Section but did not have enough capacity to establish this relationship. Funding outside of Title V is necessary to support their grantees, and no grant opportunities were available during the grant period.

Progress on ESMs
Two fact sheets, three posters, and three presentations were developed.

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

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

Accomplishments
- Eleven grantees – ten local health agencies and one tribe – were provided with individualized technical assistance throughout the grant year.
- Held the training, "Introduction to Health Literacy, Plan Language and Design", on March 19, 2019 for Title V MCH grantees and school dental sealant programs. Participants learned how to better communicate with the communities we serve. The examples used during the training were oral health related.
- The Oral Health Unit conducted a clinical training for school dental sealant programs on August 16, 2019 that included sessions on trauma informed practices and cultural humility.
- Site visits were conducted with 21 school dental sealant programs to ensure they were meeting certification requirements. One of the requirements specifies that programs must refer children for further treatment if needed.
- The Oral Health Unit collaborated with the Oregon Oral Health Coalition to promote the First Tooth training program with grantees. First Tooth trains medical providers, such as public health nurses, to deliver oral health preventive services (oral health screenings, fluoride varnish, anticipatory guidance, and referral/case management services) within their existing practice for infants and toddlers.

Challenges/emerging issues

No challenges to report.

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

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.

Accomplishments
- Seven data sources were identified within the Oregon Oral Health Surveillance System (OOHSS) can be analyzed by race, ethnicity, language, and disability (REALD).
- 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 Oral Health Unit would like to increase its capacity to decrease oral health racial and ethnic disparities in Oregon. In 2018, the Unit applied for a 2018 Dental Trade Alliance (DTA) Foundation grant titled, *"Understanding Barriers to Optimal Oral Health in Oregon's Minority Communities,*" but did not receive funding. The grant would have supported conducting a panel survey with Hispanic/Latino, Black/African American, and American Indian/Alaska Native racial and ethnic groups. The findings would have been used to develop a health equity communications plan; test oral health messages with partners in the specific racial and ethnic communities; and develop social media content and materials targeted to each specific racial/ethnic population.

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

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

Accomplishments
- Benton, Linn, and Lincoln Counties provided oral health education and referrals for dental care in their home visiting programs (Babies First! and Maternity Case Management). They also provided First Tooth training for home visiting staff.
- Morrow County provided oral health education and referral case management for their home visiting clients in the CaCoon and NFP programs.

Challenges/emerging issues
Some public health nurses are hesitant to apply fluoride varnish during home visits. Counties intend to provide regular oral health and fluoride varnish training so that staff become more comfortable.

Strategy #5: (Local) Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health

and the importance of dental visits.

Accomplishments

- Benton, Linn, and Lincoln Counties provided culturally appropriate oral health education to all clients (e.g. WIC, home visiting, etc.).
- Clackamas County incorporated oral health education and referral services into all programs administered such as WIC, school-based health centers and the federally qualified health center (FQHC).
- Douglas County collaborated with Advantage Dental to provide oral health education and preventive services at two community baby showers, a well-child clinic hosted by a local family practice, and the Douglas County fair.
- Hood River County provided oral health education and referrals to dental care for home visit and WIC clients.
- Klamath County facilitated the Klamath Basin Oral Health Coalition and developed a three-year strategic plan, which included specific strategies for children.
- Cow Creek Band of Umpqua Tribe of Indians sent out dental care kits for children who saw the dentist for the first time. The kits included culturally and age appropriate oral health education.

Challenges/emerging issues

Counties have done a good job in referring clients for dental care, but it is difficult to track whether those clients followed through on the referral. It is challenging to build a system that tracks closed-loop dental referrals.

Strategy #6: (Local) Incorporate oral health preventive services for adolescents into School-based Health Centers (SBHCs) and adolescent well care visits.

Accomplishments

- Wheeler County incorporated oral health into the adolescent well care visit at three Asher Clinic locations. Clinics had to modify their workflow to provide oral health education and referrals to dental care.

Challenges/emerging issues

No challenges to report.

Smoking (Children) 2019 Report

National Performance Measure (#14B)

Percent of children who live in households where someone smokes.

Interpretation of Data

The percent of children who live in households where someone smokes has held fairly steady over the past two years for which we have data, from 14.2% in 2016 to 14.3% in 2017. Oregon is slightly below the national average for this performance measure.

Strategies and Activities

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

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

Accomplishments
Oregon Administrative Rules related to inhalant delivery systems packaging attractive to minors were recently revised. These rules are effective as of September 1, 2018, but are only being enforced in cases where a product's packaging is so clearly attractive to minors that there is no room for doubt that it is attractive to minors.

Challenges/emerging issues
Business owners complain that ensuring packaging isn't attractive to minors is costly for them. Complaints are regularly filed with the State's Tobacco Prevention and Cessation Program.

The lead for the Smoking priority at the State Maternal & Child Health program retired in spring 2019. Her replacement was not hired until mid-October 2019. Unfortunately, this gap in coverage impacted our ability to complete some of the State level activities we had planned for this grant cycle.

Progress on ESMs
None. Gap in staffing coverage impacted ability to complete planned activities.

Strategy #2: 5As Intervention and Quit Line Referral (or other customized Evidence-Informed Program) within MCH Programs including Home Visiting, Oregon MothersCare, Family Planning, and WIC (if applicable).

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.

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

Local Level

- In Columbia County, 84% of home visiting clients who smoke received a 5As intervention and 84% also received a referral to the Quit Line, provider, or local tobacco cessation specialist. This process was made easier by incorporating smoking cessation resources into home visiting handouts.
- The Confederated Tribes of the Umatilla Indian Reservation provided 5As intervention during visits at the Yellowhawk clinic for 20% of women ages 13-44 who smoke tobacco.
- The Coquille Indian Tribe worked with multiple partners to improve the tribal clinic's policies and procedures related to commercial tobacco screening and intervention. Updates were made to the clinic's EHR to enable providers to document tobacco use, intervention and follow-up at each visit.
- Harney County worked to develop a policy agenda to decrease youth exposure to tobacco products and decrease the likelihood of initiation and use. As part of this effort, staff provided presentations at local schools, reaching over 380 youth. Staff also continued work to make all county properties tobacco free, including the county fairgrounds.
- In Lane County, 53% of home visiting clients who smoke received a 5As intervention and 100% received

education on tobacco cessation benefits. Oregon MothersCare (OMC) clients also received information on tobacco cessation benefits. The local Quit Tobacco In Pregnancy (QTIP) program provides support and incentives to quit tobacco.

- Tillamook County's home visiting program worked to use 5As screening, education and referral for pregnant clients who smoke, referred clients to the Quit Line, and enrolled pregnant people in the tobacco cessation incentive program with Columbia Pacific Coordinated Care Organization. As a result of the incentive program, 10 client quit tobacco completely and 5 cut down on their tobacco use during pregnancy.
- Yamhill County implemented the Healthy Futures smoking cessation program in partnership with a Behaviorist at Valley Women's Health prenatal care practice. Thirty percent of pregnant clients continued to be tobacco free at their 3-month postpartum visit.

Challenges/emerging issues

Local Level

- The MCH Program has a focus on home visiting and is therefore not able to serve all pregnant smokers. The result is that not all clients receive referrals to providers and may miss getting interventions. Grantees have reported challenges getting pregnant clients to accept referrals either because they are resistant or because they have already received a referral from their primary care provider. Training in motivational interviewing and trauma-informed practices may support grantees to provide these services to pregnant clients.

- Several local grantees also reported challenges with staff turnover, which hindered implementation of smoking cessation efforts.

State Level

The lead for the Smoking priority at the State Maternal & Child Health program retired in spring 2019. Her replacement was not hired until mid-October 2019. Unfortunately, this gap in coverage impacted our ability to complete some of the State level activities we had planned for this grant cycle.

Progress on ESMs

Five out of seven (71%) Title V grantees who selected smoking as a priority implemented 5As with their clients.

All Title V grantees who selected smoking as a priority area (100%) received at least two technical assistance contacts with the State Title V program.

Strategy #3: Collaborate with CCO's, DCO's, medical and early childhood/education providers to build screening and intervention processes into their work practices, including workforce training.

ESMs

- (14.2.1) Number of local and state regulatory agencies worked with, contacted, or engaged in smoke free childcare project.
- (14.2.3) Number of proposed smoking related licensing rule changes submitted to the Department of Education/Early Learning Division/Office of Child Care.

Accomplishments

State Level

- The MCH Program promoted and monitored use of the on-line training. Home visiting and PH nurses and dental professionals received information about the training and how to access it. The program also monitored availability and provided information to the Transformation Office when issues arose making the training inaccessible.

Challenges/emerging issues

State Level

While the MCH Program collaborated with the Health Transformation Office in the development of the on-line training, there was difficulty in obtaining CEUs for MCH professionals

The lead for the Smoking priority at the State Maternal & Child Health program retired in spring 2019. Her replacement was not hired until mid-October 2019. Unfortunately, this gap in coverage impacted our ability to complete some of the State level activities we had planned for this grant cycle.

Progress on ESMs

No progress was made on these ESMs during this grant cycle due to staff transitions and shifting state priorities.

DOMAIN – Child Health

2021 Application Year

Child Injury 2021 Plan

National Performance Measure 7

1. Rate of hospitalization for non-fatal injury per 100,000 children, ages 0-9; and
2. Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19.

Planned Strategies and Activities and ESMs, October 2020 – September 2021

NOTE: Due to 2021-2025 Block Grant priorities being determined so close to the start of the SFY2021 local Title V planning and funding cycle - as well as COVID-19 related delays - all of Oregon's MCAH plans for new Title V priorities in 2021 (including injury) will be at the state level. Local level partners will begin implementing work on the child injury priority July 1, 2021.

Strategy 1: By October 2020, determine state MCH staffing for the Child Injury priority and develop a cross-cutting injury team to address upstream drivers of child injury, and link to work across population domains (including safe sleep, child injury, bullying prevention, ACEs prevention, and SDOH-E). The cross-cutting injury team will research, develop, adapt or adopt an overarching theory of change for the work, in collaboration with the PHD Injury and Violence Prevention Section.

Strategy 2: By December 2020, develop evidence-based/informed strategies and measures for child injury – including strategies that address upstream drivers of maternal, child and adolescent health. Strategies will address both state and local levels work. Engage local Title V grantees and family and community representatives in the process.

ESM:

7.1.1 The number of strategies developed to address injury prevention among children across the spectrum of prevention.

7.1.2 The number of critical partners engaged in the development of upstream strategies to address child injury.

Strategy 3: By February 2021, develop and adopt a logic model for the cross-cutting child injury prevention Title V work.

Strategy 4: By March 2021, begin implementation and tracking of state level strategies for new cross-cutting child injury prevention Title V work and cross-priority Title V work; collect/track outcomes through monitoring of ESMs and NPMs.

Strategy 5: By March 2021, provide technical assistance on new injury prevention strategies and measures to Title V grantees to inform local level Title V priority selection, planning and implementation.

Strategy 6: April - June 2021, review and provide TA to local Title V Grantees on implementing injury prevention annual plans for July 2021– June 2022.

Strategy 7: July 1, 2021 through September 30, 2021- Title V grantees will implement local level strategies and

collect/track outcomes.

Critical Partnerships

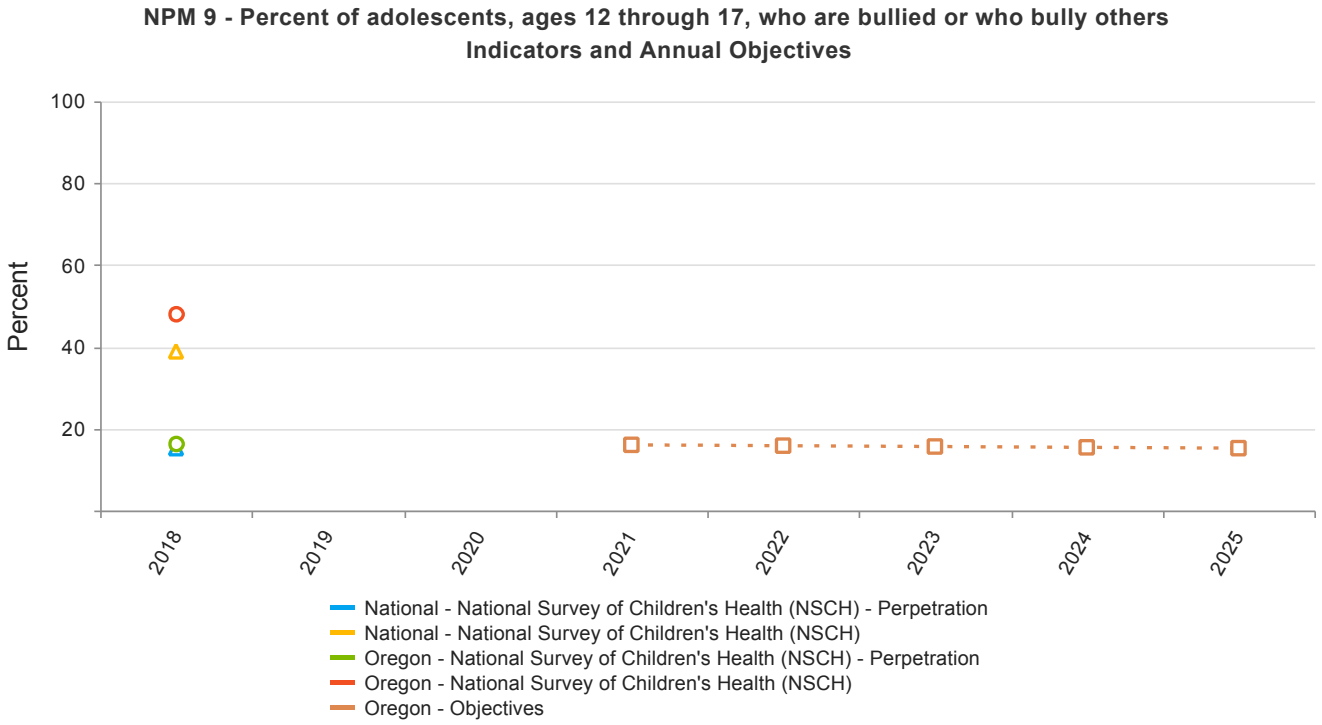
- Local Title V Grantees
- Oregon Public Health Division, Health Promotion and Chronic Disease Prevention Program
- Oregon Public Health Division, Injury and Violence Prevention Section
- Oregon Health Authority, Health Transformation Office
- Coordinated Care Organizations
- 211Info Resource and Referral
- Oregon Health Plan
- Oregon Office of Childcare
- Oregon Early Learning Division
- Oregon Safe Kids Coalition (includes Oregon Poison Control, Marine Board, Trauma Nurses Talk Tough, Fire Marshals Office)
- State Child Fatality Review Team
- Oregon Pediatric Society

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-2018	31.0	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	9.9	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	15.7	NPM 9 NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	56.1 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	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-2017_2018	11.7 %	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-2016	14.7 %	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-2018_2019	61.0 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2018	75.3 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2018	86.1 %	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-2018	83.0 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	13.3	NPM 10

National Performance Measures



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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2019
Annual Objective	
Annual Indicator	47.9
Numerator	129,756
Denominator	271,087
Data Source	NSCHV
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	16.1	15.9	15.7	15.5	15.3

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - The number of strategies developed to address bullying among youth with a focus on systems change, primary prevention, positive youth development, and/or enhancing social emotional learning

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	6.0	6.0	6.0	6.0	6.0

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

Determine state ASH staffing for the bulling prevention/positive youth development priority, and begin to collaborate with the cross-cutting injury prevention team to address upstream drivers of bullying, and link to work across population domains.

Develop evidence-based/informed strategies and measures for Oregon's Title V bullying prevention work - including strategies that address upstream drivers of bullying and positive youth development. Engage local Title V grantee,s as well as youth and community representatives in the process.

Develop and adopt a logic model for Oregon's bullying prevention/positive youth development work.

Begin implementation and tracking of state level strategies for bullying prevention/positive youth development.

Provide technical assistance to Title V grantees on bullying prevention/positive youth development strategies and measures to inform local level Title V priority selection and planning.

Review local grantee annual plans and provide TA on implementing bullying prevention/positive youth development.strategies beginning July 2021.

Begin implementation of local level injury prevention strategies and tracking of outcomes.

ESMs	Status
ESM 9.1 - The number of strategies developed to address bullying among youth with a focus on systems change, primary prevention, positive youth development, and/or enhancing social emotional learning	Active

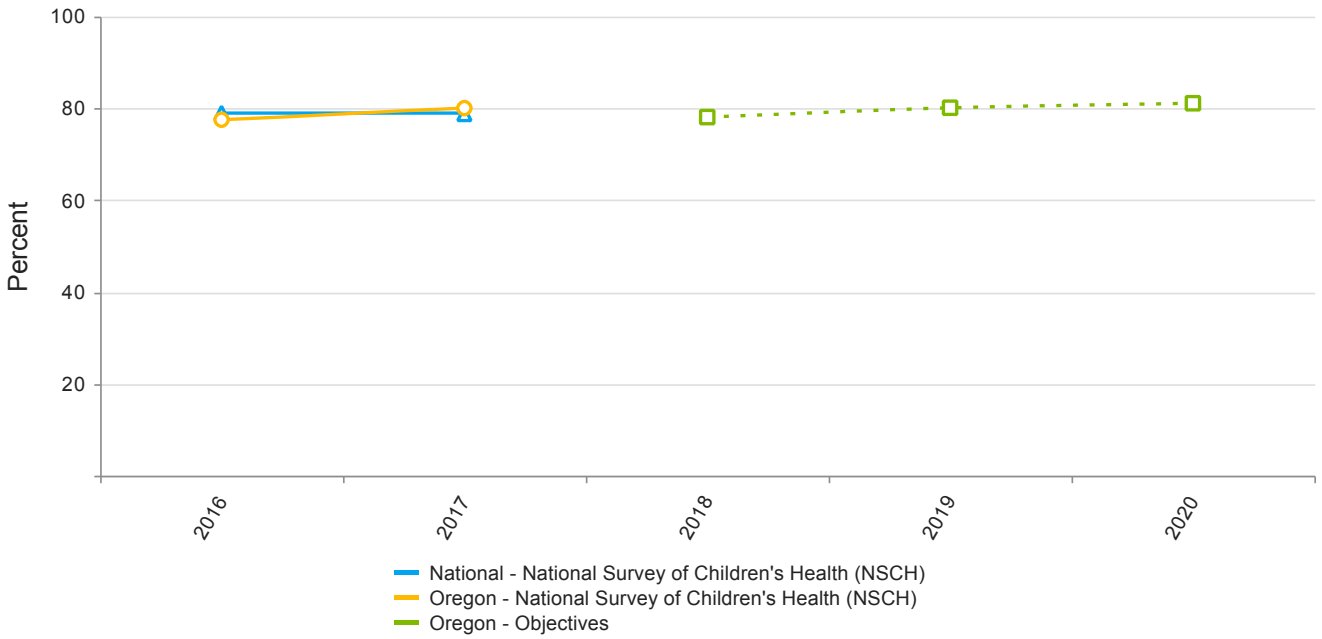
NOMs

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**
Annual Objective			78	80
Annual Indicator		77.4	79.9	79.9
Numerator		227,178	230,520	230,520
Denominator		293,358	288,666	288,666
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017

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

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**
Annual Objective				200
Annual Indicator	161	282	575	80
Numerator				
Denominator				
Data Source	Attendance sheets	Attendance sheets	Attendance sheets	Attendance sheets
Data Source Year	2016	2017	2018	2019
Provisional or 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**
Annual Objective			100	100
Annual Indicator	0	1,137	168	0
Numerator				
Denominator				
Data Source	State tracking	State tracking	State tracking	State tracking
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

DOMAIN – Adolescent Health

2019 Annual Report

Adolescent Well-Care 2019 Report

National Performance Measure (#10)
Percent of adolescents with a preventative services visit in the last year.

Interpretation of Data
The National Performance Measure (NPM 10) percent of adolescents with a preventative service visit in the last year continues to show improvement. The National Survey of Children's Health shows an increase in the rate of Oregon adolescents with an adolescent well visit (AWV) from 77.4% in 2016 to 79.9% in 2017. During the same time period, the rate of adolescents with an AWV decreased slightly at the federal level (from 78.9% to 78.7%). State level data (Oregon Healthy Teens and Medicaid data) demonstrate improvements in adolescent preventative care. From 2017 - 2019, 8th graders reporting an AWV within the last 12 months increased from 61.9% to 63.2% and 11th graders reporting an AWV increased from 62.3% to 65.7%. Through the end of calendar year 2019, Medicaid Coordinated Care Organizations' emphasis on the AWV in combination with partnerships between Medicaid, Title V, and the Oregon Pediatric Society continued to promote and increase AWV services. Moreover, the Affordable Care Act ensures access to the AWV by mandating insurance coverage for this preventive care without cost sharing.

Strategies and Activities
Strategy #1: Promote policies and practices to make youth healthcare more youth-friendly.

ESM (10.1): Number of health professionals trained on adolescent well visits.

Accomplishments
In October 2018, 80 School-Based Health Center (SBHC) staff from throughout the state participated in trainings on Supporting Transgender Youth and Providing Youth Friendly Services. The emphasis on care for transgender youth was a result of data showing transgender youth are less likely to have had an AWV in the past year. According to 2017 Oregon Healthy Teens Survey, transgender and gender diverse 11th graders (57%) were less likely to have an annual AWV than their cisgendered peers (63%).

The January 2019 SBHC Coordinators Meeting included a session on Coordinated Care Organization AWV incentive metric changes for 2019. The May SBHC Coordinators Meeting had a session on suicide prevention during AWVs. Each webinar-based meeting had approximately 80 participants.

In April 2019 over 50 participants attended Adolescent Health Day during Public Health Week. Participants were healthcare providers, teachers, youth-serving organization staff and youth. The agenda included sessions on providing care for LGBTQ+ youth and centering student voice in health advocacy.

Healthcare professionals 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.

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, six times in the reporting period. The presentations highlighted Oregon Healthy Teens data that demonstrated connections between health and educational outcomes and emphasized the benefit of the AWV.

In order to improve the relevance of health surveys for schools and youth, the Policy and Assessment Specialist conducted 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.

In August 2019, the teenhealth.or Instagram was launched to promote adolescent health and the AWV.

Challenges/emerging issues
In August 2019, it was decided that the adolescent well visit would be removed from the Coordinated Care Organization Incentive Metrics set. This change went into effect on January 1, 2020 so does not impact this reporting period but may impact Title V's ability to promote the AWV in the future.

Progress on ESMs
Over 80 providers received training on the AWV during this reporting period.

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.

Accomplishments
In September 2019, a contract to evaluate the effectiveness of YPAR was executed. Work is ongoing. The Adolescent Health Day and SBHC Coordinators meetings included youth-led sessions.

Local Public Health Authorities working on the AWV priority are encouraged to connect with their SBHCs and YACs.

- Clackamas County has actively engaged their SBHCs, conducting surveys on barriers to the AWV. In this reporting period, 8 surveys were completed.
- Curry County actively engages the YAC in monthly events.
- Umatilla County actively engages youth in health classes.

Challenges/emerging issues
Some providers and partners 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.

Strategy #3: Promote practice of going beyond sports physicals. (State and local Level)

ESM (10.2): The number of health professionals trained and informed to promote the practice of going beyond the sports physical.

Accomplishments
State-level work to move beyond the sports physical continues but is no longer emphasized. Most work is in this area is now done at the local level. Activities outlined above were successfully completed.

- Grant County supports an AWV Day and determined that more student athletes received a comprehensive AWV. 94% of charts reviewed after the event showed AWVs rather than only sports physicals.
- Harney County works collaboratively with the Eastern Oregon Coordinated Care Organization, a local hospital system and a local private provider to host AWV Days at schools.
- Morrow County is looking beyond merely providing AWV by reducing other barriers such as transportation to AWVs. Morrow County has reached out to 100% of parents of school-aged youth in their county on the importance of an annual AWV and how youth can access transportation to get to an appointment.
- North Central Health District is partnering with a variety of partners throughout its rural tri-county service

area to promote the AWV.

Challenges/emerging issues
Provider recruitment in rural areas creates barriers to adolescents accessing healthcare. There is still a need to promote an annual AWV. Sports physicals are required only every two years and more work is needed to assure people know the value of an annual visit.

Progress on ESMs
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.

Strategy #4: Increase outreach to key populations in the community.

Accomplishments
- Curry and Umatilla Counties engaged in the activities described above.
- Morrow County runs public service announcements on the AWV in local media.
- Morrow County actively collaborates with its Coordinated Care Organization Community Advisory Council.
- Local Public Health Authorities collaborating with schools to hold health fairs spread the word through school mailings and social media posts.
- Lake County collaborates with its Coordinated Care Organization to mail information directly to Oregon Health Plan (Medicaid) recipients when health fairs will occur.

Challenges/emerging issues
Local partners report that some parents are still resistant to a complete AWV and would rather have "just a sports physical."

Strategy #5: Strengthen healthcare privacy and confidentiality polices.

Accomplishments
Morrow County completed the consent to transportation work and the policy has been implemented.

Challenges/emerging issues: None to report.

Strategy #6: Develop and strengthen partnerships with public and private entities invested in adolescent health.

Accomplishments

Local Level
North Central Public Health District convened partners from local youth-serving organizations, CCOs, community providers and school districts to address the access and education barriers for AWVs and reproductive health services.

Challenges/emerging issues
Strengthening partnerships in rural and frontier areas presents many known challenges of limited time and resources.

Strategy #7: Investigate barriers to adolescent well visits.

Accomplishments

Local Level
Clackamas County partnered with school districts that have an SBHC to conduct listening sessions to understand youth's experience of care.

Challenges/emerging issues
Staff turnover in the county and at SBHCs delayed progress in survey collection.

DOMAIN – Adolescent Health

2021 Application Year

Bullying Prevention 2021 Plan

National Performance Measure 9

Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Planned Strategies and Activities and ESMs, October 2020 – September 2021

NOTE: Due to 2021-2025 Block Grant priorities being determined so close to the start of the SFY2021 local Title V planning and funding cycle - as well as COVID-19 related delays - all of Oregon's MCAH plans for new Title V priorities in 2021 will be at the state level. Local level partners will begin implementing work on the bullying prevention priority July 1, 2021.

Strategy 1: By October 2020, determine state ASH staffing for the bullying prevention/positive youth development priority and begin to collaborate with the cross-cutting injury team to address upstream drivers of bullying and injury, and to link to work across population domains (including safe sleep, child injury, bullying, ACEs prevention, and SDOH-E). The cross-cutting injury team will research, develop, adapt or adopt an overarching theory of change for the work, in collaboration with the PHD Injury and Violence Prevention Section.

Strategy 2: By December 2020, develop evidence-based/informed strategies and measures for bullying prevention/positive youth development – including strategies that address upstream drivers of adolescent health. Strategies will address both state and local levels work. Engage local Title V grantees and family and community representatives in the process.

ESM:

9.1 The number of strategies developed to address bullying among youth with a focus on systems change, primary prevention, positive youth development, and/or enhancing social emotional learning.

Strategy 3: By February 2021, develop and adopt a logic model for the bullying prevention/positive youth development Title V work.

Strategy 4: By March 2021, begin implementation and tracking of state level strategies for bullying prevention/positive youth development Title V work; collect/track outcomes through monitoring of ESMs and NPMs.

Strategy 5: By March 2021, provide technical assistance on new on bullying prevention/positive youth development strategies and measures to Title V grantees to inform local level Title V priority selection, planning and implementation.

Strategy 6: April - June 2021, review and provide TA to local Title V Grantees on implementing bullying prevention/positive youth development annual plans for July 2021– June 2022.

Strategy 7: July 1, 2021 through September 30, 2021- Title V grantees will implement local level strategies and collect/track outcomes.

Critical Partnerships

- Oregon Health Authority –
    - Health Systems Division – Child and Family Behavioral Health
    - Rape Prevention Education Program
    - Injury and Violence Prevention Program
    - State Opioid Response Program
    - Transformation Center
    - Reproductive Health Program
- Coordinated Care Organizations
- School-Based Health Centers
- Oregon School Nurses Association
- Oregon School-Based Health Alliance
- Oregon School Counselor Association
- Oregon Pediatric Society
- Oregon Pediatric Improvement Partnership
- Confederation of Oregon School Administrators
- Oregon Department of Education
- Oregon school districts
- Oregon Student Voice

Children with Special Health Care Needs

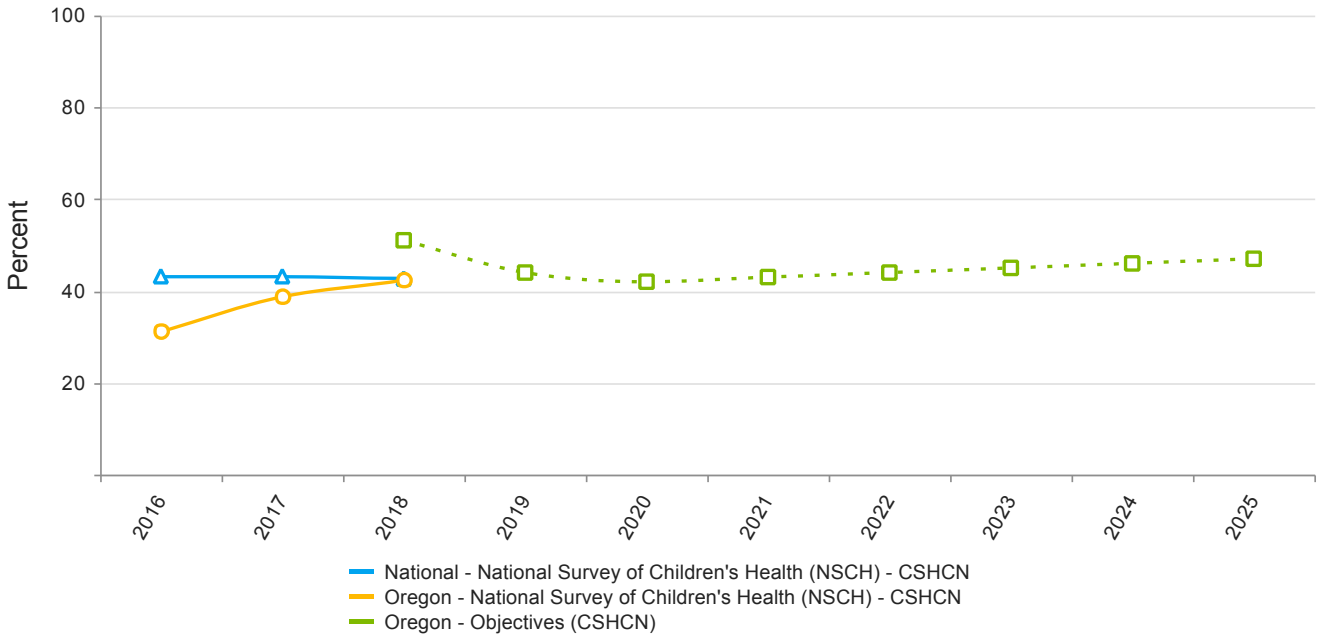
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2017_2018	15.9 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	56.1 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	90.6 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2017_2018	3.4 %	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**
Annual Objective			51	44
Annual Indicator		31.3	38.6	42.2
Numerator		49,675	61,991	70,156
Denominator		158,652	160,752	166,072
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	2021	2022	2023	2024	2025
Annual Objective	42.0	43.0	44.0	45.0	46.0	47.0

Evidence-Based or –Informed Strategy Measures

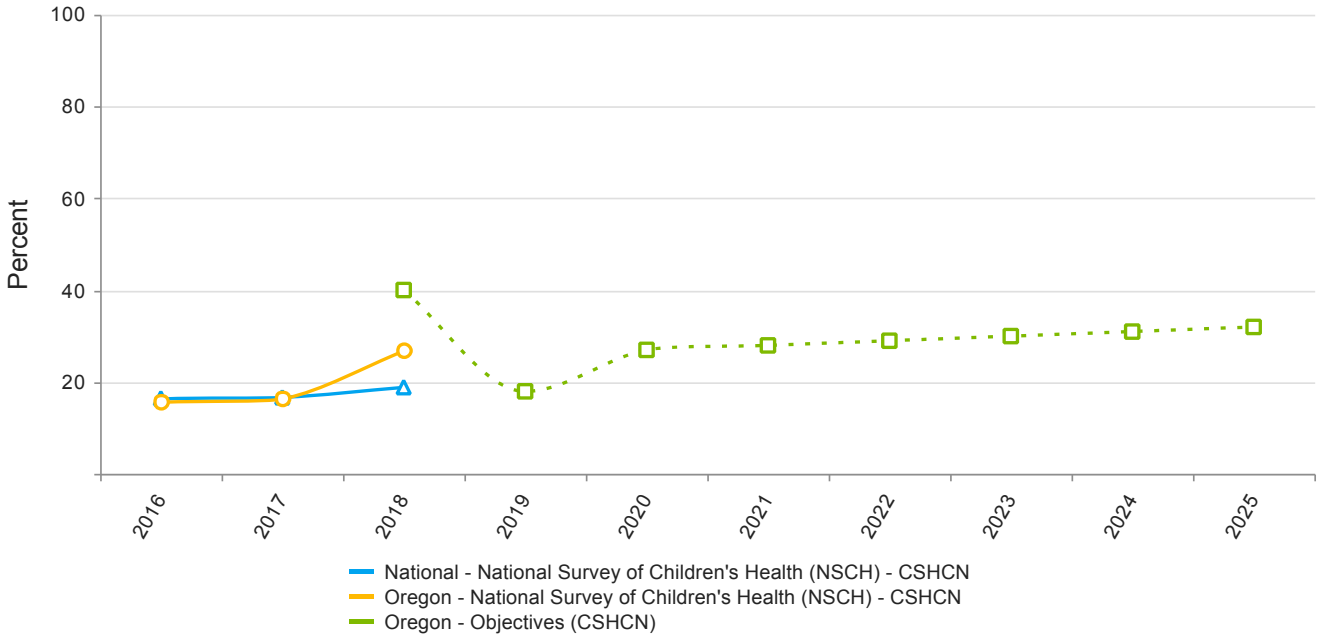
ESM 11.1 - Primary care involvement in shared care planning

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	25.0	30.0	35.0	40.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			40	18
Annual Indicator		15.8	16.5	26.8
Numerator		12,536	11,986	18,726
Denominator		79,458	72,528	69,860
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	27.0	28.0	29.0	30.0	31.0	32.0

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
Annual Objective	20.0	30.0	40.0	50.0	60.0

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 not able to obtain needed health care in the last year

State Action Plan Table (Oregon) - Children with Special Health Care Needs - Entry 2

Priority Need

High quality, family-centered, coordinated systems of care for children and youth with special health care needs

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

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

2016-2020: National Performance Measures

2019 Annual Report**: NPM 11 Medical Home**

National Performance Measure 11: Percent of children with special health care needs having a medical home.

Report on Strategies and Activities October 2018– Sept 2019

Strategy 11.1: Support regional care integration by implementing a regional, team-based approach to cross systems care coordination (CSCC) based on modifying AHRQ's (2011) medical neighborhood strategy.

Of the three original Regional Approach to Child Health (REACH) teams, OCCYSHN continued to support two: one in Central Oregon and one in Southern Oregon. Based on feedback from Local Public Health Authorities (LPHAs) on their capacity, OCCYSHN took a developmental approach and supported a continuum of system improvement activities. Due to the growth of other cross-systems care coordination initiatives supported by OCCYSHN (see Strategy 11.4), this was the last year of REACH. In May 2019, OCCYSHN had a final collaborative meeting with Southern Oregon REACH team partners. The OCCYSHN director and staff helped the team identify next steps for sustaining systems-level work, and for integrating local systems serving CYSHCN and their families. OCCYSHN prepared a data summary for the meeting using existing sources, including the Community Health Assessment, Community Health Improvement Plan, and U.S. Census data - ensuring that the numbers reflected the make-up of the communities. These data summaries presented CLAS-related information, including racial and ethnic data, percent of CYSHCN parents born outside of the U.S., percent of CYSHCN families who do not speak English as their primary language at home, poverty rates, and graduation rates for students with disabilities. Central Oregon REACH opted not to host a final collaborative meeting with OCCYSHN, but they reported that REACH helped them develop new local partnerships (especially with their CCO), and also strengthened connections between the three counties in their area.

The Central Oregon REACH team aimed to align 211info (which connects people with local health and service organizations) with existing tri-county resources. To that end, in October 2018 they organized a training for the public health workforce and other service providers on using a 211info app. The training helped increase community awareness of the resource. REACH partners in Central Oregon found 211info valuable. They advocated on a systems level to establish a 211info Local Community Resource Coordinator position for their tri-county area, but they weren't able to find funding.

The Southern Oregon REACH team's project aim was to integrate health care transition guidance into the Oregon Department of Education's annual transition handbook. Prior versions of the handbook did not address health care aspects of the transition from high school to adulthood. It will now include references to the importance of health care transition planning for youth with special health care needs who are graduating from high school, and it will include some transition tools and resources. The updated transition handbook will be published in fall 2020. The Southern Oregon REACH team was unsuccessful in engaging public health partners from neighboring Curry County to collaborate on their efforts, though other community partners from Curry County did participate. The Southern Oregon REACH team worked on integrating their CCN team into the local system of care, including increased collaboration with Advanced Health CCO. The Coos County LPHA participated on a regional care coordination team comprised of clinical and CCO care coordinators.

Due to capacity concerns for their rural workforce, Eastern Oregon's REACH team opted not to accept additional funding. Our public health partners on the Eastern Oregon team did, however, use OCCYSHN funds awarded in fall of 2018 to develop shared care planning infrastructure in their community. They worked to form new partnerships and explored opportunities for a care coordination team that met consistently. They successfully integrated their shared care planning work into an existing team comprised of mental health, developmental disabilities services and other co-located partners. This development aligned with their REACH project goal to "provide regional leadership to improve cross-systems care coordination for children and youth with special health care needs as a population." (See Strategy 12.2 for details on shared care planning infrastructure funding.)

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.

Oregon Family to Family Health Information Center (ORF2FHIC) conducted 14 trainings/listening sessions in 11 communities in rural, urban, and suburban Oregon. The events were attended by 105 families and youth. They offered comments, suggestions, and impressions about their health care experiences. ORF2FHIC also held four interactive trainings on the following subjects: health care advocacy; transition to adult health care; and resources; and person-centered One Page Profiles. ("One Page Profiles" are used to help convey important things about an individual to their health care providers.) Input from the trainings and interactive sessions helps ground the work of ORF2FHIC and OCCYSHN in the family experience. Families were asked to evaluate the trainings, and the 60 surveys returned indicated that:

- 92% felt that the information/resources they received helped them identify/learn about community services, including primary health care, intervention programs, translation services, and others.
- 93% felt that the information they learned helped them feel more confident about getting their child the health care and services they need.
- 93% felt the information/resources they received will help them partner with professionals to make decisions about their child's health care.

To support sustainability, in 2019 three new Parent Partners began learning how to conduct Regional Family Gatherings, by shadowing and supporting the Project Coordinator. ORF2FHIC also added two new trainings to its offerings: "Planning for a Trip to the Emergency Room," and "One Page Profiles for the Medical Setting." The former was co-developed by ORF2FHIC Parent Partners and professionals representing Oregon Emergency Medical Systems for Children, and is based on a 2019 toolkit of the same name. It was presented at three family events and one professional gathering. "One Page Profile for the Medical Setting" was first presented in January 2019 on a Facebook Live event attended by approximately 12 families. Introducing families to the concept of developing a person-centered One Page Profile has since been integrated into every ORF2FHIC event.

ORF2FHIC served 1,141 families and 270 professionals during its program year of June 1, 2018 – May 31, 2019. Services included training, one-to-one encounters, outreach events, webinars, and emails. The Family Voices Solutions Database was no longer functional, so with the help of OCCYSHN's Assessment and Evaluation unit and OHSU's REDCap data collection resource, ORF2FHIC established a new and significantly improved data collection process.

The Parent Partners met twice in person during 2019, and six times more via webinar. Under leadership of the Project Coordinator, the meetings focused on community resources, health care financing, medical home principles, data collection, leadership development, transition to adult health care, and data collection. Parent Partners reviewed written materials for two medical clinics, and offered their family perspective. They offered support to specific families at the request of clinicians at OHSU's Child Development and Rehabilitation Center (CDRC). They also presented to social workers and other clinical staff at Ronald McDonald House, and at OHSU's Pediatric Cardiology, Audiology, Spina Bifida, and Child Life about resources for families of children born with the conditions tracked by Oregon's Birth Anomalies Surveillance System.

Two ORF2FHIC phone lines were staffed five days a week during the program year, and posts were made to the ORF2FHIC Facebook page about three times a week. On September 30, 2019, Facebook analytics showed the page had 595 followers/page likes and 987 "total reaches" for the previous 28 days.

Three ORF2FHIC staff members received scholarships from Arc Oregon to be certified in Supported Decision Making (SDM). They subsequently supported two families to implement SDM. ORF2FHIC also led a Shared Care Planning ECHO session devoted to SDM.

OCCYSHN's Family Involvement Program Manager presented a poster at the National Emergency Medical Services for Children's Conference in Washington D.C., highlighting Oregon's efforts to inform families of CYSHCN about medical protocol letters and the importance of planning for medical emergencies.

ORF2FHIC's Parent Partner/Resource Specialist produced two new products for families: "Spina Bifida Resources for Youth" and "Coping with a Child's Death or Life-Limiting Illness." Both products resulted from work with the Oregon Birth Anomalies Surveillance System, and both were vetted by clinicians, social workers, and families with lived experience. Another product, "Spina Bifida Resources for Families" was translated into Spanish and disseminated to families at the CDRC Spina Bifida clinic.

ORF2FHIC continued to support and inform Spanish-speaking families by staffing a dedicated phone line with a bi-lingual Parent Partner. This Parent Partner also staffed an outreach table in CDRC clinics once a month, where she spoke with more than 40 family members, mostly in Spanish. She shared resources, answered questions, and otherwise supported families during their child's health visit.

In May, ORF2FHIC worked with a volunteer from the United Cerebral Palsy Latino parent support group to conduct a unique family gathering in a Portland church. The event was entirely in Spanish and included a brief religious service,

a festive meal, dancing, and a listening session.

Three other listening sessions with non-white families were conducted in the Portland metropolitan area during the grant year, one with Native American youth, one with Native American parents, and one with Central American parents.

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.

CaCoon

CaCoon is a statewide public health nurse home visiting program. CaCoon nurses help families coordinate care for their CYSHCN, and convene shared care planning teams. In 2019, OCCYSHN contracted with 28 Local Public Health Authorities (LPHAs) to implement the CaCoon program in 30 of Oregon's 36 counties, serving 1,192 CYSHCN in 6,935 CaCoon visits. 87% of CYSHCN served were insured through Medicaid. Transition-aged youth ≥ 12 years made up 14% of CYSHCN served. While OCCYSHN was without a nurse Care Coordination Specialist staff member to support the CaCoon program from June 2018 to March 2019, CaCoon work continued across the state, with the support of other OCCYSHN staff.

In 2019, OCCYSHN's new nurse Care Coordination Specialist worked closely with the Oregon Health Authority to gain a better understanding of Targeted Case Management (TCM) billing. In conjunction with one of the Oregon Health Authority's State Nurse Consultants, the Care Coordination Specialist developed a new Targeted Case Management training for LPHAs, and delivered that training in Marion, Baker and Washington counties, with subsequent trainings planned for Douglas County Public Health, and an online training to reach other LPHAs throughout the state. This training helps home visiting nurses complete TCM documentation, reviewing frequent scenarios where TCM services are provided. Local home visiting staff identified assigning ICD10 coding to TCM billing as a challenge, and had questions about billing for shared care planning meetings, and for multiple clients in one home. OCCYSHN is working with Medicaid to clarify these matters.

ACCESS (Assuring Comprehensive Care through Enhanced Service Systems)

OCCYSHN continued to support seven of the eight education-medical autism identification ACCESS teams that were still operating following the end of the HRSA state implementation grant in December 2016. The Director of the autism clinic at OHSU and OCCYSHN's Medical Consultant provided technical assistance with phone consultation and site visits. OCCYSHN put telehealth/teleconsultation equipment into place for two ACCESS sites, and began establishing usage guidelines with those teams. Some team decided to provide sequential medical and educational evaluations for children 0-5, rather than joint evaluations as envisioned by the grant. This change may prove to be a more sustainable approach to community-based educational-medical evaluations. OCCYSHN is developing plans to support ACCESS teams more fully in the next contract year.

Workforce Development

At the request of many LPHA partners, OCCYSHN committed to reinstituting a regular conference to support professional development of public health nurses and community partners. OCCYSHN planned a statewide conference for Spring 2020. Topics covered medical home, transition from pediatric to adult care and CLAS. In in the interest of expanding the workforce serving CYSHCN, nursing and social work students were invited, as well others in care coordination roles around the state.

Coffee Time Webinars

In partnership with OHSU's Department of Pediatrics, OCCYSHN supported distance-learning opportunities for Oregon health care providers with monthly "Coffee Time" webinars, which offered continuing medical education (CME) credits for physicians. OHSU Pediatrics staff provided administrative support to market and conduct the webinars. OCCYSHN's Medical Consultant chaired the planning committee, which identified topics and speakers. In FY19, webinar topics included teen anxiety and obsessive-compulsive disorder, family resources (led by OCCYSHN's Family Involvement Program Manager), adolescent depression screening and risk assessment, iron deficiency, and Adverse Childhood Experiences awareness in primary care. Each webinar lasted 35 minutes and included a didactic presentation followed by questions and answers. Presenters used case reports to demonstrate key points, provide resources, and discuss issues impacting CYSHCN and their families.

Family Involvement Program

Staff from the Family Involvement Program (FIP) helped launch a new statewide professional association for members of the peer support workforce. The Oregon Family Workforce Association (ORFWA) is a 501c6

organization designed to uplift and advance the interests of families supporting other families. In 2019 the FIP Manager led a professional development activity for 50 ORFWA members.

In Fall 2019, the FIP was awarded a “Cutting Edge Practice” designation by AMCHP’s Innovation Station for the “Planning for Meaningful Family Involvement” tool. The tool helps professionals plan for the thoughtful inclusion of family voices in policy-making. The FIP Manager also served as an Innovation Station reviewer for a “Best Practice” application regarding training professionals to provide appropriate materials on newborn screening to families.

ORF2FHIC staff conducted both formal and informal professional development sessions on CYSHCN parents’ perspective with Kaiser Pediatrics, Developmental Disabilities of Multnomah County, North Central LPHA, EHDI program, Health Share CCO, Children’s Intensive In-home Services, and OHA. ORF2FHIC Parent Partners also provided detailed written feedback to OHSU General Pediatrics on their transition and behavioral health materials.

Strategy 11.4: Enhance local community infrastructure to implement child health teams by providing consultation and technical assistance to Community Connections Network (CCN) to become self-sustaining.

OCCYSHN leveraged infrastructure and learning from Community Connections Network (CCN) teams to launch a new project called Piloting ACT.md for Care Coordination Teams (PACCT). Participating in PACCT required LPHAs to develop cross-systems care coordination teams, and to participate in an ECHO-based learning community. Additionally, they piloted the use of ACT.md (a cloud-based electronic platform for sharing care coordination information). OCCYSHN developed a request for proposals for PACCT. Five LPHAs applied, representing seven counties (Clatsop, Coos, Grant, Morrow, Sherman, Gilliam, and Wasco). All five applications were accepted.

PACCT teams were developed and convened by LPHAs. They brought together consistent networks of local professionals to support cross-systems shared care planning for CYSHCN. The teams provided shared care planning for individual CYSHCN and their families, and they monitored and modified those care plans, following families as needed over time. Thus they were able to serve a population of local CYSCHN. The consistent team make-up and meeting schedule help members form cross-sector professional connections, which in turn helped them identify and address issues in local systems of care.

PACCT used the ECHO knowledge-sharing model developed at the University of New Mexico as an evidence-based foundation for a statewide virtual learning community. The learning community used Jeanne McAllister’s “Phases of Family-centered Care Coordination” as a framework. OCCYSHN convened all the PACCT participants virtually for monthly ECHO sessions where participants heard presentations, shared their experiences implementing PACCT, and informed one another’s work.

ECHO and ACT.md both use technology to advance care coordination for CYSHCN, and to improve local and statewide capacity for serving CYSHCN. ACT.md seeks to reduce the communication barriers to shared care planning. OCCYSHN and PACCT LPHAs worked with ACT.md to develop an electronic template for the shared care plan. To promote inclusivity in shared care planning, we added a new “gender identity” field to the template.

Strategy 11.5: Integrate state systems of services for CYSHCN and their families through cross sector collaboration, workforce and system infrastructure development.

OCCYSHN sat on state and local level advisory boards, committees and workgroups to ensure the needs of CYSHCN were represented across the state. We advocated for CYSHCN care needs at every level. We gave input on policy development and dissemination, and provided testimony at local, state and national levels. OCCYSHN submitted both oral and written input to policy bodies and participated on the following: (See strategies 11.4 and 12.2 for more detail.)

- State Level:
  - CCO 2.0 Rules Advisory Committee
  - Early Hearing Detection and Intervention advisory board (EHDI)
  - Emergency Medical Services for Children Advisory Board
  - Health Aspects of Kindergarten Readiness Workgroup
  - Health Home Rules Advisory Committee

    - Medicaid Advisory Board
    - Oregon Council on Developmental Disabilities
    - Oregon Pediatric Society Board of Directors
    - Patient Centered Primary Care Home Standards Advisory Committee
    - State Interagency Coordinating Committee
- Portland Metropolitan Area:
    - Health Share (CCO) All:Ready Kindergarten Readiness Network
- OHSU
    - Institute on Development and Disability (IDD) Diversity Task Force
    - Legislative Advisory Council
    - Oregon Pediatric Improvement Partnership Steering Committee
    - Pediatrics-IDD Leadership Team
    - Primary Care Pediatrics Workgroup
    - Transition Task Force

OCCYSHN Input on CYSHCN-Related Public Policy

OCCSYHN provided input on public policies with the potential to impact Oregon CYSHCN:

- November 2018: Wrote the Oregon Health Policy Board to advocate for CCO enrollment and rates that supported CYSCHN care needs.
- February 2019: Director testified before the Oregon legislature regarding gun injury prevention for children and youth.
- April 2019: Director testified to the US Consumer Product Safety Commission regarding priorities regarding children, including CYSHCN.
- May 2019: Wrote Oregon's Joint Ways and Means Committee to support funding for 211info, which provides important information and resources to families of CYSHCN.
- August 2019: Submitted oral and written input to the CCO 2.0 Rules Advisory Committee on proposed care coordination rules with potential to impact CYSHCN. Proposed changes to rules affecting CYSCHN in the following sections: Integration and Care Coordination, Care Coordination Requirements, and Intensive Care Coordination.
- September 2019: Offered OHSU's University Center for Excellence in Developmental Disabilities (UCEDD) talking points on how the Department of Human Services' proposed Public Charge Rule could impact CYSHCN. Provided data on immigration status and eligibility for public benefits. The UCEDD team used the talking points during hill visits made as part of the 2019 *Association of University Centers on Disabilities* conference.
- 2019: Director co-authored a policy statement for the American Academy of Pediatrics regarding transportation for CYSHCN (O'Neil, Hoffman, AAP Council on Injury, Violence, and Poison, 2019).

Collaboration with 211Info

OCCYSHN's Family Involvement Program (FIP) and ORF2FHIC collaborated with 211info. This continued an effort begun with the D70 *Enhancing Systems of Care for CYSHCN* state implementation grant. The goal of the partnership was to increase 211info's knowledge of CYSHCN-related resources, and to encourage referrals to ORF2FHIC as needed. 211info administers a voluntary follow-up survey to callers, to collect data about whether callers contacted the referrals, and if so, whether their needs were met. OCCYSHN continued its financial support for collecting these survey data and provided professional development to 211info staff. The ORF2FHIC Coordinator trained 211info staff on who and how to refer to ORF2FHIC. She trained 211info staff on how to engage families in conversations that clarify unmet needs. The trainings provided ORF2FHIC with insight into the sorts of issues that might lead families to call 211info. The ORF2FHIC Coordinator worked with 211info to simplify their website's connection to ORF2FHIC. OCCYSHN's Assessment and Evaluation unit met quarterly with 211info to discuss follow-up survey and referral data from 211info's Child Care Line and Maternal and Child Health (MCH) call lines.

211info made 197 referrals to ORF2FHIC. 28 people who called the Child Care and MCH call lines responded to the follow-up survey. Of those 28 respondents, 96% reported receiving a list of referrals, and 39% reported receiving the services that they needed from the referred agency.

Emergency Medical Systems for Children (EMSC)

The Family Involvement Program (FIP) Manager served as the Family Representative to the Oregon EMSC Advisory Board. Working with physicians, EMTs, health systems, and nurses, and with input from the ORF2FHIC Parent Partners, she spearheaded development of a toolkit for families on planning for health care emergencies. OCCYSHN's Communications Coordinator designed and edited the toolkit. The FIP Manager introduced it at the August 2019 national EMSC meeting. ORF2FHIC disseminated the toolkit through Oregon Children's Intensive In-home Services program. ORF2FHIC and EMSC also collaborated to disseminate the information on social media.

Medicaid Advisory Committee

The FIP Manager continued her second term representing CYSHCN on the state's Medicaid Advisory Committee (MAC). She helped the committee craft guidance for Coordinated Care Organizations on social determinants of health, and on health-related services.

Patient Centered Primary Care Home (PCPCH) Standards Advisory Committee

OCCYSHN's director was selected as the only pediatrician on PCPCH Standards Advisory Committee, which provides the Oregon Health Authority with policy and technical expertise for the PCPCH model of care. He advocated that the PCPCH standards support children, youth, and families (especially CYSHCN).

Strategy 11.6: Conduct ongoing assessment of Oregon's CYSHCN by developing studies focused on subpopulations of CYSHCN.

Ongoing assessment of Oregon's CYSHCN consisted of the following four primary activities:

Children with Medical Complexity in Medical Home Practices

OCCYSHN's Assessment and Evaluation (A&E) unit continued 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. The study examined program implementation and outcomes from the first four years of the program. Dr. Wallace led quantitative analyses to examine changes in service utilization and costs for patients cared for in PCPCH versus non-PCPCH primary care practices. The OCCYSHN A&E Manager (Alison Martin, PhD) collaborated with Dr. Wallace in replicating these analyses for Children with Medical Complexity using the Pediatric Medical Complexity Algorithm (PMCA; Simon et al., 2014). Sara (Sally) Bachman, PhD from the Catalyst Center, consulted on the project. During FY19, Drs. Wallace and Martin continued to work on the analyses, working through challenges associated with using the PMCA for this analytic purpose. In May 2019, Shreya Roy, PhD, OCCYSHN's newest A&E Research Associate, joined Drs. Wallace and Martin in this work. Drs. Martin and Roy also began work with OCCYSHN's Communications Coordinator to develop dissemination briefs.

CYSHCN with Behavioral/Mental Health Conditions

Olivia Lindly, PhD, led the manuscript revisions of a previously prepared manuscript that Dr. Lindly, Kate Lally, MSW/MPH (OCCYSHN GSEP intern 2016), and OCCYSHN's A&E Manager prepared. The manuscript summarizes analyses using 2009-2010 NS-CSHCN data. We first submitted the manuscript to the *Maternal and Child Health Journal*, which rejected the publication. Per *MCHJ* publisher's recommendation, we resubmitted the manuscript to the *Community Mental Health Journal*.

NSCH Oversample

OCCYSHN's A&E Manager (Alison Martin, PhD) and MCH's A&E Manager, John Putz, PhD, attended the October 2018 MCHB Title V technical assistance session on the oversample and scheduled a state meeting with Ashley Hirai, PhD, MCHB Office of Epidemiology and Research Senior Scientist, and US Census Bureau colleagues. We shared this information with partners (OHA State Medical Director, OHA Office of Health Analytics, Oregon Pediatric Improvement Partnership) and identified a group of state-level partners to explore purchasing a state oversample. Dr. Martin collaborated with Suzanne Zane, DVM, MPH, Senior MCH Epidemiologist, and Elizabeth Stuart, MPH, Child Systems Collaboration Coordinator, to facilitate the group. Beginning in February 2019, the group met on a monthly basis to determine the focus of the oversample (i.e., child characteristic or geography), work through

methodological issues, and obtain cost estimates. Drs. Martin and Zane liaised with Dr. Hirai, Scott Albrecht and his colleagues from the US Census Bureau to share information and answer partner questions. In June, the group agreed on an approach for oversampling children from non-dominant races and ethnicities over two years at a cost of $146,183. The Title V and Title V CYSHCN directors discussed funding for the oversample with OHA's Office of Health Analytics and Department of Human Services Reporting, Analytics, and Information. In July, each entity (Title V, Health Analytics, and DHS) agreed to pay one-third of the cost of the oversample. OCCYSHN will serve as the contract signatory with the Census Bureau to expedite the contracting process.

Oregon Title V is extremely (a) grateful to Dr. Hirai and Mr. Albrecht for their energy, information, and time helping us develop an oversample that works for our state, and (b) proud of the collaborative efforts to develop and purchase the sample, and (c) excited to have NSCH results that 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. Although the response to the survey was tremendous with return of almost 600 usable surveys, the data did not well represent families of CYSHCN who are members of communities of Color. Therefore, OCCYSHN decided to use a participatory needs assessment approach for the 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 process and has been used for other MCH needs assessments (e.g., Wang and Pies [2004] in Contra Costa County, California). A&E identified populations of CYSHCN about which OCCYSHN needs more information. A&E solicited input from OCCYSHN staff broadly, and identified eight populations of CYSHCN. A&E presented staff with a proposal for testing a participatory needs assessment with intent to focus on three populations. We used nominal group technique, a consensus-building tool, to choose three populations on which to focus: African American/Black CYSHCN, Latinx CYSHCN, and CYSHCN with behavioral/mental health conditions. If this approach proves successful, we will use it again in the future to learn more about the five populations that were not selected this time.

In March, A&E began drafting a Request for Proposal (RFP) to contract with two community organizations: one that works with African-American/Black families, and one that works with Latinx families. We sought feedback from an ORF2FHIC Parent Partner who had experience working for an organization that serves one of these communities. We asked him what his reaction would be if the Request had come across his desk at that organization. He provided us with two rounds of excellent feedback. One of the most important points he made centered on a dominant culture organization (OHSU) "owning" the findings. He proposed that OCCYSHN instead seek to build capacity for the contracted organization to be the voice for CYSHCN within their community. This resulted in an important shift in thinking for OCCYSHN; that is, that part of our CYSHCN advocacy role includes building relationships and capacity for other organizations to advocate for CYSHCN in their respective communities.

Based on the feedback from our Parent Partner, we switched from an RFP to a Request for Information (RFI), so we could first assess whether our approach was palatable to community-based organizations. We used RFI responses to inform and finalize our RFP. The RFP Scope of Work asked community-based organizations to collaborate with OCCYSHN to (1) co-develop a partnership agreement, (2) co-develop and participate in mutual training, (3) co-develop a data collection method, including an Institutional Review Board (IRB) protocol, (4) implement data collection, (5) co-develop an analysis plan and participate in data analysis if desired, (6) co-interpret results, (7) co-disseminate findings, and (8) participate in project meetings with OCCYSHN. Only organizations that responded to the RFI could respond to the subsequent RFP. Exhibit 11.6.1 shows our timeline for awarding contracts to both the Latino Community Association (LCA) and the Sickle Cell Anemia Foundation of Oregon (SCAFO). For the remainder of the year, OCCYSHN jointly developed partnership agreements with each organization (see Appendix 1); developed the needs assessment questions, data collection methods and Institutional Review Board (IRB) protocols; and helped LCA and SCAFO project teams complete training for study team members.

Exhibit 11.6.1. Participatory Needs Assessment Contract Timeline

Date	*Activity*
April 9	RFI released
April 24	RFI responses due
May 20	RFP released
May 29	Question and Answer phone session
June 18	RFP responses due
July 2	Applicants notified of decision
July 16	Initial meeting in Bend, Oregon, with the Latino Community Association
August 8	Initial meeting in Portland with the Sickle Cell Anemia Foundation of Oregon

OCCYSHN and the OHA Adolescent and School Health section (ASH) began collaborating on a Photovoice project for youth with special health care needs (YSHCN) aged 16 through 22 years who experience behavioral or mental health conditions. Photovoice is a method that "involves providing community people with cameras so that they can take pictures of their everyday health and work realities and use these pictures as the basis of group discussion and action" (Wang & Pies, 2004, p. 184). OCCYSHN and ASH plan to recruit a small, diverse group of YSHCN in the Portland metropolitan area. Working locally will allow us ready access to support the youth in the project. If this model proves successful, we will seek to expand it to other areas of the state. OCCYSHN prepared recruitment materials and drafted an IRB protocol, with ASH's input. ASH also began communications with OHA's IRB equivalent.

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 continued to collect and analyze shared care planning (see Strategy 12.2) process evaluation data. Staff modified data collection instruments and disseminated results to LPHA partners and others.

Implementation Findings

Analysis of process evaluation data showed that 21 LPHAs created or re-evaluated 106 shared care plans for Oregon CYSHCN in 2018-2019. A Shared Care Plan Information Form (SIF) was submitted for each meeting. Of those

- 85 SIFs were for children birth to 12 years.
    - 50 were new shared care plans.
    - 35 were re-evaluated shared care plans.
- 21 SIFs were for young adults 12 to ≤ 21 years.
    - 16 were new shared care plans.
    - 5 were re-evaluated shared care plans.
- 85 SIFs were for CYSHCN identified as complex; that is, ≥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 sought to improve its family survey data collection, which OCCYSHN administers in the months following each shared care planning meeting. OCCYSHN consulted with Jeannie McAllister, BSN, MS, MHA, A&E for feedback on the family survey. In response to her advice, OCCYSHN added two of the three Parent Empowerment Scales (Koren et al., 1992) used by Ms. McAllister and colleagues, and shortened the survey instrument to items that would be most important to families. After revising the instrument, OCCYSHN pretested the survey with six parents, some who received shared care planning and some who did not, and with a Spanish-speaking parent. These parents resided in Central and Southern Oregon and the Portland metropolitan area. Results of the pretests informed minor, final revisions to the family survey.

To address poor response rates to the Family Survey, we also changed the manner in which it is administered. Previously, LPHAs presented families with a study interest form, and asked them to sign it if they were interested in completing a survey. If the family was interested, LPHA staff would fax the signed form to OCCYSHN. A&E obtained OHSU Institutional Review Board (IRB) approval to modify the Shared Care Plan Information Form (SIF) to collect family contact information. LPHAs complete the SIF following each shared care planning meeting. Submitting the family's contact information to OCCYSHN relieves LPHAs from having to discuss the study with the family.

Dr. Martin and Katharine Zuckerman, MD, MPH, considered revising our MCHB R40 FIRST impact evaluation grant proposal submitted in 2017-2018, but ultimately decided to wait until OCCYSHN finalized some programmatic changes.

CityMatCH Presentation

A&E presented year one formative evaluation findings focused on transition to adult health care at CityMatCH in 2018. We stated in our 2017-2018 report that we would share findings from this presentation in our 2018-2019 report. Select slides from this presentation follow.

A Novel Approach to Developing Shared Plans of Care for Transition-Aged CYSHCN

September 13, 2018

Alison J. Martin, PhD; Sheryl Gallarde-Kim, MSc; Tamara Bakewell, MA; Marilyn Berardinelli, BS; & Caroline B. Neunzert, MSc, RN

Oregon Center for Children and Youth with Special Health Needs

Big Picture Results, Year 1

Total SPOC Initiated	137
• Children < 12 years	102 (74%)
• Children ≥ 12 – 21 years	35 (26%)
Strategy Objectives	
• 20% of LPHAs met contract requirement	26%
• 80% of YSHCN plans address transition planning	46%

Source: 2016-2017 SPOC Information Forms

Youth Descriptives

Young Adult (n = 35) *12 years old up to 21 years*
Average age: 15 years
Reported frequency of condition types • Developmental (80%) • Social complexity (80%) • Behavioral/mental (69%) • Medical (69%)
Race/Ethnicity • 89% Caucasian/White • 6% "I don't know" • 31% Hispanic or Latino origin or descent
Language: 17% speak Spanish as their primary language

Source: 2016-2017 SPOC Information Forms

Types of Partners Involved in the Creation of a SPOC

Partner type	Young Adult (%)
Family members*	**91**
Public health*	**86**
Education (not EI/ECSE)	**69**
Primary medical care	**54**
Mental Health	**49**
DHS DD Services	40
Other	31
Specialty Medical Care	29
YSHCN	20
Insurer	**17**

Source: 2016-2017 SPOC Information Forms

Why shared care planning for this young adult/family?

Reasons	%
Family indicated that they need more help or support	80
Young adult or family has considerable unmet basic needs or environmental risks	63
Young adult's family has trouble making, keeping, or getting to appointments	60
Young adult's medical conditions are complex	57

Source: 2016-2017 SPOC Information Forms

Transition Goals

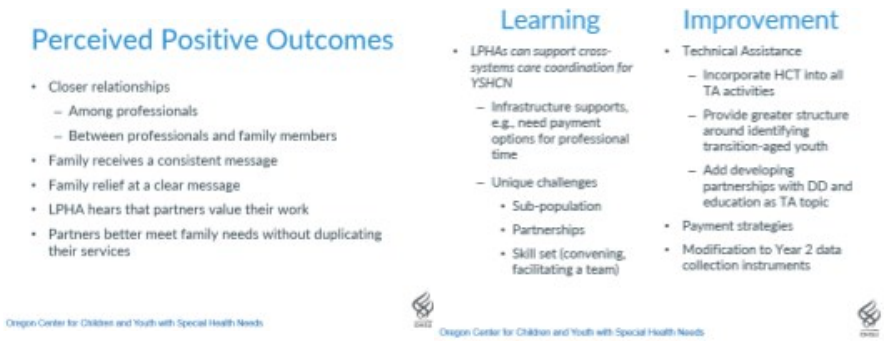
- 9 LPHAs included healthcare transition goals
- For 16 YSHCN

Transition Goals (cont.)

- Managing own healthcare (n=8 counties)
  - *"For the youth to manage his factor infusions on his own, instead of relying on his parents to do them."*
- Achieving/supporting non-healthcare transition (n=5)
  - *"...to create a plan for community involvement after high school."*
- Identifying an adult provider (n=2)
  - *"Identifying possible adult primary provider for client."*
- Working with DD services (n=1)
  - *"Connect with Developmental Disabilities Services to provide continued support now and when client ages out of other programs."*

Barriers/Challenges

- Difficulty identifying YSHCN (n=4 counties)
  - *"Given our usual referral sources only send us pregnant moms and infants, we have reached out to our local Developmental Disabilities Department as well as the local OHSU affiliate..."*
- Time consuming work (n=6)
  - *"Time required to get a meeting off the ground; can be a full time job even with cooperating partners"*
- Limited LPHA staff time/schedules (n=4)
  - *"Staff time is limited, and there is no clerical support"*
- Identifying and engaging partners (n=5)
  - *"Getting the school on board; they didn't initially see the value"*
  - Provider participation (n=4)
    - *"Obtaining provider participation is difficult because the provider will lose 8+ visits participating in a 2 hour meeting"*
- Partner schedules (n=3)
  - *"All partners have differing schedules; aligning them is challenging"*



2019 Report: NPM 12 Health Care Transition (HCT)

National Performance Measure 12: Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care.

Report on Strategies and Activities October 2018– Sept 2019

Strategy 12.1: Increase the number of family members of YSHCN who are informed about HCT through community conversations and the dissemination of resources based on Got Transition materials.

The Family Involvement Program (FIP) Manager sits on the Advisory Board, the Implementation Team, and the Core Team for the Oregon's Children with Medical Complexity (CMC) CoIIN project. Oregon's project focus is transition from pediatric to adult health care. In this role, she helped coordinate interviews conducted with 12 families of children with medical complexity. A number of families reported challenges in the transfer from pediatric to adult specialty care. Because the focus of the CoIIN is transfer from pediatric to adult primary care, the FIP Manager initiated collaboration with the CDRC Transition Lifespan Clinic (TLC) to help families with transitions to adult specialty care.

The FIP Manager and the TLC met three times to design a toolkit for families to be used in their child's 16th or 17th year to help them find adult medical specialists. The 48 page workbook draft will be vetted with parents of transition-aged youth in March, 2020. The workbook draws on materials from the ORF2FHIC, Got Transition, and the University of South Florida. The goal was to help families whose youth experience Intellectual/Developmental Disabilities, as well as those who do not, and, and to help families navigate the transition to adult health care in general.

The ORF2FHIC workshop "Planning for a Healthy Transition" was presented six times in five communities, reaching 124 families. The training included activities to spark awareness of the upcoming transition in health care, orientation to "Got Transition" readiness checklists, a review of ways for families to identify potential adult health care providers, examples of key questions to ask both pediatric and adult providers, and an introduction to a One Page Profile to introduce CYSHCN to new health care providers.

Twenty-seven youth participated in two listening sessions focused on their experience with health care as they near transition age. One session was comprised of Native American youth from Portland. The other was held at the Kidney Kids Camp in Turner Oregon, which draws teens from Oregon and southwest Washington. The discussions centered on whether or not youth experienced barriers in health care, and if they did, how they overcame them. Many noted that they were unaware of barriers or problems but if there were any, their parents managed them. One youth commented, "My mom is there and I am lucky." Some youth noted that they could use more support for healthy eating, and others discussed concerns about working with school nurses. Both groups discussed what they felt youth could do to promote their own health care, and highlighted such things as "We can ask for help" "share our experiences" and "help each other." Both groups included youth who said that mental health needs should be considered part of overall health.

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.

CaCoon

CaCoon is a statewide public health program that provides community-based care coordination for CYSHCN (0-21 years old) through nurse home visiting and shared care planning. Since integrating shared care planning into the CaCoon workflow, OCCYSHN has encouraged the public health workforce to target services to transition-aged youth. OCCYSHN has also focused technical assistance on building capacity for the public health workforce to support youth and families with the transition from pediatric to adult health care.

In March 2019, OCCYSHN hired a new nurse Care Coordination Specialist to support the CaCoon program. The new Care Coordination Specialist visited 14 LPHAs in person to gain a better understanding of the CYSHCN work happening in their counties, and to learn what they need to serve transition-aged youth. Each meeting covered the following: staffing and staff roles; documentation and use of electronic record-keeping systems; county-level training of new staff; community collaboration and community understanding of the work; barriers to serving transition-aged youth; Targeted Case Management billing; collaboration with Coordinated Care Organizations (CCOs); and caseloads. These meetings strengthened OCCYSHN's relationships with the public health workforce. OCCYSHN learned about the successes and challenges LPHAs encountered as they implemented CaCoon, and offered individualized technical assistance. These visits provided context that informed OCCYSHN's statewide planning efforts.

Several LPHAs reported difficulty identifying transition-aged youth to serve, and a shortage of local community resources for this age group. CaCoon nurses serve mostly CYSHCN aged 0-5 years. Despite these challenges, there was steady improvement in the number of transition-aged youth who received shared care planning. Clackamas County developed a relationship with the CDRC Lifespan Transition Clinic in Portland. The CaCoon nurse attends the clinic's meetings regularly to discuss her transition-aged clients. The clinic appreciates the opportunity for closed-loop referrals to community resources. OCCYSHN shared tools and resources for LPHA nurses and community health workers to use with transition-age youth. These included the following tools from Got Transition: a) transition readiness assessments for youth and caregivers; b) transition readiness assessments in Spanish; c) transition readiness assessments for youth with intellectual disability; and d) a coaching tool to use with families to gauge their attitudes towards planning for transition. OCCYSHN also developed and shared sample language to guide discussion with families and youth, and a transition planning timeline. OCCYSHN provided technical assistance to some LPHAs on implementing shared care planning for transition-aged youth.

Turnover in the CaCoon workforce was high, and new hires were often inexperienced. A shortage of nurses in rural areas impacted LPHA capacity. Three new nurses completed the CaCoon orientation for LPHA staff, which consists of a PowerPoint curriculum, an assessment, and participation in a 30-60 minute three-way phone call with the nurse trainee, their supervisor, and OCCYSHN's Care Coordination Specialist. During the call, the group discusses the new nurse's knowledge of CYSHCN needs, and their plans for continuously improving their CaCoon practice.

Additionally, in partnership with the OHA's Maternal Child Health (MCH) Nurse Team, OCCYSHN developed a series of three web-based gatherings for LPHA staff who are in their first couple years of CaCoon and/or Babies First! work. The objectives of these gatherings were to: a) provide an introduction or review of both programs; b) ensure that all staff have access to and know how to access trainings and resources; c) review required documentation and data entry; d) create an opportunity to support and learn from each other; and e) answer specific questions from staff. Nine staff attended, including both nurses and Community Health Workers. The September 2019 meeting included an overview of both programs, descriptions of target populations, a home visiting competency review, the basics of Targeted Case Management billing, and training resources.

OCCYSHN's Care Coordination Specialist participated in planning meetings for the development, training, and rollout of a new data collection system for LPHAs: Targeting Home Visiting Effectiveness (THEO). Additionally, the Care Coordination Specialist met monthly with the OHA MCH Nurse Team to ensure that statewide home visiting programs aligned. This collaboration was important given overlap in the local public health workforce. Twenty-six of 29 LPHA staff who implement CaCoon also implement Babies First!, which is OHA's MCH public health nurse home visiting program for expecting mothers, infants, and children up to five years of age.

Shared Care Planning

OCCYSHN explored ways to support a learning community for public health staff who engage in shared care planning. We shifted from a monthly didactic webinar format to using the University of Mexico's Project ECHO Model, which emphasizes case-based learning and group problem-solving. All OCCYSHN implementation staff took part in a three-day immersion training in Albuquerque, NM, to understand how to implement and support the ECHO model. Each ECHO session features a short, 15-20 minute didactic presentation, with the rest of the session

devoted to case-based learning. Instead of shared care planning cases, which can be too narrowly focused on individual children and conditions, partners shared “practice situations,” which outlined shared care planning themes like workflow, partnership development, or systems challenges. Feedback from participants was generally positive, especially when sessions featured special guest presenters. Following each session, OCCYSHN shared relevant materials, recordings, and other resources in Box—a secure, cloud-based platform—where partners could access the materials at their convenience.

The transition to the ECHO model occurred incrementally over the last year. We incorporated aspects of case-based learning as early as December 2018, when we began a three-part monthly series on shared care planning for a hypothetical transition-aged youth. Other monthly technical assistance topics focused on culturally and linguistically appropriate services, including communicating clearly about shared care planning, and hosting attorneys from the Oregon Law Center and Immigration Counseling Service to discuss immigration law and public benefits. Sessions on family-centered issues included communicating with families about shared care planning, and linking shared care planning goals to family-led organizations and resources. Most sessions included the Family Involvement Program Manager as an expert panelist representing the family perspective. Official ECHO sessions started in April 2019, when the Doernbecher Lifespan Transition Clinic talked about goal-setting and prioritization for YSHCN.

OCCYSHN staff consulted monthly via virtual meetings with Jeanne McAllister, BSN, MS, MHA, a national subject matter expert on medical home and shared care planning. OCCYSHN’s shared care planning for CYSHCN got national attention in October 2018, when it was featured in a National Academy for State Health Policy (NASHP) report entitled “State Strategies for Shared Plans of Care to Improve Care Coordination for Children and Youth with Special Health Care Needs” (Wirth et al., 2018). The report was published online with an accompanying webinar featuring OCCYSHN staff and Jeanne McAllister.

ESM 1: Percent of shared care plans initiated or re-evaluated by county public health departments contracting with OCCYSHN that serve transition-aged youth 12 years and older. The FY18 objective was 15%, and 19.3% of shared care plans created or re-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 FY18 objective was Our FY18 objective was 85%, and 66.7% of shared care plans addressed transition planning (see Form 10 for more detail).

Regional Meetings

OCCYSHN continued to host annual regional meetings with public health partners statewide. In 2019, regional meetings were held in Salem, Tualatin (Portland metropolitan area), La Grande, Roseburg, and Bend. The relationship between the shared care planning process and CaCoon practice was an ongoing topic of discussion at the meetings, where local public health partners worked in tandem with their colleagues and community partners. Together, they brainstormed new strategies and reflected on the successes and challenges of implementing shared care planning. OCCYSHN’s Family Involvement Manager and Director each led interactive sessions with meeting attendees.

As a highlight of the annual Regional Meetings, Jeanne McAllister spoke via Zoom conference about her practice-based workflow for shared care planning, and the importance of co-producing care plans with families. Despite the technical challenges of hosting five remote sessions, partners in remote parts of the state benefitted from her expertise and consultation.

Contracts and Funding

OCCYSHN maintained the LPHA CaCoon contract requirements that 70% of the award be used to implement shared care planning and 30% to support the implementation of home-visiting services. OCCYSHN allowed some flexibility in scopes of work based on LPHA and community needs, and where there were opportunities for innovation in cross-systems care coordination for CYSHCN.

In fall of 2018, OCCYSHN awarded supplemental funding to 28 public health partners implementing shared care planning. The funds were intended to help partners build the community infrastructure necessary to support shared care planning more robustly, including developing partnerships, processes, policies, tools, and technology. OCCYSHN provided guidance on how to use the funds, integrating a quality improvement approach. LPHAs were encouraged to develop change packages to improve their shared care planning work. They shared their ideas about using the infrastructure funds with one another. OCCYSHN intentionally allowed for flexibility in how LPHAs used the funds.

OCCYSHN tracked the use of the infrastructure funds with additional questions on the End of Year Report required of all contracted partners. About two-thirds of contracted LPHAs reported using all the additional funding, and about one-third reported using some of it. Most reported that the infrastructure funds were used to develop new partnerships for shared care planning, such as with local medical providers or Developmental Disabilities offices.

About half developed new processes to support shared care planning, such as a referral process between public health and education, or translation services to increase meaningful language access. Six LPHAs developed shared care planning templates for electronic health records. These templates were shared on Box for other LPHAs to adopt or adapt.

Some examples of infrastructure fund investments include projects developed by North Central Public Health District (NCPHD), Deschutes County Public Health, and Marion County Public Health. NCPHD, which encompasses three counties, used part of their infrastructure funds to host outreach meetings in The Dalles and Moro. In these meetings, the OCCYSHN director was invited to present to local health care providers about shared care planning, and opportunities to participate on North Central's developing care coordination team. Other counties improved their infrastructure for shared care planning by developing tools and integrating technology. Deschutes County, for example, developed a smart phrase in their electronic health record that allowed them to quickly locate a child or youth's shared care plan. Finally, Marion County planned and hosted a conference on the transition from pediatric to adult health care. They invited local and statewide partners to share strategies and resources to improve systems of care for transition-aged youth.

Innovation

Due to workforce capacity issues, two LPHAs were not able to implement the CaCoon program this contract year. Instead, they focused on innovative ways to meet care coordination needs. OCCYSHN and Umatilla County Public Health began collaborating on a care coordination needs assessment for CYSHCN, while Josephine County Public Health began exploring a new, collaborative model of care coordination.

Strategy 12.3: Increase the capacity of adult providers to provide care for transition YSHCN by conducting professional development activities using Got Transition resources with 4 adult practices.

OCCYSHN continues to build staff capacity to support adult health care providers on addressing transition. OCCYSHN staff have developed expertise in transition by a) developing transition materials for LPHAs, b) researching Oregon-specific transition information in preparation for a technical assistance visit from the National Alliance to Advance Adolescent Health, c) participating in a visit with Got Transition, d) participating on the OHSU Transition Task Force and e) attending a transition-related trainings.

As OHA was planning for the second round of contracts with Coordinated Care Organizations, Oregon's Governor directed that contract efforts be aimed at four key areas, one of which was "increasing value and pay for performance." Given this state context and the potential to bolster transition work, OCCYSHN requested technical assistance from the National Alliance to Advance Adolescent Health (NAAAH) on value-based payments. Staff prepared for the site visit by researching policies on CCO rules, reimbursement CPT codes, and other state regulations. NAAAH staff provided two days of technical assistance for five OCCYSHN staff and two providers from OHSU's General Pediatrics and Adolescent Health Clinic. OCCYSHN collaborated with NAAAH to develop a plan to promote value-based payment for the transfer from pediatric to adult care. The next steps will support CMC CoIIN efforts (see below).

OCCYSHN continued to collaborate with OHSU Institute on Development and Disability's (IDD) Lifespan Transition Clinic (LTC). The clinic assesses transition needs and helps families and youth identify transition goals. Youth are referred by OHSU General Pediatrics and pediatric specialty clinics. OCCYSHN supported relationships between the Lifespan Transition Clinic and two LPHAs that were working with local medical homes to coordinate care for youth with special health care needs (YSHCN) and their families.

OCCYSHN collaborated with IDD and OHSU General Pediatrics to put together a town hall event focused on autism and transition. A panel of professionals representing various systems, youth and young adults experiencing autism, and parents of youth with autism shared their perspectives on transition. The panel took questions from an audience of about 100 parents, youth, and professionals.

OCCYSHN participated in a workgroup to develop OHSU Transition Guidelines. The workgroup also included representatives from General Pediatrics and Adolescent Health, General Internal Medicine, Child Development and Rehabilitation Center, Knight Cardiovascular Center, Schnitzer Diabetes Center, and the Office of Clinical Integration. The guidelines, which provide structure for undertaking transition work, were approved by the Clinical Knowledge and Therapeutic Executive Committee and the OHSU Professional Board. The workgroup is developing a plan for dissemination and implementation among all OHSU departments, and is also informing the development of a transition template to be integrated into Epic's Healthy Planet module. Future work for the group will focus on the transfer to adult care.

OCCYSHN provided technical assistance to Marion County Public Health Department to develop a conference focused on cross-systems care coordination for transition. The goal was to share transition information, and to

increase local partnerships for serving YSCHN. OCCYSHN presented at the conference. Marion County Public Health's efforts were supported with shared care planning infrastructure funds from OCCYSHN.

OCCYSHN provided technical assistance to the Coos County LPHA to support their systems-level transition work, and to build the capacity of local healthcare providers.

Children with Medical Complexity (CMC) CoIIN Project

To align with our state Title V CYSHCN priority, Oregon's CoIIN project focuses on health care transition. FY19 overlapped with CoIIN project years two and three. During this time, members of the Advisory Team formed three workgroups. Each workgroup explored the feasibility of a quality improvement strategy that aligned with one of our prioritized root causes. The workgroups focused on the following strategies: (1) Explore a payment approach that incentivizes adult providers to work with Young Adults with Medical Complexity (YAMC); (2) Test the use of a payor-level structure to facilitate transition between pediatric and adult medical and mental health providers; and (3) Develop and test an eConsult model for adult providers to use when working with YAMC, based on the work of Anderson et al. (2018) and the Oregon Psychiatric Access Line - Kids (OPAL-K). After consulting with Boston University's grant leadership and our state coach, we agreed to focus our clinical quality improvement project on the second option.

We met initially with a health plan administrator who works with three of Oregon's Coordinated Care Organizations (CCOs). She expressed interest in exploring how their Regional Care Team concept for adults could support transfer of care for YAMC. Unfortunately, the timing of our project development coincided with OHA's release of the next round of CCO contracts ("CCO 2.0"). Therefore, no CCO had bandwidth to explore a project with us.

As an alternative, we collaborated with Reem Hasan, MD, PhD, and Reyna Lindert, PhD, RN. Dr. Hasan is an Internal Medicine/Pediatric Physician ("med peds") and leads the Complex Care Collaborative at Doernbecher Children's Hospital's General Pediatrics and Adolescent Health Clinic. Dr. Lindert is a clinic nurse with significant experience in care coordination. We formed a CoIIN Implementation Team consisting of our Oregon CoIIN Principal Investigator (Alison Martin), Project Coordinator (Shreya Roy), OCCYSHN Family Involvement Program Manager (Tamara Bakewell), CoIIN Family Representatives (Ana Valdez, BranDee Trejo), OCCYSHN Systems & Workforce Development Manager (Marilyn Berardinelli), OCCYSHN Assessment & Evaluation Research Associate (Sheryl Gallarde-Kim), Dr. Hasan, and Dr. Lindert. The Implementation Team started developing a three-stage process for transferring YAMC from pediatric to adult primary care. Drs. Hasan and Lindert worked with OHSU Hospital research analysts to develop a reporting tool to identify YAMC aged 17 years and older still seen in the pediatric clinic, and a workflow for asking pediatric PCP permission to approach the family about the project. Implementation of the QI project began in September 2019 and is ongoing.

In March 2019, Ms. Bakewell, Ms. Trejo, Ms. Valdez, and Dr. Martin presented at AMCHP's annual conference in San Antonio. The presentation, entitled *Creating Meaningful Settings to Strengthen Family Involvement*, described Ms. Trejo and Ms. Valdez's roles on the CoIIN Advisory Team and their unique roles in developing a data collection method and collecting interview data for the environmental scan. Presenters also talked about team processes that supported their meaningful involvement. The presentation is available on YouTube (https://www.youtube.com/watch?v=AUjGEh8Cb74).

Strategy 12. 4: Increase pediatric provider awareness of transition services by incorporating HCT assessment in adolescent well visits.

OCCYSHN and OHA MCH Adolescent Health were planning to integrate transition readiness assessments into the OHA Adolescent Well Care Guide in line with the OHA Transformation Center. A CCO metric on increasing overall adolescent well-care rates for young adults 18-21 was expected to drive this work. We stopped work on this effort when the metric was changed, effectively eliminating the driver for change.

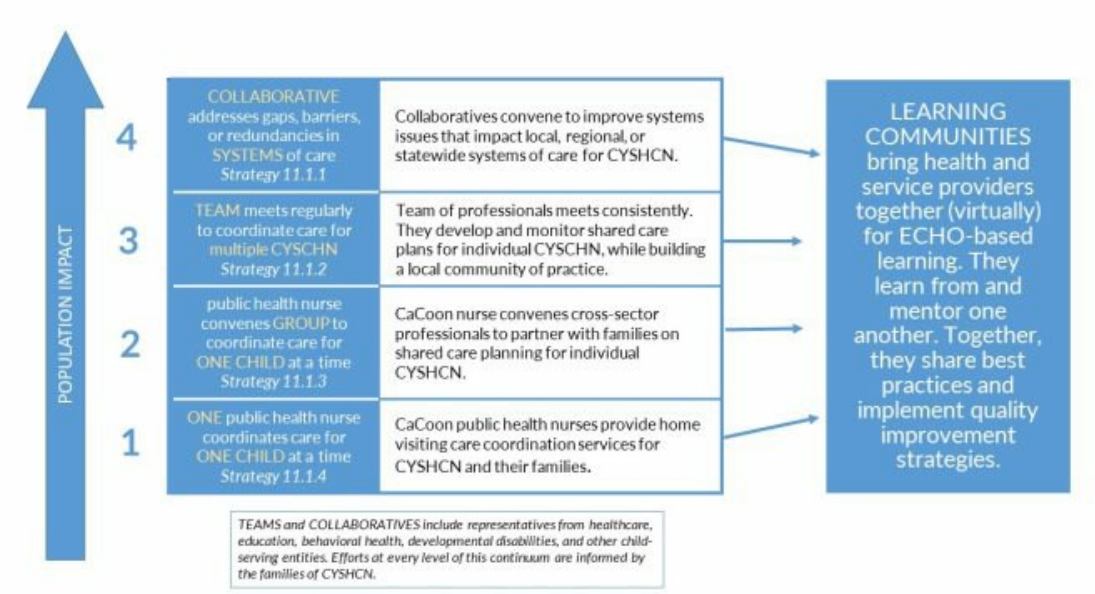
2021 Plan: NPM 11 Medical Home

National Performance Measure 11: Percent of children with special health care needs having a medical home

Planned strategies, ESMs and activities for October 2020 – September 2021

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.

OCCYSHN supports a continuum of cross-systems care coordination efforts at four levels, using evidence-informed approaches:



11.1.1. Quality Improvement Collaboratives for CYSHCN (QICC)
Over the next five-year block grant period, OCCYSHN will build on CaCoon, shared care planning, and community-based care coordination teams to support Quality Improvement Collaboratives for CYSHCN (QICC). These collaboratives may work at the local, regional or state level. Collaboratives will identify needs, barriers, gaps, and inefficiencies in the system of care for CYSHCN. They will work to address those issues using evidence-based quality improvement approaches. They may be informed by the work of community-based care coordination teams (see 11.1.2), though that is not required. The goal is to align systems and supports to effect change for CYSHCN, which ultimately benefits children and youth more broadly. OCCYSHN will align the work of QICCs with the Community Alignment component of Family Connects, OHA's universally-offered newborn home visiting program. OCCYSHN will use lessons learned from the Regional Approach to Child Health (REACH) pilot to inform support of QICCs.

11.1.1.1. Family Involvement. We will leverage our Family Involvement Program (FIP) and the Oregon Family-to-Family Health Information Center (ORF2FHIC) to ensure that family perspective is consistently represented in the work of QICCs.

11.1.1.2. Culturally and Linguistically Appropriate Services (CLAS). We will engage culturally responsive service organizations to inform development and function of QICCs.

11.1.1.3. Systems & Policy. Through the work of QICCs, OCCYSHN will identify key systems-level issues that impact the well-being of CYSHCN. We will support individual QICCs to address these issues at local and county levels, and we will collaborate with key partners to address the issues at health systems, state and federal levels. Systems issues assessed and addressed will include payment, scope of practice and service waiting lists.

11.1.1.4. Evaluation. We will continue to develop and implement formative and process evaluation of QICCs.

11.1.1.5. Communication. We will develop and disseminate products to communicate findings and learning to local, state, and national audiences.

11.1.2. Piloting "Activate Care" Care Coordination Teams (PACCT)

OCCYSHN continues to leverage lessons learned from the Community Connections Network program, which was in place for more than 30 years, and formally concluded in September 2017. For the Piloting "Activate Care" Care Coordination Teams (PACCT) project, community-based care coordination teams meet regularly to triage referrals, review open care plans, problem-solve, and coordinate services for the population of CYSHCN in their community, and to provide shared care planning services for individual CYSHCN and their families. PACCT teams participate in a virtual learning community, using the ECHO model for building distance-based learning communities. PACCT is also piloting Activate Care (formerly ACT.md), which is a cloud-based care coordination software platform. OCCYSHN will continue to provide funding and technical assistance to support existing PACCT teams, and to develop new community-based care coordination teams with LPHAs and other entities (e.g., primary care clinics, Education Service Districts, and Coordinated Care Organizations). OCCYSHN will continue piloting Activate Care through BGY 2022-2023.

11.1.2.1. Family Involvement. We will leverage our Family Involvement Program and the ORF2FHIC to ensure that family perspective is represented on community-based care coordination teams.

11.1.2.2. CLAS. We will engage culturally responsive service organizations to develop materials (e.g., curriculum, Transformation Center video, etc.) for workforce development.

11.1.2.3. Systems & Policy. We will continue to inform the health information technology work at Oregon's Health Leadership Council, and strengthen our relationships with stakeholders there. We will explore financial barriers to health care provider participation in community-based care coordination teams, and payment codes that support their participation.

11.1.2.4. Evaluation. We will continue to implement formative and process evaluation activities (e.g., those begun in 2019-2020) for new and continuing PACCTs.

11.1.2.5. Communication. We will develop and disseminate products to communicate our findings and learning to local, state, and national audiences.

11.1.3. Shared Care Planning

LPHAs integrate a shared care planning process into their CaCoon work with families to ensure a family and child centered approach to addressing needs and meeting goals. CaCoon nurses convene individual families and professionals who serve their CYSHCN to develop a family-centered shared care plan. Shared care planning includes the CYSHCN's primary care provider and appropriate health, education and community service providers. We will continue to provide funding and technical assistance for shared care planning (including support for quality improvement efforts), to LPHAs and other partner entities (e.g., primary care, Education Service Districts [ESD], Coordinated Care Organizations [CCO]).

To address public health workforce deficits, we will support the expansion of Community Health Workers (CHW) in LPHAs. We will develop a family-centered, team-based care coordination training curriculum for CHWs across the state, including those in public health, pediatric primary care practices, CCOs, and community-based organizations.

11.1.3.1. Family Involvement. We will leverage the FIP and the ORF2FHIC to ensure that families are involved in curriculum development. FIP will be available for technical assistance to LPHAs, primary care practices, CCOs and other health systems connected to OCCYSHN work.

11.1.3.2. CLAS. Oregon LPHAs who contract with OCCYSHN most frequently serve White and Latinx CYSHCN. We will collaborate with service organizations that serve Oregon Latinx communities to critically review and provide feedback on the cultural responsivity of our shared care planning materials. We will collaborate with partners to adapt or modify these materials as needed. OCCYSHN will develop internal capacity to support our partners to address the healthcare needs of the LGBTQ+ population. We will incorporate inclusive language into program materials, including incorporating a field for client pronouns in the shared care planning template. OCCSYHN will identify professionals from the field to provide technical assistance and training on culturally and linguistically appropriate services for LPHAs and their partners.

11.1.3.3. Systems & Policy. We will collaborate with state-level partners implementing Oregon's Integrating Care for Kids (InCK) grant to ensure alignment between their strategies and Title V CYSHCN shared care planning. We will continue to build and nurture relationships with Oregon CCOs and commercial insurers to expand support for shared care planning, and we will engage them as partners with other stakeholders in the process. We will explore the use of existing billing codes to reimburse behavioral/mental, primary, and specialty health care provider/representative for participating in shared care planning. ORF2FHIC Parent Partners and other family leaders will inform this work.

11.1.3.4. Evaluation. We will continue to design and implement evaluation activities to build a local evidence base for shared care planning activities. In addition to our Family Survey data collection, we will develop a telephone interview data collection method and administration procedures to collect qualitative data describing families' experiences with shared care planning.

> **ESM for NPM 11:** The percentage of shared care plans that have a representative of primary care help LPHAs prepare for or participate in shared care planning meetings. **Objective:** 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.

11.1.3.5. Communication. We will develop and disseminate products to communicate our findings and learning to local, state, and national audiences.

11.1.4. Care Coordination (CaCoon) Public Health Nurse Home Visiting

For over 30 years, OCCYSHN has contracted with LPHAs to coordinate care for CYSHCN using public health nurse home visiting. OCCYSHN will continue to contract with LPHAs to provide this service, and will continue to provide technical assistance and training to the CaCoon workforce. Support will include information about CYSHCN generally, condition-specific information, cross-systems care coordination, and training for CaCoon supervisors on public health modernization. We also will continue to collaborate with OHA MCH to align training topics, given that CaCoon and Babies First! share a public health nurse workforce.

11.1.4.1. Family Involvement. The FIP staff, including Parent Partners, will contribute to workforce training efforts by providing family perspective, and by sharing resources and connections to relevant community supports and services.

11.1.4.2. CLAS. We will provide the CaCoon workforce with technical assistance and training to improve and increase culturally and linguistically appropriate services.

11.1.4.3. Systems & Policy. We will collaborate with OHA MCH and other state-level partners to align our efforts with other home visiting (HV) programs.

11.1.4.4. Evaluation. We will continue to support alignment of required forms and data collection for CaCoon with Babies

First! home visiting program. We will continue to support migration of home visiting data from ORCHIDS to THEO. We will provide analytic results for program implementation monitoring purposes triannually.

11.1.4.5. Communication. We will develop and disseminate products to communicate our findings and learning to local, state, and national audiences.

11.1.5. Emergency Medical Systems for Children (EMS-C) Registry for CYSHCN

Through OCCYSHN's contributions to state-level policy bodies affecting CYSHCN (See 11.1.6.3), opportunities have arisen for leading innovation in cross-systems care coordination. Learnings from families and EMS professionals point to the need for both planning and coordination should CYSHCN require emergency treatment, transport, and care. For CYSHCN who are medically complex or who experience psychiatric conditions, EMS services are an often-used and vital part of their care. The following innovation fits well within OCCYSHN's Medical Home strategies.

In addition, we will collaborate with Oregon's Emergency Medical Systems for Children agency and the Oregon Health Authority to explore developing a voluntary, statewide EMS-C Registry for CYSHCN. The registry would allow families of children with medical or behavioral complexity to inform EMS agencies and hospital systems about their unique needs before a health emergency occurs.

11.1.6. Leverage Family-to-Family Health Information Center Grant

The co-location of the Oregon Family to Family Health Information Center within OCCYSHN will provide opportunities to integrate family voice and experience into all efforts. In addition to leveraging the lived expertise of the Parent Partners who work at OCCYSHN, we will recruit diverse family leaders from programs around the state, as well as OR F2F HIC callers with compelling personal stories related to issues OCCYSHN is working on. We will pay families an honorarium for their time and expertise.

1. We will continue to engage families in topic-specific listening sessions to inform our innovation and planning. Families will receive training and orientation related to tasks they are asked to complete. For example, families will be taught about the basics of federal block grants before being asked to advise on OCCYSHN Block Grant application.
2. At least twice a year, ORF2F will train 211info call center staff on appropriate referrals for CYSHCN, new resources, and information about the experiences of CYSHCN families.
3. We will collaborate with the Autism Society of Oregon, United Cerebral Palsy and other established, condition-specific family organizations to implement ECHO-based trainings for family members of CYSHCN. The purpose is to inform families about medical home and healthcare transition concepts, and to enhance family-professional relationships.
4. We will start developing a youth advisory board for the Family Involvement Program, to ensure that the lived experience of youth with special health care needs is reflected in OCCYSHN's work.

11.1.6.1. CLAS. We will continue building "Familia a Familia" through the efforts of the new Bilingual Training and Outreach Specialist. Familia a Familia will provide ORF2FHIC services to Oregon's Spanish-speaking communities. Rather than translate existing materials from English, we will collaborate with families to develop culturally responsive and linguistically appropriate materials.

We will engage culturally specific service organizations to help us develop appropriate materials for families (e.g., curriculum, Transformation Center video, and other materials) from other cultural groups as well.

11.1.6.2. Systems & Policy. We will support family representation on Oregon's Medicaid Advisory Committee, the State Interagency Coordinating Council, the Oregon Insurance Advisory Council, Emergency Medical Systems for Children, and the Medicaid Ombudsman's Advisory Council. Using a framework for meaningful family involvement, we will support state and federal agencies (e.g. OHA, DHA, and FEMA Region X) in their efforts to recruit and retain family representatives.

11.1.6.3. Evaluation. The Assessment and Evaluation unit at OCCYSHN will continue to support data collection, analysis, and reporting for ORF2FHIC. We will continue to collaborate with 211info and FIP to analyze and report on follow-up call data. We will collaborate on administration of 211 info “secret shopper” data collections, and we will analyze and report on these data.

11.1.6.4. Communication. We will develop and disseminate products to communicate our findings and learning to local, state, and national audiences. We will partner with families to find and share first-person stories that illustrate the impacts of systems issues and interventions.

11.1.7. Policy

OCCYSHN will continue to serve on policy-making bodies, including the PCPCH Standards Advisory Committee, and we will track policy relevant to equitable access to care for CYSHCN. OCCYSHN will provide information on systems barriers related to social determinants of health for low-income CYSHCN to inform the policy agendas of the Oregon Health Authority, community-based organizations, and advocacy groups. These include the Oregon Law Center, Oregon Pediatric Society, Oregon Medical Association, and the All:Ready Network. We will continue to submit testimony, public comment and guidance as appropriate. We will develop, strengthen, and leverage strategic partnerships in support of our National and State Performance Measure strategies.

11.1.8. Assessment

OCCYSHN will conduct ongoing needs assessment activities during each block grant year. 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. Ongoing needs assessment activities will include:

1. Annual examination of updated National Survey of Children’s Health (NSCH) results
2. Biannual preparation of data “snapshots” summarizing NSCH results across years (e.g., 2016-2017 compared to 2018-2019, compared to 2020-2021, etc.) that will be available on our website and disseminated to relevant decision-makers
3. Implementation of participatory needs assessment activities to better understand the needs of specific populations of CYSHCN (e.g., Asian, Native Hawaiian/Pacific Islander, Native American/Alaska Native, living in foster care, or those who experience behavioral/mental health conditions) for whom state-level data are not available. This work will be based on OCCYSHN’s test of participatory needs assessment with the Latino Community Association (Latino CYSHCN in Central Oregon) and Sickle Cell Anemia Foundation of Oregon (Black CYSHCN throughout Oregon) for our 2020 five year needs assessment.
4. Collection of administrative or other data that describe barriers to accessing specific care and, when able, data describing the waiting lists for specific care and services (see Section S2.1.1.).

Critical Partnerships

- County Local Public Health Authorities
- Culturally-Specific Organizations (AYCO, IRCO, LCSNW, Open Doors, Unete)
- DHS Community Developmental Disabilities Programs
- Doernbecher Maternal Fetal Medicine Clinic
- Family Voices/LFPP
- Health Share Systems Integration All:Ready Task Force
- Latino Community Association
- LEND trainees and Training Coordinators (7 disciplines)
- Neal Wallace, PhD, OHSU-PSU School of Public Health
- OHA Medicaid Advisory Committee
- OHA Ombuds Program
- OHP Care Coordination Program
- OHSU General Pediatrics
- OHSU IDD/CDRC
- OHSU Language Services
- OHSU OPAL program
- OHSU specialty clinics
- Oregon Department of Consumer Business Services (Insurance Regulative Authority)
- Oregon Emergency Services for Children
- Oregon Family Networks (9)
- Oregon Health Authority Birth Anomalies Surveillance System
- Oregon PCPCH Program
- Other family organizations (15)
- Professional Organizations (Oregon Pediatric Society, Children's Health Alliance, Oregon Family Workforce Association, Oregon Nurses Association)
- Sickle Cell Anemia Foundation of Oregon

2021 Plan: NPM 12 Health Care Transition (HCT)

National Performance Measure 12: Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care.

Planned strategies, ESMs and activities for October 2020 – September 2021

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.

12.1.1. Workforce Development

OCCSYHN will continue to integrate the transition from pediatric to adult health care into PACCT team efforts, shared care planning, and CaCoon home visiting services. In support of this work, we will continue providing technical assistance and training to families, health care providers and other OCCYSHN partners. We will focus on continuous quality improvement, and also explore innovative partnerships focused on health care transition using competitive RFPs.

OCCYSHN will host regular statewide conferences to build workforce capacity for cross-systems care coordination, and to support the transition from pediatric to adult care. OCCYSHN will also organize regional meetings that build capacity of our contracted partners as well as their local partners and teams.

12.1.1.1. Family Involvement. The FIP/ORF2FHIC will support health care transition workforce development by providing parent and youth voices to training and technical assistance activities. This will help maintain a grounding in the family experience for professionals. We will connect professionals to transition-specific materials and resources from national family organizations such as Family Voices.

12.1.1.2. CLAS. OCCSYHN will provide technical assistance and training on CLAS topics as they relate to the transition from pediatric to adult care. These will include topics such as meaningful care for the LGBTQ+, African-American, and Latinx populations. Through the ORF2FHIC's "Familia a Familia," we will begin to train Spanish-speaking families on health care transition concepts.

12.1.1.3. Systems & Policy. OCCYSHN representatives on Oregon's Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee, Medicaid Advisory Committee and the Department of Consumer and Business Services Insurance Advisory Council will advocate for policies that support health care transition and related care-coordination services.

12.1.1.4. Evaluation. See Sections 11.1.2.4 and 11.1.3.4.

12.1.1.5. Communication. We will develop and disseminate products to communicate our findings and learning to local, state, and national audiences.

12.1.2. Children with Medical Complexity Collaborative Improvement and Innovation Network Activities
We will continue quality improvement activities and learning begun with our leadership of Oregon's Children with Medical Complexity (CMC) Collaborative Improvement and Innovation Network (CollN). We will continue primary and specialty transfer of care activities through at least July 2021 (when CollN funding ends). We will develop relationships with other Oregon health systems (e.g., Providence, Legacy, St. Charles) to learn about their transition activity successes and challenges to promote this learning throughout the state. We will explore the possibility of developing a health care transition (HCT) workgroup, per technical assistance we received from the National Alliance to Advance Adolescent Health in September 2019.

12.1.2.1. Family Involvement. We have learned that even young adults with medical complexity and/or their families who are excited about participating in the CollN have difficulty prioritizing participation in the project. Depending on our QI learning over the next year, we may launch an educational campaign describing the importance of a seamless transfer of care between pediatric and adult health care. We will recruit youth to contribute to our understanding of transition barriers, and use their experiences to inform CollN partners and the larger community.

12.1.2.2. CLAS. We will engage culturally responsive family and service organizations to advise on how to increase the cultural sensitivity and responsiveness of the intervention and materials we have developed.

12.1.2.3. Systems & Policy. We will continue to explore payment strategies to support clinical staff time spent on transfer of care activities. At the time of this writing, we are collaborating with Deborah Rumsey, Children's Health Alliance/Children's Health Foundation Executive Director (CollN Advisory Team member) and the National Alliance to Advance Adolescent Health to understand whether existing billing codes might be combined to support our CollN intervention activities. In 2020-2021, we will continue to gather information about the use, or non-use, of existing CPT codes (i.e., are codes used or not; are they paid by public and private payors; are there barriers to providers using them [e.g. onerous charting, or lack of awareness?]). We will incorporate our findings into an action plan to either increase their utility and usage or propose an alternative payment approach.

During the FY 2021-2025 Block Grant cycle, we will advocate for a transition metric to be added to the menu of CCO Incentive Metrics. We will need to increase our understanding of CCO Metric and Scoring Committee's process for adopting

a new metric, the adoption timeline, and develop strategy for the metric's importance and measurement. The metric that is available for use from the Health Plan Quality Metrics menu is measured through collection of family self-report data, and we know that health plans are reluctant to implement survey data collections because of the resources needed to support survey administration.

12.1.2.4. Evaluation. We will continue to administer and analyze family, youth, and clinical staff (CollN) surveys and process tracking sheets that clinical staff complete to enable us to monitor intervention implementation and achievement of outcomes.

> **ESM for NPM 12:** The percentage of young adults with medical complexity (YAMC) or their families enrolled in transfer of care intervention who participate in their scheduled transfer preparation appointments. **Objective:** 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.

12.1.2.5. Communication. We will continue to develop and disseminate products to communicate our findings and learning to local, state, and national audiences.

12.1.3. Leverage Family-to-Family Health Information Center Grant

OCCYSHN will continue to integrate the family perspective in Title V activities and program planning using Parent Partners' expertise and community connections. The ORF2FHIC will continue to offer its 60-minute training for families entitled "Planning for a Healthy Transition." This training introduces the topic that many families have not considered, gives suggestions for approaching transition conversations, and details the roles of families, youth, and providers in the transfer of care process. During these trainings, Parent Partners learn about families' real experiences with seeking transition support and accessing adult providers and services. These impressions, as well as findings from more structured listening sessions, will inform both the ORF2FHIC and OCCYSHN in general. OCCYSHN will continue to support and collaborate with the CDRC Lifespan Transition Clinic to build a transition-focused toolkit for families whose children use multiple specialists. The toolkit publication is planned for late 2020.

12.1.4. Policy

In addition to the payment and transition metric work, OCCYSHN staff will continue to track policy relevant to our Title V Block Grant strategies. We will continue to submit public comment as appropriate. We also will develop, strengthen, and leverage strategic partnerships in support of State and National Performance Measure strategies.

12.1.5. Assessment

See activities described in Section 11.1.8.

Critical Partnerships

- Boston University Catalyst Center
- CDRC Lifespan Transition Clinic
- Children's Health Alliance/Children's Health Foundation
- CMC CoIIN Family Representatives (Ana Valdez, BranDee Trejo)
- County Local Public Health Authorities
- DCH General Pediatrics and Adolescent Health Clinic (Reem Hasan, MD, PhD; Reyna Lindert, PhD, RN)
- Family Organizations (15)
- Jeanne McAllister, BSN, MS, MHA at Indiana University
- Katharine Zuckerman, MD, MPH, OHSU General Pediatrics
- Latino Community Association
- National Alliance for Advancing Adolescent Health (NAAAH)/Got Transition
- OHA Adolescent and School Health (ASH)
- Oregon Community Developmental Disabilities Programs
- Oregon Council on Developmental Disabilities
- Oregon Family Networks (9)
- Professional Organizations (OPS, OPAAC, CHA, OFPA)
- Shriners Hospitals for Children – Portland
- Sickle Cell Anemia Foundation of Oregon
- The Arc Oregon
- Youth ERA
- Youth Transition Programs
- YSHCN and YSHCN families

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - A) Percentage of new mothers who experienced stressful life events before or during pregnancy B) Percentage of mothers of 2 year olds who have adequate social support

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		43	41	43
Annual Indicator	43.9	41.3	44.8	44.8
Numerator	19,174	18,021	18,675	18,675
Denominator	43,650	43,639	41,666	41,666
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2017
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	43.0	42.0	41.0	40.0	39.0	38.0

SPM 2 - A) Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs B) Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		90.7	94.6	93.5
Annual Indicator	90.5	94.4	93.3	94
Numerator	733,554	671,582	694,824	575,326
Denominator	810,688	711,654	744,578	612,049
Data Source	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
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	94.2	94.4	94.6	94.8	95.0	95.2

SPM 3 - A) Percent of children in low-income households with a high housing cost burden B) Percent of children living in a household that received food or cash assistance C) Percent of households with children < 18 years of age experiencing food insecurity

Measure Status:	Active
State Provided Data	
	2019
Annual Objective	
Annual Indicator	68
Numerator	
Denominator	
Data Source	American Community Survey
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	67.0	66.0	65.0	64.0	63.0

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 - A) Percentage of new mothers who experienced stressful life events before or during pregnancy B) Percentage of mothers of 2 year olds who have adequate social support

Objectives

By October 1, 2025 decrease exposure to toxic stress/trauma and ACES and build foundations for resilience as measured by: a decrease from 44.8% to 38.0% in the percentage new mothers who experienced stressful life events before or during pregnancy; and an increase from 92.5% to 95.5% in the percentage of mothers of two year old children who have adequate social support.

Strategies

Provide technical assistance to local Title V grantees implementing toxic stress, trauma, ACES and resilience work in their communities.

Promote family friendly policies that decrease stress and adversity for all parents, and/or increase economic stability.

Provide outreach and education to increase understanding of NEAR (neurobiology, epigenetics, ACEs and resilience) science, and the impact of childhood adversity on lifelong health.

Engage partners to build capacity for safe, connected, equitable and resilient communities.

Conduct assessment, surveillance, and epidemiological research. Use data and NEAR science to drive policy decisions.

Develop trauma-informed workforce, workplaces, systems, and services.

Strengthen protective factors for individuals and families through support for programs that: build parent capabilities, social and emotional competence, supportive/nurturing relationships; and foster connection to community, culture, and spirituality.

OCCYSHN will promote trauma-informed care for CYSHCN and their families by incorporating a family-informed, trauma-informed lens to workforce development activities.

State Action Plan Table (Oregon) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Improved health equity and reduced MCAH disparities

SPM

SPM 2 - A) Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs B) Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care

Objectives

By October 1, 2025 improve cultural and linguistic accessibility of MCAH services as measured through an increase from 94.0% to 95.2% in the percentage of children age 0-17 who have a healthcare provider sensitive to their family's values and customs; and a decrease from 10.9% to 9.8% in the percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care.

Strategies

Develop and improve organizational policy, practices, and leadership to promote culturally and linguistically responsive services (CLAS) and health equity.

OCCYSHN will improve CYSHCN and their families' access to culturally sensitive and responsive care through workforce development.

State Action Plan Table (Oregon) - Cross-Cutting/Systems Building - Entry 3

Priority Need

Enhanced social determinants of health

SPM

SPM 3 - A) Percent of children in low-income households with a high housing cost burden B) Percent of children living in a household that received food or cash assistance C) Percent of households with children < 18 years of age experiencing food insecurity

Objectives

By October 1, 2025, improve the social determinants of health of women, children, and families as measured by a decrease in the percentage of children living in low income households with a high rent burden from 68% to 63%; a decrease in the percentage of households with children that receive food or cash assistance from 42.3% to 41.3%; and a decrease in the percentage of households with children that are experiencing food insecurity from 19.2% to 18.7%.

Strategies

Develop a cross-cutting Title V priority team to address upstream drivers of maternal and child health, and link work across population domains and state priorities. The team will research, develop, adapt or adopt and overarching theory of change for the work.

Develop evidence-based/informed strategies and measures for Oregon's Title V social determinants of health and equity (SDOH-E) work - including strategies that address upstream drivers of maternal, child and adolescent health. Engage local Title V grantees; family and community representatives in the process.

Develop and adopt a logic model for Oregon's cross-cutting SDOH-E work.

Begin implementation and tracking of state level Title V strategies for SDOH-E.

Provide technical assistance to Title V grantees on SDOH-E strategies and measures to inform local level Title V priority selection and planning.

Review local grantee annual plans and provide TA on implementing SDOH-E strategies beginning July 2021.

Begin implementation of local level SDOH-E Title V strategies and tracking of outcomes.

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.

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**
Annual Objective		15.9	14.1	12.8
Annual Indicator	16.1	16.1	12.9	11.1
Numerator				
Denominator				
Data Source	USDA	USDA	USDA	USDA
Data Source Year	2013-15	2014-16	2015-17	2016-18
Provisional or Final ?	Final	Final	Final	Final

DOMAIN – Cross-Cutting/Systems Building

2019 Annual Report

Toxic Stress, Trauma, ACEs and Resilience 2019 Report

State Performance Measure 1 (#1A & #1B)

1. Percentage of new mothers who experienced stressful life events before or during pregnancy.
2. Percentage of mothers of 2-year olds who have adequate social support.

Interpretation of Data

The percent of new mothers who experienced stressful life events before or during pregnancy stayed relatively stable between 2016 and 2018, from 43.9% to 44.8%. The percent of mothers of 2-year olds who have adequate social support increased between 2016 and 2018, from 70% to 92.5%.

Strategies and Activities

Strategy #1: Provide technical assistance to local Title V Grantees implementing toxic stress, ACEs, and resilience work in their communities.

Accomplishments

- Grantees were provided individualized technical assistance throughout the grant year.
- Information related to the topic, including local and national conferences, trainings, and webinars were disseminated throughout the grant year, and made available through the Title V website.

Challenges/emerging issues

The field of trauma, ACEs, and resilience is growing so quickly that keeping up with new information and providing ongoing to support to local public health agencies to develop trauma-informed workforce and practices, as well as to engage in community level ACEs initiatives is challenging. Each grantee is in a different stage of developing this work, and community readiness to address this issue varies widely. As the field continues

Strategy #2: Promote family friendly policies that decrease stress and adversity for all parents, increase economic stability, and/or promote health.

Accomplishments

- Title V staff served on a cross-agency work group to develop a trauma-informed policy for the Oregon Health Authority.
- Title V continued implementation of a Social Determinants of Health CoIIN focused on access to high quality, affordable, safe, and healthy, culturally appropriate childcare. Parents from around the state were engaged to produce digital stories about their experiences of childcare as a social determinant of health, and these digital stories were used to educate policy makers in a variety of settings.
- The Title V program strengthened partnerships with several organizations who work to reduce parental stress and promote family friendly policies, including Family Forward, an organization whose mission is to support policy change which decreases stress for women in their roles as caregivers.
- Data from the Adverse Childhood Experiences (ACEs) module of Oregon's Behavior Risk Factor Surveillance Survey (BRFSS) survey, and the Pregnancy Risk Assessment Monitoring System (PRAMS) and PRAMS follow-up surveys were provided to state and local partners to inform local and state policy

work.

- Oregon's Title V program provided support to disseminate information about and support implementation of several bills related to trauma and trauma-informed approaches which were passed by the 2017 Oregon legislature, including HCR 33 (related to developing a trauma-informed state workforce), as well as paid family leave.
- Oregon's Title V program supported the development and passage of Oregon's Universally offered home visiting legislation in spring 2019, and continues to support its implementation.

Challenges/emerging issues
Opportunities for promoting family friendly policies to reduce toxic stress and trauma for children and families are vast, and the challenge is primarily in finding the resources and staff time to support the work.

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.

Accomplishments

- 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, Crook, and Lane Counties provided outreach and education on trauma and ACEs to community partners.

Challenges/emerging issues
Challenges related to this strategy were primarily related to the variations in familiarity partners have with NEAR science, its public policy, and program implications. Although some partners are very familiar and ready to engage and move forward, others are still at the introductory stages. Furthermore, the broad underlying causes of toxic stress and the complex links to racism and generational trauma can make the issues difficult to grasp and feel overwhelming for some audiences.

Strategy #4: Engage partners to build capacity for safe, connected, equitable and resilient communities.

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.
- The State Title V Program continued to fund an MCH information and referral line as well as two dedicated MCH specialists as part of Oregon's 211info service. These services provide information and referral for a wide range of health, housing, childcare, and other human service needs statewide, as well as more in-depth resources and support to families with specific MCH needs spanning parenting, child health, etc.
- Title V funding also supported local Title V grantees in delivering MCH services including Oregon MothersCare and Home Visiting. Both of 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.
- Grant and Jefferson Counties convened partners to develop shared trauma informed training for community

providers, and in the case of Jefferson County to explore opportunities to measure resilience in the community.

Challenges/emerging issues
Interest in this issue and requests for participation in a variety of groups examining all aspects of trauma and resilience continue to grow. The impacts of COVID-19 on MCAH populations further highlight the need to address both trauma and equity.

Strategy #5: Conduct assessment, surveillance, and epidemiological research. Use data and NEAR science to drive policy decisions.

Accomplishments
- Oregon's Title V program funded the inclusion of the ACEs module in Oregon's BRFSS, and supported the PRAMS and PRAMS 2 (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 PRAMS 2 surveys were analyzed.
- The Oregon subset of the National Survey of Children's Health (NSCH) data on children's exposure to ACEs for Oregon children was analyzed and information on flourishing and ACEs, as well as other children's resiliency indicators was disseminated to partners.
- Title V staff convened a partnership to support a National Survey of Children's Health oversample for Oregon, and devised a survey strategy. The Oregon survey oversample will be conducted 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.

Accomplishments

State Level
- The State MCH trauma-informed care work group integrated with the MCH health equity work group to ensure that the links between toxic stress and adversity, and racism and health equity are recognized and interwoven throughout our work.
- State Title V staff lead the trauma-informed workforce workgroup within the Maternal and Child Health Section. This work group addresses equitable access to workplace supports, transparent communications, modifications in physical space, and workplace practice to promote balance and prevent re-traumatization. During this grant year the work group developed a variety of tools, implemented physical workplace changes to address staff concerns, and provided activities to promote "trauma readiness' within our workplace and workforce. These have included changes to physical space, development of trauma-informed meeting guidelines, policy changes, and staff wellness activities.

Local Level
Nine local grantees – Benton, Crook, Deschutes, Jefferson, Jackson, Lane, Lincoln, Linn, and Washington Counties - used Title V funds to develop trauma-informed workforce, workplaces, and services. Their activities included staff training, as well as development and implementation of policy and practices to integrate ACEs and trauma awareness into MCH services.

Challenges/emerging issues
Challenges related to this strategy include the recognition that development of trauma-informed systems and services is complex and long-term, spanning both how our MCH systems treat employees and workforce, as well as how we address trauma and racism and their impacts on health.

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).

Accomplishments
- Nine local Title V grantees – Benton, Deschutes, Jackson, Jefferson, Lane, Lincoln, Linn, Umatilla, and Washington Counties – supported 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 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.

Challenges/emerging issues
Most of the challenges related to this strategy are reported at the local level, where ongoing support is needed to develop methods for successfully integrating NEAR science into home visiting.

Food Insecurity 2019 Report

State Performance Measure (#2A & #2B)
1. Percent of households experiencing food insecurity.
2. Percent of households with children <18 years of age experiencing food insecurity.

Interpretation of Data
Households experiencing food insecurity significantly declined to 11.1% (2016-2018 data). State level data from USDA for households with children experiencing food insecurity has not been updated. Food security rates have improved with the economic recovery however improvement is uneven as African American, American Indian and Hispanic populations as well as single-parent households and rural households experience food insecurity at higher rates. The improvements Oregon has made are fragile and will likely spike again during the economic downturn of Covid-19.

Strategies and Activities
Strategy #1: Provide technical assistance to grantees working on strategies to reduce food insecurity in their communities.

Accomplishments
Title V grantees have successfully incorporated food insecurity screening into their client intake processes. Collectively about 3700 clients have been screened. Food Insecurity Strategy Implementation Toolkit has been updated with new resources and shared with all Title V grantees. Oregon is the only state that selected Food Insecurity as a state priority – Title V lead presented on a national webinar as well as on a MCHB technical assistance call to share strategies and toolkit. Title V lead provided support and resources to local Title V grantees as requested.

Challenges/emerging issues
Local Title V grantees are challenged with staff capacity to address food insecurity more broadly in their communities using policy, system and environmental change strategies, e.g convening or participating on local food policy councils and strengthening broader community partnerships. Another challenge was data collection and

retrieval by local grantees – some have been working on incorporating screening into their EHR but still have issues with full implementation and staff training about food insecurity screening.

Strategy #2: Screen clients for food insecurity and provide referrals for food assistance.

Accomplishments

- Josephine County implemented a single screening question during client intake in WIC and home visit programs resulting in all clients screened and referred if needed; community resource guide continues to be updated and shared with clients.
- Lane County used the screen and intervene tool which is embedded into the EHR so it is a standard part of the home visit intake process 90% of clients (250) were screened.
- Malheur County screened 100% clients (23) and referred 6 for resources. Transportation barriers to food resources are an issue in this small, rural county so coordination with food pantries throughout the county were developed to allow home visitors to pick up and deliver food boxes to families.
- North Central Public Health District trained 10 staff across programs about food insecurity to implement screening and referral; screening and referral were implemented in home visit, clinic and WIC programs resulting in 1225 total clients screened, and 136 of these screened positive. Home visit program is in process of embedded questions into their EHR system.
- Umatilla County exceeded their target in conducting comprehensive health assessment screening, including food insecurity, with 463 middle and high school students in 4 districts by Wellness Hub nurses.

Challenges/emerging issues

- Josephine County had consistent documentation of screening and referral into data system is an ongoing effort.
- Lane County positively screened only 69% of clients for food insecurity and were referred to resources; this may be a result of different charting habits among staff and identifies a need for continued training and staff support.
- Malheur County struggled with picking up food boxes, which sometimes took significant time for the nurses; some families declined needed food resources like WIC because they felt it was not beneficial for them so strategies to increase families accessing WIC are being implemented.
- North Central Public Health District identified a universal screening tool for all programs as WIC uses a 1-question screen, and not having a data tracking system for all other programs. Staff turnover results in not all staff having food security training and importance of conducting screening; not having staff capacity to participate on regional food security coalition.
- Umatilla County had a limited ability to track follow-up for referral to food resources due to the high (and unanticipated) volume of responses to health screening.

Strategy #3: Support or provide food security education.

Accomplishments

Wellness Hub nurses from 4 out of 6 districts provided nutrition curriculum in 22 classes to 589 students. Partnership with the Wellness Hub nurses who have established roles in schools ensure easy integration of content into classrooms by individuals known and trusted by students.

Challenges/emerging issues

Schools face many demands for topics to be taught in classrooms so ensuring nutrition content is taught in each district was challenging as other topics took priority.

Strategy #4: Increase access to healthy, affordable food.

Accomplishments

The community dietitian in Josephine County focused on developing partnerships with stores and farmers markets that accept SNAP and WIC. SNAP matching funds were available as Double Up Food Bucks through local grants and donations (including from AllCare and Primary Health CCOs). Local markets reported increased revenue based

on participation from local SNAP users who visited the market for this first time. In collaboration with AllCare CCO the RD was able to work with their Manager of Social Determinants of Health to connect with local growers and farmers market managers to conduct outreach to SNAP recipients in the community. As a result of this work 29 partnerships were developed within the Rogue Valley Food Network.

Challenges/emerging issues
Due to recent changes in leadership and reorganization of Josephine County Public Health, significant staffing challenges occurred. A coalition of community partners plans to create a Veggie Rx program for medically at-risk health plan members did not occur despite available funding from a local CCO. None of the local stores were able to commit to redemption of the Veggie Rx coupons.

Strategy #5: Engage with state and local partners to enhance policies, systems and programs that address reduction of food insecurity in Oregon families. Provide technical assistance to grantees working on strategies to reduce food insecurity in their communities.

Accomplishments
Food insecurity was an issue that was frequently addressed during partner meetings in order to share and collaborate on activities such as contributing to content and promoting the Food Hero social marketing platform across agencies. Nutrition Council of Oregon's strategic planning process identified nutrition security as issue that all member organizations could support and collaborate. The SHIP identified and reported on progress on activities addressing food insecurity.

Challenges/emerging issues
There are many organizations across the state that address food insecurity so it is challenging due to limited time and resources to learn about the vast network and opportunities available.

Culturally and Linguistically Responsive Services (CLAS) 2019 Report

State Performance Measure (#3A & #3B)

1. Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs.
2. Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care.

Interpretation of Data

Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs: 94% (2018)

There is no updated data available the percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care.

Strategies and Activities

Strategy #1: Provide effective, equitable, understandable, and culturally responsive services.

Accomplishments

- Warm Springs MCH staff recruited 28 participants to participate in baby board classes. Classes not only included parents-to-be, but also invited extended family members to participate.
- Multnomah County's Future Generations Collaborative (FGC) did not host the Gathering of Native Americans this year, but rather supported Native-serving organizations in hosting their own events and gatherings. This was in response to multiple community requests to support Native-led work and events rather than hosting them from the county program.

- Multnomah County has had a significant number of training and technical assistance requests for FASD prevention-intervention and a deepening of existing partnerships with Department of Community Justice and the Confederated Tribes of Grand Ronde.
- 40 refugee families were served through Multnomah County's We Are Home Community Health Worker Program

Challenges/emerging issues

- Warm Springs saw a decline in the number of births, so MCH staff connected with Child Protective Services and made three baby boards for infants in their care. This was a benefit to the foster families and enabled the class to continue despite low attendance.
- Multnomah County found it difficult to fulfill requests for training and technical assistance increase for FASD prevention because budgets are flat.
- Due to uncertainty in funding sources outside of Title V, Multnomah County's CHW program suffered from staff turnover and leadership changes. Recruiting, hiring and training new staff created barriers to accomplishing policy and advocacy goals of the project.

Strategy #2: Develop and improve organizational policy, practices, and leadership to promote CLAS and health equity and infuse them throughout all planning and operations.

Accomplishments

State Level

- The state office continued its work on the three domain areas identified from the organization's assessment with a focus on organizational climate, culture and communications and workforce diversity, training, and retention.
- MCH State Health Equity Workgroup met twice a month to discuss priorities and develop plans for moving equity work forward.
- We did not implement CLAS professional development requirements for all MCH staff to participate in.
- MCH CLAS lead helped plan and lead 12 educational events and discussions for Public Health Division staff covering topics such as workplace discrimination, implicit bias, racial trauma, institutional racism and other topics related to health equity.
- The State Office completed the Hiring for Equity Guidelines, and will work through challenges and barriers to implementation in the next grant cycle. This will include revisiting and editing the guidelines based on feedback.

Local Level

- Marion County staff person participated in a variety of workforce development and cultural responsiveness trainings and events and developed a Cultural Competency Committee to analyze current systems and processes and implement changes.
- Polk County implemented staff trainings to deepen their understanding of inequities that exist in their community. These trainings focused on social determinants of health as a foundation for understanding.
- Coos County hosted 3 all day training sessions on cultural responsiveness and health equity. 100% of staff participated.

Challenges/emerging issues

Dedicated staff to carry out state level initiatives is a long-term barrier to this work.

Strategy #3: Conduct ongoing assessments of the organizations' CLAS related activities and integrate CLAS related measures into CQI activities.

Accomplishments

- The State level equity workgroup assessed progress to date and identified future areas of work and growth. Organizational culture and communications is the primary area of work for the next cycle.
- Local grantees did not participate in organizational assessment, so we did not provide any technical assistance in this area.

Challenges/emerging issues

Moving forward, requiring grantees to participate in assessing and implementing health equity and CLAS standards

work into their Title V plans could provide a mechanism for widespread impact on vulnerable communities.

OCCYSHN Culturally and Linguistically Responsive Services (CLAS) 2019 Report

Strategies and Activities

Strategy: Develop a set of evidence-informed state and local level strategies and resources for addressing CLAS Standards.

OCCYSHN continued professional development to increase staff knowledge about CLAS-related topics. In October 2018, OCCYSHN staff participated in a training by Dr. Mercedes Avila, a nationally recognized expert on structural competence and social determinants of health. In May 2019, all OCCYSHN staff took an Unconscious Bias training through OHSU's Office of Equity and Inclusion (OEI). Additionally, OCCYSHN's Communications Coordinator completed OEI's Inclusion Ambassador Training, designed to promote and spread inclusion throughout OHSU.

OCCYSHN worked to foster a more inclusive work environment. OCCYSHN managers attended a training by OHSU's OEI on recruiting and hiring for diversity, and successfully applied lessons learned to recruit and hire a more diverse staff.

OCCYSHN's ORF2FHIC Project Lead participated on the Institute on Development & Disability (IDD) Diversity Taskforce. OCCYSHN's internal journal club devoted a session to discussing "Immigrant Children with Special Health Care Needs: A Review" by Sandra McKay, MD.

OCCYSHN's Assessment and Evaluation unit developed partnerships with two community-based organizations that serve Communities of Color. We contracted with these organizations to collect qualitative data about Latino and Black CYSHCN and their families. We developed partnership agreements, completed requirements for IRB, and developed culturally-responsive focus groups and interview guides (see strategy 11.6 for more detail.)

In August and September 2019, we recruited members and started planning for an OCCYSHN internal CLAS workgroup to launch in October 2019. Planning included developing a workgroup structure that includes quarterly meetings, representation from all OCCYSHN's four units, and a process for both internal learning and external progress on OCCYSHN's CLAS activities.

DOMAIN – Cross-Cutting/Systems Building

2021 Application Year

MCAH Toxic Stress, Trauma, ACEs and Resilience 2021 Plan

State Performance Measure 1

1. Percentage of new mothers who experienced stressful life events before or during pregnancy.
2. Percentage of mothers of 2-year olds who have adequate social support.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Note also: Due to COVID-19, submission of local Title V annual plans has been delayed, so we do not know which local grantees will select this priority and are unable to write about specific local level activities planned for the upcoming year at this time.

Planned MCAH strategies and activities for October 2020 – September 2021

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.
- Convene periodic 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.
- Provide and/or facilitate access to technical assistance for local grantees and other partners.

Strategy #2: Promote family friendly policies that decrease stress and adversity for all parents, increase economic stability and/or promote health.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Develop and disseminate information for Oregon MCH 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.

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.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- The State Title V program will continue to partner with other state offices and community partners to sponsor presentations and discussions on Trauma and ACEs with policy makers, state and community partners as the opportunity arises throughout the year.

Strategy #4: Engage partners to build capacity for safe, connected, equitable and resilient communities.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Provide ongoing support and MCH participation/leadership to cross-agency efforts such as the Public Health Division's trauma work group, Trauma-Informed Oregon, OHA's trauma-informed system initiative, etc.
- Provide support and resources to local Title V grantees working to implement community partnerships and cross-system initiatives.
- Partner with the Oregon Climate Health and Injury and Violence prevention program to promote community resilience and strengthen protective factors for the MCH population.
- Support implementation of the State Health Improvement Plan priority on Adversity, trauma and toxic stress.

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 PRAMS 2 surveys.
- Analyze past years' data on parental stress and social support.
- Analyze the NSCH data on children's exposure to ACEs for Oregon.
- Work with partners to develop and fund an NSCH oversample in Oregon for 2021.
- Educate policy makers and others about Oregon's ACEs data, the lifelong impact and cost of trauma and ACEs; and policy approaches to prevent or mediate the impact.

Strategy #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.

Strategy #7: Strengthen protective factors for individuals and families through support for programs that build parent capabilities, social emotional competence, supportive/nurturing relationships, and foster connection to community, culture, and spirituality.

Activities – State Level

- Partner with Oregon's Early Childhood Home Visiting and Early Learning Divison programs to support implementation of home visiting and other early childhood programs.
- Support MCH and early childhood workforce development efforts around that state to enhance trauma informed approaches into Oregon's early childhood programs.

Critical Partnerships

- Oregon home visiting programs (including MIECHV)
- Early childhood providers
- Trauma Informed Oregon

- Oregon Parenting Education Collaborative
- Oregon Early Learning Division
- 211 Info
- Addictions and mental health providers
- Pediatric and Family Practice providers
- Coordinated Care Organizations
- OHA Health Systems Division
- OHA Injury Prevention Section

OCCYSHN - Toxic Stress, Trauma, ACEs and Resilience 2021 Plan

Strategies and Activities

Strategy 3.1. We will promote trauma-informed care for CYSHCN and their families by incorporating a family-informed, trauma-informed lens to our workforce development activities.

S3.1.1. Workforce Development
We will build relationships with organizations already focused on trauma-informed care (e.g., Trauma Informed Oregon). We will seek to collaborate with these organizations to: (a) Review and modify our cross-systems care coordination processes and materials to align with the principles of trauma-informed care, (b) Review and modify other OCCYSHN and ORF2FHIC materials, and (c) Co-create an informational brief about trauma and CYSHCN.

S3.1.2. Develop Expertise on Medical Trauma and CYSHCN
Pediatric medical traumatic stress, or "medical trauma" refers to 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. Medical trauma may occur as a response to a single or multiple medical events. We will conduct a literature review on medical trauma and CYSHCN. We also will seek to learn from families/medical community about medical trauma. We will use both sources of information to ensure that our workforce development trainings contain information about medical trauma. With this knowledge, the ORF2FHIC will collect, vet, and disseminate resources for families about ways to prevent or manage medical trauma.

S3.1.3. Develop OCCYSHN Internal Capacity
We will allocate resources to ensure that all OCCYSHN staff get training about trauma-informed care.

> **CYSHCN ESM for SPM 3.1:** The number of OCCYSHN staff who participated in a trauma-informed care training out of all staff. **Objective:** By September 2025, all OCCYSHN staff will complete at least one training about trauma-informed care.

MCAH Culturally and Linguistically Responsive Services (CLAS) 2021 Plan

State Performance Measure 2

1. Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's

values and customs.
2. Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Note also: Due to COVID-19, submission of local Title V annual plans has been delayed, so we do not know which local grantees will select this priority and are unable to write about specific local level activities planned for the upcoming year at this time.

Planned strategies, ESMs, and activities for October 2020 – September 2021

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. We will provide or link grantees to web-based training on CLAS standards, as well as trainings on addressing racism in maternal health and the equity-related impact of COVID-19.
- The Title V program will integrate CLAS, health equity, and anti-racism strategies into the upcoming strategy planning for each NPM and into the cross-cutting state-specific priority work (including trauma/ACES and SDOH-E) for the 2021-2025 Title V Block Grant cycle.
- Title V program will continue to provide leadership within the PHD, across OHA and with other state agency partners to advance health equity and anti-racism work, as well as to assure that the MCAH impacts of these issues are understood and addressed.
- 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 implementing anti-racist policies and practices and improve our internal culture through trauma informed workplace practices. Additionally, we will focus on developing our relationships with community partners and continue to assess and address the ongoing equity related data collection and reporting needs.
- The Title V program will contract with a consultant to advance the health equity and anti-racism work of the Maternal and Child Health Section. The structure of this work is still being developed but it will focus on systems and policy change as well as workforce development.
- The State Office will continue to build on the existing website (www.healthoregon.org/mchequity)

Critical Partnerships

- Oregon Health Authority, Office of Equity and Inclusion
- Oregon Center for Children and Youth with Special Health Care Needs (OCCYSHCN)
- OHA Internal equity workgroups
- Oregon tribes: specifically Warm Springs
- US DHHS: Think Cultural Health
- Local Public Health grantees workforce
- Native American Youth & Family Center
- Public Health Division Health Equity Workgroup

OCCYSHN - Culturally and Linguistically Responsive Services (CLAS) 2021 Plan

Strategies and Activities

Strategy S1.1. We will improve CYSHCN and their families' access to culturally sensitive and responsive care through workforce development.

S1.1.1. Workforce Development
We will partner with culturally-responsive community-based organizations to review and modify our cross-systems care coordination (see 11.1.1.2 and 11.1.2.2) and health care transition (12.1.1.2) workforce development strategies to be sensitive and responsive to the needs of CYSHCN and families from non-dominant cultures.

S.1.1.2. Promotion of Culturally Appropriate Health Care
In collaboration with culturally-responsive community-based organizations, we will identify providers, clinics and health systems currently providing culturally sensitive and responsive care. We will interview staff (and possibly patients) of these clinics to learn how culturally responsive care is provided in Oregon. We will incorporate lessons learned and collaborate with providers, community based organizations and advocacy groups to promote adoption and dissemination of these practices.

S.1.1.3. Multicultural Family Organizations
In collaboration with culturally-responsive community-based organizations, we will examine the feasibility of replicating multicultural family organizations such as Open Doors for Multicultural Families, located in Washington State. We will leverage the community connections forged by the ORF2FHIC. Several organizations, including Lutheran Community Services Northwest, the African Youth Service Organization, and Immigrant and Refugee Community Organization (IRCO), have previously expressed willingness to provide CYSHCN resources and information to their families who need them. The ORF2FHIC will continue to collaborate on translation of key family materials and offer workshops on health care advocacy, as requested by these organizations, and will include them in all outreach efforts.

S1.1.4. OCCYSHN CLAS Workgroup
We will continue OCCYSHN's CLAS workgroup. The workgroup continues to focus on increasing OCCYSHN staff's knowledge and growth about issues that influence CLAS. The CLAS work group will also continue to inform and monitor OCCYSHN's progress on Block Grant CLAS activities.

S1.1.5. Policy
OCCYSHN will continue to work with the All:Ready Network, whose mission is to transform early childhood through mitigation of poverty, racism and ableism. We also have expanded our relationship with the Oregon Law Center and will continue to align our work in equity and disparity 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 also will develop, strengthen, and leverage strategic partnerships with colleagues in support of State and National Performance Measure strategies.

S1.1.6. Assessment
See activities described in Section 11.1.8.

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.

MCAH - Social Determinants of Health and Equity 2021 Plan

State Performance Measure 3

3A: The percentage of children in low-income households with a high housing cost burden

3B: The percentage of children living in a household that received food or cash assistance

3C: The percentage of households with children < 18 years of age experiencing food insecurity

Planned Strategies and Activities

NOTE: Due to 2021-2025 Block Grant priorities being determined so close to the start of the SFY2021 local Title V planning and funding cycle - as well as COVID-19 related delays - all of Oregon's MCAH plans for new Title V priorities in 2021 (including SDOH-E) will be at the state level. Local level partners will begin implementing work on the SDOH-E priority July 1, 2021.

Strategy 1: By October 2020, determine state Title V staffing for and develop a cross-cutting Title V priority team to address upstream drivers of Maternal and child health, and link work across population domains and state priorities (SDOH-E, trauma and ACEs prevention, CLAS). The team will research, develop, adapt or adopt an overarching theory of change for the work, in collaboration with the cross-cutting injury prevention team.

Strategy 2: By December 2020, develop evidence-based/informed strategies and measures for SDOH-E – including strategies that address upstream drivers of maternal, child and adolescent health. Strategies will address both state and local levels work. Engage local Title V grantees and family and community representatives in the process.

Strategy 3: By February 2021, develop and adopt a logic model for the Title V's SDOH-E work.

Strategy 4: By March 2021, begin implementation and tracking of Title V's state level strategies for SDOH-E; collect/track outcomes through monitoring SPMs.

Strategy 5: By March 2021, provide technical assistance on new SDOH-E strategies and measures to Title V grantees on to inform local level priority selection, planning and implementation.

Strategy 6: April - June 2021, review and provide TA to local Title V Grantees on implementing SDOH-E in their annual plans for July 2021– June 2022.

Strategy 7: July 1, 2021 through September 30, 2021- Title V grantees will implement local level strategies and collect/track outcomes.

Critical Partnerships

- Local Title V grantees
- Oregon Department of Human Services
- Oregon Department of Community Housing
- Local health and human service providers
- Oregon home visiting programs (including MIECHV)
- Early childhood providers
- Trauma Informed Oregon
- Oregon Parenting Education Collaborative
- Oregon Early Learning Division
- 211 Info
- Addictions and mental health providers
- Pediatric and Family Practice providers
- Coordinated Care Organizations

- OHA Health Systems Division
- OHA Injury and Violence Prevention Section

OCCYSHN - Social Determinants of Health and Equity 2021 Plan

Strategies and Activities

Strategy S2.1. We 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.

S2.1.1. Barriers to Receipt of Care

We will conduct a root cause analysis of the barriers CYSHCN encounter regarding access to durable medical equipment, and Autism evaluation and services. That analysis will include professional stakeholders and affected families. Using the results of the root cause analysis, we will develop strategies to reduce or eliminate barriers. We will use a similar process to assess and address other access issues over the course of the next five years, including access to behavioral health, Children's Intensive In-Home Services, housing, transportation, and respite care.

> **CYSHCN ESM for SPM 2.1:** The completion of root cause analyses for DME (Dec. 2021), Autism evaluation (June 2022), respite care (June 2023)(Yes/No). **Objective:** By 2025, we will have completed root causes analyses of the barriers that inhibit CYSHCN and their families from timely access to DME, Autism evaluation, and respite care.

S2.1.2. Systems and Policy

OCCYSHN's director has led the development of a Medical-Legal Partnership serving OHSU's Neonatal Intensive Care Unit. OCCYSHN will continue to partner with the Medical Legal Partnership of Oregon and the Oregon Law Center. We will leverage their expertise on equity issues and systems-level advocacy to help our community partners improve access to services for CYSHCN and their families.

OCCYSHN's director will continue to serve on the State Leadership Team for High Quality Inclusive Preschool, and lead the Funding and Political Will Workgroup of the All:Ready Network. Both initiatives focus on full inclusion of CYSHCN, and mitigation of inequity to ensure kindergarten readiness for children. We will continue to build relationships and provide technical assistance on health to child care providers and both early and K-12 education. We will promote engagement in cross-sector shared care planning.

2.1.3. Strengthen and Leverage Existing Relationships

CYSHCN in Oregon face many barriers to access, including a paucity of qualified health care and service providers, geographic distance from service providers, and fiscal disincentives for health care providers caring for them. OCCYSHN will work to strengthen key relationships with payors, especially CCOs, to identify opportunities to align and incentivize systems-level change. Partnerships with the Oregon Community Health Workers Association and with state nursing programs will lead to transformations in workforce development, improving access for vulnerable communities.

Strategy S2.2. OCCYSHN will increase access to community-based autism diagnostic services through implementation of community-based autism evaluation teams.

S2.2.2. Community-Based Medical-Education Autism Identification Teams: Assuring Comprehensive Care through Enhanced Service Systems (ACCESS)

OCCSYHN supports six community-based autism evaluation teams that provide coordinated diagnostic services addressing both educational eligibility for autism services and a medical diagnosis for children up to age five. These evaluations help address long waits for autism evaluation at tertiary centers, and streamline a cumbersome process by

integrating medical and educational assessments. By expanding the number and location of teams across the state, we will increase the number of children and families served. OCCYSHN will support existing ACCESS teams to expand capacity to evaluate more children, as is appropriate and feasible for their communities. In some communities, OCCYSHN will support expanding team capacity to provide evaluations to the school-aged population. We will collaborate with the Autism Program at OHSU to provide technical assistance and training to educators and medical providers in communities across Oregon. Technical assistance and training activities include site visits, ECHO sessions, phone consultations, and an annual meeting. We will support ACCESS teams to seek sustainable funding for education-medical autism evaluations through coding and billing, community benefit, braided funding among partners, or other mechanisms.

S2.2.2.1. Family Involvement. One or more FIP staff with lived experience as the parent of a child with Autism Spectrum Disorder (ASD) will be available to the ACCESS project for technical assistance, resources, and reflection.

S2.2.2.2. CLAS. OCCYSHN will support teams to engage diverse providers on autism evaluation teams. We will provide training and technical assistance on topics related to CLAS through the autism ECHO sessions.

S2.2.2.3. Systems & Policy. We will advocate for a coordinated, unified statewide process for ASD diagnosis and eligibility assessment on policy boards such as the State Interagency Coordinating Council.

S2.2.2.4. Evaluation. We will develop an evaluation plan.

> **CYSHCN ESM for SPM 2.2:** The annual number of children receiving an Autism evaluation through our community-based autism evaluation teams. **Objective:** By 2025, we will expand the number of children receiving an Autism evaluation through our community-based autism evaluation teams by 5%.

S2.2.2.5. Communication. We will disseminate our learnings about community-based autism evaluation models.

Strategy S2.3. We will improve agencies' knowledge of and ability to respond to CYSHCN and their families during an emergency or disaster response.

S2.3.1. Emergency/Disaster Preparedness for CYSHCN

Over the next five years, OCCYSHN aims to ensure that the needs of CYSHCN and their families are integrated into existing hospital, county, and regional emergency preparedness plans. We will solicit input and leadership from families to meet this aim. The work will involve building relationships with emergency preparedness contacts across systems serving CYSHCN and families in Oregon. We will ensure that technical assistance is provided to all partners, including families. We will inform the state's resource and toolkit development for vulnerable populations in emergencies as needed. Our FIP/ORF2FHIC will, when requested, assist state partners to recruit families with lived experience to serve as advisors. We will disseminate emergency/disaster preparedness information to families through social media, list-serves, and other outreach efforts.

> **CYSHCN ESM for SPM 2.3:** The 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.

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's work in policy and systems development includes support for OCCYSHN staff to collaborate with state partners and participate on relevant committees. The aim of this work is to increase awareness about the needs and challenges facing Oregon CYSHCN, their families, and their care providers and to identify opportunities to inform change across systems. OCCYSHN staff participate on the following:

- The Director and the Assessment and Evaluation Manager are members of Oregon's Title V Leadership Team and the Title V-Medicaid MOU team, which meets on a quarterly basis.
- The Director and Systems and Workforce Development (S&W) Manager meet regularly with OHA home visiting nurse consultants.
- The S&W Manager participates in the monthly Title V Priority Leads coordination meetings.
- The Director and unit managers attend state-level committee meetings (e.g., Early Learning Council, Health Plan Quality Metrics) when the content or decision-making of meeting topics will directly affect CYSHCN.
- The Family Involvement Program (FIP) Manager sits on the state Medicaid Advisory Committee (MAC) and the Insurance Advisory Council of the Oregon Department of Consumer and Business Services.
- The Care Coordination Specialist sits on the State Interagency Coordinating Council to ensure interagency coordination of quality statewide services for young children and their families, including children with disabilities.
- The Director serves on the Oregon Commission on Developmental Disabilities, the Children with Special Needs Workgroup, the Early Childhood Inclusion State Leadership Team, and the state Individualized Service Plan Redesign workgroup.
- The FIP Manager, S&W Manager and Director serve on a regional Kindergarten Readiness Network Advisory Board.
- S&W staff serve on OHSU's Health Care Transition Taskforce.
- Staff participate on Medicaid Rules Advisory Committees when rules will directly affect CYSHCN.

The S&W unit at OCCYSHN 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 2020-21.

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, PRAMS2, BRFSS, Oregon Healthy Teens surveys, Birth Anomalies Surveillance System, and Oral Health Surveillance System), ongoing needs assessment, evaluation and data collection/management and MCAH data dissemination functions across MCAH populations and programs. A critical project that crosses SSDI and Title V work continues to be the online Title V database that is available to all Title V grantees (Local public health and Tribes). This database allows grantees to enter their Title V reports, plans, measures – as well as to record how much of their Title V funds will be directed to work in each Title V priority area. Title V staff can review and analyze the grantee plan, as well as extract reports on strategies and priorities being undertaken across the state.

CYSHCN

OCCYSHN supports an Assessment and Evaluation (A&E) unit, which is the data center of OCCYSHN. A&E is comprised of an A&E Manager, two 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, in 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.

Title V MCAH Public Input Process

Throughout the grant year, the Title V program actively sought stakeholder and public input into the Title V Needs Assessment and Selection of Oregon's Title V Block Grant priorities for the upcoming five-year grant cycle. Additionally, Title V participated in the public input process for the selection of new State Health Improvement Plan priorities and strategies - which has important MCAH components. The development of each of these had significant state and local level public input which Title V supported, and whose input was incorporated into the Title V Needs Assessment. Methods used to solicit both public, and stakeholder, input this year have included: Presentations and dialogue at 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 ongoing 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 state Title V State leads conducted webinars on each Title V priority to solicit input on the program, strategies and measures, and to support implementation issues in Title V communities around the state. These webinars were also used to generate input into modification of the priority specific logic models and standardized measures which provide a foundation for Oregon's Title V program infrastructure and local level data collection. Program input is also solicited in writing twice a year as part of the Title V grantee annual plan and reporting process.

Lists of Title V strategies, maps of priority work around the state, logic models, and other resources and information related to the Title V program are publicly available on the Title V website (http://healthoregon.org/titlev), which is open for public input on an ongoing basis.

Engagement/input for 2020 Title V Block Grant Needs Assessment

Oregon's 2020 Title V Needs Assessment involved extensive engagement and input from partners, as well as the public. Methodologies and input are described in detail in the Needs Assessment Summary, Section III.C.I of this application. They included: a scan of more than 50 needs assessments conducted in communities around the state, an online survey of partners and providers, and "Community Voices" grants to communities which had been

traditionally under-represented in the Needs Assessment. The Community Voices grants collected public input through a variety of mechanisms, including house to house outreach, surveys at community events, community meetings, and focus groups. Once the Needs Assessment data was collected and analyzed, community agencies, Local Public Health, tribal health, and family representatives were engaged to review the findings and develop recommendations for Title V priorities for the 2021-2025 cycle. Engagement of these stakeholders and partners was conducted through a remote process that included dissemination of summary needs assessment findings, webinars, and an online survey. Once input was analyzed and recommendations generated, they were circulated for final vetting with a wider array of partners. Remote engagement methods developed through this cycle's Needs Assessment process – which preceded COVID-19 – will likely prove useful in future years' public input processes if physical distancing measures continue to limit options for in person engagement.

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 supported and benefited from the State Health Improvement Plan (SHIP) community meetings and the community-based SHIP strategy develop process. MCH priorities feature prominently in the new SHIP 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 nearly 100 followers on Facebook, and have doubled our followers on Twitter. We have posted nearly 150 posts related to maternal and child health on both platforms, currently reaching thousands of people through our networks (reach includes our content showing up on a user's screen). In the last year, followers have engaged with our content 1,500 times (this means that have "liked" something, commented on a story, or clicked on a link provided). With the focus this Spring on COVID-19, Title V staff have been serving in numerous outreach and communications capacities for the emergency response, ensuring that the needs of MCH populations are being considered as we send out information and support Oregonians with COVID-19 related services.

Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) Public Ir

OCCYSHN obtained input from essential stakeholder groups in developing its 2020-2021/2025 strategic plan. This included families, LPHAs and LPHA community partners, and Children with Medical Complexity CoIIN Advisory and Implementation Team members. A description of our input process follows.

Families

ORF2FHIC, in partnership with OCCYSHN, conducts family listening sessions around the state to collect information about family experiences with health services, including issues with gaps, and access. This past year, 14 family listening sessions were conducted. Eight of those listening sessions were in rural communities, 1 was conducted in Spanish, one was with Native American Youth, one with Native American parents, and one with youth experiencing End-Stage Renal Disease. The information gleaned from families at these events was shared with OCCYSHN leadership and staff; OCCYSHN's Family Involvement Program (FIP) presented summaries of families' experiences, stories, and concerns heard during these listening sessions at three OCCYSHN staff meetings, and OCCYSHN leadership also used the information to inform its strategic planning.

OCCYSHN held a virtual meeting with seven parents of CYSHCN in spring, 2019 to provide input on the 2020 plan. In addition to the ORF2FHIC Parent Partners, participants included the parent of a child with profound cerebral palsy, and the parent of a child with non-verbal autism. After receiving an overview of the Title V Block Grant, the families walked through each section and commented on sections of interest. The families supported OCCYSHN's proposed activities and strategies, and some expressed interest in participating again in 2020.

LPHA and Community Partners

OCCYSHN's Systems and Workforce Development (S&W) unit hosted six regional meetings across the state in 2019. These meetings brought together LPHA staff that implement OCCYSHN programs (i.e., shared care planning, CaCoon, REACH and PACCT) and their community partners. The purpose of these meetings was to discuss shared care planning implementation, the relationship between CaCoon and shared care planning, and lessons learned from the shared care planning process. Input was gathered about engaging primary care, incorporating quality improvement in the shared care planning workflow, preparing families for a shared care planning meeting, developing trusting relationships with families though goal setting, and ways that OCCYSHN can further support local success. OCCYSHN used these meetings as an opportunity to learn from local partners to improve implementation experiences, identify areas for program improvement, and address challenges facing organizations and communities, including public health nurse recruitment and retention.

In addition to regional meetings, OCCYSHN's new Care Coordination Specialist visited the majority of LPHAs with whom we contract to strengthen relationships and gather input about successes and opportunities where OCCYSHN might provide additional support. OCCYSHN uses information from regional meetings and visits to LPHAs to improve technical assistance quality, and support the development of cross-systems care coordination. This includes increasing support for the development of community-based care coordination teams serving as local infrastructure for care coordination. This all serves to inform our strategic planning.

CMC CoIIN Team Members

The Advisory Team consists of three family representatives including OCCYSHN's FIP Manager, Shriner's pediatric surgeon, Doernbecher Children's Hospital General Pediatrics and Adolescent Health Clinic pediatrician, 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, prioritized causes on which to focus our quality improvement (QI) project, and advise, co-develop, and co-monitor our QI project. This work directly informed our strategic planning.

Needs Assessment and Prioritization

OCCYSHN continues to use results of its 2015 Needs Assessment (https://www.ohsu.edu/sites/default/files/2019-02/OCCYSHN%20NA%20Final%206.22.15.pdf) to guide our efforts. The needs assessment collected data from families of CSHCN, YSCHN, providers who serve CYSHCN (including CaCoon nurses), and other key stakeholders who work in systems that serve CYSHCN and their families. Additionally, our 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 communities in Oregon. These results informed our strategic planning. Additionally, LCA, SCAFO, CoIIN Family Representatives, and LPHA public health nurses provided input for our state's Needs Assessment Prioritization Process.

General

Like OHA's Maternal and Child Health Section, OCCYSHN maintains a website and a general mailbox where people can submit feedback to OCCYSHN. The feedback is shared with OCCYSHN leadership, and it helps inform our work.

III.G. Technical Assistance

Data support to local Title V grantees in Oregon

Brief description:
Local Title V grantees in Oregon, which include counties and tribes, are expected to select priority areas based on local needs assessment activities. Due to differing levels of local evaluation and epidemiological staff capacity, several grantees could benefit from training and guidance on how to complete these needs assessment and evaluate related Title V activities. Opportunities to provide TA may include online sessions or piggybacking on other state-wide meetings that grantees may attend during the grant year.
Performance Measure: NA
Proposed TA source: TBD
Estimated Budget: TBD
Estimated Dates: TBD

Trauma informed workforce, workplaces, and MCAH systems of care

Brief description:
Oregon is working on both state and local levels to implement trauma-informed approaches to MCAH and promote family and community resilience. To that end, the Title V program may request TA for trauma-informed workforce development activities which may include state and/or local MCAH staff training and/or support for a statewide meeting of local MCAH programs that are engaged in developing work around ACEs and trauma. 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

Technical support and training for state and local child fatality reviews

Brief description: MCH Title V staff at the state level and in local public health agencies (LPHAs) participate in child fatality reviews, though not every county team has MCH representation. Many teams would benefit from the participation of MCH Title V expertise, and many counties struggle to implement and sustain effective, prevention-focused child fatality reviews. Through Title V technical assistance, Oregon proposes to bring consultation, training and technical assistance to state and local Title V staff to build expertise in the review process, support and improve Title V participation in state and local reviews, increase the number and completeness of reviews, and improve the effectiveness of reviews for prevention of child injury and death. In addition, Oregon would seek consultation to improve coordination with other reviews, such as the maternal mortality, DV and others.
Performance measure: # of Title V state and local staff trained; # county CFT teams with MCH representation; pre-post measures of knowledge, practices, etc;
Proposed TA source: The National Center for Fatality Review and Prevention
Estimated Budget: Unknown
Estimated Dates: Unknown

Trauma-informed support for pregnant people

Brief description: Oregon is working on both state and local levels to implement trauma-informed approaches to MCAH and promote family and community resilience. Many local Title V grantees connect pregnant people with health-related resources to support a healthy pregnancy, such as smoking cessation programs, health insurance and

prenatal care. Several Title V grantees have requested technical assistance to help staff develop skills, practices and policies to deliver these services in a trauma-informed, culturally competent manner. Grantees have also requested support in taking a strengths-based approach to addressing health risk behaviors, such as smoking and substance use.
Performance measure: State Toxic stress, trauma, and ACEs performance measure
Proposed TA source: TBD
Estimated Budget: $5,000
Estimated Dates: 01/2021 – 06/2021

Enhancing medical homes for CYSHCN through collaboration with legal experts

Brief description: It is no secret that social impactors of health have a massive influence on the well-being of children and families. A significant responsibility of a primary care medical home is care coordination, much of it involving those social impactors. While the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) has expertise in medical homes for CYSHCN in terms of clinical care, systems change and partnership with local and state care coordination resources, there are many aspects of the health of CYSHCN that involve legal matters, and remain out of our scope. Medical Legal Partnerships (MLP's) have been around for over 30 years and have been incredibly effective in connecting legal services to families through partnership between lawyers and primary care medical homes. We are not aware of work aligning legal knowledge with Title V CYSHCN efforts to help address the social impactors and inform approaches to systems change. OCCYSHN is in the process of contracting with the Oregon Law Center (OLC), a non-profit organization that works to address issues of equity and disparity at systems level, using legal knowledge to impact policy processes. We would like to leverage the existing expertise of national MLP leaders to inform our work. Our collaboration with OLC would be solely advisory, and there will be no provision of legal services to OCCYSHN or to any family. Through a better understanding of legal process and resources, we hope to improve the health of children in Oregon.
Purpose: Support OCCYSHN in long-term planning and systems level change
Performance Measure: NPM 11, CLAS State Performance Measure
Proposed TA source: Megan Sandel MD, Boston medical Center, or Joel Teitelbaum or Ellen Lawton, National Center on Medical Legal Partnerships
Estimated budget: $10,000
Estimated dates: 01/2021 – 12/2021

Systems change and systems of services for CYSHCN: long term planning consultation

Brief description: Oregon's healthcare system transformation is significantly changing healthcare delivery and organizational structures at the state and regional levels. Cross cutting systems, transformation is ongoing in health, education and public health, simultaneously with changes occurring in healthcare and MCH at the federal level. OCCYSHN seeks consultation on long-term planning for responding to these changes cutting across all community, regional and state levels within the state.
Purpose: Support OCCYSHN in long-term planning and systems level change
Performance Measure: NPM 11 & 12, CLAS State Performance Measure
Proposed TA source: Pennie Foster-Fishmann, Ph.D., System exChange
Estimated budget: $12,000
Estimated dates: 01/2021 – 09/2021

Photovoice training

Brief description: In the conduct of needs assessment, Title V grantees often rely on quantitative research methods

such as surveys and analysis of secondary data. These methods are useful for capturing needs and challenges broadly but can be difficult to meaningfully disaggregate by subpopulations of CYSHCN because of small sample sizes. Such data collection methods may not align well with the cultures of these subpopulations. OCCYSHN is planning to pilot Photovoice in its 2020 needs assessment as a tool to capture the perspective of youth with special health care needs (YSHCN) to inform our NPM 12 work. We anticipate this tool will increase our understanding of the experience and educational needs of YSHCN with behavioral/mental health conditions. This builds upon NSCH analyses we conducted in partnership with Dr. Olivia Lindly, which we are currently seeking to publish. Photovoice has been successfully used with youth on a variety of topics. It is well-suited to the policy environment, helping to "tell the story." If it works well, OCCYSHN will use the method with families of subpopulations of CYSHCN. OCCYSHN's Director, Assessment & Evaluation (A&E) Coordinator and one 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: $17,000

Estimated dates: 11/2021

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_Attachment_1.pdf

Supporting Document #02 - OCCYSHN_Attachment _2_Needs_Assessment.pdf

Supporting Document #03 - Supporting Doc 3_MCAH NA Summary.pdf

Supporting Document #04 - Supporting Document 4 MCAH Guiding Documents.pdf

Supporting Document #05 - Supporting Document 5 Local Title V MCAH Grantee Info.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - BG2021_Combined OCCYSHN and OHA Org Chart June 2020.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Oregon

	FY 21 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,172,689	
A. Preventive and Primary Care for Children	$ 2,746,276	(44.4%)
B. Children with Special Health Care Needs	$ 1,851,808	(30%)
C. Title V Administrative Costs	$ 617,268	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,215,352	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 13,276,271	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 9,707,490	
5. OTHER FUNDS (Item 18e of SF-424)	$ 11,838,611	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 34,822,372	
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)	$ 40,995,061	
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)	$ 43,526,340	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 84,521,401	

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 618,706
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 150,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 240,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 190,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 715,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 8,500,000
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	$ 2,683,898
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 29,630,381
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 463,355

	FY 19 Annual Report Budgeted		FY 19 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,129,512		$ 6,172,689	
A. Preventive and Primary Care for Children	$ 2,704,082	(44.1%)	$ 2,746,276	(44.4%)
B. Children with Special Health Care Needs	$ 1,838,854	(30%)	$ 1,851,808	(30%)
C. Title V Administrative Costs	$ 612,951	(10%)	$ 617,268	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,155,887		$ 5,215,352	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 10,116,862		$ 11,960,373	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 7,003,170		$ 9,707,490	
5. OTHER FUNDS (Item 18e of SF-424)	$ 7,684,389		$ 9,783,913	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 24,804,421		$ 31,451,776	
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)	$ 30,933,933		$ 37,624,465	
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)	$ 37,139,702		$ 44,501,432	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 68,073,635		$ 82,125,897	

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 395,111	$ 618,706
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 150,000	$ 117,002
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 120,252	$ 53,352
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 423,186	$ 534,562
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 195,263	$ 212,337
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 483,920	$ 463,355
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 8,386,641	$ 8,957,531
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 75,077	$ 87,563
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 208,708	$ 215,599
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 1,360,939	$ 927,146
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,620,825	$ 2,683,898
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 22,719,780	$ 29,630,381

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: This is based on the FFY 19 Notice of Award (NOA).	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2021**
	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 FFY2021.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: This is based on the FFY 19 Notice of Award (NOA).	
9.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Based on the BG 3.0 guidance and 2016-2020 priorities, the Title V funds allocated for direct family planning services in FFY 2015 were redistributed to preventive and primary care for children population group in FFY2019.	
10.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Transfering 30% of the Oregon MCH Block Grant appropriation to the OCCYSHN for serving the children withspecial health care needs.	
11.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

	Field Note: CP&HP considers the 10% cost allocation of central support services to represent Administrative costs. The 10% of the total budget limit is maintained by transferring excess expenses to the State general funds.	
12.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: FY 21 projected budget is based on the additional general funds for the Universal Home Visiting $1.4 M in FY 20.	
13.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: FY 21 projected budget is based on FY 19 expenditures.	
14.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Increase in public health lab screening fees and tobacco settlement funds in FY 21 projected budget.	

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 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 560,089	$ 560,089
2. Infants < 1 year	$ 207,573	$ 207,573
3. Children 1 through 21 Years	$ 2,746,276	$ 2,746,276
4. CSHCN	$ 1,851,807	$ 1,851,807
5. All Others	$ 189,676	$ 189,676
Federal Total of Individuals Served	$ 5,555,421	$ 5,555,421

IB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 720,213	$ 720,213
2. Infants < 1 year	$ 11,782,612	$ 8,699,352
3. Children 1 through 21 Years	$ 19,094,243	$ 19,094,243
4. CSHCN	$ 1,500,000	$ 1,212,664
5. All Others	$ 1,725,304	$ 1,725,304
Non-Federal Total of Individuals Served	$ 34,822,372	$ 31,451,776
Federal State MCH Block Grant Partnership Total	$ 40,377,793	$ 37,007,197

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:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2019 actual expenditures at the time the 2021 Block Grant Application was prepared.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2019 actual expenditures at the time the 2021 Block Grant Application was prepared.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2019 actual expenditures at the time the 2021 Block Grant Application was prepared.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2021**
	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:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2019 actual expenditures at the time the 2021 Block Grant Application was prepared.	
6.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2021**

	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2019 expenditures at the time the 2021 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:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2019 expenditures at the time the 2021 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:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2019 expenditures at the time the 2021 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:	**2021**
	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:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2019 expenditures at the time the 2021 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:	**2019**
	Column Name:	**Annual Report Expended**

	Field Note: Expenditures are based on the actual expenditures at the time the 2021 lock 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:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2021 lock 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:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2021 lock 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:	**2019**
	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:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2021 lock 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:	**2019**
	Column Name:	**Annual Report Expended**

	Field Note: Expenditures are based on the actual expenditures at the time the 2021 lock 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:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2021 lock 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:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2021 lock 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:	**2019**
	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:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2021 lock 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:

- CSHCN, Application Budgeted does not equal Form 2, Line 1B, Children with Special Health Care Needs, Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- CSHCN, Annual Report Expended does not equal Form 2, Line 1B, Children with Special Health Care Needs, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: Oregon

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 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	$ 2,449,552	$ 2,449,552
3. Public Health Services and Systems	$ 3,723,137	$ 3,723,137
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	$ 6,172,689	$ 6,172,689

IIB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 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	$ 27,970,735	$ 27,970,735
3. Public Health Services and Systems	$ 3,481,041	$ 3,481,041
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	$ 31,451,776	$ 31,451,776

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:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2021**
	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.	
6.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2021**
	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:	**2019**
	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:	**2019**
	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:	**2019**
	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:	**2019**
	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:	**2019**
	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:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note:	
	Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services budgets.	
19.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2019**
	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:	**2019**
	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:	**2019**

	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:	**2019**
	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:	**2019**
	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:	**2019**
	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: 41,758 **Data Source Year: 2019**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	41,758 (100.0%)	847	41	41 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency
Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy	

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	41,758 (100.0%)	0	0	0 (0%)
Short Chain Acyl-CoA Dehydrogenase Deficiency	41,758 (100.0%)	5	0	0 (0%)
Malonic Aciduria	41,758 (100.0%)	8	0	0 (0%)
Hyperphenylalanemia	41,758 (100.0%)	0	0	0 (0%)
Arginase Deficiency	41,758 (100.0%)	33	0	0 (0%)
2-methylbutyryl CoA dehydrogenase deficiency	41,758 (100.0%)	1	1	1 (100.0%)
Carnitine palmitoyl transferase	41,758 (100.0%)	19	0	0 (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 2019

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	4,159	49.4	0.0	19.3	22.0	9.3
2. Infants < 1 Year of Age	1,131	55.5	0.0	6.1	1.0	37.4
3. Children 1 through 21 Years of Age	51,050	50.7	0.0	21.7	13.9	13.7
3a. Children with Special Health Care Needs	12,422	59.0	0.0	39.8	0.4	0.8
4. Others	34,883	29.4	0.0	19.8	49.9	0.9
Total	91,223					

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	42,188	Yes	42,188	93	39,235	4,159
2. Infants < 1 Year of Age	42,705	Yes	42,705	100	42,705	1,131
3. Children 1 through 21 Years of Age	1,029,137	Yes	1,029,137	11	113,205	51,050
3a. Children with Special Health Care Needs	205,416	Yes	205,416	45	92,437	12,422
4. Others	3,116,317	Yes	3,116,317	2	62,326	34,883

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2019**
	Field Note: Pregnant individuals served by Maternity Case Management, Babies First and Oregon Mother's Care.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2019**
	Field Note: Infants served by Babies First	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: Children served by School Based Health Centers, Babies First, Family Planning for females <22 years of age, and dental sealant programs.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: CYSHCN served in FY19 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:	**2019**
	Field Note: Family planning for reproductive aged women (22 to 54 years of age), and non-pregnant adult caregivers served by Babies First.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2019**
	Field Note: Percentage includes pregnant individuals served by Maternity Case Management, Maternal, Infant, and Early Childhood Home Visiting, Oregon Mothers Care, the Special Supplemental Nutrition Program for Women, Infants, and Children, and local (county and Tribal) Title V grantee activities.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2019**
	Field Note: Percentage includes infants served by Newborn Screening, Early Hearing Detection & Intervention, Babies First, and local (county and Tribal) Title V grantee activities. Total unduplicated number served = 84,992.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: Percentage includes children served by family planning for children < 22 years of age, Babies First, Maternal, Infant, and Early Childhood Home Visiting, dental sealant programs, the Special Supplemental Nutrition Program for Women, Infants, and Children, and local (county and Tribal) Title V grantee activities.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2019**
	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 2018, approximately 60,410 (36%) CYSHCN are publically insured (CAHMI, 2020). 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 60,410 to generate our numerator.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: Percentage includes non-pregnant caretakers served by Maternal, Infant, and Early Childhood Home Visiting, and women of reproductive age (22 to 54 years) served by family planning.	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Oregon

Annual Report Year 2019

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	40,967	27,102	1,000	7,940	382	2,397	321	1,524	301
Title V Served	5,003	3,060	173	1,107	82	87	50	50	394
Eligible for Title XIX	17,742	9,803	685	5,328	262	513	235	760	156
2. Total Infants in State	40,967	27,102	1,000	7,940	382	2,397	321	1,524	301
Title V Served	3,726	2,062	158	1,078	96	86	52	187	7
Eligible for Title XIX	17,742	9,803	685	5,328	262	513	235	760	156

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2019**
	Column Name:	**Total**
	Field Note: Number of pregnant individuals served by Oregon Mother's Care and Maternity Case Management, and Babies First clients enrolled prenatally.	
2.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2019**
	Column Name:	**Total**
	Field Note: Number of infants served by Babies First and CaCoon.	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Oregon

A. State MCH Toll-Free Telephone Lines	2021 Application Year	2019 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 211-0000	(800) 211-0000
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health	Maternal and Child Health
3. Name of Contact Person for State MCH "Hotline"	Ciara Doyle	Ciara Doyle
4. Contact Person's Telephone Number	(503) 416-2704	(503) 416-2704
5. Number of Calls Received on the State MCH "Hotline"		23,016

B. Other Appropriate Methods	2021 Application Year	2019 Annual Report Year
1. Other Toll-Free "Hotline" Names	211Info	211Info
2. Number of Calls on Other Toll-Free "Hotlines"		101,737
3. State Title V Program Website Address	www.211info.org	www.211info.org
4. Number of Hits to the State Title V Program Website		248,835
5. State Title V Social Media Websites	facebook.com/211info; twitter.com/211info; htpps://www.instagram.com/211info/	facebook.com/211info twitter.com/211info https://www.instagram.com/211info/
6. Number of Hits to the State Title V Program Social Media Websites		25,737

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 6 - "hits to social media" - include 10,102 Facebook likes, 10,524 Facebook followers, 3,245 Twitter followers, and 1097 Instagram followers, and 769 Linked In followers

Form 8
State MCH and CSHCN Directors Contact Information

State: Oregon

1. Title V Maternal and Child Health (MCH) Director	
Name	Cate Wilcox, MPH
Title	Title V Director, MCH Manager
Address 1	800 NE Oregon St
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
State Priorities – Needs Assessment Year

State: Oregon

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
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
2017	64.6	4.0	265	41,051
2016	60.5	3.8	256	42,343
2015	67.3	4.6	215	31,961
2014	64.0	3.9	268	41,888
2013	65.9	4.0	268	40,656
2012	57.6	3.8	235	40,766
2011	50.2	3.5	212	42,264
2010	49.8	3.4	214	42,979
2009	51.2	3.4	229	44,729
2008	46.4	3.2	214	46,166

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
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
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
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
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
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
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
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
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 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	11.6 %	1.3 %	4,897	42,265
2013	10.1 %	1.2 %	4,310	42,599
2012	8.1 %	1.5 %	3,376	41,756
2011	8.2 %	1.0 %	3,499	42,764
2010	6.9 %	0.9 %	2,977	43,216
2009	9.0 %	1.1 %	4,056	44,989
2008	7.4 %	1.1 %	3,470	46,776
2007	8.7 %	1.1 %	4,022	46,240

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	65.5 %	4.6 %	43,746	66,739
2017	70.3 %	3.5 %	46,334	65,927
2016	58.1 %	3.6 %	38,570	66,434
2015	67.4 %	4.0 %	45,180	67,036
2014	65.3 %	4.1 %	43,220	66,233
2013	66.6 %	3.3 %	43,732	65,631
2012	66.7 %	3.4 %	44,433	66,581
2011	61.7 %	4.2 %	42,146	68,339
2010	51.9 %	3.5 %	36,929	71,200
2009	44.3 %	3.3 %	31,925	72,095

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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
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
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
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
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
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
2015	9.7 %	1.1 %	4,112	42,451
2013	11.8 %	1.2 %	4,998	42,467
2012	9.5 %	1.5 %	4,040	42,498

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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**
Annual Objective	60	60	61	57
Annual Indicator	58.0	59.2	56.5	70.8
Numerator	394,235	409,007	391,780	517,099
Denominator	680,107	691,064	693,242	730,360
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	71.0	72.0	73.0	74.0	75.0	76.0

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**
Annual Objective	93.6	93.8	94	89.6
Annual Indicator	92.5	93.2	89.4	93.5
Numerator	37,456	44,505	38,219	35,799
Denominator	40,509	47,759	42,729	38,275
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	93.6	93.7	93.8	93.9	94.0	94.1

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**
Annual Objective	34	35	39	34
Annual Indicator	30.6	38.3	33.4	31.6
Numerator	11,501	17,140	13,911	11,640
Denominator	37,583	44,757	41,664	36,894
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	31.8	32.0	32.2	32.4	32.6	32.8

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
Annual Objective	
Annual Indicator	127.1
Numerator	609
Denominator	479,233
Data Source	SID-CHILD
Data Source Year	2017

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	125.0	123.0	121.0	119.0	117.0

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
Annual Objective	
Annual Indicator	16.3
Numerator	44,259
Denominator	270,893
Data Source	NSCHP
Data Source Year	2018

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2019
Annual Objective	
Annual Indicator	47.9
Numerator	129,756
Denominator	271,087
Data Source	NSCHV
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	16.1	15.9	15.7	15.5	15.3

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: 2021 objective for perpetration = 16.1% 2021 objective for victimization = 47.4%	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: 2022 objective for perpetration = 15.9% 2022 objective for victimization = 46.9%	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: 2023 objective for perpetration = 15.7% 2023 objective for victimization = 46.4%	
4.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: 2024 objective for perpetration = 15.5% 2024 objective for victimization = 45.9%	
5.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: 2025 objective for perpetration = 15.3% 2025 objective for victimization = 45.4%	

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**
Annual Objective			51	44
Annual Indicator		31.3	38.6	42.2
Numerator		49,675	61,991	70,156
Denominator		158,652	160,752	166,072
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	42.0	43.0	44.0	45.0	46.0	47.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			40	18
Annual Indicator		15.8	16.5	26.8
Numerator		12,536	11,986	18,726
Denominator		79,458	72,528	69,860
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

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						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	27.0	28.0	29.0	30.0	31.0	32.0

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**
Annual Objective			30	31
Annual Indicator		29.7	30.9	32.8
Numerator		88,810	91,445	98,353
Denominator		298,807	296,257	299,920
Data Source		NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017	2017_2018

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**
Annual Objective			78	80
Annual Indicator		77.4	79.9	79.9
Numerator		227,178	230,520	230,520
Denominator		293,358	288,666	288,666
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017

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

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**
Annual Objective	62	63	54	54
Annual Indicator	57.0	53.5	53.5	53.5
Numerator	24,297	22,955	22,955	22,955
Denominator	42,656	42,925	42,925	42,925
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2015	2015

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**
Annual Objective			80.5	82
Annual Indicator		80.1	81.8	82.5
Numerator		647,060	662,516	671,363
Denominator		808,103	810,225	813,993
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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**
Annual Objective	9.6	9.3	9.2	8.8
Annual Indicator	9.9	9.5	8.9	8.4
Numerator	4,517	4,326	3,880	3,523
Denominator	45,489	45,405	43,455	42,041
Data Source	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018

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**
Annual Objective			14	14
Annual Indicator		14.2	14.3	12.1
Numerator		118,807	121,667	104,275
Denominator		838,336	849,982	858,440
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

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 - A) Percentage of new mothers who experienced stressful life events before or during pregnancy B) Percentage of mothers of 2 year olds who have adequate social support

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		43	41	43
Annual Indicator	43.9	41.3	44.8	44.8
Numerator	19,174	18,021	18,675	18,675
Denominator	43,650	43,639	41,666	41,666
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2017
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	43.0	42.0	41.0	40.0	39.0	38.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
SPM 1B: Percentage of mothers of 2 year olds who have adequate social support.
2016 Annual Objective: N/A
2016 Annual Indicator: 68.7%
Numerator: 29,079
Denominator: 42,355
Data Source: PRAMS-2
Data Source Year: 2013
Provisional or Final? Final
Annual Objectives: 2017, 70%; 2018, 71%; 2019, 72%; 2020, 73%; 2021, 74%; 2022, 75%

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
SPM 1B: Percentage of mothers of 2 year olds who have adequate social support.
2017 Annual Objective: 70%
2017 Annual Indicator: 89.1%
Numerator: 39,107
Denominator: 43,906
Data Source: PRAMS-2
Data Source Year: 2016 (2014 Births)
Provisional or Final? Final
Annual Objectives: 2018, 90%; 2019, 91%; 2020, 92%; 2021, 93%; 2022, 94%; 2023, 95%

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
SPM 2A: Percentage of mothers of 2 year olds who have adequate social support.
2018 Annual Objective: 90%
2018 Annual Indicator: 92.5%
Numerator: 40,375
Denominator: 43,639
Data Source: PRAMS-2
Data Source Year: 2017
Provisional or Final? Final
Annual Objectives: 2019, 93%; 2020, 94%; 2021, 95%; 2022, 96%; 2023, 97%; 2024, 98%

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
No new data is available for SPM 1A or SPM 1B.

SPM 1B: Percentage of mothers of 2 year olds who have adequate social support.
2019 Annual Objective: 90%
2019 Annual Indicator: 92.5%
Numerator: 40,375
Denominator: 43,639
Data Source: PRAMS-2
Data Source Year: 2017
Provisional or Final? Final
Annual Objectives: 2020, 93%; 2021, 93.5%; 2022, 94%; 2023, 94.5%; 2024, 95%; 2025, 95.5%

SPM 2 - A) Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs B) Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		90.7	94.6	93.5
Annual Indicator	90.5	94.4	93.3	94
Numerator	733,554	671,582	694,824	575,326
Denominator	810,688	711,654	744,578	612,049
Data Source	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
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	94.2	94.4	94.6	94.8	95.0	95.2

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: SPM 3B: Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care. 2016 Annual Objective: N/A 2016 Annual Indicator: 12.5% Numerator: 5,419 Denominator: 43,368 Data Source: PRAMS Data Source Year: 2014 Provisional or Final? Final Annual Objectives: 2017, 12.3%; 2018, 12.1%; 2019, 11.9%; 2020, 11.7%; 2021, 11.5%; 2022, 11.3%	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

	Field Note: SPM 3B: Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care. 2017 Annual Objective: 12.3 2017 Annual Indicator: 8.5% Numerator: 3,691 Denominator: 43,639 Data Source: PRAMS Data Source Year: 2015 Provisional or Final? Final Annual Objectives: 2018, 8.2%; 2018, 7.9%; 2020, 7.6%; 2021, 7.3%; 2022, 7%; 2023, 6.7%	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: SPM 3B: Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care. 2018 Annual Objective: 8.2% 2018 Annual Indicator: 10.9% Numerator: 4,561 Denominator: 41,666 Data Source: PRAMS Data Source Year: 2017 Provisional or Final? Final Annual Objectives: 2019, 10.8%; 2020, 10.6%; 2021, 10.4%; 2021, 10.2%; 2023, 10%; 2024, 9.8%	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: There is no updated data for SPM 2B. SPM 2B: Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care. 2019 Annual Objective: 8.2% 2019 Annual Indicator: 10.9% Numerator: 4,561 Denominator: 41,666 Data Source: PRAMS Data Source Year: 2017 Provisional or Final? Final Annual Objectives: 2020, 10.8%; 2021, 10.6%; 2022, 10.4%; 2023, 10.2%; 2024, 10%; 2025, 9.8%	

SPM 3 - A) Percent of children in low-income households with a high housing cost burden B) Percent of children living in a household that received food or cash assistance C) Percent of households with children < 18 years of age experiencing food insecurity

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	68
Numerator	
Denominator	
Data Source	American Community Survey
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	67.0	66.0	65.0	64.0	63.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
SPM 3B: 2019 = 42.3% (2018 National Survey of Children's Health data); Objectives: 2021, 42.1%; 2022, 41.9%; 2023, 41.7%, 2024, 41.5%, 2025, 41.3%

SPM 3C: 2019 = 19.2% (2003-11 USDA data); Objectives: 2021, 19.1%; 2022, 19%; 2023, 18.9%; 2024, 18.8%; 2025, 18.7%

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**
Annual Objective		15.9	14.1	12.8
Annual Indicator	16.1	16.1	12.9	11.1
Numerator				
Denominator				
Data Source	USDA	USDA	USDA	USDA
Data Source Year	2013-15	2014-16	2015-17	2016-18
Provisional or 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	

Form 10
Evidence-Based or –Informed Strategy Measure (ESM)

State: Oregon

ESM 1.1 - 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
Annual Objective		500	600	700
Annual Indicator	0	0	0	2,085
Numerator				
Denominator				
Data Source	Log of brochures distributed, social media views/l	Unable to track this year	Unable to track this year	Outreach tracking
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	800.0	900.0	1,000.0	1,000.0	1,000.0	1,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Work has not yet begun on this activity.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: We were not able to access social media data in time for this year's report, but we are looking into alternative ways of accessing this data for next year.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: We were not able to access social media data in time for this year's report, but we are looking into alternative ways of accessing this data for next year.	

ESM 1.2 - 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
Annual Objective	100	100	100
Annual Indicator	100	100	100
Numerator	11	9	11
Denominator	11	9	11
Data Source	Minutes from TA trainings and phone calls	Minutes from TA trainings and phone calls	Minutes from TA trainings
Data Source Year	2017	2018	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - 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
Annual Objective		
Annual Indicator		38
Numerator		
Denominator		
Data Source		State Tracking
Data Source Year		2019
Provisional or Final ?		Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	15.0	15.0	15.0	15.0	15.0	15.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Number of health care providers trained in breastfeeding support

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective		50	50
Annual Indicator	112	50	11
Numerator			
Denominator			
Data Source	Grantee annual report on strategy measures	Grantee annual report on strategy measures	Grantee annual report on strategy measures
Data Source Year	2017	2018	2091
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.1 - The number of strategies developed to address injury prevention among children across the spectrum of prevention

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	6.0	6.0	6.0	6.0	6.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.2 - The number of critical partners engaged in the development of upstream strategies to address child injury

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	8.0	8.0	8.0	8.0	8.0

Field Level Notes for Form 10 ESMs:

None

ESM 9.1 - The number of strategies developed to address bullying among youth with a focus on systems change, primary prevention, positive youth development, and/or enhancing social emotional learning

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	6.0	6.0	6.0	6.0	6.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Primary care involvement in shared care planning

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	20.0	25.0	30.0	35.0	40.0

Field Level Notes for Form 10 ESMs:

None

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
Annual Objective	20.0	30.0	40.0	50.0	60.0

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 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**
Annual Objective		
Annual Indicator		62.5
Numerator		5
Denominator		8
Data Source		Local reporting databse
Data Source Year		2019
Provisional or 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**
Annual Objective	100	100	100
Annual Indicator	100	100	100
Numerator	5	5	6
Denominator	5	5	6
Data Source	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018	2019
Provisional or 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**
Annual Objective			3
Annual Indicator			3
Numerator			
Denominator			
Data Source			State Tracking
Data Source Year			2019
Provisional or 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**
Annual Objective			3
Annual Indicator			3
Numerator			
Denominator			
Data Source			State Tracking
Data Source Year			2019
Provisional or 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**
Annual Objective				200
Annual Indicator	161	282	575	80
Numerator				
Denominator				
Data Source	Attendance sheets	Attendance sheets	Attendance sheets	Attendance sheets
Data Source Year	2016	2017	2018	2019
Provisional or 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**
Annual Objective			100	100
Annual Indicator	0	1,137	168	0
Numerator				
Denominator				
Data Source	State tracking	State tracking	State tracking	State tracking
Data Source Year	2016	2017	2018	2019
Provisional or 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.

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**
Annual Objective		
Annual Indicator	0	1
Numerator		
Denominator		
Data Source	Shared Care Planning End of Year Report	Shared Care Planning End of Year Report
Data Source Year	2018	2019
Provisional or 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.	

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**
Annual Objective		10	15	20
Annual Indicator	0	25.5	19.3	19.8
Numerator		35	21	21
Denominator		137	109	106
Data Source	SPOC Information Form	SPOC Information Form	SPOC Information Form	SPOC Information Form
Data Source Year	2016	2017	2018	2019
Provisional or 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.	

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**
Annual Objective		80	85	68
Annual Indicator	0	45.7	66.7	42.9
Numerator		16	14	9
Denominator		35	21	21
Data Source	SPOC Information Form	SPOC Information Form	SPOC Information Form	SPOC Information Form
Data Source Year	2016	2017	2018	2019
Provisional or 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.	

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**
Annual Objective			7
Annual Indicator			7
Numerator			
Denominator			
Data Source			State Tracking
Data Source Year			2019
Provisional or 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**
Annual Objective	30	30	20
Annual Indicator	28	30	21
Numerator			
Denominator			
Data Source	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018	2019
Provisional or 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

Baseline data was not available/provided.

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**
Annual Objective	75	75	75
Annual Indicator	50	100	71.4
Numerator	5	10	5
Denominator	10	10	7
Data Source	Local grantee reports	Local grantee reports	Local grantee reports
Data Source Year	2017	2018	2019
Provisional or 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**
Annual Objective	80	80	80
Annual Indicator	90.9	100	100
Numerator	10	10	7
Denominator	11	10	7
Data Source	Log of technical assistance provided	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018	2019
Provisional or 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

Baseline data was not available/provided.

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Oregon

SPM 1 - A) Percentage of new mothers who experienced stressful life events before or during pregnancy B) Percentage of mothers of 2 year olds who have adequate social support
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	A) To reduce the experience of chronic stress before and during pregnancy B) To improve social support among mothers of young children
Definition:	**Numerator:** A) Number of new mothers who experienced two or more of 16 types of prenatal stress 12 months prior to giving birth, including intimate partner violence prior to or during pregnancy B) Number of mothers of 2 year olds with adequate social support **Denominator:** A) Number of new mothers B) Number of mothers of 2 year olds **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	A) Pregnancy Risk Assessment Monitoring System (PRAMS) B) PRAMS-2 (Oregon's PRAMS follow-back survey)
Significance:	Adults who experience violence and trauma are also at increased risk for a variety of poor health and social outcomes. Without effective support and intervention, the risk increases for inter-generational exposure to toxic stress and trauma, creating a “vicious circle” of self-reinforcing mechanisms that undermine population health and well-being. A public health approach to reducing toxic stress includes strategies for preventing or reducing extreme stress and trauma, building resilience, and providing effective care and treatment for people who have been exposed to trauma.

SPM 2 - A) Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs B) Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>A) To improve the cultural sensitivity and responsiveness of healthcare providers who serve children < 18 years of age B) To eliminate discrimination experienced by women during healthcare</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>A) Number of children age 0 - 17 years who have a healthcare provider who is usually or always sensitive to their family's values and customs B) Number of new mothers who have ever experienced discrimination while getting health or medical care</td></tr>
<tr><td>Denominator:</td><td>A) Number of children age 0 - 17 years B) Number of new mothers</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>N/A</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>A) National Survey of Children's Health (NSCH) B) Pregnancy Risk Assessment Monitoring System</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 - A) Percent of children in low-income households with a high housing cost burden B) Percent of children living in a household that received food or cash assistance C) Percent of households with children < 18 years of age experiencing food insecurity
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Goal: A) To reduce the burden of housing costs among families B) To reduce poverty among families C) To reduce food insecurity among families
Definition:	**Numerator:** A) Number of children in low-income households with high housing cost burden B) Number of children living in households that received food or cash assistance C) Number of households with children < 18 experiencing food insecurity **Denominator:** A) Number of low-income households B) & C) Number of households with children < 18 **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	A) American Community Survey B) National Survey of Children's Health C) United States Department of Agriculture
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:	**Numerator:** A) Number of households experiencing food insecurity B) Number of households with children < 18 years of age experiencing food insecurity **Denominator:** A) Number of households B) Number of households with children < 18 years of age **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	A) NWS-13: Reduce household food insecurity and in doing so reduce hunger; Baseline: 14.6%, Target:6%. B) NWS-12: Eliminate very low food security among children; Baseline: 1.3%, Target: 0.2%.
Data Sources and Data Issues:	United States Department of Agriculture (USDA)
Significance:	Food insecurity is defined as limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways. Food insecurity influences health status in several ways. Level of access to adequate and nutritious food is related to overweight and obesity, hypertension, high cholesterol and diabetes. In addition, food insecurity affects child development and readiness to learn, and has long-lasting impacts during pregnancy. Compared to children living in foodsecure households, those with inadequate access to food have higher rates of iron deficiency anemia, which may cause slow cognitive and social development, higher hospitalization rates, and increased psychosocial and academic problems.

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 - Number of women reached using traditional and social marketing campaigns such as CDC Show Your Love brochures, social media including Facebook and Twitter, attendance at health fairs and community meetings, and public service announcements.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To expand public education and decrease stigma about preconception and well-woman care through the use of traditional and social media.
Definition:	**Numerator:** Number of women reached using traditional and social marketing campaigns such as CDC Show Your Love brochures, social media including Facebook and Twitter, attendance at health fairs and community meetings, and public service announcements. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10,000
Data Sources and Data Issues:	Log of brochures distributed, social media views/likes/shares/retweets/etc., health fair and community meeting attendance records, estimated reach of public service announcements, etc.
Significance:	In Oregon, two local health departments and the state Title V program will work to expand public education and decrease stigma about preconception and well-woman care through traditional and social media. This measure will allow the Oregon Health Authority to track this work of raising awareness of the importance of well woman visits. This work is necessary as a well woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services as well as anticipatory guidance to ensure the health of future pregnancies.

ESM 1.2 - Percent of local health departments receiving technical assistance to support implementation of the well woman care priority area.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Provide technical assistance (TA) to support implementation of routine pregnancy intention screening local public health programs.
Definition:	**Numerator:** Number of local health departments receiving technical assistance to support implementation of the well woman care priority area **Denominator:** Number of local health departments that choose Well-Woman Care as a priority for their Title V work. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Minutes from TA trainings and phone calls
Significance:	Local public health programs in Oregon are at different stages of implementation for pregnancy intention screening. TA will promote continuous quality improvement to support implementation that is sustainable and creates systems change.

ESM 1.3 - Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of partners engaged to improve access to and quality of well-woman care and reproductive health services.
Definition:	**Numerator:** Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	Local tracking
Significance:	Reproductive health providers are an important partner in providing well-woman care as well as providing education and referral to well-woman care. Building partnerships and aligning efforts with reproductive health providers at the state and local level will allow us to reach more women.

ESM 4.1 - Number of health care providers trained in breastfeeding support
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the availability of breastfeeding support from professionals.
Definition:	**Numerator:** Number of health care providers such as community health workers, nurses, dietitians, physicians, trained in breastfeeding support **Denominator:** N/A **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	Grantee annual report on strategy measures
Significance:	Health care providers play a critical role in breastfeeding initiation and continuation. While lack of support from health care providers has been identified as a major barrier to breastfeeding, support and encouragement from health care providers is one of the most important interventions in helping women breastfeed. Families need comprehensive breastfeeding support and lactation care from trained, qualified providers. A variety of trained care providers may include community health workers, doulas, nurses, dietitians, physicians and International Board Certified Lactation Consultant providers. Supporting training of the public health workforce who serve women and their infants will ensure a network of skilled lactation support throughout the state.

ESM 7.1.1 - The number of strategies developed to address injury prevention among children across the spectrum of prevention
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 develop injury prevention strategies across the spectrum of prevention
Definition:	**Numerator:** The number of strategies developed **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	State Tracking
Significance:	Unintentional injury is the leading cause of death for children ages 1 through 11. For those who survive severe injuries, many will have lasting challenges such as disability and chronic pain. Education, stronger laws, and safer environments can prevent and reduce serious injuries. Effective strategies, such as increasing knowledge and changing attitudes and behaviors, passing and enforcing legislation and policies that encourage safe behaviors, and changing the design of products and the environment, can prevent many injuries and improve the quality of life for children and adolescents, as well as their families.

ESM 7.1.2 - The number of critical partners engaged in the development of upstream strategies to address child injury
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 engage critical partners in upstream strategy development to address child injury
Definition:	**Numerator:** The number of critical partners engaged **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	State Tracking
Significance:	Unintentional injury is the leading cause of death for children ages 1 through 11. For those who survive severe injuries, many will have lasting challenges such as disability and chronic pain. Education, stronger laws, and safer environments can prevent and reduce serious injuries. Effective strategies, such as increasing knowledge and changing attitudes and behaviors, passing and enforcing legislation and policies that encourage safe behaviors, and changing the design of products and the environment, can prevent many injuries and improve the quality of life for children and adolescents, as well as their families. Critical partners in the development of these strategies include Local Title V Grantees, Oregon Public Health Division, Health Promotion and Chronic Disease Prevention Program, Oregon Public Health Division, Injury and Violence Prevention Section, Oregon Health Authority, Health Transformation Office, Coordinated Care Organizations, 211Info Resource and Referral, Oregon Health Plan, Oregon Office of Childcare, Oregon Early Learning Division, Oregon Safe Kids Coalition (includes Oregon Poison Control, Marine Board, Trauma Nurses Talk Tough, Fire Marshals Office), State Child Fatality Review Team, and Oregon Pediatric Society.

ESM 9.1 - The number of strategies developed to address bullying among youth with a focus on systems change, primary prevention, positive youth development, and/or enhancing social emotional learning
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To develop strategies to address bullying among youth
Definition:	**Numerator:** The number of strategies developed **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	State Tracking
Significance:	Bullying is unwanted, aggressive behavior among school-aged youth that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Youth who bully use their power—such as physical strength, access to embarrassing information, or popularity—to control or harm others. Bullying in school can often mirror systematic oppression in society at large. Power imbalances can change over time and in different situations, even if they involve the same people. There are negative outcomes for both victims and perpetrators of bullying including: poor academic achievement and school dropout, and negative physical and mental health outcomes. Youth who are the victims of bullying and who also perpetrate bullying may exhibit the poorest functioning, in comparison with either victims or bullies, with effects lasting into adulthood.

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
ESM Subgroup(s):	CSHCN
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:	**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. **Unit Type:** Percentage **Unit Number:** 100
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 requests that LPHAs complete their SIF within two weeks of a shared care planning meeting. We established objectives at the time of block grant writing (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.
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 professionals partner with families to 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 necessary to make transitions to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>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.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of enrolled YAMC patients/their families who participate in at least one of their preparation-to-transfer appointments.</td></tr>
<tr><td>Denominator:</td><td>Number of enrolled YAMC patients/their families.</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The data source for this ESM is the Children with Medical Complexity (CMC) CoIIN project process tracking form. We established objectives at the time of block grant writing (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.</td></tr>
<tr><td>Significance:</td><td>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 the targets of the intervention.</td></tr>
</table>

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase breastfeeding though education of pregnant and postpartum women.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of local grantees who have met their target for breastfeeding education among pregnant and postpartum women</td></tr>
<tr><td>Denominator:</td><td>Number of local grantees who conduct breastfeeding education among pregnant and postpartum women</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Local grantee reports</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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:	**Numerator:** Number of local grantees supported/provided with technical assistance to work on developing school wellness policies or safe routes to school, among those that selected the child physical activity priority area **Denominator:** Number of local grantees that selected the child physical activity priority area **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Log of technical assistance provided
Significance:	Title V state and local partners can make a lasting impact on opportunities and access for physical activity for children by creating and strengthening policies, systems and the environment in communities. Two key opportunities include strengthening school wellness policies and developing Safe Routes to School programs. Children spend a significant portion of their days in school settings. Comprehensive inclusion of physical activity in school and district wellness policies can help assure that there is designated time and space for all children to meet national physical activity guidelines during the school day. Active transportation to and from school offers health benefits to children, parents and other community members alike, while changing the context for commuting.

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To improve physical activity standards and practices within state early care and education systems.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>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)</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>10</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>State tracking</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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:	**Numerator:** Number of school districts who have participated in focus groups to explore challenges and opportunities to implement physical activity before, during and after school **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	State tracking
Significance:	Schools are important settings to influence physical activity for children. Teachers and staff can create and support a culture of lifelong health by promoting physical activity before, during and after the school day. Oregon law requires physical education and activity minutes for children grades K-8, and many schools struggle to achieve those minutes for every child. Educators recognize the benefits of physical activity for health, learning, and emotional/behavioral regulation, but need support to implement required minutes.

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.

Measure Status:	Active
Goal:	To promote policies and practices to make health care more youth friendly through provider and health professional training.
Definition:	**Numerator:** Number of health professionals who attend trainings or informational presentations on the promotion of youth friendly services (through trainings on positive youth development, confidentiality and privacy, and population health data on youth.) **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Attendance sheets of all professionals attending training.
Significance:	The degree to which providers and clinical settings are youth-friendly can influence youth acceptance and attitudes toward preventive care visits, both in adolescence and beyond. The Oregon Health Authority, Adolescent and School Health Section will be conducting training and informational presentations on the promotion of adolescent well visits for providers and health professionals, including Coordinated Care Organizations, providers, and youth service organizations. The measure will allow the Oregon Health Authority to see the scope of the providers trained.

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>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>N/A</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>2,000</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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>We seek to track the progress that PACCT teams make towards involving primary care in piloting ACT.md for care coordination.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>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.</td></tr>
<tr><td>Denominator:</td><td>Number of PACCT teams. There are five teams around the state.</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>5</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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 necessary to make transitions to adult health care

Measure Status:	Active
Goal:	We seek to ensure that county public health staff include transition-aged youth in their shared care planning efforts and address HCT when participating in shared care planning.
Definition:	**Numerator:** Of the total number of SPOC that county public health staff initiated or re-evaluated, the number of SPOC initiated for youth 12 years of age and older. **Denominator:** The total number of SPOC that county public health staff initiated or re-evaluated. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	After initiating a, or re-evaluating an existing, SPOC, county public health staff completes OCCYSHN's online SPOC Information Form. The form tracks the number of SPOC initiated or re-evaluated, the number of SPOC initiated or re-evaluated for transition-aged youth, and number of SPOC for transition-aged youth that included transition goals. The form also asks county public health staff to describe how the children were identified, what general category of condition they have, the reasons for selecting the child or youth, and demographic information about the child/youth and family. County public health staff fills out one form per child or youth. OCCYSHN trained county public health staff in the use of the form and sends reminders to county staff to submit their forms following SPOC initiation. Lack of timely receipt affects the completeness of the data and, consequently, their analysis.
Significance:	The CaCoon Public Health Nurse home visiting program serves children from birth to age 21, although county public health departments have the latitude to determine those children and families that are served by their CaCoon program. In 2014, only 5% of CaCoon clients were 12 years of age and older. We learned from our 2015 statewide needs assessment that health care transition is not well understood by providers. OCCYSHN hopes that by requiring the county public health workforce to engage in shared care planning for transition aged youth, including HCT planning, that the work will help to expand awareness and understanding of HCT practices by both providers and families. This effort also will contribute to increasing the number of transition-aged youth who receive HCT services.

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 necessary to make transitions to adult health care

Measure Status:	Active
Goal:	We seek to ensure that county public health staff include transition-aged youth in their shared care planning efforts and address HCT when participating in shared care planning.
Definition:	**Numerator:** Of the total number of SPOC that county public health staff initiated or re-evaluated for youth 12 years of age and older, the number of SPOC that address transition planning. **Denominator:** The total number of SPOC that county public health staff initiated or re-evaluated for youth 12 years of age and older. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	After initiating a, or re-evaluating an existing, SPOC, county public health staff completes OCCYSHN's online SPOC Information Form. The form tracks the number of SPOC initiated or re-evaluated, the number of SPOC initiated or re-evaluated for transition-aged youth, and number of SPOC for transition-aged youth that included transition goals. The form also asks county public health staff to describe how the children were identified, what general category of condition they have, the reasons for selecting the child or youth, and demographic information about the child/youth and family. County public health staff fills out one form per child or youth. OCCYSHN trained county public health staff in the use of the form and sends reminders to county staff to submit their forms following SPOC initiation. Lack of timely receipt affects the completeness of the data and, consequently, their analysis.
Significance:	The CaCoon Public Health Nurse home visiting program serves children from birth to age 21, although county public health departments have the latitude to determine those children and families that are served by their CaCoon program. In 2014, only 5% of CaCoon clients were 12 years of age and older. We learned from our 2015 statewide needs assessment that health care transition is not well understood by providers. OCCYSHN hopes that by requiring the county public health workforce to engage in shared care planning for transition aged youth, including HCT planning, that the work will help to expand awareness and understanding of HCT practices by both providers and families. This effort also will contribute to increasing the number of transition-aged youth who receive HCT services.

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:	**Numerator:** Number of data sets analyzed for oral health disparities **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	State tracking
Significance:	The Oregon Health Authority, Maternal and Child Health Section is using oral health surveillance from the Oregon Oral Health Surveillance System (OOHSS) to identify minority and underserved populations disproportionately affected by cavities and oral disease. This measure will ensure that all data sets within the OOHSS can be analyzed by race and ethnicity, urban/rural status and other select variables to identify oral health disparities. Results will be used to identify gaps in data collection and provide culturally responsive communications and access to oral health services.

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:	**Numerator:** Number of school oral health programs and Title V local grantees provided with technical assistance to enhance the quality of oral health services and increase oral health visits. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 40
Data Sources and Data Issues:	Log of technical assistance provided
Significance:	School oral health programs and Title V grantees are critical partners in the effort to improve the oral health of pregnant women and children. The Oregon Health Authority, Maternal and Child Health Program will be providing a webinar for school oral health programs on how health equity can improve the reach of their programs. Topics will include cultural competency, health literacy standards, and trauma informed care practices. The Oregon Health Authority, Maternal and Child Health Program will also be providing a webinar for Title V grantees on developing oral health educational materials, health literacy standards, and providing dental referrals. Other technical assistance may be provided throughout the year as specific needs are identified. This measure will allow the Oregon Health Authority to see the number and type of organization provided with technical assistance.

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:	**Numerator:** Number of oral health providers provided with training on oral cancer and HPV. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	State tracking
Significance:	Rates of HPV-related oropharyngeal cancer are increasing in Oregon, especially for males. The Oregon Health Authority, Maternal and Child Health Program is partnering with the State Immunization Program and American Cancer Society to increase HPV vaccination rates among adolescents. Activities will leverage momentum gained with the passage of House Bill 2220 in 2019 allowing dentists to administer vaccines in Oregon. The Oregon Health Authority, Maternal and Child Health Program will be providing the “You are the Key” webinar opportunities for dental providers to increase awareness around oral cancer and the HPV vaccine. This measure will allow the Oregon Health Authority to see the number of dental professionals trained.

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>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>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</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:	**Numerator:** Number of local Title V grantees who have selected smoking as a priority area who have at least two technical assistance contacts. **Denominator:** Number of local Title V grantees who have selected smoking as a priority area. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Log of technical assistance provided
Significance:	Providing support and technical assistance around the 5As and other best practice interventions will allow for continued quality in ensuring success.

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:	**Numerator:** Number of external partners engaged in developing a policy agenda to decrease youth exposure to tobacco **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	State tracking
Significance:	Coordination between partners is the optimal way to successfully develop policies to decrease smoking in households with children.

Form 11
Other State Data

State: Oregon

The Form 11 data are available for review via the link below.

Form 11 Data