



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Oregon**

**Application for 2013
Annual Report for 2011**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are on file in the Office of Family Health.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

The Office of Family Health (OFH) and Oregon Center for Children and Youth with Special Health Needs involves communities, stakeholders, and program participants, including family consultants, in policy and program decision-making at many levels. The priorities, budgeting and expenditures, performance measures trends and outcomes, are presented and reviewed by stakeholder and program participants of MCH and family health services across Oregon. The Title V and related programs outreach to local public health, tribal health, community-based organizations, primary care, and safety-net providers. The venues range from needs assessment processes and program evaluation to advisory committees and task force efforts.

Oregon Title V Office (Office of Family Health) has a website for resources and for public comment on the Block Grant and the Five-Year Needs Assessment priorities. The website and public comment can be found at <http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/MCHTitleV/Pages/mchform.aspx>.

Once the Needs Assessment and priority issues are finalized, the strategy for using this website will be reviewed and updates to assure partners, stakeholders, and the public feel comfortable using this site. The OCCYSHN website (<http://www.ohsu.edu/xd/outreach/occyshn/>) links to this website.

The Five-Year Assessment public engagement activities provided new contacts and strategies for collecting input on plans for implementing the priorities. Regular opportunities for input occur through public meetings and sessions with stakeholders and local partners, such as Conference of Local Health Officials- MCH Committee and local Nursing Supervisors, to discuss policies and capacity in Oregon's state and local Title V programs, including those programs administered by OCCYSHN. Family consultants provide input on program and policy development in both OCCYSHN and in OFH, and link other family consultants to participate in planning activities beyond Title V program areas.

/2012/ In addition to ongoing public input activities described above, OFH convened Collaboratives with local Title V programs to focus on specific priority issues. The Public Health

website was redesigned in 2011, and the update to the input page will be included in the last part of 2011. OFH plans to use the site for input on the priority goals established in the five-year needs assessment. Other public input is occurring in projects that Title V leadership is participating or leading with other agencies. These include the home visiting parent surveys and the ABCD-3 Initiative which held community cafes with parents. Other opportunities for public input that support Title V goals and programs include advisory committees for Immunization and WIC. The input from these committees and groups are shared across MCH public health programs.

OCCYSHN convened a two-day Family Gathering/Leadership training for OCCYSHN/CDRC family staff. In addition to the training provided, OCCYSHN received input into the Title V Block Grant, in particular the new state priority goals for CSHCN. The input process also provided opportunities for discussion of issues facing families of CSHCN in Oregon, which included adequacy of health care financing, limited availability of family supports, cultural barriers to care, and other unmet needs. The information collected through the input process will inform program planning and evaluation efforts over the next fiscal year. //2012//

/2013/ The Public Health Division structure and website are being revised and the public input page for the MCH Block Grant will also be revised during FY 2013.

The Youth Advisory Council provided input to the Title V Adolescent Health program efforts to develop a framework that facilitates communication between State staff and young people. This input is leading to the development of a "youth development" position description for the Adolescent Health Section to facilitate more input for the Title V Adolescent Health program and for School-Based Health Centers. The input is also helping with the development of a toolkit to help School-Based Health Centers start their own youth advisory councils. //2013//

/2013/ A two-day Family Gathering/Leadership Training was convened for OCCYSHN/CDRC family staff at which input into the Title V Block Grant, in particular the new state priority goals for CSHCN, was received. The input process also provided opportunities for discussion of issues facing Oregon families of CSHCN including adequacy of health care financing, limited availability of family supports, cultural barriers to care, and other unmet needs. The information collected through the input process will inform program planning and evaluation efforts over the next fiscal year. Family staff also provided input on improvement of OCCYSHN's Community Connections Network program relative to strategies to enhance family-centered care and family involvement.

Five Oregon F2F HIC Family Listening Sessions in were conducted five rural communities and one suburban community to collect information about family experiences with health services delivery, gaps, and access. Input from these sessions was shared with OCCYSHN.

OCCYSHN conducted interviews with key community-based CCN partners and stakeholders to learn from communities about the opportunities and barriers to assuring coordinated services for children with special health needs through a community-based multi-disciplinary team model. CCN teams, individual team members and referring parties were included in the interviews. Over this next year, OCCYSHN will share the lessons learned in state and local policy arenas and with communities looking to implement multidisciplinary care coordination teams for children with special health needs. A report containing key findings and recommendations was developed and disseminated. //2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Oregon Five-Year Assessment found some priority needs continuing and others emerging more prominent. The need for better access and more culturally appropriate services continues to be a problem in many communities and among populations, such as access and referral systems to mental health services for all population groups, preventive oral health services, and healthy weight and physical activity. Emerging areas in the 2011 assessment include more critical and difficult issues, such as family violence, and alcohol and drug abuse. For these areas, more research, assessment, and planning to identify those actions and roles for public health to influence a positive health outcome in a generally social justice issue.

The methods for Oregon's Assessment covered a broad range in order to assure input from as many stakeholders and experts as possible and analysis that balances the quantitative and qualitative research. The methods covered three different processes: research, surveys, and engagement.

2011-2016 Priority Needs and Goals

1. Need: Family violence prevention, including intimate partner violence and child abuse
Goal: Improve Oregon's systems and services for screening women for domestic and sexual violence (DSV) and for linking those affected by DSV to adequate services.
2. Need: Alcohol and Drug Use Prevention, including accessibility of services (and prevention of Fetal Alcohol Syndrome)
Goal: Decrease the risk of lifetime dependence on alcohol for teens and adults
3. Need: Mental health including accessibility of services
Goal: Improve Oregon's systems and services to identify, treat and support women with perinatal mental health disorders and support their infants and families
4. Need: Oral health and early childhood cavities prevention, including accessibility of services
Goal: Increase the percent of children under 3 years old who have a preventive dental visit each year
5. Need: Parents' resources and parenting behaviors (including parenting education and other support services) to support young children's health, development, safety, and social-emotional health
Goal: Improve the state's capacity for supporting parents in building parent skills and for linking parents to resources.
6. Need: Preventing overweight and obesity
Goal: Prevent and address overweight and obesity in older children and adolescents, including nutrition, food security, physical activity and screen time: Increase the percent of children/adolescents with a healthy body weight
7. Need: Access to preventive physical and mental health services
Goal: Increase access to preventive physical and mental health services
8. Need: Lack of linkages or referral pathways to appropriate mental health services for children

and youth with special health needs

Goal: Increase linkages to mental health services for children and youth with special health needs.

9. Need: Limited access to specialized health and related services (specialty care, mental health, PT/OT, etc.) for children and youth with special health needs particularly in rural and frontier areas:

Goal: Increase access to specialized health and related services for underserved populations of children and youth with special health care needs.

10. Need: Families and providers lack knowledge and awareness of support services available for families of children and youth with special health need

Goal: Increase access to family support services among families of children and youth with special health needs.

//2012/ The Title V Office is identifying initial resources available and needed to begin a planning and implementation stage for the new goals. In some cases, capacity exists and efforts are funded and underway. In others, the goals represent new areas that may need evaluation of the framework, best practices, staffing, and funding. Plans and activities are highlighted in Section IV.D. and Table 4b for the State Performance Measures. //2012//

//2013/ The Public Health Division has a new vision, mission and five-year goals. Significant for the MCH population is the selection of issues such as family violence prevention, obesity prevention, suicide prevention, and tobacco use prevention. These align with both the state and federal Title V priorities and goals and provide an opportunity to apply Title V and life course frameworks to these issues. Reorganization from five offices into three centers will help to focus efforts even further to plan interventions and allocation of Title V resources towards those priorities. More information about the Public Health Mission, Values, and Goals can be found at <http://public.health.oregon.gov/PHD/Pages/Goals.aspx> . //2013//

III. State Overview

A. Overview

Oregon Title V leads and engages partners in the improvement, development and coordination of maternal and child health services system and policies across the state. The Title V Services are administered by two agencies - the Office of Family Health (OFH) in the Oregon Health Authority, Public Health Division, and the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) from within the Child Development and Rehabilitation Center at the Oregon Health and Sciences University. The relationships of the two Title V Offices provide unique partnerships and opportunities for collaborations with state and local public health delivery system and the health professional training and academic research system. Together the Title V Offices assess population health and needs, collaborate and coordinate policy development and implementation, and plan and implement services that reach all of the targeted MCH populations.

The Oregon Agency Title V Overview is organized to give background and context for the delivery of Title V health services, beginning with an overview of the statewide determinants of health, the state's health care delivery system, and a summary of current policy issues. The content is: 1) Geography and Environment; 2) Demographics; 3) Economy and Income; 4) Housing and Education; 5) Safety Net and Health Care System; 6) Oregon Health Authority; 7) Federal Health Reform in Oregon; 8) Oregon Center for Children and Youth with Special Health Needs.

1. Geography and Environment

Oregon is located in the Pacific Northwest with a population of 3.8 million living in 96,981 square miles and 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, which still meets the technical definition of a frontier. Oregon shares borders with Washington to the north, California to the south, and Idaho to the east, and a small section of Nevada to the southeast and the Pacific Ocean along its 300 mile western border. Much of these borders are along rural and frontier areas and people transverse these borders for their goods and services.

There are four major mountain ranges that make traveling in Oregon both beautiful and challenging for residents, especially for those living in these areas. Oregon has multiple opportunities for outdoor recreation, from skiing in the winter in these ranges, to camping in one of its 188 state parks, hiking along Coast, in the mountains, or near waterfalls in the Columbia River Gorge, biking along the 40-mile loop in Portland, or kayaking on one of Oregon's many rivers and tributaries. There are 15.7 million acres National Forest Service lands and 15.7 million acres of Bureau of Land Management lands, covering approximately 46.2 percent of the total acreage of Oregon. Agricultural lands cover over 16.3 million acres or over 26 percent of the total land area. Of this, 55.8 percent is pastureland, 3.6 percent is cropland, and 10.5 percent is woodland. (Oregon Dept. of Agriculture, State Facts)

Portland is largest metropolitan area located in the northwestern part of the state, with about 1.8 million people residing in Oregon, and an additional 442,000 living across the Columbia River in Washington, totaling 2.2 million considered the Portland-Vancouver-Hillsboro Metropolitan Statistical Area (MSA), the 23rd largest in the U.S. Other urban centers include Salem, the state capital, Eugene, in the mid-Willamette Valley, and Medford, in Southern Oregon. About 75 percent of Oregonians live in urban areas and 25 percent in rural and frontier areas. Oregon has five Congressional districts.

Oregon is primarily a rural and frontier state, with an overall population density of 37 people per square mile covering 99.1 percent of the state. 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 (Rural Assistance Center, USDA Economic Research Service). There are 10 federally recognized tribes in Oregon and 43 member tribes participating with the Northwest Portland Area Indian Health Board and other

urban health facilities located in Oregon, Washington and Idaho. The Title V Office of Family Health provides formula grants funded with the MCH Block Grant to three federal tribal government health clinics in Oregon. /2012/ The number of tribal government health clinics receiving MCH Block Grant funds increased to five in 2011, with all the largest tribes participating in the program. //2012//

2. Demographics

Oregon's estimated population on July 1, 2009 reached 3,823,460. That was an increase of 0.85 percent over the 2008 population. The growth rate has slowed down since the highs of 2005 through 2007 when it exceeded 1.5 percent on average. (Oregon Economic and Revenue Forecast, Vol. XXIX, No. 2, May 2009, Oregon Office of Economic Analysis.)

/2012/ Oregon's profile from the U.S. Census Fact Finder (<http://www.census.gov/prod/cen2010/profiletd.pdf>) for the general population and housing Census results show Oregon with 3,831,074 people, which is a slight increase from the population projection of 2009 and a 12% increase over the 2000 U.S. Census. About 6.2% of the population is under 5 years and the median age is 38.4 years of age. The 2010 Census shows the race and ethnicity changing in Oregon, particularly in reporting race: 83.6% reported as White only, a significant reduction from the 90.1% projected in 2008. However, reports for "some other race" increased to 5.8% while two or more races increased to 3.9%. These changes seem to be reflected in the Census results for Blacks or African Americans which was reduced from 2.0% to 1.8%. Other races are about the same with Asian at 3.7% and American Indian/Alaska Native at 1.4%. Hispanic or Latino population is 450,062 or 11.7% of the total population, which is little change to projections but a 64% increase over the 2000 U.S. Census. //2012//

Oregon averages 45,000 births per year, and a birth rate of about 13.4 per 1000 live births. Of these births, over 20 percent are Hispanic of all races, while about 69 percent are White, 2.3 percent are African American, less than 2 percent are Native American and 5.3 percent are Asian. Birth rates are lower than the U.S., 66 per 1,000 women aged 15.44 in 2007, compared to the U.S. at 69.2 per 1000. The median age of mothers for all Oregon births was 27 and the median age at first birth was 25. The first birth rate decreased slightly from the previous year to 26.9 first births per 1,000 women age 15-44, slightly lower than the 2007 national rate of 27.9. Age-specific births for women age 15-19 was 35.1 per 1000, 94.4 per 1000 for 20-24 year olds, and 116.1 per 1000 for 25-29 year-olds. The rate per 1000 for women aged 30-24 was 92.9 per 1000. The largest percentage increase was among women aged 35-39 at 48.7 per 1000. (U.S. Census Bureau and Oregon Center for Health Statistics)

Oregon's is one of about nine states with consistent low birthweight percentages below 6.5 percent, while the U.S. was 8.2 percent in 2007, for 2500 grams or less. Oregon's infant mortality rate of 5.5 per 1000 live births compared to Oregon the national rate of 6.7 per 1000 live births. Over the past five years, the overall infant mortality rates are about 240-277 per year. About 75 percent of these are White, while small numbers for the remaining populations makes annual calculations unreliable. Generally, the infant mortality rates are higher for Hispanic populations than for infants of other races and ethnicities.

Of the 1,034,458 Oregon children ages birth to 18 years, the 2006 National Survey of Children with Special Health Needs estimates 13.3 percent has one or more special health care needs. Over 100,000, or 22 percent, households in Oregon have one or more children with special health care needs (CSHCN). The proportion of ethnicity of the CSHCN population is about the same as the state's population, 11 percent are of Hispanic ethnicity and 16 percent of these children are non-white.

3. Economy and Income

Oregon's economic condition heavily influences the state's population growth and state revenues for public education and services. Migration population change was about 48 percent in 2009, down from 57 percent in 2002. Oregon's employment in trade, transportation and utilities

accounts for nearly one in five Oregon jobs. Currently, the top employment industries are food services, administrative and support services, trade contractors and constructions, followed by health care services and hospitals, computer and electronic product manufacturing, and retail services. (Oregon Blue Book, 2009).

Unemployment: Oregon's seasonally adjusted unemployment rate was 10.6 percent in May, 2010 (223,000 Oregonians), peaked in May, 2009 at 11.6 percent. (Oregon Labor Market Information System, <http://www.olmis.org/pubs/pressrel/0610.pdf>, retrieved, June, 2010).

/2012/ Unemployment rate as of May 2011 was 9.3%, slightly changed from April's 9.5%, but a substantial improvement over 2010's 11% rates, and still slightly higher than the U.S. unemployment rate of 9.1%. (<http://www.qualityinfo.org/olmisj/OlmisZine>, retrieved June 21, 2011) //2012//

/2013/ Oregon's monthly unemployment rate continues to improve a little more rapidly than the rest of the U.S. Oregon's rate peaked at 11.6 percent in 2009 compared to the U.S. rate of 9.6 percent at the same time. In May 2012, the Oregon rate was 8.4% while the rest of the U.S. 8.2% in the same period. (<http://www.qualityinfo.org/olmisj/OlmisZine> , retrieved June 15, 2012) //2013//

Income and Poverty: The U.S. Census Bureau ranks Oregon 34th in the country for the three-year average median household income, at \$51,394. (U.S. Census Bureau, Current Population Survey, 2006 to 2008 Annual Social and Economic Supplements. Three-Year-Average Median Household Income by State: 2006-2008). The Small Area Income and Poverty Estimates (SAIPE) report for 2008 for Oregon, shows that all populations ages in poverty are 13.5 percent; under age 18 is 17.5 percent and under age 5 is 21.1 percent (<http://www.census.gov/cgi-bin/saipe/saipe.cgi>). The West Coast Poverty Center reported that, as was the case nationwide, children in the west coast states were generally more likely to live in poverty than working age or elderly adults in 2008. Ethnic and racial minorities in the West Coast states were more likely to be living below poverty than non-Hispanic whites in 2008. (<http://depts.washington.edu/wcpc/povertyinthewestcoaststates>)

Over 40 percent of CHCSN ages 0-17 live in household with incomes 100 percent or more of the federal poverty level. Over one quarter of CYSHN in Oregon (27.5 %) lived in geographic areas classified as Large Towns or Small Towns/Rural. These areas are located predominantly in the rural or frontier counties in the central and eastern regions of the state.

State Revenues and Budgets: More than 90 percent of the state's general fund supports three core functions: education; health and human services; and public safety. Oregon is one of five states that does not have a sales tax, which is a benefit for consumers, but the leading source for tax revenue comes from income taxes and therefore highly vulnerable to fluctuations in employment rates. In January, 2010, Oregonians passed two ballot measures that will raise taxes on corporations and on the wealthiest individuals. However, this new revenue will not prevent a \$577 million shortfall in the 2009-2011 biennium or a projected \$2 billion shortfall in 2011-2013. The Governor has implemented a 9% cut in state agency budgets, which is about \$157 in the Department of Human Services agencies. These cuts are in addition to the state employee furloughs for 10 state office closure days and up to 4 additional days, over the 24 month budget period.

/2013/ While Oregon's economy is slowly growing, reductions continue to be necessary in State General Fund budgets. In the February 2012 Legislative session, \$28 million was reduced in mid-level management, public affairs positions, contract positions, and advertising expenditures to rebalance the 2011-13 biennial budget. The Oregon Health Authority (OHA) abolished 34 positions for a \$3.9 million General Fund savings. These included eliminating three management positions are eliminated in Public Health, for a General Fund savings of \$0.2 million. Another \$0.3 million will be eliminated in Services

and Supplies by reducing community education and outreach efforts for the family planning program and the School Based Health Centers program. //2013//

4. Housing and Education

Housing: The American Community Survey (U.S. Census Bureau), estimates that Oregon had a total of 1.6 million housing units, 9 percent of which were vacant during 2006-2008. Oregon ranks 12th in the country in foreclosure rates as of March, 2010. Oregon households that spent 30 percent or more of their income on housing, 49 percent were renters, 40 percent were owners with mortgages, and 15 percent were owners without mortgages. The median monthly housing costs for mortgaged owners was \$1,551, non-mortgaged owners \$413, and renters \$770. Four percent of the households did not have telephone service and 8 percent of the households did not have access to a car, truck, or van for private use. (U.S. Census Bureau. Oregon Population and Housing Narrative Profile: 2006-2008, American Community Survey 3-Year Estimates.)

Education: Oregon's education system starts at birth when infants are screened for early developmental delays and medical problems and referred to services for early development interventions or medical interventions. Over the lifespan, children have access to private and public preschools and pre-kindergarten, Head Start, public schools, community colleges, universities and graduate studies.

//2012/ Governor Kitzhaber, elected for a third term in November 2010, is ambitiously making proposals to improve early child education outcomes by establishing an Education Investment Board and an Early Learning Council. More information is in III.E. State Agency Coordination. //2012//

According to the 2009 IDEA Part C Annual Performance Report, 2,762 total children aged birth to 3 years of age received services 33 EI/ECSE programs in Oregon in 9 service areas with an Individualized Family Service Plan (IFSP). Each site serves from 112 to 444 children with IFSPs. Of those ages birth to three with an IFSP, 21.7 percent were Hispanic and 70.1 percent were White, and 2.9 percent were African American. The number of 3-4 year olds enrolled in pre-kindergarten special education was 5,703 or 6.1 percent of the population. The proportion of children engaged with EI/ESCE represents about the 3.5 percent of the total child population aged birth to 4.

Oregon has six Early Head Start sites in Oregon, funded directly from the federal Office of Head Start and 37 Head Start grantees, funded by the federal Office of Head Start and the Oregon Department of Education. As of January, 2009, there were 1,018 children, or 3 percent of the eligible population, under age 3, was enrolled in Early Head Start, and 12,582 children were enrolled in Head Start or 68% of eligible families, including Native American children served by Tribal governments and children of seasonal farm worker families. The Migrant/ Seasonal Head Start (Oregon Child Development Coalition) serves an additional 1,877 children, ages 0-5, from mobile migrant farm worker families.

Oregon has 198 public school districts, which operate a total of 1,306 public schools, enrolling a total of 561,698 students from kindergarten through grade 12 for 2009-2010 school year. While Oregon schools have a much lower proportion of minority enrollment compared to the U.S. average, other measures show that Oregon students are more likely than the national average to be non-English speaking or participating in the free and reduced-price school lunch program (Oregon Blue Book, 2010). In 2008-09, Oregon Department of Education data reports that 41,198 persons completed high school, of which 35.6 percent are considered economically disadvantaged, and Oregon has a drop-rate of 3.4 percent (Oregon Department of Education).

Oregon has 17 community colleges, enrolling over 91,000 students in the 2007-08 school year, 7 public universities, enrolling over 112,000 students, and another 37,000 are enrolled in Oregon 20 non-profit accredited universities. Oregon has one academic research school, the Oregon Health and Science University (OHSU) which includes schools of medicine, dentistry, nursing and

science and engineering, as well as the Child Development and Research Center and OCCYSHN. Title V offices and local providers have a strong tradition of partnerships with these education institutions to help train and employ graduates from Oregon schools.

5. Safety Net and Health Care System

Oregon's public health statutes and programs are administered by the Public Health Division (Oregon Health Authority) and each of 36 county jurisdictions are the designated health authority. Currently, there are 33 county health departments and 1 health district serving 3 small rural county populations. Primary care and safety net health services are available through private medical providers and through the following facilities.

Total Health Care Facilities: 263 Clinics and 58 Hospitals in 116 Sites

Federally Qualified Health Centers: 93 Clinics in 46 Cities and 25 Counties

Rural Health Clinics: 57 Clinics in 43 Cities and 24 Counties

Migrant Health Centers: 15 centers in 12 cities in 10 counties

Tribal and Indian Health Service: 11 Clinics among 9 Tribes and 9 Counties

School Based Health Centers: 54 Clinics in 20 Counties

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

Oregon's Health Professional Shortage Areas (HPSA), established by the Office of Shortage Designation, Bureau of Health Professionals, to determine where reports 102 designations for primary care in Oregon in 15 service areas, and 54 practitioners needed to remove designation. There are 76 HPSA dental care designations and 118 dental practitioners are needed and 54 mental health HPSA designations and 20 practitioners needed to remove the designation. Mean travel to time to nearest hospital across Oregon is 23.7 minutes in the unmet need areas of rural Oregon, with several areas up to an hour or more to the nearest hospital facility. Thirty-seven rural towns had a 10 minute travel time to the nearest hospital (Oregon Office of Rural Health). At least one practicing pediatrician is practicing in 23 of Oregon's 36, and of the 13 counties without a practicing pediatrician, 11 are located in rural or frontier counties Children living near eastern and northeastern Oregon border are more likely to travel to Boise, Idaho, or to Washington State than to Portland or other metropolitan areas in Oregon. However, a lack of Medicaid interstate transportability has made it increasingly difficult for children to receive care in Idaho or Washington.

Health Safety Net Access: Oregon's safety net health care system provides vulnerable and underserved individuals with prenatal care, immunizations, treatment for communicable diseases and chronic disease management. The Safety Net System cares for over 270,000 patients, including about 720,000 primary care visits, nearly 150,000 mental/behavioral health visits, nearly 110,000 oral health visits. Patients seen by federally supported clinics include about 60,000 well-child health supervision patients, aged birth to 11 years, 12,500 migrant/seasonal farm-worker patients, and 19,212 homeless patients. The Oregon Primary Care Association reports that 24,686 homeless used Federal Qualified Health Centers (FQHC) in 2008. Also, migrant and seasonal farm workers usage of FQHC's increased from 16,491 in 2001 to 19,595 in 2007 and a high of 22,226 in 2008 (Oregon Primary Care Association, 2008).

Oregon's safety net includes 55 certified School Based Health Centers are located in 31 high schools, 4 middle schools, 11 elementary schools, and 8 combined-grade campuses. Eleven counties are using planning grants to create 14 new certified centers. In 2009, there were 47,511 students with access to SBHCs at their schools and SBHCs served nearly 25,000 students with over 72,000 visits, and 47 percent of these clients were uninsured.

//2012/ The SBHCs plan to expand to 65 centers in 2011 in 22 counties (Oregon has 36 counties), which relies on State General Fund and other local sources to pay for the Centers. Several Oregon centers have applied for facilities funds under the Affordable Care Act. //2012//
//2013/ There are 63 SBHCs in Oregon. //2013//

Geography represents a significant barrier to obtaining care, particularly specialty care, for CSHCN. Specialty care services for children are concentrated in the urban areas, particularly Portland, where the only teaching hospital, Oregon Health & Science University (OHSU), is located. Cardiology is the most common specialty service available in these and other outlying communities. Little or no specialty care services are available in the rural and frontier counties of central or eastern Oregon. Similar to the rest of the nation, dental and mental health services are the most difficult services to access geographically, and is particularly for CYSHN and their families, as providers in their areas are not trained to provide care to CYSHN. Families of CYSHN are burdened financially and with time away from work, not to mention the difficulty of traveling in winter, to receive specialty services for their children in Oregon's urban areas.

Birth deliveries: In Oregon, most infants are born in hospitals (80.9 percent) and delivered by physicians. However, there has been an increase in prevalence of births attended by certified nurse midwives (CNM) in hospitals and out of hospitals. In 2007, 15.4 percent of hospital deliveries were CNM-attended, a slight increase from 2006 (14.6 percent) and almost three times the proportion in 1988 (5.3 percent). This is almost twice the national proportion of 7.4 percent births attended by CNM. The proportion of out-of-hospital births was almost double that of the U.S. births, with about 2.5 percent of Oregon births occurred out-of-hospital in 2007 compared to 2006 U.S. proportion, most recent data available, of 0.9 percent. As in past years, the majority of out-of-hospital births occurred in the mother's home (67.8 percent). More than one-fourth of the births occurring out-of hospital and 345 births were at freestanding birthing centers. Out-of-hospital births were predominately attended by licensed direct entry midwives (LDM), who delivered over half of the out-of-hospital births in 2007. Both certified nurse midwives and naturopathic physicians delivered approximately one in 10 out-of-hospital births and non-medical attendants, including non-licensed lay midwives, delivered 346 babies or 27.3 percent of the out-of-hospital births. The majority of births (69.8 per 100) continue to be vaginal deliveries without prior cesarean, while the rate of delivery in 2007 was 28.9 per 100 births, well below the 2007 national rate of 31.8 per 100 births. The rate for vaginal delivery after a previous cesarean was only 1.3 while repeat cesarean was 12.2 per 100 births. (Oregon Center for Health Statistics, 2006 and 2007 Annual Reports).

//2013/ In 2011, the Oregon legislature passed House Bill 3311. This mandated the Oregon Health Authority (OHA) to explore options for providing or utilizing doulas in the state medical assistance program to improve birth outcomes for women who face a disproportionately greater risk of poor birth outcomes. A twelve member committee representing a variety of pregnancy-related providers and insurances, convened and staffed by the OHA Office of Equity and Inclusion, Office of Family Health and the Division of Medical Assistance Programs (Medicaid), met for 4 months to fulfill the legislative requirements. The Oregon PRAMS data demonstrated consistent patterns of disparities in birth outcomes between women of color and the non-Latino white population regardless of geography or payer. In addition, national evidence demonstrated that providing a doula for women during pregnancy, childbirth and postpartum reduces poor birth outcomes among women of color and non-Latino white women. Based on the data analyzed, the Committee recommended doulas as an overall strategy to improve birth outcomes funded by both Medicaid and private insurances. Next steps include exploring options for creating a Medicaid State Plan Amendment to obtain a waiver to allow doulas reimbursement under Medicaid. Simultaneously, a similar bill mandated exploration of using unlicensed community health workers to fulfill various functions within the context of Coordinated Care Organizations (CCOs). How these two cadres of health care providers will fit within the new health care system of CCOs has yet to be seen. OFH will continue to be involved in the on-going conversation of using the breadth of providers available to improve birth outcomes for all Oregonians. //2013//

Health Insurance: The 2008 American Community Survey reports that Oregon is 35th in the country for individuals without health insurance with 16.5 percent uninsured. This survey also reports that private insurance covers the 2.6 million residents in Oregon. These data were

collected a year before Oregon's unemployment rate 12.6 percent in early 2009, so it is assumed the rate of un-insurance has increased dramatically. The uninsured Hispanic/Latino population was 35.1 percent, or 144,000 Hispanics without health insurance. (Oregon Health Policy and Research: Oregon's Uninsured: Analysis of the 2008 American Community Survey, May 2010).

Oregon Health Plan (OHP) Overview: Between 1989 and 1993, the Oregon Legislature passed a series of laws that have become known as the Oregon Health Plan. The OHP is a public/private partnership made up of three main components: Medicaid reform and expansion, private and employer-sponsored insurance subsidy to help those not eligible for Oregon Medicaid (Office of Private Health Partnerships), and the Prioritized List of Health Services, managed by the Health Services Commission (HSC). The Prioritized List of Health Services is ranked to the entire population to be covered, based on relative importance and the effectiveness of a clinical intervention as gauged by public input and the clinical expertise on the HSC judgment. Within categories of health services (e.g., maternity and newborn care; comfort care), individual condition/treatment pairs (e.g., ICD-9 and CPT codes) are prioritized according to impact on health and demonstrated effectiveness. The resulting prioritized list is used by the Legislature to allocate funding for Medicaid and SCHIP, but the Legislature cannot change the priorities set by the independent Commission. Prevention tables guide standards for preventive services by age groupings and correspond to the prioritized list. It is important to note that perinatal care, child and adolescent preventive services are at the top of the list.

The Division of Medical Assistance Programs (DMAP) administers the Oregon Health Plan. Currently, most adults, aged 19-64 with incomes up to 100% FPL are eligible for OHP Standard, for which there is a waiting list. Pregnant women and persons with disabilities with incomes up to 185% FPL are eligible for OHP Plus. Oregon does not have a presumptive eligibility law for pregnant women. OHP Plus includes Oregon's SCHIP program, now called "Healthy Kids," which covers children up to age 19, who have or are in families with incomes up to 200% FPL, with subsidies for co-pays and/or premiums for employer plans.

As of April 2010, DMAP reports that 522,704 people were enrolled in the Oregon Health Plan Standard and Plus. Of those, over 60 percent are White, over 23 percent are Hispanic or Latino, about 4 percent were Black/African American, almost 2% were American Indian/Alaskan Native, and almost 7 percent reported other or unknown race or ethnicity. (DMAP, DSSURS data warehouse, 5/3/2010).

/2012/ Senate Bill 99 establishes the Health Insurance Exchange Corporation to design and build an Oregon exchange in anticipation of federal health reform. Through the exchange, people and small businesses will have access to affordable coverage that will meet the high quality standards established by a citizen board of directors. In February 1, 2012, a business plan for the exchange will be presented to lawmakers for review. After approval, the exchange will begin providing coverage in January 2014; it's estimated that some 350,000 Oregonians will ultimately use it to gain access to their health insurance coverage. For individuals, tax credits will be available to assist those who cannot afford the high cost of premiums. Federal premium tax credits and subsidies will be available for people with incomes up to 400 percent of the federal poverty level (\$89,400 for a family of four). For small businesses with 50 or fewer employees, coverage through the exchange will be available beginning in 2014. //2012//

/2013/ The Health Insurance Exchange legislation passed in February 2012 and the Essential Health Benefits (EHB) Workgroup was established by Governor Kitzhaber for the purpose of recommending an essential health benefits package benchmark plan for Oregon's individual and small group market to work with the Health Insurance Exchange. The EHB Workgroup is chartered to recommend an EHB benchmark plan for the State of Oregon that applies to the individual and small group market both inside and outside the Exchange. The Workgroup will also review potential legislative language, if determined to be needed, to implement the recommended benchmark. //2013//

/2012/ In June of 2011, Governor Kitzhaber and the state Legislature passed HB 3650 to create coordinated care organizations (CCOs) across the state and serve about 600,000 Oregonians covered by the Oregon Health Plan. Components of the plan include: a) Local control so that different models for CCO may be developed to fit communities; b) Coordination that will integrate physical health, mental health, and dental health services to create a single point of accountability for the health of the entire population served by CCOs; c) Global budgets and shared savings for CCOs to be reimbursed for OHP services through a global budget designed to cover all types of care. Organizations and providers will be paid in a different way and resources allocated more strategically through the CCO. And if a CCO meets performance goals -- healthier patients and fewer hospitalizations for instance-- there could be opportunities for shared savings among providers and organizations; d) Metrics/performance measures for accountability and transparency will be built in the CCO contracts to ensure that care is being improved while costs are being reduced; e) Primary care health homes is an element of CCOs as the center of patients' coordinated care. The primary care health home will be defined as a team that works on keeping patients at their healthiest, focusing on preventive care and managing chronic health conditions. //2012//

/2013/ The 2012 Legislature approved Coordinated Care Organizations "to achieve the goals of universal access to an adequate level of high quality health care at an affordable cost." The financial analysis of CCOs has shown a savings of about \$11 billion in total health care costs over the next decade. The first phase of CCOs will begin August 2012 and about fourteen Oregon-based groups are submitting applications to become a CCO. If all are approved, it would mean that more than 90 percent of Oregon Health Plan clients would have access to care through a CCO. Governor Kitzhaber secured an agreement with the DHSS, related to a waiver request Oregon submitted to the Centers for Medicare and Medicaid Services, that will give the state both the flexibility and upfront investments to support the work of Coordinated Care Organizations. With this agreement, Oregon's Medicaid program will receive \$1.9 billion for health care transformation. More information about CCOs can be found at <http://health.oregon.gov> . //2013//

Healthy Kids (HK) is an OHP program approved by the 2009 Legislature (HB 3418) as a significant part of the overall health reform passed in Oregon that year. Healthy Kids aims to insure all children up to age 19, reducing the uninsurance rate from 12 percent to 5 percent by 2011. The federal SCHIP program is integrated into Healthy Kids/OHP. As of May, 2010, over 318,000 children age 19 or less, were enrolled in Healthy Kids/Oregon Health Plan, a 17.76% increase over June 2009. The law imposes a tax on hospitals and health plans to fund the insurance expansion, school based health centers expansion, and, increases reimbursement rates. There are three avenues of coverage: 1) Oregon Health Plan (OHP) Plus (Medicaid); 2) Employer Sponsored Insurance (ESI) insurance; or 3) Healthy KidsConnect, a private market insurance option. Children in families earning 200% FPL (\$44,100 for a family of four) or less will receive Healthy Kids coverage at no cost. Children in families between 200% and 300% FPL will receive a sliding scale subsidy for the cost of their premium.

The Healthy KidsConnect (HKC) plan is for families with eligible uninsured children between 201% through 300% FPL can receive a premium subsidy for insurance carriers contracted in the HKC program. Uninsured children above 300% FPL can purchase coverage through the HKC program by paying the full premium cost. For the Employer Sponsored Insurance (ESI) component, those families who are at 300 % FPL or higher can receive premium assistance in the form of a reimbursement, as long as the employer plan meets federal guidelines. As of March, 2010, there were 832 enrolled in HKC/Oregon Health Plan; 74% had incomes between 201% and 250% FPL, 25% had incomes between 251% - 300% FPL, and 1% or 9 children of families over 300% FPL, were helped with HKC.

/2012/ As of early 2011, 85,000 children were enrolled in the Healthy Kids plan. Senate Bill 514 passed out of the House and was signed by Governor Kitzhaber May 23, 2011. The bill allows parents to purchase health insurance for their children at any time of year, by providing a

mechanism for health insurance companies to evenly share the costs of covering high-risk children. The federal Affordable Care Act prohibits insurance companies from denying coverage for children with pre-existing conditions. That requirement pushes insurers to have just two open enrollment periods each year for uninsured children in order to ensure that parents do not wait until their child is sick before purchasing insurance. SB 514 aims to rectify this problem. //2012//

6. Oregon Health Authority

The Oregon Health Authority (OHA) was created by HB 2009 by the 2009 Legislature and in effect as of July 2011. Most health-related programs in the state are joined together to form the Health Authority, including the Public Employees and Oregon Education Benefit Boards. The Oregon Health Policy Board oversees the OHA and is a nine-member, citizen-led board appointed by the Governor and confirmed by the Senate.

Health (Medical) Homes: With the passage of House Bills 2009 and 2116 in 2009, the Oregon Legislature created the Patient Centered Primary Care Home advisory committee under the Office of Health Policy and Research. The Advisory Committee was charged with guiding Oregon Health Policy and Research in the development of standards and quality measures. Oregon's Medicaid agency was mandated to develop a payment system to fund the "integrated health home" model for providers. The intent is to find ways to fund the services that link and coordinate primary care, mental health care, and the care coordination that must occur between those services.

/2012/ In late 2010, the Patient-Centered Health Care Standards were reviewed for applicability to the pediatric client. A final set of Standards was adopted by the Health Policy Board and the challenge to build a payment system around the Standards began in early 2011. The payment structure will be based on the three tiers of the Standards, with a base payment for meeting Tier 1 standards, and adding incentive payments as providers accomplish Tier 3 Standards. The implementation will be through the Oregon Health Plan contractors, the Public Employee and Oregon Education Benefit Board purchasers. Contracts were beginning to be amended with the Standards structure in mid-2011, with the hope of complete implementation by the end of calendar year 2011. //2012//

/2013/ The Patient Centered Primary Care Homes (PCPCH) began in January 2012. A provider or clinic may apply to be "recognized as a PCPCH" by completing a self-assessment and submitting an application. The PCPCH is responsible for coordinating those services within the area and population they serve. Primary care homes are encouraged to partner with local public health agencies and community organizations to educate patients, identify community health priorities, and develop plans to improve the overall health of their communities. Currently, there are about 150 recognized PCPCH clinics, including large health system clinics, school-based health centers, and rural clinics. The state requires the Coordinated Care Organizations to include PCPCH providers in their areas. //2013//

CHIPRA Quality Improvement Demonstration Grant: An \$11 million grant was awarded to the Tri-state Children's Health Improvement Consortium (T-CHIC), an alliance between the Alaska, Oregon, and West Virginia Medicaid/CHIP programs formed to improve children's health care quality. The Oregon-led consortium, working in collaboration with the state Medicaid/CHIP programs, expert consultants, and a broad range of stakeholders, will demonstrate the unique and combined impact of patient-centered care models and health information technology (HIT) on the quality of children's healthcare. The project will assess child health quality measures and the identification of the features of patient-centered care models -- including their incorporation of HIT and electronic information exchange -- that produce the greatest improvements in quality across a range of provider types, delivery systems, and geographic settings. The T-CHIC's proposal rests on three major strategies: development and validation of quality measures, including the AHRQ/CMS initial core measures; infrastructure improvement for electronic or personal health records (EHRs/PHRs) within robust health information exchanges; and implementation and

evaluation of patient-centered care models such as medical homes and care coordination hubs.

Pediatric Improvement Partnership: In 2009, Oregon was awarded a technical assistance grant to create a child health improvement partnership (IP), from the Vermont Child Health Improvement Partnership. The Oregon IP is a public-private partnership of the Dept. of Pediatrics in Oregon Health and Science University, Child and Adolescent Health Measurement Initiative (CAHMI) also in OHSU, Oregon Health Authority -- Office of Family Health (Title V) and Division of Medical Assistance Programs (DMAP-Medicaid), the Oregon Center for Children and Youth with Special Health Needs (OCCSYHN -- Title V), the Children's Health Foundation, the Oregon Pediatric Society, and the Oregon Rural Practice Based Research Network (at OHSU).

/2012/ Since its official launch in July 2010, the Oregon Pediatric Improvement Partnership (OPIP) has been successful in partnering on many important initiatives aimed at improving healthcare quality for Oregon's children. The OPIP Executive Committee and Board is comprised of representatives from Medicaid (DMAP), Public Health (Title V Director), OCCYSHN Title V Director, and pediatric and family physician practitioners. OPIP is contracting with DMAP as an "External Quality Review Organization-like" entity to implement the federal CMS's Performance Improvement Project (PIP) in conjunction with the Assuring Better Child Health and Development (ABCD) III grant (from National Academy of State Health Policy) through DMAP (Medicaid office). The purpose of the PIPs is for the Managed Care Organization contractors (MCO) to enhance linkages and communication between primary care and referral resource for at-risk children under age 3 who are screened in pediatric visits. OPIP is also collaborating with the CHIPRA Demonstration Grant by providing general technical assistance on state sponsored, practice level quality improvement, pediatric quality measures, and data usage to guide and inform improvement efforts at the state, health plan and practice level. //2012//

7. Federal Health Reform in Oregon

Electronic Health Records: Oregon has initiated another key element of health care reform -- increasing the use and effectiveness of electronic health record technologies -- through two federal grant awards. Through the American Recovery and Reinvestment Act (ARRA) of 2009, Oregon will receive more than \$21 million over the next four years to develop a system of statewide health information exchange between hospitals, doctors' offices, pharmacies and other health care providers and help health systems develop electronic health record systems. The \$21 million will be allocated through two grants. The Office for Oregon Health Policy and Research will receive \$8.58 million to administer for the Health Information Technology Oversight Council (HITOC) to develop plans for secure statewide health information exchange (HIE) between providers and across jurisdictions. The second grant, for \$13.2 million, went to OCHIN Inc. and Oregon Health & Sciences University, as partners in Oregon's designated Regional Extension Center (REC). The organizations will provide technical assistance to health care providers to purchase, upgrade and implement health care providers' electronic health record (EHR) systems. Oregon's center is one of dozens set up across the country for this purpose. The centers, modeled on the national agricultural extension center system, will also be central places to share information and best practices. OHA agencies including Title V and SSDI (State Systems Development Initiative) are participating on work groups for these projects.

/2012/ Starting August 2011, Oregon will provide incentive payments to qualified hospitals and eligible medical professionals who attest to meeting objectives for achieving meaningful use of EHRs. To qualify for these payments, hospitals and eligible professionals must demonstrate meaningful use of EHRs based on 15 core (mandatory) and 5 of 10 menu set (optional) objectives. At least one of the menu set objectives must come from one of three Public Health objectives (reporting to Immunizations, Electronic Laboratory Reporting, and Syndromic Surveillance). Oregon is ready to accept data from hospitals and providers. The new Immunization Information System (IIS) is in the process of rolling out a bi-directional web service that will both send and receive immunization histories and forecasts. Electronic Laboratory Reporting (ELR) has been active in Oregon for the past decade and is used by laboratories statewide and available as a meaningful use option. The Syndromic Surveillance is a Public

Health meaningful use option available to hospitals in Stage 1 of the meaningful use objectives.
//2012//

Children's Health Insurance Program Reauthorization Act (CHIPRA): The Children's Health Equity Outreach Project (CHEOP) is a federally funded outreach and enrollment grant through the CHIPRA, administered through the Centers for Medicare and Medicaid Services. The grant is administered by the Office of Family Health, in collaboration and coordination with the Office of Healthy Kids (OHK). The grant uses a public health approach in communities to reach and enroll a significant portion of the eligible uninsured children in the state, those citizen and legal resident children living in mixed status and unauthorized immigrant households. CHEOP reaches eligible children through the Safety Net Providers' existing community networks and local expertise. The goal for CHEOP is to outreach to at least 12,000 children and enroll 6,000 children in the intended population. Grantees will develop and/or support sustainable community level systems and partnerships that support outreach and enrollment efforts.

/2012/ The evaluation of the CHIPRA outreach and enrollment project will be completed by OFH staff and findings disseminated through presentations and publication. The CHIPRA outreach grant will be funded for another year in a no-cost extension. //2012//

Patient Protection and Affordable Care Act (PPACA) in Oregon:
Federal Health Reform legislation of 2010 complements and affirms Oregon's House Bill 2009 and the creation of the Oregon Health Authority. Like HB 2009 which created the Oregon Health Authority, the federal legislation creates an exchange that allows people and small businesses without group care to shop and compare prices and policies. An affordable option will be available for adults, similar to the Healthy Kids Plan. Additionally, the federal legislation helps to expand Oregon Health Plan coverage to low-income working families and make it more feasible to achieve Oregon's goal of affordable health care for all by 2015. The legislation will bring \$5 billion in new Medicaid funds to Oregon over the next 10 years. Oregon's high-risk health insurance pool provides coverage for people who have been blocked from other health care plans is already up and running. This pool will provide a bridge to 2014 when the federal legislation prohibits private insurance carriers from denying coverage to people with pre-existing conditions. Oregon has begun working on establishing electronic health record systems and quality standards for health care providers and hospitals. The Oregon Health Authority is well-positioned to be a national leader in these elements contained in the federal legislation. Under Oregon HB 2009, the OHA and the Board will deliver a comprehensive blueprint that will ensure coverage for all Oregonians by 2015. [Oregon Health Authority http://www.oregon.gov/OHA/features/feature_federal_intersect_ore.shtml, retrieved 6/10/2010]

PPACA: Home Visiting Restructure: Oregon Title V Programs in the Office of Family Health and in the Oregon Center for Children and Youth with Special Health Needs are collaborating with state and local partners and stakeholders to redesign the service structure for home visiting in Oregon. OFH staff is leading a cross-agency work group to conduct the required needs assessment for home visiting, and will lead the development and submission of the application, assessment and plan for Oregon. The structure will provide home visiting, maternity case management and assessment of risks for pregnant women through public health (and Title V) services. The family will then be triaged to either a evidence-based home visiting services targeted to either high risk or lower risk families.

/2012/ Under the leadership of the OFH and the state Home Visiting Steering Committee (HVSC), Oregon continues to make strides in its effort to create a framework for a comprehensive, coordinated and culturally responsive home visiting system that addresses unmet needs. The HVSC is comprised of representatives from the Governor's Office, Head Start, Child Welfare & Self-Sufficiency, Commission on Children and Families, OHA Divisions for Addictions & Mental Health, OFH/ Public Health, Oregon Center for Children and Youth with Special Health Needs (OCCYSHN). Through a number of strategic events and dialogues, the HVSC continues to engage state and local home visiting stakeholders in identifying the strengths,

challenges, gaps and opportunities in the current home visiting system. In addition, Oregon recently submitted a grant application for federal home visiting dollars through the Maternal, Infant and Early Childhood Home Visiting Program (MIECHVP), submitted an application for the competitive grant on July 1, 2011, and will be submitting the third application for the funding formula grant. Over the next few months and upcoming years, a number of evidence-based home visiting programs will be implemented in or expanded to urban, rural and frontier counties deemed at-risk through the state home visiting needs assessment. //2012//

/2013/ Oregon was awarded the formula-based and a competitive HRSA Maternal, Infant and Early Childhood Home Visiting grants. The formula grant will expand the Early Head Start and Healthy Families America evidence-based models in three counties. The 2-year competitive grant will establish the Nurse Family Partnership evidence-based home visiting model in 5 counties. Both grants work in urban, rural and frontier environments. In addition to serving more than 400 families, these funds will resource the continued development of a statewide home visiting system that, for the first time, aligns services of 9 home visiting programs, establishes common outcome measures and monitors progress through a common data system and evaluation process. To date, the system design stakeholders group have finalized a vision, mission, guiding principles and a map of Oregon's home visiting system. We are currently developing common outcome measures loosely based on the MIECHV benchmarks, a home visiting data system which will be populated by all home visiting programs, and a common home visiting entry tool used by all programs to help ensure families are directed to the programs that best fit their needs. These products reflect much growth by all partners in collaboration and breaking down of well-established silos of excellence, and a subsequent emergence of a true system. The next steps will involve rolling out the "system" in a few pilot communities. //2013//

PPACA: Teen Pregnancy Prevention Grants: Oregon submitted an application for federal Office of Adolescent Health grant funds for the Teen Pregnancy Prevention Cooperative Agreement to replicate with fidelity the Safer Sex intervention. The overall goal of Oregon Safer Sex Project is to improve sexual health of adolescent females by improving risk knowledge and reducing risk behaviors. The state Adolescent Health Section will coordinate the Oregon Safer Sex Project with other teen pregnancy prevention initiatives through the existing statewide Teen Pregnancy Prevention-Sexual Health Partnership with the Children, Adults and Family Division and TANF programs.

//2012/ Oregon applied and did not receive a grant to replicate the Safer Sex intervention. However, the Office of Family Health was awarded the a Personal Responsibility Education Program grant administered by the federal Administration for Children and Families, Family and Youth Services Bureau to implement Cuidate, a Latino-specific teen pregnancy prevention program. The five-year award amount is \$591,798 for the first year, and each year afterwards through FY 2014. //2012//

/2013/ The Office of Family Health is supporting the implementation of ;Cuidate! in 6 Oregon counties: Crook, Deschutes, Jackson, Jefferson, Marion and Multnomah with an objective of reaching 1,000 per year by June 30, 2013. //2013//

8. Oregon Center for Children and Youth with Special Health Needs

It is estimated that 14 to 18 percent of Oregon children birth to 21 years have special health needs (2005-06 NS-CSHCN, 2007 NSCH) . Significant advances in science and technology have reduced the risk of mortality for CYSHN, resulting in an increase in morbidity due to chronic illnesses. More youth and young adults with special health needs are living longer and assuming productive lives. However, fewer than 30 percent of these youth and young adults are employed, due to lack of experience in managing their own health and unaware of available resources to support their health needs.

According to the 2005/2006 National Survey of CSHCN, 116,988 Oregon children have a special health need, and 5,138 of these children have a condition that significantly interferes with day-to-day activities. Children with cerebral palsy, autism, arthritis, Down syndrome, ADHD, rare metabolic disorders, spina bifida, cleft lip and palate, and mental and behavioral disorders represent the diversity of the population served by the Title V CYSHN program. Oregon has one of the highest reported prevalence rates of Autism Spectrum Disorder (ASD) in the country (7.6% v 5% nationally). Nearly 8,000 Oregon children and youth ages 3 to 21 years are currently identified with ASD according to the Oregon Department of Education within Oregon's educational system.

/2013/ According to prevalence data obtained from the recently released 2009/2010 National Survey of CSHCN, 13.7% or approximately 119,187 Oregon children, birth to 17 years, have a special health need. Nearly 30% of these children have a condition that consistently affects their daily activities (vs. 27% nationally) and over 48% experience four more difficulties related to functionality (vs. 45% nationally). Oregon continues to have one of the highest rates of Autism Spectrum Disorder (ASD). According to the Oregon Department of Education, 8,644 children age 3 to 21 years have a current educational diagnosis of ASD. //2013//

/2012/ Every child in Oregon identified as in need of special education has at least one of the disabilities defined in the Individuals with Disabilities Education Act (IDEA). In Oregon, children must have an established diagnosis of developmental delay in order to receive Early Intervention (EI) services; children who are at risk of developmental delay are not served by Early Intervention or Early Childhood Special Education. The total number of Oregon children, age 3-21, in special education was 83,991 and 2,940 children birth to through age 2 received EI services (Oregon Department of Education, IDEA Part C, 2010-11). The majority of the 9,403 children under the age of 18 receiving federally administered SSI payments lived in their parent's household and according to 2009 SSA data. //2012//

/2013/According to the most recent data available from the Oregon Department of Education 81,718 Oregon children ages 3 to 21 years receive special education and 2,990 children ages birth to 2 years receive Early Intervention. //2013//

Birth Anomalies: Oregon does not currently have a birth anomalies registry. Children with risk factors or conditions that receive services through the Care Coordination program (CaCoon) are tracked through a statewide database. The most frequent risk factors and conditions cited for CaCoon recipients during FY '09 were developmental delay, congenital heart disease, genetic disorders, oral motor dysfunction and other chronic conditions. Children can have more than one risk factor recorded. During FY 09, approximately 69 percent of children in the CaCoon program had multiple risk factors. Several additional risk factors were added to the database last year including fetal alcohol syndrome, Autism spectrum disorder, and behavioral or mental health disorders that are coexisting with developmental delays. Over past several years, Oregon initiated a surveillance system for fetal alcohol spectrum disorders (FASD) in the Office of Family Health. Data from this system are currently being compiled and analyzed.

/2013/ The Title V Program in the Public Health Division is developing a Birth Anomaly Registry in partnership with funding from Environmental Public Health funding and SSDI funding. More information is available in III.D. Other Agency Capacity. //2013//

/2012/ Autism: The Oregon Commission on Autism Spectrum Disorder (OCASD) was created by Executive Order of the Governor in 2009. The OCASD's charge was to build from information and recommendations of the 2008 Oregon Autism Project and to create a 10-year plan for Oregon that helps target limited resources and uses best practices to improve services to all individuals and families experiencing autism spectrum disorders (ASD). Work was conducted through 6 topical subcommittees and overseen by an executive committee. Cross-agency collaboration, public private partnerships, and active participation of individuals with ASD and their families was

incorporated in each committee and recognized as critical to success in implementing recommendations of OCASD for improving services for children, youth and adults with ASD. OCASD recommendations for improvement have been finalized and include increased expertise of healthcare providers, a collaborative approach of families and professionals, identification and access to resources and service coordination. OCCYSHN has applied for a HRSA grant to implement a component of the Oregon Autism State Plan to Improve, Redesign and Enhance Systems (ASPIRES). The Oregon ASPIRES project will address key health and health-related recommendations as prioritized in the OCASD State Plan. Work proposed in this grant reflects the shared goals of the OCASD and OCCYSHN to improve the community-based system of care for Oregon children and youth with ASD and other developmental disabilities and their families. The project will partner with the OCASD and other key stakeholders and utilize a variety of strategies including disseminating information and awareness materials, training of families and providers, community engagement, and community-based team efforts to achieve goals. //2012//

//2013/ Oregon was not awarded the HRSA systems grant, Oregon ASPIRES Project. OCCYSHN continues to work collaboratively with the OCASD to improve the system of care of children and youth with ASD. In light of the absence of the HRSA systems grant, OCCYSHN has explored and initiated small steps with existing CCN teams to increase their capacity to also serve as community-based ASD screening, evaluation and diagnostic teams in selected rural Oregon communities. //2013//

The goal of the OCCYSHN Medical Home Initiative (OMHI) is to increase the opportunity for Oregon CYSHN to receive coordinated, ongoing, comprehensive care within a medical home. Two primary goals this year are to inform and ensure CYSHN population needs are integrated into both OHA Health Home policies and the policies and practices of local or regional Coordinated Care Organizations (CCOs) as they develop. The OMHI objectives are to incorporate the needs of CYSHN into the state's definition of medical home; support the implementation of medical home standards; and incorporate the needs of CYSHN into reimbursement policies. Activities include informing policy development, participation on the Gubernatorial appointed Oregon Health Policy Board CCO Certification Work Group, education and dissemination activities and participation in the Oregon Pediatric Improvement Partnership's (OPIP) demonstration of medical home project. The OMHI engages partners and stakeholders from state agencies, professional groups, and local stakeholders.

B. Agency Capacity

Overview of Title V Program Capacity Goals

The mission of the Office of Family Health (OFH) is to improve the overall health of Oregon's women, children and families through preventive health programs and services. Objectives and activities include:

- Collecting and sharing data through the data system to assess the health of women, children and families;
- Developing and implementing public health policy based on these data;
- Assuring the availability, quality and accessibility of health services, health promotion and health education;
- Reducing and eliminating disparities; and
- Providing technical assistance, consultation and resources to local health departments and other community partners

The mission of OCCYSHN is to improve the health, development, and well-being of children and youth with special health needs, through the following activities:

- Partner with families, communities, providers and agencies
- Provide leadership in policy development and advocacy

- Assess needs of families and their children
- Support efforts to coordinate and maximize resources;
- Work with communities to strengthen their capacity to meet the needs of children and their families;
- Honor the strengths and diversity of families

State Statutes related to Title V

The Title V Agency for Oregon is the Office of Family Health (OFH) in the Oregon Health Authority, located in Portland, Oregon. ORS 431.375 authorizes Oregon Health Authority (OHA) ... "To provide for basic public health services the state, in partnership with county governments, shall maintain and improve public health services through county or district administered public health programs." ORS 431.375(4) authorizes the Oregon Health Authority "...contract for the provision of maternal and child public health services with any tribal governing council of a federally recognized Indian tribe that requests to receive funding and to deliver services under the federal Title V Maternal and Child Health Services Block Grant Program."

The Oregon Revised Statutes (ORS) 444.010, 444.020 and 444.030, the Oregon Health and Science University (OHSU) is designated to administer a program to extend and improve services for children with special health needs, including the administration of federal funds made available to Oregon for services for children with disabilities and children with special health needs. Within OHSU, the Child Development and Rehabilitation Center administers and implements the Title V Block Grant program for children with special health care needs through its Oregon Center for Children and Youth with Special Needs (OCCYSHN).

The Title V Program in the OHA and the Title V Program for CYSHN in OHSU have an interagency agreement to document the roles of each agency and to directly transfer 30% of the Title V allocation (without indirect costs). State Title V Agencies in OFH and OCCYSHN collaborate in coordinating service delivery, building partnerships, identifying gaps and opportunities in delivery systems, and advocating for actions and policies that improve health among maternal and child populations. The state Title V programs support community MCH programs through intergovernmental agreements and formula grants with county health departments and tribal governments. There are no satellite state MCH offices in counties, though OCCSYHN works through the CDRC site in Eugene in the middle of the state.

County governments are the designated health authorities delivering health and mental health services and/or linking the public to health and mental health services, through county or regional health departments. Local Title V programs are defined as county health departments and tribal governments who are receiving Block Grant funds through contracts with the state Title V program. There are currently 34 county health departments, 1 regional health department (three rural counties), and 3 tribal governments receiving Block Grant funds. **//2013/ As of January 2012, 5 of the 10 tribal governments will be receiving Block Grant Funds. //2013//** Local partner agencies include the DHS regional offices for social services such as self-sufficiency, food stamps, disabilities, and foster care; regional offices for the Education Service Districts for early intervention and special education services (Part B and Part C services), to services and providers for children and youth with special health needs, and to private or public primary care, mental health, and dental health providers, including insurance enrollment.

Preventive and Primary Care Services for MCH Populations

Capacity and services for Oregon's MCH populations are described organizationally around programs in the Office of Family Health and the Oregon Center for Children and Youth with Special Health Needs.

Capacity and Services For Women Before and Between Pregnancy

The Reproductive and Women's Health Section assures preconception and reproductive health services are available across the state through several federal and state programs. The Family

Planning Program includes the Family Planning Expansion Project (FPEP), under a HCFA 1115 waiver and the federal Title X Family Planning programs. Oregon's Family Planning Programs contracts, funds and provides technical assistance with local Family Planning clinics who deliver health services, health education and counseling about reproductive and preventive health concerns, such as breast/testicular self-examination, birth control, STD/HIV risks, infertility, pregnancy counseling, and domestic violence.. Title V supports services for individuals not eligible for FPEP.

/2012/ FPEP changed its name to CCare (Contraceptive Care) in 2010. //2012//

The Breast and Cervical Cancer Program (BCCP) helps women access screening programs for early detection of breast and cervical cancers. BCCP is funded by the Centers for Disease Control and Prevention and the Susan G. Komen for the Cure Oregon. Each year, approximately 7,000 eligible individuals receive screening services. The WISEWOMAN Program is a CDC program "Well-integrated Screening and Evaluation for Women Across the Nation" -- WISEWOMAN -- promotes early detection, risk factor screening, risk reduction and access to medical treatment for low-income, uninsured and underinsured women aged 40 to 64, with incomes up to 250% FPL and who are receiving screening services through the Oregon BCC. BCCP contracts with a network of qualified providers, who have an approved medical services agreement to provide screening and services through this program. The majority of the funds are used to reimburse health care providers on a fee for service basis for office visits and colorectal cancer screenings for low-income, uninsured Oregonians.

/2012/ The Legislature passed SB 433 to allow more women diagnosed with breast and/or cervical cancer to be presumed eligible for full Medicaid benefits in order to access necessary treatment. By January 2012, the benefits are extended to any woman who was diagnosed with breast and/or cervical cancer by a provider that is recognized by the BCCP. //2012//

/2012/ The Office of Family Health is participating in an AMCHP Preconception Health Action Learning Collaborative (ALC) to Preconception Health Recommendations for young adults with disabilities. The ALC Team is an interagency and inter-disciplinary team composed of the Title V Women's Health Manager, Adolescent Health Manager, Women's with Disabilities Health Equity Coalition, National Youth Leadership Network, Oregon Health Sciences Office of Women's Health, Portland State University, GimpGirl.com, and youth with disabilities community representative. The group has performed a literature review, data analysis, and on-line survey of youth with disabilities to inform the recommendations. The recommendations are in their final stages of being edited and plan to be released in the Fall of 2011. OFH is also forming an internal team to focus on developing preconception policies and frameworks in our Title V programs. //2012//

Capacity and Services For Pregnant Women, Mothers and Infants, and Young Children
The Maternal and Child Health Section in the Office of Family Health administers a majority of the MCH services and programs for pregnant women and children. The section also includes an assessment and evaluation unit devoted to surveillance, evaluation and ensuring program impact; a policy unit that explores and addresses emerging issues and practices; and a communications unit that ensures effective outreach with communities and partners.

The Women's Health Program is a systems development program to raise awareness, engage stakeholders, and improve resources for women's health concerns across the lifespan. This Program oversees preconception health and domestic violence prevention assistance. Preconception Health is a policy focus area in OFH that aims to assure that preconception health is the norm for Oregon women of reproductive age through promotion of preconception health with women planning a pregnancy within the 2 months. The Oregon Public Health Preconception Health Action Plan was created by a collaboration of Oregon's state and local Maternal and Child Health public health agencies created in 2008. This plan provides guidance for continuing development of preconception strategies across MCH programs. The Sexual Violence Prevention Program is the Rape Prevention and Education (RPE) funding from the Centers for Disease

Control and Prevention (CDC), and participates on a statewide sexual violence prevention planning committee to implement "Recommendations to Prevent Sexual Violence in Oregon: A Plan of Action" (2006).

Perinatal Health Program aims to improve the health of pregnant women and birth outcomes through promotion of optimal prenatal care and other pregnancy related services for all pregnant women. Title V resources support statewide policy development, surveillance, and local funding for improving the health of peri-conceptual and pregnant women. Program activities include technical assistance and consultation with local health departments in delivery of perinatal services including outreach, advocacy, systems development, community-based health education; and administering the Pregnancy Risk Assessment Monitoring System (PRAMS). Maternity Case Management (MCM) services are provided by county health departments, contracted health plans and private providers through the Oregon Health Plan (OHP). MCM services include assessment of the pregnant woman's individual strengths and needs; development, implementation and monitoring of a client service plan and communication with the client's prenatal care provider; client education; assessment of the client's home and environment for health and safety; and ongoing referral and linkage to necessary services. The Oregon MothersCare (OMC) Program supports early access to prenatal care for all Oregon women. OMC links pregnant women to health insurance benefits and community resources, including oral health care. OMC sites area partner with state and local government, non-profit agencies, and private medical and dental providers. There are currently 28 OMC sites in Oregon in 23 counties, providing services to over 5,000 pregnant women per year. Another program incorporated into perinatal home visiting program is the screening for environmental health exposures for children and pregnant women.

Maternal Depression Prevention Initiative is a policy focus area that emerged as a top priority from Oregon's Maternal and Child Health (MCH) leadership retreat in 2008 and from the Oregon Legislature who passed HB 2666 in 2009. The initiative seeks to develop and implement a public health action plan to improve perinatal mental health and enhance systems and services for prevention, identification, treatment, and support of perinatal depression/anxiety. HB 2666 created a work group on Maternal Mental Health disorders (prenatal through one year postpartum) composed of public and private health and mental health providers and experts. The Maternal Mental Health Work group will submit recommendations to the Legislature by September, 2010, for effective, culturally competent, and accessible prevention, screening/identification, and treatment strategies and evidence-based practices for health care providers and public health systems, including private and public funding models.

/2012/ The Oregon Legislature passed HB 2235, the Maternal Mental Health Patient and Provider Education Act. This legislation is based on recommendations contained in the HB 2666 Maternal Mental Health Work Group report. It requires the Oregon Health Authority-OFH to develop a website and materials for provider and patient education, and to seek funding to expand maternal mental health awareness and provider training opportunities around the state.

//2012//

Capacity and Services For Young Children and Youth

The Office of Family Health implements the following programs and initiatives for children, youth, and adolescents.

Early Hearing Detection and Intervention Program facilitates Oregon's Newborn Hearing Screening legislation (ORS 433.321) which mandates that all infants born in facilities with 200 or less births be screened for hearing loss within 6 months of birth. The EHDI program supports parents of newly diagnosed infants with hearing loss, conducts a parent mentoring program (Guide By Your Side), disseminates EHDI program materials developed for parents, maintains a tracking and recall registry to ensure all infants are screened and receive necessary follow-up services. Participants in the EHDI registry include hospitals, diagnostic audiology centers and Early Intervention (Part C) programs who report individual-level results. Out-of-hospital births

screening is provided through partnerships that provide free screening and enable the EHDI program to purchase and loan out screening equipment. The program also continues to loan hearing screening equipment to Early Head Start programs for the purpose increasing the State's capacity to track late-onset or progressive hearing loss. The program receives federal support from the CDC grant for EHDI.

Babies First! Program is a public health nurse home visiting programs that provides primary and secondary prevention program in the home for infants and children up to age 5 and their families. Funded with state general funds and Targeted Case Management funds, county health department public health nurses provide assessment of the mother and infant attachment and the home environment, screening for developmental delays, vision and hearing, counseling, case management, advocacy and education, as well as referral and follow-up. The Babies First! Program is coordinated at the local level with CaCoon home visiting for children with special health needs, and Oregon Healthy Start administered by the Oregon Commissions on Children and Families.

/2012/ The New Framework for Oregon's Public Health Home Visiting System will reframe Oregon's home visiting system to include evidence based models suitable for statewide sustainability. //2012//

A pilot initiative to integrate a system of wellness, prevention, and treatment for children birth to age 8, is currently being implemented in two counties, supported by the LAUNCH (Linking Actions for Unmet Needs for Children's Health) grant initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA). LAUNCH is implementing evidence-based interventions across the lifespan, and evaluating for policy and program development.

/2012/ Oregon was awarded a second LAUNCH grant to the Multnomah County Education Service District. This grant will focus on increasing linkages and coordination around early childhood screening, identification of developmental delays, and follow up care by Early Intervention/Early Childhood Special Education. //2012//

The Oral Health Program aims to improve oral health and prevent cavities and decay of children and adults through statewide oral health systems infrastructure development, policy development for fluoridated community water systems, school-based sealant programs, school-based fluoride supplement program, and an early childhood cavities prevention program. Title V provides resources for public health dentist consultant and the school-based fluoride supplement program. Federal HRSA funds support the school-based dental sealant projects and the oral health infrastructure planning and implementation, from CDC. The Oral Health Program collaborates with the Oregon Oral Health Coalition and other partners to address oral health and its links to other chronic conditions. A new federal HRSA grant, First Tooth, will support training medical providers to screen young children for oral health needs through a new federal grant.

/2012/ The Oral Health Unit is implementing a HRSA grant for workforce development. The project, called First Tooth, trains medical pediatric providers to incorporate early childhood cavities prevention strategies into the well-child visit and trains general dentists to access the young child by the first birthday. First Tooth is a critical piece of creating a continuum of care as Smile Survey 2007 showed that many children have decay by the time they enter school, 10% have never had a dental visit by the time they entered school, and the prevalence of decay in permanent teeth is high. //2012//

Infant and Child Nutrition Consultants provide consultation and leadership to build environments and public policies that increase nutrition and physical activity of infants, children and adolescents, and prevent obesity and overweight conditions. The Consultants promote the Breastfeeding Mother Friendly Employer laws; integrates nutrition into all existing MCH programs to increase support healthy eating, access to healthy foods, and physical activity; coordinates between MCH and the Special Supplemental Nutrition Program for Women, Infants and Children

(WIC) for healthy eating and breastfeeding; strengthens existing institutional nutrition services by ensuring services are provided by appropriately qualified personnel; and participates in assessment of the nutritional status of the MCH population. Nutrition Consultants provide consultation and technical assistance to state and local MCH programs and partner with the Chronic Disease Section on mutual healthy living policies and activities, and participate with coalitions working to develop public policies that support good nutrition and physical activity.

Oregon's Early Childhood Comprehensive Systems (ECCS) Initiative coordinates integration of early childhood policies and strategies within existing activities and programs. The project works in collaboration with Title V programs in OFH and OCCYSHN and other agencies that participate in the Early Childhood Council. A Governor's Summit on Early Childhood, in March, 2008, launched " Early Childhood Matters: Oregon's Framework for A Birth through Five Early Childhood System." This framework has three core elements: Health Matters; Early Learning Matters; and Family Matters. The state ECCS Program co-chairs the Health Matters sub-committee. ECCS initiative facilitates a DHS workgroup is convened to work on common early childhood issues and policies and includes representatives from Children, Adults and Families Division -- foster care and child protective services, Addictions and Mental Health Division -- early childhood mental health program, and Division of Medical Assistance Programs (Medicaid/Oregon Health Plan).

/2012/ Oregon's structure for early childhood policy development and coordination is changing in 2011, with legislation passed and signed by the Governor in June, 2011. See Section III.E. State Agency Coordination, for more information. //2012//

WIC - Special Supplemental Nutrition Program for Women, Infants and Children is designed to improve health outcomes and influence lifetime nutrition and health behaviors in a targeted, at-risk population. The State WIC Program contracts with 34 local health agencies to provide WIC services to over 109,000 pregnant and postpartum women, infants, and preschool children each month in all geographical areas of the state. WIC contracts with farmers and farmers' markets to provide coupons to participants and partners with the Farm Direct Nutrition Program, Oregon Dept. of Agriculture, Oregon Seniors and People with Disabilities, Oregon Farmers' Market Association, and Oregon Food Bank. WIC's new Fruit & Veggie Voucher Program, Fresh Choices, provides WIC families with checks to purchase fresh, locally-grown fruits, vegetables and cut herbs directly from local farmers. The Oregon WIC data system, TWIST, provides important data to identify trends and risk factors to better target nutrition education and assistance to the WIC-eligible women, infant and child population.

Injury and Violence Prevention Section (IVPS), located in the Office of Disease Prevention and Epidemiology, Public Health Division, examines data that describe injury problems among Oregonians to identify prevention strategies, plan interventions and evaluate outcomes. The Child Injury Prevention Program, supported by Title V funds in the OFH, conducts education, technical assistance and information on injury topics to communities and groups in Oregon; trains local health department staff as certified safety seat technicians; and supports local capacity development to deliver safety seat clinics and distribute safety seats. The Oregon SAFE KIDS Coalition includes public and private organizations including emergency responders, law enforcement, health and safety professionals as well as interested citizens who work together to reduce unintentional preventable injury and death in Oregon's children Ages birth to 14. Nine chapters and five local coalitions geographically represent Safe Kids Oregon, reaching approximately 85% of Oregon's children under the age of 14. Also in IVPS, the Youth Suicide Prevention Program collaborates with the Adolescent Health Section in OFH to develop and implement the Statewide Youth Suicide Prevention Plan. The Plan includes 15 strategies for state and community-based action require a commitment to partnership and shared responsibility among state agencies, between state and local governments, and between public and private sectors. IVPS also implements an Intimate Partner Violence Surveillance Project develops and maintains a statewide IPV data collection system that helps to determine statewide IPV incidence and prevalence, estimates and identifies the risk and protective factors associated with IPV, and

helps guide program design and policies in partnership with the OFH Women's Health Program.

//2012/ Oregon was awarded one of twenty CDC Violence and Injury Prevention Program Core I grants for five years beginning August 2011. The major focus for Oregon's grant will be integration of motor vehicle, suicide, poisoning, and falls prevention efforts with early childhood educators and home visiting nurses. The Title V Injury Program will collaborate with the CDC Injury Core Grant to collect baseline health impact measures and outcome and impact measures related to the Oregon's child and youth public health programs. Lead partners with Safe Kids on the window falls project includes hospitals, private business, and city governments, and includes a new website, www.stopat4.com, as a communication vehicle for the project. //2012//

Capacity and Services For Older Youth and Adolescents

The Adolescent Health Section aims to maximize the health and functioning of Oregon's adolescent population, and it includes the Oregon Genomics Program. Title V funds support leadership and policy development activities at the state level, health promotion activities and infrastructure development in county health departments, and ongoing assessment, data collection and technical assistance for implementing statewide policies and programs related to adolescent health at the local level. The Teen Pregnancy Prevention/Adolescent Sexual Health Partnership (TPP/SHP) is a coalition of state, county and community advocates and non-profit organizations. This group coordinates and implements the Oregon Youth Sexual Health Plan, a holistic action plan to address all aspects of youth sexual health, built on a foundation of scientific evidence, findings of current health and youth development research, Oregon youth-lead research, and community forums. The Plan emphasizes collective responsibility to provide youth with accurate information and skill-building opportunities so that they may chose behaviors that nurture healthy relationships, prevent unwanted pregnancies and decrease risk of sexually transmitted infections.

School Based Health Center (SBHC) Program administers Oregon's 63 School-Based Health Centers (SBHCs) as a unique health care model in which comprehensive physical, mental and preventive health services are provided to youth and adolescents in a school setting. SBHCs see children who otherwise would not get care; help students get back to the classroom faster; lessen the demand on parents to take time off to get children to well and urgent care needs, and improves students' health. The Healthy Kids Learn Better (HKLB) Program (Coordinated School Health model) is a statewide initiative to help local schools and communities form partnerships and reduce physical, social and emotional barriers to learning. HKLB works to reduce barriers to learning by promoting connections between health and education; builds supportive funding, leadership and policy through implementation of the Coordinated School Health Blueprint for Action; provides technical assistance to local school districts on forming Healthy Kids Learn Better Teams, assesses their local needs and developing a Coordinated School Health Approach; trains teachers on research-based health and prevention curricula; provides assistance on building and selecting comprehensive health education programs that work. There are about 60 HKLB sites in Oregon.

Oregon's Genomics Program mission is to promote the health and well-being of individuals and families who are impacted by inherited conditions or birth defects through public health assessment, policy development, assurance, and collaboration. The goals of the program are to reduce morbidity and mortality from inherited conditions and birth defects, to improve the quality of life for individuals and families impacted by inherited conditions and birth defects, and to empower people to make informed decisions about genetics and health.

The Immunization Section aims to prevent and mitigate vaccine preventable disease for all Oregonians. Activities include surveillance, outreach and social marketing, vaccines, registry, education, technical assistance and quality improvement for providers. Immunization ALERT is a statewide immunization information system that collects immunization data from public and private health care providers and links the data to provide accurate and up-to-date records. The Vaccines for Children Program (VFC) supplies federally purchased vaccines for immunizing

eligible children in public and private practices, at no cost to participating health care providers. Oregon Partnership to Immunize Children (OPIC) is a public and private partner collaboration that advises on policies and programs to ensure Oregon's children are protected against vaccine-preventable diseases. The Oregon Adult Immunization Coalition, a statewide network of health and community partners, promotes prevention and control of vaccine-preventable disease through immunization of adults in Oregon and Southwest Washington.

/2012/ Legislation passed in 2011 will allow sharing of Immunization registry demographic data with other Public Health programs to enhance follow-up. //2012//

Capacity and Services For Children and Youth with Special Health Needs

The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) ensures a statewide system of services reflecting comprehensive, community-based, coordinated and culturally competent family-centered care as well as engaging in policy and systems development, needs assessment and data studies, and family involvement in all activities.

The CaCoon (Care Coordination) Program provides funding, training and consultation to public health nurses (PHNs) in 35 of Oregon's 36 counties to provide care coordination to CYSHN from birth to age 21. Following a comprehensive child and family assessment of needs, PHNs develop a care plan, and then support families with the information and skill training needed to coordinate their children's care. CaCoon PHNs help families and children develop management skills (e.g. feeding an infant with cleft lip/palate); refer and link families to appropriate services; and participate on community planning groups.

/2013/ OCCYSHN was awarded a HRSA grant to expand innovative evidence based models for improving the system of services for children and youth with special health care needs. OCCYSHN aims to expand CaCoon services to a greater number of youth (12 to 21) with special health needs to ensure their successful transition to adult health care, including assuring access to a medical home. CaCoon for Youth is being implementing within three Oregon counties (Benton, Deschutes and Union) committed to reaching adolescents with special health needs. OCCYSHN provides training and technical support to the participating counties and documents the unique strategies of each county to outreach and serve a greater number of CYSHN. CaCoon for Youth funding will continue through 2014, at which time OCCYSHN will explore opportunities to expand CaCoon for Youth statewide. //2013//

The Community Connections Network (CCN) serves Oregon CYSHN, from birth to age 21. Multidisciplinary CCN Teams are located in 10 mostly rural communities across Oregon. The team is made up of the family and local health care, education and social service providers, and on some teams, Family Liaisons who support families during CCN meetings and assure family centered care in all team activities. CCN teams convene monthly to address unmet needs of local CYSHN referred to the team.. The meetings help ensure continuity between that child's family life, education, and health care. The meetings also serve as a forum for identifying and addressing gaps in local systems of care for CYSHN.

/2013/ The CCN team in Deschutes County has been retired as a new developmental clinic is initiated within the St Charles Tertiary Care Center called the PEDAL clinic: Pediatric Evaluation, Diagnosis and Assessment Clinic. This clinic draws upon the same tertiary care center professionals who participated in the local CCN team. The clinic is committed to assuring that services will be available to all CYSHN regardless of health insurance or income. OCCYSHN, in partnership with the CDRC Clinical program, is working to explore and establish a regional Bridge Nurse who will assure coordination and access to needed services across the multiple service sectors and linkages between the tertiary care center and the community services for CYSHN living in Deschutes and surrounding counties. //2013//

The Family Involvement Network (FIN) promotes opportunities for families and professionals to support and nurture each other as equal partners. FIN provides education for Family Liaisons and for medical and other professionals on the value of partnering with families and support for families engaged in a variety of program and health policy activities. The FIN statewide network of CYSHN families provides parent perspectives, supports to CCN teams, trains parents on working with health professionals and on multi-disciplinary teams.

/2013/ OCCYSHN was awarded its grant application to implement the Oregon Family to Family Health Information Center (F2FHIC). The Oregon F2FHIC provides families of children and youth with special health needs (CYSHN) with information related to locating community resources, understanding insurance and eligibility requirements, navigating service systems, and assuring quality care for their CYSHN. Oregon F2F HIC is integrated with the OCCYSHN FIN program. OCCYSHN FIN Family Liaisons with available time have increased their activities through involvement with the OR F2F HIC. Families are strategically located around the state and are available to respond to the information needs for both providers and families to address the challenges of navigating complex systems of care. //2013//

The Family Support Program (FSP) administers the distribution of the Sidney and Lillian Zetosch charitable fund, which supports the purchase of adaptive equipment to help children with disabilities be successful in school.

Evaluation consultation is provided within OCCYSHN, with occasional technical assistance from the Child and Adolescent Health Measurement Initiative (CAHMI) located at OHSU. CAHMI helps support program development, continuous improvement monitoring, and CYSHN needs assessments. OCCYSHN also partners with the Oregon Office on Disability and Health to support the analysis and use of the BRFFS and Oregon Healthy Teen Surveys.

/2013/ OCCYSHN has established a partnership with the newly created Disability and Health Research Group (DHRG) which is housed, along with OCCYSHN, within the Institute on Development and Disability (previously known as CDRC). DHRG is staffed with experienced researchers, epidemiologists and data analysts. In addition to conducting their own initiated research agenda, DHRG provides research and evaluation consultation and technical assistance, as well as contracting for services on evaluation and research projects. OCCYSHN and DHRG are collaborating on two projects: 1) the PRAMS dataset surveillance and evaluation and 2) needs assessment data analysis and report development. //2013//

OCCYSHN and the Child Development and Rehabilitation Center (CDRC) clinical program have integrated CDRC's clinical activities with OCCYSHN's public health activities to benefit children with disabilities and complex conditions throughout Oregon. The integration will improve efficiencies in policy, systems of care, provider and parent preparation in the care of CYSHN. Areas of the integrated clinical and public health program include emphasis on care coordination, behavioral health, medical consultation in developmental pediatrics with specialty emphasis on autism, genetics and high risk infant care and follow-up. The integration of clinical activities allows OCCYSHN to draw on clinician expertise from a variety of specialties including speech, PT, OT, metabolic, genetic, craniofacial, spina bifida, neuro-developmental, child development and autism to better serve children and their families.

Oregon Health & Science University's University Center for Excellence in Disability and Development (UCEDD), houses the Leadership Excellence in Neuro-developmental Disabilities (LEND) training program, the Oregon Office on Disability and Health (OODH), and the Center on Self Determination (CSD). The UCEDD builds capacity of communities by working with people with disabilities, families, state and local agencies, and community providers on projects that provide training, technical assistance, service, research, and information sharing. The co-location and coordination of UCEDD with the Title V CSHCN program strengthens its capacity to address

the needs of children with special health needs and their families and incorporate family centered approaches to care in education of preservice students as well as community providers. OCCYSHN's partnership with LEND is strengthened by incorporating the community-based programs as training sites for trainees. LEND trainees regularly participate in Title V activities, including direct clinical services in CCN clinics, making referrals to CaCoon nurses, and consulting with nursing staff about the clinical problems of individual children. The OODH supports activities to improve the health and wellness of people with disabilities. The Center on Self Determination identifies, develops, validates and communicates policies that promote the self-determination of people with disabilities.

Cultural Competency Policies and Programs

The Oregon Title V Program at OFH and OCCYSHN recognize the significant disparities and inequities that exist for residents around health care access and utilization. Oregon's diverse populations are defined by rural and frontier areas, race and ethnicity, language, and socio-economic status. To address inequities and disparities, the Office of Family Health surveillance and program planning include engaging diverse communities for input on issues, analyzing datasets for disparity issues and trends, and identifying evidence-based interventions and best practices in policies and programs to reduce inequities and disparities.

The Office of Multicultural Health and Services (OMHS), in DHS, adds capacity to MCH programs by providing technical assistance, consultation, and education in addressing cultural issues in health delivery and services. OMHS works with state and local government and community partners to improve health and human services programs and policies for underrepresented populations in Oregon through culturally specific and culturally competent approaches. The Office of Multicultural Health and Services also supports affirmative action, cultural competency and diversity initiatives that create and sustain welcoming environments that are inclusive and respectful of staff, customers and partners. The Oregon Health Care Interpreting Program was created by the 2009 Legislature to create a certification and registry program to assure the persons with limited English proficiency (LEP) are not excluded from medical, dental or mental health care based on inaccurate or incomplete information. OMHS, administers the health care interpreter certification laws and supports the Oregon Health Interpreter Council was also created to establish education, qualification standards for health care interpreters.

CDRC has been active with the National Center on Cultural Competency to increase the cultural competency of its staff in the provision of services to families of CYSHN. OCCYSHN also promotes cultural competency on CCN community teams and has worked to include cultural diversity in training and hiring of Family Liaisons. The CaCoon program supports promotoras to assist in providing culturally competent care to Latino families in 4 rural counties.

C. Organizational Structure

Oregon is one of several states in which the Title V Block Grant is administered by two separate agencies. The designated Title V Agency is the Office of Family Health (OFH) in the Public Health Division, Oregon Health Authority (OHA). ***/2013/ As of July 1, 2012, the Title V Agency is the Center for Prevention and Health Promotion in the Public Health Division. //2013//*** The Director of OHA is appointed by the Governor and sits on the Governor's Cabinet. OHA has fiscal responsibility for the Block Grant, and transfers 30% of total funds required for children with special health care needs to OHSU. /2012/ The OHA permanently separated from the Department of Human Services as of July 1, 2011. //2012//

The Title V CSHN services are administered through the Child Development and Rehabilitation Center (CDRC), an independent division at OHSU, by the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) at the Oregon Health and Science University, under Oregon statutes 444.010, 444.020 and 444.030, is the designated entity to administer services for

children with special health needs. ***//2013/ As of July 1, 2012, CDRC will be the Institute on Developmental Disabilities and continue to include OCCYSHN. //2013//***

The Oregon Title V Director is Katherine J. Bradley, PhD, RN, Administrator of the Office of Family Health. Melvin Kohn, MD, is the Director for the Public Health Division and State Health Officer. Bruce Goldberg, MD, is Director of OHA and a member of the Governor's cabinet. OFH employs 217 staff and 199.76 FTE. Information about the OFH is found at <http://www.oregon.gov/DHS/ph/ofhs/index.shtml>. ***//2012/ No significant changes in staffing in 2011. OFH is currently recruiting for both a medical consultant and a dental health officer. //2012//***

//2013/ The Public Health Division is undergoing a significant reorganization starting in July 2012. The most significant impact is the merging of the Title V Program in OFH with the Health Promotion and Chronic Disease Prevention and Injury Prevention Sections into a Center for Prevention and Health Promotion. This provides an exceptional opportunity to focus programs and policies based on the life course framework. Transitions for this new organization will be ongoing throughout 2013. The Interim Director of this new Center will be the designated Oregon Title V Director. Dr. Bruce Gutelius is serving as interim director. //2013//

The Title V CYSHN Director is Marilyn Sue Hartzell, M.Ed., Director of the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN). As part of the Child Development and Rehabilitation Center, oversight for OCCYSHN and its programs is under the Public Health, Community Outreach and Policy Administrator, Charles Drum JD, PhD; Brian Rogers, MD, Director of CDRC, has executive oversight for OCCYSHN. Robert Nickel, MD, a CDRC developmental pediatrician, serves as OCCYSHN Medical Consultant. OCCYSHN employs 13 staff with 8.52 FTE. Information about OCCYSHN is at <http://www.ohsu.edu/cdrc/oscsn/>.

//2012/ In November, 2010, Charles Drum JD PhD accepted a position as the new Director of the Institute on Disability/UCED at the University of New Hampshire. CDRC re-organized its administrative leadership at that time. Oversight for OCCYSHN and its programs continues under Brian Rogers, MD, Director of CDRC. Marilyn Hartzell is now supervised by Donald Lollar, EdD, Associate Director of CDRC for Academic Affairs, also Director of the OHSU UCED, formerly known as the Oregon Institute on Disability and Development (OIDD). Robert Nickel, MD, a CDRC developmental pediatrician, serves as OCCYSHN Medical Consultant working in relation to Ms. Hartzell's programmatic leadership. OCCYSHN employs 13 staff with 9.82 FTE. Information about OCCYSHN is available at <http://www.ohsu.edu/cdrc/oscsn/>. //2012//

//2013/ The CDRC is reorganized and now recognized as the Institute on Development and Disability (IDD) within the OHSU the OHSU School of Medicine. The Institute is organized with two "arms" - the CDRC and Public Health, Research and Education. The CDRC, under the direction of Dr. Brian Rogers, includes the CDRC clinical programs located in Portland and Eugene and clinical research. The area of Public Health, Research and Education, under the oversight of Don Lollar, EdD, includes the Title V CYSHCN/OCCYSHN, the Oregon Office on Disability and Health (OODH), the OHSU University Center for Excellence in Disability and Development (UCEDD), the Disability and Health Research Group (DGRG). OCCYSHN currently employs 15 core staff at 10.65 FTE, including grant funded staff. //2013//

Oregon Health Authority

In 2009, the Oregon Legislature passed HB 2009 to create the Oregon Health Authority (OHA), set to open in July 2011. The OHA changes DHS so that social services programs for children, seniors, and disabilities remain in DHS and most health-related programs in the state will be joined together to form the Health Authority. The OHA is overseen by a nine-member, citizen-led board called the Oregon Health Policy Board, appointed by the Governor and confirmed by the Senate.

Three DHS divisions are included in the OHA: Addictions and Mental Health Division (AMHD), Division of Medical Assistance Programs (Oregon Health Plan/Medicaid), Office for Oregon Health Policy and Research (OHPR), and the Public Health Division. Child protective services, senior services, disabilities services (non-CYSHN), and services such as SNAP food stamp program will continue as part of DHS. Unique to the OHA are the other programs joining the former DHS agencies including: Family Health Insurance Assistance Program (FHIAP), Oregon Medical Insurance Pool (OMIP), Oregon Private Health Partnerships (OPHP), Oregon Prescription Drug program (OPDP), the Oregon Educators Benefit Board (OEBB and the Public Employee Benefit Board (PEBB). The joining of public and private health care services offers unique opportunities to bridge the gap between population-based preventive care and individual and family health care coverage and coordinated services.

Office of Family Health

//2013/ The Office of Family Health, the current Title V Office, will be named the Office of Prevention and Health Promotion as of July 1, 2012. All of the sections and programs listed below will continue in the same structure, except Immunization will be in the Center for Practice. //2013//

The Office of Family Health consists of sections that administer statewide programs and local contracts for services across the life course of MCH populations. OFH programs range from preconception through adolescence and young adults, and program staff are leading and participating in needs assessment, policy development, program implementation and evaluation, epidemiology and research, consultation and technical assistance to local agencies. The current organization structure for the OFH follows.

OFH Administration includes office business and fiscal services and MCH support services, which include the Title V and Family Health Projects Manager, Early Childhood Comprehensive Systems (ECCS) Grant, Medical Consultant, MCH Informatics manager, MCH Epidemiologist, and Dental Health Officer.

FamilyNet/Orchids is the statewide client data system linking MCH client data through the Oregon CHildrens Information Data System; and development of an MCH-Public Health Informatics system.

Maternal and Child Health (MCH) Section includes programs, local services, and assessment and evaluation from pregnancy through children up to nine years of age, including oral health for all populations.

- Perinatal Health: Maternity Case Management, Oregon MothersCare enrollment and outreach; PRAMS.

- Infants and children to age 9: Babies First! High risk infant/public health nurse home visiting; EHDI-Early Hearing Detection and Intervention (HRSA), LAUNCH grant (SAMSHA); CHIPRA Outreach Grant (CMS); breastfeeding promotion; child care consultation; public health nurse consultation with local health departments and tribal governments, nutrition and physical activity promotion;

- Oral Health Programs: Oral Health Systems Improvement Project, State Oral Health Plan, Sealant Program, fluoride supplement program, early childhood cavity prevention project, Smile Survey; "First Tooth" Workforce Development grant (HRSA); Oregon Oral Health Coalition.

- MCH Assessment and Evaluation Unit: MCH Epidemiology; Title V and MCH needs assessment; MCH program evaluation; PRAMS and PRAMS-2; data analysis and updates.

//2012/ The MCHB Home Visiting Program is currently organized in the MCH Section. //2012//

Adolescent Health and Genetics includes Adolescent health promotion and policy development; School-Based Health Centers; Coordinated School Health Program; Teen Pregnancy Prevention consultation; Healthy Teen Survey (Oregon's YRBS); nutrition and physical activity consultation.

- Genetics Program includes public health genomics planning and implementation, family history project.

Women's and Reproductive Health Section includes women's health, family planning, and breast and cervical cancer screening.

- The Women's Health Programs sexual violence prevention through Rape Prevention Education; Fetal Alcohol Syndrome prevention through surveillance; chronic disease reduction through health screening via the WISEWOMAN (Well-integrated Screening and Evaluation for Women Across the Nation -- CDC) Program; Women's Health Network is a statewide coalition focused on advocacy, education, research, and networking, and promotion of healthy choices for women before they conceive to ensure healthy pregnancies.

/2012/ The Women's Health Programs, except WISEWOMAN, moved to the MCH Section above. //2012//

- Family Planning programs Title X Family Planning (HRSA), Family Planning Expansion Project (Medicaid waiver).

- Oregon Breast and Cervical Cancer Program helps low-income, uninsured, and medically underserved women gain access to lifesaving screening programs for early detection of breast and cervical cancers. (CDC, Susan G. Komen for the Cure Oregon and SW Washington Affiliate, and the American Cancer Society).

/2012/ - Chronic disease reduction through health screening via the WISEWOMAN (Well-integrated Screening and Evaluation for Women Across the Nation - CDC) Program //2012//

Immunization Program includes the Provider Services and Vaccines for Children, ALERT Immunization Registry, IRIS client data system, School Law and forecasting, research and training services. **/2013/ Immunization Section will move to the Center for Health Practice as of July 1, 2012. The Title V Program will continue to work closely with this Section around the National Performance Measures and other goals. //2013//**

Nutrition and Health Screening (WIC) includes Nutrition Education and Supplemental Food Program, Farmers Market, Senior Farmers Market, Breastfeeding Promotion, and demonstration projects such as Peer Counseling for Breastfeeding and Five-A-Day Fruits and Vegetables promotion; TWIST client data system and analysis.

Oregon Center for Children and Youth with Special Health Needs

OCCYSHN consists of six programmatic efforts which include two community-based programs for CYSHN and their families; the provision of family support through the administration of the Sidney and Lillian Zetosch Fund, the assurance of family involvement and family professional partnership in all OCCYSHN activities, assessment and evaluation, policy and systems development and supplemental grants and initiatives of special focus. Community-based programs include:

- CaCoon is a public health nurse home visiting and care coordination program for CYSHN birth to 21 years.

- Community Connections Network (CCN) serves CYSHN, from birth to age 21, with unresolved health or related issues and their families. CCN teams across Oregon provide community-based multidisciplinary evaluation, consultation, and care coordination services including a Family Liaison as a key member of the teams.

OCCYSHN coordinates with its community-based services to link families to services and programs provided at the CDRC. The CDRC provides a variety of tertiary care clinics in both Portland and Eugene, as well as regional outreach clinics around the state. Clinics are housed in Doernbecher Children's Hospital in Portland and at the Regional Service Center in Eugene in conjunction with the UCEDD at the University of Oregon.

Attached are organizational charts for the Center for Prevention and Health Promotion (effective July 1 2012), Oregon Center for Children and Youth with Special Health Needs, and the

relationship of both to the Governor.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The Oregon Title V Director is Katherine J. Bradley, RN, PhD. Dr. Bradley has over 35 years experience in the health field working in nursing, research, and hospital administration before coming to the Title V Agency in 2004. She has a PhD in nursing and health care outcomes management and research. ***//2013/ Bruce Gutelius, MD, MPH, will be interim Title V Director and Director of the new Center for Prevention and Health Promotion. He is currently the State Deputy Epidemiologist with a focus on chronic disease and injury epidemiology. //2013//***

The Oregon CYSHN Title V Director is Marilyn Sue Hartzell, M.Ed. Ms. Hartzell, M.Ed., has 35 years of experience working with and for programs supporting children with special needs and their families, as well as experience with policy and program development to support effective services to CYSHN. She has extensive experience developing and implementing evaluations of programs serving children with special health needs as well as doctoral work in public administration and policy.

In the Office of Family Health, each section is staffed with many years experience in public health program planning, implementation, and evaluation, and includes research analysts to evaluate data from a variety of data sources; most staff has graduate or doctoral level degrees in public health, health policy, public administration or medical or dental professional degrees. Professional consultants, section managers, and administration positions report to the Title V Director. Consultants include the MCH Medical Epidemiologist, Medical Family Practice Consultant, Early Childhood Mental Health Consultant, MCH Informatics, and MCH Program Specialist. The Child Injury Prevention Coordinator is supported with Title V funds and is located in the Injury Prevention Program, in the Office of Disease Prevention and Epidemiology, within the Public Health Division. The Injury Prevention Program also conducts research and surveillance of intimate partner violence, working in partnership with the OFH Women's Health Program.

The Office of Family Health employs approximately 220 permanent and temporary staff, with expertise and skills in all program areas. The direct delivery of MCH programs is provided by staff at local health departments, funded by Title V and other federal and state funds through grants to counties. There are approximately 2,000 county public health staff persons in Oregon, not including staff at non-profit or tribal health centers. This includes 34 health department administrators, 510 public health nurses and nurse practitioners, and 130 other health professional staff in Oregon LHDs. The Office coordinates the OFH local Agency Review process on a three-year on-site cycle to provide consultation for local public health services. A parent consultant is currently working with the Early Hearing Detection Intervention program to assist with parent perspectives in screening and referring infants.

Office of Family Health supports local Title V Programs that are delivered through county health departments through intergovernmental contracts. Counties develop annual program plans for MCH, Family Planning, Immunization and WIC. Program policies and resource issues are negotiated through the Conference of Local Health Officials, and the MCH Committee. Other advisory groups partnering with OFH programs to develop policies and programs include: Health Matters Early Childhood Committee, Oral Health Advisory Committee, WIC Advisory Committee, Oregon Partners to Immunize Children, Immunization Advisory Committee, Genetics Advisory Committee, Teen Pregnancy Prevention Task Force, FamilyNet Advisory Committee. ***//2013/ All of the OFH programs and staff, except for Immunization, will be merged into the Center for Health Promotion and Prevention. //2013//***

The Oregon Health Authority Director is Dr. Bruce Goldberg, appointed by Governor Ted

Kulongoski to lead the formation of the Health Authority. Dr. Goldberg is the current director of the Oregon Department of Human Services (DHS). He will simultaneously serve as leader of both agencies during the transition, which will be complete by July, 2011. /2012/ Dr. Goldberg was officially appointed as OHA Director by current Governor Kitzhaber. //2012//

The Oregon Center Children and Youth with Special Needs (OCCYSHN) staff has expertise in public health nursing, developmental pediatrics, special education, community engagement and development, family involvement and family professional partnerships, rehabilitation services, health policy and evaluation and assessment. The Center is comprised of 6 core program activities: Assessment, Evaluation and Surveillance, Policy and Systems, Community Connections Network (CCN), CaCoon Program, Family Involvement Network (FIN), Family Support Program (FSP) including administration of the Zetosch fund. OCCYSHN has 23 staff including the community-based Family Liaisons.

/2012/ Currently OCCYSHN has 13 core staff member (9.82 FTE). In addition to the Director and two administrative staff, there are two Registered Nurses, one special education specialist, two parents of a child with special health needs, a public health genetics counselor, a specialist in learning disabilities and community development, a Communications Coordinator, Policy and Systems Specialist, a developmental pediatrician in the role of Medical Consultant, and a program evaluator. Additional consultative resources are available within CDRC as needed, including developmental pediatricians, speech pathologists, occupational therapists, physical therapists etc. The core program staff is augmented by the extensive array of contracted time and effort delivered throughout the state by public health nurses, other health and health related professionals and Family Liaisons who implement community-based programs around the state. The OCCYSHN program purchases access to and reports from the state ORCHIDs data system (described below) to support its monitoring and evaluation of the CaCoon program. //2012//

/2013/ OCCYSHN expanded its evaluation and assessment unit with the addition of a Research Assistant. A Project Coordinator was also hired to coordinate the development and implementation of the Oregon Family to Family Health Information Center (F2FHIC). The F2FHIC Project Coordinator is a parent of a child with special health needs and works closely with OCCYSHN family staff. Further, OCCYSHN continues to develop and support family of CYSHN who work as Family Liaisons within the Community Connections Network teams and the F2FHIC. CaCoon for Youth, a new project within OCCYSHN, includes the expertise of the FIN Coordinator as a means to develop the family perspective within the expansion of CaCoon to youth with special health needs and their families. //2013//

Activities that integrate public health activities and perspective into CDRC clinical activities receive support from OCCYSHN. Areas of focus are behavioral health, care coordination, medical consultation with an emphasis on autism spectrum disorders, genetics and high-risk infant care, care coordination, feeding and nutrition, and family/professional partnership and family centered care. This effort has increased outreach to healthcare providers, families, educators and other community providers in rural communities through consultation and training by an array of specialists including developmental pediatricians, behavioral psychologists, and pediatric nurse practitioners, and other clinical specialists. Also addressed are ongoing consultation and support of families and their children around complex genetic issues, outreach to the Hispanic community to increase their access to necessary services, follow-up on children discharged from the NICU; and outreach to rural Oregon communities with specialty clinics.

/2012/ OCCYSHN continues its commitment to integrating family input and perspective in program management, grant planning and evaluation, administration of gift funds and training initiatives. Through the Family Involvement Network (FIN), family staff share the parent perspective to enhance connections throughout the state with parents of CYSHN, and assists and arranges training opportunities for families and professionals. Family members provide staffing within CDRC programs and the LEND program. OCCYSHN funds family consultants who provide

critical input and perspectives with other initiatives such as the Oregon Commission on Autism Spectrum Disorders, Oregon Pediatric Improvement Partnership and the LEND program. //2012//

//2013/ The Oregon Family to Family Health Information Center (F2FHIC), administered by OCCYSHN, provides family-to-family support and navigational assistance to families of CYSHN. Families who are currently part of OCCYSHN's Family Involvement Network and work with local multi-disciplinary teams have been given the opportunity to expand their roles to provide navigation and support services. The F2FHIC and the FIN work closely to provide training and networking opportunities that allow Family Liaisons to share expertise and strategies. //2013//

The MCH Assessment, Evaluation and Informatics Unit (AEI) is responsible for surveillance, assessment and epidemiology for strategic planning, policy and program development, grant writing and progress reporting. The unit is also tasked with evaluation of MCH programs and initiatives.

The AEI team includes a medical epidemiologist, seven research analysts and an MCH epidemiology fellow, all of whom work closely with management, program and informatics staff to address a wide range of data and analysis needs. Having a team of highly skilled staff working across all of MCH fosters a comprehensive and strategic approach to the use of data by state and local programs and decision-makers.

//2013/ The MCH Assessment and Evaluation Unit and the Informatics Unit merged in 2012 to form the MCH Assessment, Evaluation and Informatics Unit (MCH AEI). The work of the two units was very inter-related, so the merger allowed for enhanced alignment of priorities and efficient management.

The evaluation and assessment staff has focused on the following activities over the last year:

- county-level home visiting needs assessments, including all prenatal and early childhood home visiting services in Oregon***
- evaluation of MCH programs and activities, including county-level analysis of program impacts on an issue-by-issue basis. For example, analysis was conducted on clients assessed with a need for a specific intervention to determine the percentage that had their need met***
- comparative analysis on Medicaid HEDIS measures for children receiving MCH services versus children not receiving those services***
- development of a Birth Anomalies Registry***
- epidemiology studies of various MCH risk factors, especially among populations experiencing health disparities***
- development of shared outcomes across the home visiting system, including all prenatal and early childhood home visiting services in Oregon***

//2013//

Oregon's SSDI (State Systems Development Initiative) supports the informatics staff of the MCH Assessment, Evaluation and Informatics (AEI) Unit, in addition to other funding sources. The informatics staff has created a shared, standardized repository of information in a web-based data warehouse, along with tools that enable users to access, manipulate and analyze the data. The informatics staff is working with the Office of Health Information Technology (OHIT) to implement Health Information Exchange (HIE) across Oregon. Informatics staff is working with Immunizations to expand the functionality of the IIS to include other information about a child, including hearing screening results and follow-up, and Body Mass Index measurements.

//2012/ The Maternal and Child Health Informatics (MCHI) Unit has expanded its resources, adding two public health informatics specialists who have increased access to data by the MCH staff. The unit is also continuing its promotion of public health informatics through presentations at

conferences such as the Public Health Informatics Conference in Atlanta and local presentations at the Department of Medical Informatics and Clinical Epidemiology at the Oregon Health & Science University. //2012//

//2013/ MCH Informatics joined the Assessment and Evaluation Unit in 2012. The informatics staff is contributing the Information Architecture chapter to an update of the Public Health Informatics textbook and serving on the National Association of City and County Health Officials, Public Health Informatics Work Group. //2013//

/2012/ The MCHI Unit's outreach also extends to partners in county health departments. The MCHI Unit plays an advisory role to the information management committee of the Oregon Coalition of Local Health Officials (CLHO-IM). The Unit provides input and guidance to the committee in shaping the adoption of data standards, shared services and health information technologies at the county level.

Additionally, the MCHI Unit has been closely collaborating with Project LAUNCH in Deschutes County. Project LAUNCH is a federally funded program to aid at-risk children by providing the family with a cluster of services which include: training and instruction for parents; family focused case management; and mental and physical health services. The MCHI Unit is creating a system that links these disparate sources of information so that program evaluators have a unified view of the services that a family receives. This system allows the evaluator to track the child's progress through the LAUNCH constellation of services, as well as gauge the satisfaction and efficacy of parenting classes offered. //2012//

//2013/ In line with Oregon's goal of streamlining the various home visiting programs that serve disadvantaged populations, the MCH AEI Unit is participating in the design, development or acquisition, and implementation of a consolidated home visiting data system that promises to standardize and integrate all home visiting data across the state, including Nurse Family Partnership, Early Head Start and Healthy Families of Oregon. The creation of such a major system will facilitate program evaluation and the tracking of client outcomes, both of which promote care quality. The home visiting system will draw on data obtained via HIE. Oregon was awarded two grants from HRSA to address the home visiting problem: Maternal, Infant and Early Childhood Home Visiting and the Formula Home Visiting (MIECHV) grants. These grants will enable Oregon to adopt a solution that is standards-based, promotes evidence-based practice, is flexible and based on open source technology and will be a major focus through 2013 and bring about significant interagency interoperability.

In alignment with the home visiting work, the MCH AEI Unit is also working on planning for the Governor's Early Learning Council (ELC) data system. The two initiatives focus on much of the same population and require similar functionality; however, the home visiting work predates the ELC and is farther along so the development work for the home visiting data system will serve as the pilot for and foundation of the ELC. Significant effort was made to translate technical concepts for ELC members advancing an informatics policy to converge ELC and Home visiting efforts.

The informatics staff of MCH AEI Unit has successfully promoted the standards-based Data Management Association (DAMA) model for adoption for the ELC and home visiting data systems.

The MCH AEI Unit is developing a measures database to enable MCH research analysts to access validated performance measures at the state and local level. Informatics staff is seeking to model the system on the federal health data initiative. Informatics staff updated the Oregon Mothers Care database and streamlined reporting. This involved adding spatial analysis functions and enhanced report construction to support expanded use.

The MCH AEI unit is partnering with the Office of Environmental Public Health (OEPH) to create a Birth Anomaly Registry. Oregon is currently one of 9 states without a Birth Anomaly Registry. Supported by funding from the OEPH and the SSDI, the new Birth Anomaly Registry will employ passive surveillance through combining existing data sets from vital records and hospital discharge data. Other source to be explored in subsequent stages include metabolic screening and HIE with EHRs. The project is leveraging the work completed around the EHDI system, a single issue birth anomaly tracking system, to cover multiple anomalies.

//2013//

E. State Agency Coordination

State Title V Programs in the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) and the Office of Family Health (OFH) value collaboration and coordination among partners, stakeholders, and between their respective programs. With the Title V programs in two different agencies, the effort to coordinate and cross-communicate regarding common stakeholders and partners and common endeavors is a high priority to both programs. The new Oregon Health Authority will provide significant opportunities for leveraging the Title V priority issues across state health and mental health programs as well as health plans and managed care organizations. Collaborations and partnerships with social service agencies will continue, with attention to sustaining partnerships as the agencies move to different oversights.

Title V has collaborative relationships with the federal programs housed in the Public Health Division, Addictions and Mental Health Division, and the Division of Medical Assistance Programs (Medicaid agency), as well as social service providers such as the Division for Children, Adults and Families and Commission for Children and Families. Each of these divisions uses state and federal funds to implement initiatives that link individuals to care, improve quality of care, promote behaviors and actions that reduce risk and improve health outcomes, and improve efficiencies in delivering public services and health care. Contacts or liaisons with expertise in MCH issues and services are available for Title V programs to engage in the course of policy development and analysis, program development and delivery, and participation in public and community work groups or meetings focusing on issues.

A) Title V Relationship with State and Local Agencies

Social Service Services Agencies: The state social service programs in Oregon are delivered through the Department of Human Services and the Oregon Department of Education. OFH-Title V partners and coordinates with these programs extensively at the state level through shared leadership and participation around policies affecting MCH populations across the state. The Public Health Director sits on the DHS cabinet with directors from social service divisions. DHS agencies include Oregon's Self-Sufficiency and child protective services are administered by the Children, Adult and Families Division (CAF). CAF includes programs such as TANF, SNAP, teen pregnancy prevention, Social Services Block Grant, child protective services, foster care, and adoption services. the Seniors and People with Disabilities Division, where programs include long term care licensing, senior programs, Disabilities Determination Unit, and Vocational Rehabilitation. Locally, MCH and family support services are coordinated directly with the local DHS offices, and in smaller counties, health and social services may be co-located for better services.

Early Childhood Systems: Oregon's Early Childhood Comprehensive Systems (ECCS) Project is collaborating with social service agencies to increase coordination across state social and health programs and is implemented through the Office of Family Health, and supervised by the Title V Director. The ECCS Project Manager, Title V Agency Director and the Title V CYSHN Director

are active participants on the Governor's Early Childhood Council. The Council is a public-private coalition of early childhood service agencies, providers, and stakeholders that includes three committees -- Health Matters, Education Matters, and Family Matters. Membership includes the Oregon Pediatric Society, the Oregon Department of Education, Head Start, Child Protective Services, and advocates for child health and wellbeing. Each committee has identified priority issues and their work monitors and coordinates the many initiatives and activities across the state addressing their priorities. The ECCS Project Manager is co-chair of the Health Matters Committee. The Health Matters Committee functions as the State Council on Young Childhood Wellness for the LAUNCH grant project.

/2012/ Governor Kitzhaber has made early childhood a priority for his administration as part of his vision for creating a 'world-class education system that starts early and produces results'. To execute the vision, state lawmakers recently enacted legislation (SB 909B) to create a seamless birth to age 20 education system. The redesign entails the establishment of an Early Learning Council to serve under the authority of a new Education Investment Board. The Board will have oversight responsibilities for Oregon's publicly funded early care and preschool programs as well as primary, secondary, and post-secondary education. The Early Learning Council will assist the Board in overseeing a unified system of early childhood services under the leadership of an Early Childhood System Director, to be appointed by the Governor. This governance framework is intended to integrate state funded services, agencies and structures to ensure that 'every child enters school ready and able to learn, enters first grade ready to read, and leaves first grade reading'.

Results-driven and evidence-based early childhood services are recognized as the foundation for ensuring kindergarten readiness and setting the stage for achieving important milestones throughout a child's academic career with the ultimate goal of boosting Oregon's high school graduation rates and workforce productivity. Although the Early Childhood Matters Advisory Council which served under the previous governor will be disbanded, the new Early Learning Council is expected to build upon and facilitate the work of existing statewide stakeholder groups, including the Early Childhood Matters Committees -- Early Learning, Family, and Health Matters - as well as the Home Visiting Steering Committee. Through continued collaboration, the Council will refine and adopt additional strategies to achieve measurable outcomes impacting school readiness. The prevention and early intervention focus that will drive much of the Early Learning Council decision-making process will align with and advance Title V goals including those related to child health, language, literacy and learning, social- emotional health, parent and family support and cognitive development.

An important component of the Governor's policy agenda calls for strengthening support services at the local level and the introduction a regionalized case management system to ensure families are connected to the most appropriate community resources. Home visiting programs have been cited as central to this case management model and, as such, will play an increasingly critical role in assisting families with young children at risk of poor outcomes. //2012//

/2013/ Per the Federal Register issued on May 11, 2012, the Early Childhood Comprehensive Systems (ECCS) Grant has been extended for one more year in order facilitate alignment of more recent system-building initiatives housed within several different federal agencies including: Maternal, Infant, and Early Childhood Home Visiting program (Health Resources and Services Administration/Maternal & Child Health Bureau); State Advisory Councils (Administration for Children & Families/Office of Head Start); Project LAUNCH (Substance Abuse and Mental Health Administration); and Early Challenge Grant/Race to the Top (Department of Education). The ECCS coordinator's ongoing involvement in the working committees of Oregon's Early Learning Council (the new State Advisory Council established by statute in 2011) will provide a vehicle for this effort. The Early Learning Council's resolve to improve prevention and early intervention services in creating a statewide, seamless early childhood system can be advanced by incorporating principles and best-practices embraced by the initiatives mentioned above

as well as Title V goals.

Throughout the year, ECCS will continue to identify strengths and weakness of the current infrastructure impacting families' access to high quality services within all five essential elements of the early childhood system. In addition to contributing overall support to system-building activities during FY 2013, the ECCS project will lend resources to advance specific priority areas identified by the Early Learning Council, including the design of a cross-sector longitudinal data system to inform policy and practice, selection of screening tools to assure timely identification of children at-risk for or experiencing developmental delays, and strategies for efficient service coordination within a new regional framework. Other specific priority areas will emerge over the next several months should Oregon's bid for Race to the Top, Early Learning Challenge Grant win approval. The Governor's Office recently received word that Oregon was among five state's eligible for the second round of RTTT funding and may receive up to \$25 million over a four year period beginning in 2013 to implement the plan. The ECCS coordinator was one of the authors of the original application and anticipates future involvement in revising the proposal to reflect the new dollar amount as well as in implementation of the resulting plan. //2013//

Adolescent Health Services: Title V programs collaborate and coordinate with programs in the Division of Mental Health and Addiction Services, Children, Adult and Families Division (for teen pregnancy prevention), and the Oregon Department of Education. Collaborative work is around the Mental Health Initiative in the Healthy Kids Learn Better Program (coordinated school health), teen sexuality and pregnancy prevention services and policy issues, and surveillance through teen behavioral health surveys.

Local Public Health Agencies: State Public Health Division works closely with local public health agencies across the range for promotion of public health and protection of health risks. OCCYSHN works with local public health agencies and communities through coordinated care networks linking families and children to services and supports. Both Title V Agencies provide formula grants for local services and support those grants with statewide training, technical assistance, and consultation year-round and on-site. State and local MCH public health nurse leaders, over the last four years, have met to identify leading needs and issues and to collaborate in planning and implementation of programs and services that work. These collaborations have resulted in action plans around perinatal depression, preconception health, oral health, unintentional injury, and physical activity and nutrition as well the expansion of care for CSHCN up to age 21. The priorities are included in the MCH Five-Year Needs Assessment.

Primary and Tertiary Care Services: Primary care programs and services that reach the MCH populations are administered by other offices in the Oregon Health Authority (OHA). The Title V program collaborates with the Primary Health Care Office (PHC) in the Health Policy and Research Office (OHA). This office, in collaboration with the Oregon Primary Care Association, has oversight of the Federally Qualified Health Centers (FQHCs) and community health clinics.

CDRC Clinics includes tertiary care clinics in Eugene and Portland and outreach clinic sites in Medford, Klamath Falls, Roseburg and Bend including Metabolic, Genetic, Craniofacial, Spina Bifida, Neuro-developmental, Child Development and Autism programs. Interdisciplinary teams and individual clinicians provide diagnostic assessment, consultation, and management for children and youth with established or suspected chronic conditions or disabilities. Relationships between the OCCYSHN and CDRC clinicians are critically important to the support provided to individual children and families at the community level through OCCYSHN's community-based programs. Joint quality improvement projects are conducted with the clinics and involved the specialists in needs assessment of direct services.

Health Professionals Education and Organizations: Title V Programs in both OCCYSHN and OFH have relationships and collaborations with leading statewide professional organizations. With the Oregon Pediatric Society (OPS), Title V has collaborated to improve the preventive child

health visit with increased developmental screening and referrals for young children, increase medical home practice for CYSHN, and collaborate with the OPS Committee on Children with Disabilities (CCWD). Title V is also collaborating with OPS and the Child and Adolescent Health Measurement Initiative (CAHMI) to implement a child health Improvement Partnership, which will identify clinical quality improvement measures. Title V also works with OB/GYN organizations and OHSU School of Nursing to work with Title V on the Maternal Depression initiative as well as family planning and women's health issues. OCCYSHN has established a linkage with the Oregon Academy of Family Physicians around initiatives addressing healthcare transition for youth with chronic conditions and disabilities.

/2013/ OCCYSHN is a member of the OPIP Executive Committee and participates in the Oregon Pediatric Improvement Project activities. As a member of OPIP, OCCYSHN is participating with other state leaders in setting standards for implementing and measuring Medical Homes for Oregon's children, including children and youth with special health care needs. //2013//

OCCSYHN and the Leadership Excellence in Neuro-developmental Disabilities (LEND) training program have a strong and enduring partnership to improve knowledge and skills in the health and health-related workforce through distance learning efforts. OCCYSHN partnered with LEND to link a LEND developmental pediatric fellow with the rural Lincoln County Community Connections Network team to provide the specialty medical perspective on cases seen within CCN, as well as consultation and training to local primary care providers.

/2012/ OCCYSHN partners closely with LEND in its planning and implementation of its family discipline activities including support of a Training Discipline Coordinator who mentors the family trainee, and the Family Mentor program. //2012//

Oregon's Early Hearing Detection Intervention (EHDI) program collaborates with OHSU and professional organizations to address Oregon's shortage of pediatric audiologists. OHSU audiologists created a mentoring program for audiologists to provide pediatric audiology across the state to increase the capacity for diagnostic testing while serving the uninsured and rural communities.

/2012/OCCYSHN participates actively on the EHDI Advisory Committee to assure coordination and collaboration relative to the needs of children with hearing loss. //2012//

Western States Genetic Services Collaborative (WSGSC): The WSGSC is a multi-state project to increase access to genetic services among states and territories including Alaska, California, Guam, Hawaii, Idaho, Oregon, and Washington. The project is a cooperative agreement among the Health Resources and Services Administration, Maternal and Child Health Bureau, Genetic Services Branch and Hawaii Department of Health. Activities aim to improve the health of children with disorders detected by the newborn screening blood test, birth defects and other genetic disorders. OCCYSHN's Public Health Genetics Specialist is active on the WSGC Steering Committee. OCCYSHN staff participates in activities to improve reimbursement for genetics services and develop a portable medical record for children with genetic conditions.

B) Title V and Other Federal Programs

EPSDT: The federal Early Periodic Screening, Diagnosis, and Treatment services in Oregon is administered and implemented through DMAP (Medicaid agency) and its contractual arrangements with managed care and other providers. While there is not a distinct EPSDT program, the services are included in the Oregon Health Plan prevention guidelines and the prioritized list of services. Title V and its public health programs as well as the Early Intervention/Early Childhood Education (EI/ECSE) programs of the Oregon Department of Education coordinate with DMAP and health care providers, especially in relation to early screening, care coordination and some therapies. In 2010-11, Oregon is one of five states

participating in ABCD-III, sponsored by the National Academy of State Health Policy and the commonwealth Fund to improve Oregon's system for medical home care coordination services. DMAP is the lead agency, sharing leadership with the Title V Agency, Oregon Pediatric Society, Early Intervention/Early Childhood Special Education (IDEA Part C), and the Child and Adolescent Health Measurement Initiative.

Related to EPSDT is the Early Hearing Diagnosis and Intervention Program (EHDI), established in the OFH and reporting directly to the Title V Director. A multi-disciplinary advisory committee provides direction for the entire newborn hearing screening process in which both the OFH and OCCYSHN participate. EHDI and the CDRC collaborate to assure appropriate follow up for children with potential hearing loss.

//2012/ The Early Learning Transition Report was very clear about linking education and health and should help to support the intent of the federal EPSDT program. //2012//

Newborn Metabolic Screening is administered by the Public Health Laboratory provides screening to all infants born in Oregon. Newborn screening follow-up, program consultation, quality assurance and education are provided by the CDRC. Through this agreement, all infants suspected of having metabolic problems are referred to the CDRC for follow-up.

WIC, Family Planning, Head Start, Education Services: The Nutrition and Health Screening Program (WIC) is in the Office of Family Health, under the direction of the Title V Director. WIC collaborates and coordinates across public health on delivery of local WIC services, and provides training and technical assistance to local WIC offices to coordinate locally with Title V programs. Additionally, WIC and OFH infant child nutrition consultants collaborate and coordinate with federal CDC funded programs centered in the Office of Disease Prevention and Epidemiology for chronic disease prevention, particularly in implementing the State Plan on Nutrition and Physical Activity, Diabetes, Asthma, and Breast and Cervical Cancer. These partnerships result in policies and programs that address the MCH populations as well as the adult population that achieves a kind of life course approach to issues.

Education and Child Care Providers: Both OFH and OCCYSHN work together on issues that cross health and education include early intervention and Child Find, early Head Start, coordinated school health, adolescent transition, early referral from NICUs to community-based programs, and workforce training. Lead staff from OFH and OCCYSHN participate on the State Interagency Coordinating Council and OCCYSHN co-leads the CDRC-ODE Child Find subcommittee. Joint efforts with the Oregon Department of Education include revising established and probable risk categories for EI, reviewing screening tests/protocols, and reviewing an universal screening tool.

Linkages with Title XIX and Oregon Health Plan: Title V programs have several projects and initiatives that coordinate with Medicaid and link the MCH population eligible to OHP coverage. In the Office of Family Health, Oregon's MothersCare is an initiative to link women to early prenatal care through coordination of referral systems such as the MCH state toll-free hotline (SafeNet) for pregnancy test sites, local health departments, Maternity Case Management, WIC and other agencies that provide prenatal services, and sites that assist with OHP enrollment.

Other collaborations between OFH and DMAP include outreach and assistance to undocumented and isolated families to enroll their eligible children in the Healthy Kids/Orego Health Plan. The Oral Health program in OFH collaborates with DMAP to implement state and federal preventive practices for enrolled children.

OCCYSHN and DMAP have an interagency agreement to address reimbursement rates for services provided at tertiary clinics. Committees formed by CDRC and OCCYSHN include the Medical Director and staff of DMAP to discuss policies and issues for CYSHN enrolled in the Oregon Health Plan.

Both Title V Agencies in Public Health and OCCYSHN regularly provide information and presentations to the medical, dental, and mental health directors of Oregon Health Plan managed care organizations, as well as the Quality Improvement Coordinators Work Group. The purpose of the presentations is to provide information on community services and linkages for referrals, recent public health prevention initiatives, and specific collaborations or performance improvement programs for implementation by providers of the OHP contractors.

/2012/ The OHA Oral Health Strategic Planning project is convening agencies across the Oregon Health Authority to create a model of collaboration and strategic vision that will align all oral health/dental programs within the various health programs. Agencies include the Medicaid Agency (DMAP), Public Employee/Education Employee Benefit Boards, and Oregon Partnership of Health Plans. //2012//

Social Security, Disabilities Services and Family Support (CYSHN): The Child Development Rehabilitation Center (CDRC), Social Security Administration (SSA), and the Disability Determination Services (DDS) of Vocational Rehabilitation Division (VRD) educate providers about Childhood SSI eligibility, outreach to potentially eligible families, and ensure that families who apply for SSI receive information about available services. Representatives of VRD participate on the community teams around issues such as youth transition. VRD and SSA staff regularly participates in educational conferences sponsored by OCCYSHN and Title V.

/2012/ OCCYSHN is a member entity on the Oregon Developmental Disabilities Council. This collaboration is focused on the attainment of necessary policies and programs that will meet the needs of children and youth with developmental disabilities. OCCYSHN supports the development of family and consumer partners. //2012//

/2012/OCCYSHN and the OFH's Adolescent Health section initiated a collaborative effort with the CDRC UCEDD and the Oregon Office of Disability and Health to improve systems of care for youth and young adults with chronic conditions and disabilities. In February 2011, the four programs convened the Oregon Youth Health Forum, as a consorted effort to bring together key stakeholders to address the issues and challenges facing this population as they transition into adulthood as well as prioritize action steps for improving services. OCCYSHN and the OFH continue to engage forum participants and other stakeholders to participate in "action coalitions" around the prioritized action steps. //2012//

The Title V OCCYSHN nurse consultants collaborate with NICUs and high risk nurseries for discharge planning and referrals to CaCoon home visiting nurses. The CDRC and Shriners Hospital collaborate on adolescent health transitioning and medical home issues and CDRC pediatricians regularly staff clinics at the Shriners Hospital. Shriners' care coordinators have participated in Title V OCCYSHN sponsored conferences.

/2012/ Oregon Commission on Autism Spectrum Disorder: OCCYSHN is highly involved with the OCASD in state efforts to improve services and the system of care for individuals with Autism Spectrum Disorder. The partnership between the OCASD and OCCYSHN led to submission of several grant requests to assist in implementing components of the OCASD state plan.//2012//

Family Support Organizations: OCCYSHN has partnerships with family-based organizations. These partnerships bring critical perspectives and insight to state level policy, program development and implementation, and help to illuminate unmet needs of families of CYSHN. Family support organizations include Juntos Podemos to support Hispanic families, Northwest Down Syndrome Organization, Lifespan Respite, Family and Community Together (FACT), and Parent to Parent Planning Group. These organizations assist OCCYSHN and the Family Involvement Network (FIN) to identify families who can provide input and participate in projects, meetings, trainings, and planning efforts across the state. Oregon Family Voices frequently works with OCCYSHN to link parent consultants to activities and groups that are working to improve

systems and services for CYSHN and their families. The Family Voices coordinator is also a staff member of OCCSYHN.

/2013/ The Oregon Family to Family Health Information Center, housed within OCCYSHN program, has established relationships with the majority of parent-based organizations across the state. The F2FHIC has partnerships with Oregon r.i.s.e (the Oregon Parent Training Information Center), Autism Society of Oregon, Oregon Parent-to-Parent, Hands and Voices and Oregon Family Support Network and several other local/regional organizations to meet the information and resources needs of families of CYSHN. //2013//

F. Health Systems Capacity Indicators

Asthma Hospitalizations (HSCI #1)

Hospital discharge data using ICD-9 codes are readily available from the Asthma Program for Title V reporting. The hospital data is provided to the Asthma Program by the Oregon Health Policy and Research Division.

The rate of hospitalization for asthma among children less than five has steadily declined from a high of 18.1 per 10,000 children in 2004 to a low of 11.9 in 2011, remaining at a rate of 14.1 in both 2007 and 2008, below the Healthy People 2020 target of 18.1. Prior to 2008, Oregon asthma cases included children hospitalizations in 3 hospitals in Vancouver, Washington, which might have contributed to the higher cases in 2004 through 2006.

In 2009, the rate increased slightly, which is potentially reflective of natural variability in the data sources. A report on Oregon children with asthma on Medicaid in 2004-2005 showed that for every 100 children under five years old with asthma, there was an average of over 6 hospitalizations for asthma a year (source: <http://library.state.or.us/repository/2007/200712051040433/index.pdf>). The highest rates for hospitalization in this report were in mostly rural counties.

In general, factors that may influence asthma hospitalizations in children include environmental conditions (both indoor and outdoor), parent's ability to read and comprehend health information, secondhand smoke exposure, cultural differences, and access to care.

The Oregon Title V program has not used resources to reduce hospitalizations for children with asthma. However, the Oregon Asthma Program partners with Division of Medical Assistance Program Managed Care Organizations to improve how health systems manage all people living with asthma. Evidence-based intervention goals are to increase use of controller medications by people with asthma and ensure that people who experience an asthma exacerbation that results in admittance to emergency department receive follow up care from their primary care doctor to adjust their medication and self management goals in order to prevent future emergency department visits. The state's public health home visiting programs for pregnant women and young children is implementing the Healthy Homes initiative with the objective to implement environmental screening and education for the families to decrease asthma in children.

/2013/ The life course approach is an important concept for understanding, preventing, and managing asthma. In addition to hospital discharge data, public health surveillance data are available from the Oregon Health Teen survey and Behavior Risk Surveillance System survey to assess asthma in older children and adults. A 2010 asthma report (http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Asthma/Documents/burden/or_asthma2010.pdf) showed that 11.1% of Oregon 8th and 11th grade students have asthma. Among 8th graders (13-14 years of age), more male students tend to have asthma compared to female students. The prevalence of asthma among Oregon adults (both lifetime and current asthma) is higher than the asthma national average. The prevalence among females is significantly higher than males, and this mirrors national

data. Some of the biological and contributing factors for the higher asthma prevalence in female include: having smaller airways and different hormones; obesity and some socio-economic factors. //2013//

Initial periodic screens for infants enrolled in Medicaid/SCHIP (HSCI #2 and #3): Oregon's SCHIP and Medicaid Programs are integrated and reported as a single indicator. Medicaid data is readily available from the Division of Medical Assistance Programs. SCHIP data is rolled into Medicaid data as a seamless Oregon Health Plan (waiver) program. The percent of Medicaid enrollees whose age is less than one who received at least one initial periodic screen has remained around 90% since 2005 and continues at the same rate.

The Title V Program has been actively engaged in statewide efforts and partnerships to increase early childhood screening and referral. The efforts have included policy changes for MCOs and Early Intervention/Early Child Special Education (Part C). Additionally, the Title V Program and the Early Childhood Comprehensive Systems Coordinator is actively engaged in a Governor's initiative to increase early childhood screening as one of the objectives for the goal to assure children enter kindergarten ready to learn.

DMAP (Medicaid agency) has developed data analysis methods to track the utilization of standardized screening among Oregon Health Plan enrollees. An indicator was developed by the DMAP program to measure the rate per 10,000 children on OHP aged 6 months through 37 months old who received a developmental screen (96110 CPT code claim). Other ongoing efforts are to train pediatricians to integrate early developmental surveillance, screening and referral in their well-child visits. **//2013/ The current ABCD-3 Initiative is using CMS-required External Quality Review and Performance Improvement Projects, implemented by Oregon MCO contractors, to implement community-based systems for screening and referral. The desired outcome is to measures within the Medicaid reporting systems for screening, referral and follow-up for EPSDT-eligible and all OHP covered children. This will include finding a CPT claims code to measure referrals to Part C and feedback with child's medical home //2013//**

Births of women with adequate prenatal care (HSCI #4):

The Title V Office has direct access to vital statistics data. Prior to 2008, Oregon calculated the Kotelchuck indices relating to the amount of an adequacy of prenatal care. In 2008, Oregon implemented the use of the 2003 US Standard Birth Certificate of Live Birth that has different data fields used for the Kotelchuck index in 2007 and prior. A new computation method based on similar variables in the new birth certificate is used to obtain data for 2008 and subsequent years and trends should be tracked from 2008 onward; the 2008 method is based on 2 indexes (adequacy of prenatal care + adequacy of received prenatal care services).

Based on existing data, the percent of women with a Kotelchuck Index of 80% or greater shows slight improvement, from 67.5% in 2007 to 76.7 in 2011 (provisional data). More accurate data on the date of prenatal care initiation may contribute to the trends in this indicator.

//2013/ While early and adequate prenatal care is an overall priority for the Oregon Title V Program, sufficient resources have not been available to collaborate with health providers and systems to improve this indicator. In 2013, renewed efforts around increasing prenatal care systems of care will be initiated by the Title V Program. //2013//

Disparities of Medicaid vs. Non-Medicaid populations (HSCI #5A-D):

//2013/ In 2013, the Oregon Title V Program intends allocate staff resources to begin planning goals and strategies to reducing disparities and inequities represented by the comparisons of the indicators on this form. The trends in these populations are relatively flat for the state as a whole, but too low for populations of color and in rural/frontier areas. //2013//

Low birth weight: Oregon's Title V Program does not have activities that directly focus on decreasing low birth weight either for Medicaid or non-Medicaid insured women. However, Oregon does have programs for smoking cessation in pregnant women, which may contribute to a decrease in the rate of low birth weight births.

Infant Mortality: Oregon's SIDS prevention program works through local health departments and is therefore likely to have the most impact on Medicaid-insured women. About 40% of Oregon women are taking folic acid at the time they become pregnant. Public health education campaigns are often targeted at low SES women but probably reach both low SES and high SES populations. Taking folic acid decreases the risk of neural tube defects including some, like anencephaly, that is fatal.

Early and Adequate Prenatal Care: The prenatal care indicators are showing some improvement over previous years, including the disparity between Medicaid and non-Medicaid births. Oregon does not have presumptive eligibility that would allow prenatal care providers to be reimbursed for care delivered to pregnant women even if they are later determined to not be eligible for Medicaid.

//2013/ Provisional data for 2011 indicates that 70.6% of Medicaid-enrolled pregnant women with adequate prenatal care (Kotelchuck index) showed a slight increase from 2009 at 65.8%. However, the disparity with non-Medicaid women continues at the same rate. //2013//

Eligibility for Oregon Health Plan (Medicaid waiver) (HSCI #6A --C):

Children: Healthy Kids is a program of the Oregon Health Plan that mandates all eligible children will have health insurance regardless of income. Healthy Kids offers three avenues of coverage: 1) Oregon Health Plan (OHP) Plus (Medicaid); 2) Employer Sponsored Insurance (ESI) insurance; or 3) Healthy KidsConnect, a private market insurance option.

Children in families earning 200% FPL or less are eligible for Healthy Kids coverage at no cost. Children in families between 200% and 300% FPL are eligible for a sliding scale subsidy for the cost of their premium.

Healthy KidsConnect (HKC) plan is a private insurance option. Children in families with eligible uninsured children between 201% through 300% FPL can receive a premium subsidy for insurance carriers contracted in the HKC program. Uninsured children above 300% FPL can purchase coverage through the HKC program by paying the full premium cost.

For the Employer Sponsored Insurance (ESI) component, those families who are at 300 % FPL or higher can receive premium assistance in the form of a reimbursement, as long as the employer plan meets federal guidelines.

Pregnant Women: The Division of Medical Assistance Programs (DMAP) administers the Oregon Health Plan. Currently, most adults, aged 19-64 with incomes up to 100% FPL are eligible for OHP Standard, for which there is a waiting list. Pregnant women and persons with disabilities with incomes up to 185% FPL are eligible for OHP Plus. Oregon does not have a presumptive eligibility law for pregnant women.

Eligible children receiving services (HSCI #7A):

The percent of potentially Medicaid eligible children aged 1-21 years old who received a service paid for by Medicaid in 2010 was 84%. This is higher than year 2007 (77.5%). However, caution should be exercised when making comparisons across years due to methods variability with 2007 through 2009 data, and the methods used for 2004 through 2007.

//2013/ More children actually became eligible for Medicaid (about 25,000 more children) during 2010 (last year of data) and should show even greater increases in 2011 and 2012.

The Coordinated Care Organizations and Patient-Centered Primary Care Health systems are just starting up in 2012. The Oregon Title V Program will be involved in outreach to providers to increase preventive care for children enrolled in the Oregon Health Plan. //2013//

Eligible children receiving dental services (HSCI #07B):

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year was 47.3% in 2008. This percentage is higher than prior years, which ranged from a low of 40.1% in 2004 to a high of 45.4% in 2007. However, caution should be exercised when making comparisons across years as we are unable to determine whether the methods used for 2008 and the methods used for 2004-2007 are comparable.

/2013/ The most currently, available 2010 data shows that half (53%) of those children enrolled are getting preventive dental services. //2013//

This data represents those children aged 6 to 9 years who have received a dental service paid for by the Oregon Health Plan. Dental coverage for children has been increasingly reduced and outreach for enrollment continues to be limited due to budget restraints. Oregon's Oral Health Statewide Plan, along with a new broad Oral Health State Coalition, and workforce related project called First Tooth, will be addressing many issues surrounding dental care for children in the next few years. The changes in the Oregon Health Plan, however, continue to cover dental services to families with up to 185% of the federal poverty level.

SSI Beneficiaries (HSCI #8): The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

A reliable data source is not available for this measure. In the past, the list of children seen at the Child Development and Rehabilitation Center Clinic for rehabilitation services was compared to the list of children receiving SSI from Department of Human Services. This strategy is no longer possible because of time-restraints and HIPAA requirements. A proxy measure explored is the number of notices mailed to families regarding eligibility to CSHN program by the DHS-SSI office.

In relation to this indicator, OCCYSHN has continued to use a proxy measure to assess its program. As described in the prior year's notes, OCCYSHN worked collaboratively with the Oregon Department of Human Services, Disability Determination Services (DDS), to provide a letter to families of children and youth who applied for Supplemental Security Income (SSI) benefits. The content of this letter explains to families the availability of OCCYSHN community based programs and services. DDS has been sending the letter to families since the beginning of FY2008.

The numerator for this indicator is equal to the number of letters sent to families of children who were newly awarded SSI benefits (n=1,675). The source of the numerator value was provided by DDS. The denominator for this indicator is equal to the number of children in Oregon under the age of 16 receiving federally administered SSI payments as of December 2010 (n= 8,893). The source of the denominator value is the Social Security Administration Supplemental Security Record, "Table --Number and percentage of children in Oregon receiving federally administered SSI payments, by selected characteristics, December 2011".

/2013/ Starting FY2013, OCCYSHN will use Oregon Medicaid data for this indicator. An annual analysis of Oregon Medicaid data will be conducted to determine the number of children less than 16 who are eligible for Medicaid based on SSI status. SSI children not enrolled in Medicaid would not be counted. The assumption is that all children SSI eligible will be enrolled in Medicaid. The use of a proxy measure will be discontinued.//2013//

Access to Data Sources (HSCI #9A-B): The ability of States to assure Maternal and Child Health

(MCH) program access to policy and program relevant information.

The State Title V Program in the Public Health Division has direct access to most data sources. Oregon has both a PRAMS surveillance system and a self-funded PRAMS-2 longitudinal survey of mothers with 2 year old children.

//2013/ A Birth Defects Registry will be launched in 2013. //2013//

Adolescents: Oregon does not have the CDC-YRBS, but instead implements the Oregon Healthy Teen survey, and includes questions on tobacco use. Oregon MCH Programs have electronic access to the Oregon Healthy Teens Survey (Oregon's YRBS system) to monitor health status for 8th and 11th graders. Title V staff participate on the collaborative group charged with development and analysis of the survey. The Oregon Healthy Teens Survey (OHT) is the one state-sponsored survey designed to monitor the health and well being of adolescents (Oregon's Youth Risk Behavior Survey). An anonymous and voluntary research-based survey, the OHT is designed and administered through a collaborative group of Oregon state agencies.

While tobacco use is a high priority for the Public Health Division and for all populations, the Oregon Title V Program has not had resources for a focus on prevention and cessation of tobacco use among adolescents.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Priorities were selected using a multiple step process engaging stakeholders, interested persons, evaluating data sources, and brainstorming program activities. Capacity assessment and strategic planning for all the priority areas will be continuing throughout the five year cycle. Most activities will be focused on more in-depth assessment, partnership-building, planning activities within the Title V roles and responsibilities, and determining areas for systems building. In each area, the Title V Offices are committed to assess and plan work to reduce disparities and inequities related to each priority area. Performance measures were selected based on available data sources or process data that will be created during the planning stage and reflect, as much as possible, the work feasible for the Title V Offices.

2011 Priority Unmet needs

1. Family Violence -- Family violence, including intimate partner violence and child abuse
2. Alcohol and Drug Use -- Drug and alcohol abuse, including accessibility of services (and prevention of Fetal Alcohol Syndrome)
3. Mental Health -- Mental health, including accessibility of services
4. Oral Health -- Oral health and early childhood cavities prevention, including accessibility of services
5. Resources for Parent Education and Skills -- Parents' resources and parenting behaviors (including parenting education and other support services) to support young children's health, development, safety, and social-emotional health
6. Overweight and Obesity -- Prevent and address overweight and obesity in older children and adolescents, including nutrition, food security, physical activity and screen time
7. Physical and Mental Health Services Access -- Access to preventive physical and mental health services
8. Linkages for CYSHN to Mental Health Services -- Lack of linkages or referral pathways to appropriate mental health services for children and youth with special health need
9. Access to Specialized Services -- Limited access to specialized health and related services (specialty care, mental health, PT/OT, etc.) for children and youth with special health needs particularly in rural and frontier areas
10. Access to Family Support Services -- Families and providers lack knowledge and awareness of support services available for families of children and youth with special health need (family support needs)

B. State Priorities

In the Oregon assessment, the selection of priorities evolved over the course of the assessment with input from surveys and from stakeholder engagement. As some of the priority areas were pertinent to more than one population group, the Leadership Team determined to select one population group to focus that priority need. With the phased survey and prioritization methods, the selection of the priority health needs was straightforward. The Title V Leadership Team reviewed the summary report prepared by the assessment team, consulted the needs and priorities collected from stakeholders, reported in Section 4 above. The Leadership Team then

used the following criteria for selecting the final priorities and goals.

- Level of rankings across all processes for a specific population group
- Existing or potential of working on the issue by the Title V Offices
- Ability to influence change in a measure with activities conducted or leveraged by the Title V Office in both agencies
- Leadership for the priority area is handled in another sector or state agency

The challenge with selecting priorities are that many of the issues rooted in problems related to social determinants of health like poverty, employment, education, health care access, and language or cultural differences. Balancing the expressed need with the scope and current uses of Title V resources presented the greatest challenge in deciding on final priority goals for action.

//2013/ The Public Health Division has recently adopted Division-wide priorities that are related to the Title V priorities (See Attachment to this section). The Title V Program will contribute the information collected through the Needs Assessment to contribute to the strategic planning around these priorities. //2013//

Direct Health Care Services

Needs:

Disparities or inequity in access to health services is apparent for all populations, and particularly for families of color, immigrants with resident children, and all persons living in rural and isolated areas, particularly for families with children with special health needs. In both urban and rural/frontier communities, there is a particular deficiency in available mental health and dental health services and providers. Services are needed that meet the traditional or transitional needs of those who are non-English speaking, non-white, have little or no health insurance, and/or living in rural and frontier areas of the state. Public funding or support, combined with untrained health and service providers are needed to begin reducing these disparities and inequities in access to medical, dental and mental health care access. The Oregon Primary Care Office reports on Oregon's Health Professional Shortage Areas (HPSA) show that Oregon has 102 primary care HPSAs, 76 dental care HPSAs, and 54 mental health HPSAs.

Oregon geography presents a significant barrier to obtaining care where the mean travel time is 23.7 minutes in rural Oregon, with several areas taking up to an hour or more to the nearest hospital facility. The distance to services is especially difficult for reaching specialty care needed by CYSHN and their families. Specialty care is concentrated in urban areas, predominantly in Portland. There is little or no specialty care services in the rural or frontier counties, where the existing providers are not adequately trained to provide care for CYSHN.

Oregon geography presents a significant barrier to obtaining care where the mean travel time is 23.7 minutes in rural Oregon, with several areas taking up to an hour or more to the nearest hospital facility. The distance to services is especially difficult for reaching specialty care needed by CYSHN and their families. Specialty care is concentrated in urban areas, predominantly in Portland. There are few, if any, specialty care services located in the rural or frontier counties, where the existing providers report they are not prepared to provide care for complex CYSHN.

With mental health wellness a major concern across the MCH populations, not only is access at issue but also availability of age-appropriate, family-centered, culturally appropriate services. The community mental health system meets only 46 percent of the need, and many providers are not trained in screening of young children for social-emotional and behavioral problems or for maternal depression disorders. Improvement in availability of preventive screening, referral sources, care coordination and management, and treatment, particularly by pediatric providers, is needed for preventable and manageable mental health conditions. Input by stakeholders included a need for mental health services that are integrated or co-located with primary care service delivery, that meet the language and cultural norms of all persons needing care. Mental health consultation for pediatric primary care providers and for families of children and youth with special

health needs would help to bridge primary care or community services who have inadequate access to mental health specialists. Access is also a problem for new mothers may lose coverage on the Oregon Health Plan two months postpartum, and therefore lose the ability to continue treatment for maternal depression, if needed. Flexibility in the policies regarding coverage of the mother as it relates to the early development of the child is needed to prevent the negative effects of maternal depression and other behavioral and mental health disorders.

Dental health care is a concern, especially for pregnant women and very young children. Prenatal and pediatric health care providers are not trained or confident in screening pregnant women for oral health diseases, and dentists are reluctant to serve under/uninsured women and children. Stakeholders reported a need to assure fluoride varnish is applied in well-child visits and to provide dental insurance or care up to six months postpartum for pregnant women, where the Oregon Health Plan currently covers dental care for pregnant women through two months postpartum. Oregon citizens have a long history of advocating, as well as opposing fluoridation of community water systems and this issue continues to be a high priority for optimal prevention of early childhood cavities.

Opportunities:

The needs identified for direct services are preventive or are early interventions that prevent associated conditions across the individual's lifetime. Opportunities to build capacity in direct services was identified by the Title V Group and will help guide additional capacity assessment and planning for each of the priority areas.

Enabling Services

Needs:

Community-based supports and coordination of services are needed to assure MCH populations are able to reach available services. Parents need access to information, training, skill-building and support systems that help them nurture and support the developmental and emotional needs of the young child in all families. Resources and mentors for parents, including fathers, are needed to assure children have the attachment and bonding needed for optimal social emotional health. Families of CYSHN in particular have complex social, emotional, medical, and financial needs. Family support and resources and help these families address these needs and better navigate through the systems of care. Cultural competence in all aspects of service delivery is especially important as Oregon demographics shift to more first and second generation immigrant families.

Adequate resources in the community, at schools, and at worksites are needed to bridge gaps and inequities for linking families to information and services they need to establish healthy and safe families. Outreach can be more effective by using natural supports, such as faith organizations, apartment buildings, and community organizations, to connect to needed physical, dental, mental, and specialized services. Statewide home visiting services and supports need to improve policy and program coordination at the state level to better support outreach and linkages for clients to appropriate resources and programs.

Opportunities:

The needs identified for enabling services are focused on reducing the gaps in services inherent in Oregon's rural/frontier geography and the need to include extended family members not traditionally part of the federal MCH population definitions. Opportunities for enabling services identified by the Title V Group will provide foundations for continuing assessment and planning around each of the priority health issues.

Population-Based Services

Needs:

Stakeholders raised concerns about the limited protective community practices and preventive health care services available to reduce behaviors and conditions that increase risk and safety among families. These include community practices about healthy choices for food and exercise,

and preventive services that support healthy mental and physical health conditions. Messages and information about mental health wellness and services could be improved to reduce stigma among those needing mental health services. Increased understanding and awareness by community organizations, schools, health, and service providers is needed to improve community-based investments that support prevention of intimate partner or domestic violence, early brain development and parent-child interaction, as well as healthy food choices and exercise.

Preventive screening of children and adolescents should occur where they are, such as child care, Head Start, and schools to identify CYSHN and link them to appropriate resources and services.

Communities need to be plan and build environments that support families, pregnant women, fathers, and children and youth with special health needs. Communities can be built so that healthy choices are the easy choices for children, youth, and their families. Social marketing and health education that is cultural appropriate could increase healthy choices limiting access to sweetened beverages for children under five years old, increasing affordable and available fresh fruits and vegetables, and reducing TV or computer screen time for all children.

Public education and awareness is needed to increase preventive physical, dental, and mental wellness screening of children and adolescents, perhaps by increasing screening in locations where these populations are located during the day, like schools and child care centers.

Community-based health promotion would increase the understanding about local practices that can prevent preventable communicable and chronic diseases, including cavities and obesity and overweight conditions. Adolescent-friendly settings are needed to provide affordable and comprehensive physical and mental health services, as well as support and promotes positive youth development. Culturally appropriate education and discussion about sexual health behaviors is needed to increase acceptance among diverse populations and settings.

Opportunities:

Population-based services cover the promotion of preventive practices and activities that can be implemented by communities appropriate to the diversity of their own populations. Stakeholders suggested opportunities that provide healthy choices and health education in neighborhoods, worksites, and educational and faith institutions. Programs currently in some communities could be expanded statewide to reach more populations or adapted to reach those communities experiencing disparities. Population-based opportunities identified by the Title V Group will guide additional capacity assessment and planning.

Infrastructure and Systems Building

Needs:

Oregon's infrastructure and systems have gaps, strengths, and emerging activities that address the concerns and needs across all MCH populations, though disparities continue to exist within the systems of health care and community-base prevention services. Additional capacity assessment is needed to determine where and how to address the gaps and barriers in Oregon's system of services for the MCH populations. From the stakeholder input, the overriding need in statewide or community infrastructures and systems was the lack of cultural and linguistic appropriate services that are linked or coordinated with the established services and providers, especially for mental health and preventive physical and dental health services. A critical need is for integrated and more effective care coordination throughout the health services and preventive care delivery system. An effective system that is responsive to the community it serves is needed to increase access to appropriate and comprehensive mental health services, dental health services, and preventive physical and developmental services. State policies and professional practice standards could mandate that interpretive and language services are always available in service delivery in all parts of the state. Resources in funding and in expertise are needed assist communities in building safe neighborhoods with readily available walkways to schools, physical

activities, and healthy choices in food.

Training and continuing education for the health and community service providers is needed to increase knowledge about delivery and care coordination for MCH populations, particularly for young children and children and youth with special health needs. Service and health providers need culturally appropriate training in preventive screening for women and pregnant women for depression, oral health, tobacco/alcohol and drug use, intimate partner violence, and appropriate weight. The statewide infrastructure could invest resources in to support community efforts to build systems that provide linkages and coordination among services and referral sources and delivery of health and health related services.

The expanded use of technology, such as electronic health records, will effectively coordinate and provide more efficient health services wherever people access those services. Technological options are underused in Oregon, particularly in rural and frontier areas where connectivity continues to be a problem. Access to specialists and health consultants through on-line video discussions would greatly enhance the availability of services appropriate to the need of individuals and families. Training and increased connectivity is needed to increase the use of technology in rural and frontier areas as well as with populations experiencing disparities caused either by geographic or ethnic isolation.

Opportunities:

The MCH system of services and supports for families has many opportunities both through existing efforts and resources to build infrastructure and through local initiatives or demonstrations that can be expanded to other communities. Stakeholders suggested opportunities for improved infrastructure are found in maximizing technology conveniences, conducting assessments and surveillance to better define problems and interventions, and investing resources in systems or methodologies most efficient to addressing the issues. Opportunities for building infrastructure in several areas were identified by the Title V Group and this list guide additional capacity assessment and planning.

An attachment is included in this section. IVB - State Priorities

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	60	51	61	56	53
Denominator	60	51	61	56	53
Data Source		Oregon Public Health Lab	Oregon Public Health Lab	Oregon Public Health Lab	Or Public Health Lab
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5					

and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

Source: Newborn Screening, Public Health Lab.
 Data based on the total number of referred positive as reported on Form 6, column D.

Notes - 2010

Source: Newborn Screening, Public Health Lab.
 Based on calendar year. 2010 data is as of 2/11/11 and based on the total number of referred positive as reported on Form 6.

Notes - 2009

Source: Newborn Screening, Public Health Lab.
 2009 data based on the total number of referred positives as reported on Form 6.

a. Last Year's Accomplishments

The newborn screening (NBS) panel continued to include the 29 core conditions recommended by the American College of Medical Genetics and the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and adopted by the Secretary of Health and Human Services.

The NBS program began investigating laboratory procedures and follow-up options for adding Severe Combined Immunodeficiency to the screening panel as recommended in 2010 by the Secretary's Advisory Committee on Heritable Conditions in Newborns and Children.

Systems continued to be in place to assure all infants with positive NBS results received diagnostic testing and a health care provider accepts responsibility for treatment/monitoring. The primary care physicians of all children with metabolic conditions requiring treatment or monitoring were offered assistance and follow-up through the OHSU/CDRC Metabolic clinic. The primary care providers of infants with hemoglobinopathies, endocrinopathies, and cystic fibrosis detected by newborn screening continued to be offered assistance and follow-up through the OHSU Doernbecher Children's Hospital's pediatric hematology, endocrinology, and pulmonology programs.

The CaCoon program continued to offer care coordination for children with conditions detected by NBS. CaCoon nurses enter data on services provided into the statewide ORCHIDS System.

The CDRC Metabolic clinic continued to process WIC vouchers for medical formula for eligible children under age 5 with inborn errors of metabolism.

To assure appropriate long-term follow up and evaluate outcomes for children with inborn errors of metabolism, data about children with metabolic conditions seen in the CDRC Metabolic Clinic were entered into the Long Term Follow-up Database.

The CDRC Metabolic Dietician promoted third party reimbursement for medical foods for treatment of metabolic conditions by working with the National PKU Alliance on developing medical food cost estimates for the Congressional Budget Office and participating in a national committee addressing HCPCS coding issues.

To assure access to accurate, timely information about NBS, information for parents and health care providers was updated and is maintained on the Northwest Regional Newborn Screening Program website.

Access to NBS results continued to be provided to hospitals and physicians through the secure, web-based tool, WebRad, developed by the Oregon State Public Health Laboratory.

NBS program, OFH, and CDRC staff members continued to participate in the Western States Genetic Services Collaborative, and other regional and national work groups and committees. NBS program and CDRC staff participated in multiple regional and national NBS-related workgroups, including those on emergency preparedness and long-term NBS follow-up.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State law mandates that all newborns receive metabolic screening			X	
2. Contractual partnerships between Oregon State Public Health Lab and CDRC/OHSU	X			X
3. Practitioner manuals updated and distributed throughout the state; online resources available			X	
4. Collaboration between CDRC Metabolic clinic and WIC to assure medical formula provided for infants/children under the age of five with metabolic disorders of metabolism (e.g.PKU)	X	X		X
5. Assure follow-up and treatment through CaCoon, Community Connections Network and CDRC Genetics and Metabolic Clinics	X	X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The NBS panel continued to include the 29 Core conditions recommended by the American College of Medical Genetics and the Secretary of HHS.

The NBS program continued investigating strategies for adding Severe Combined Immunodeficiency to the screening panel; updated its Neometrics data system; and continued to provide hospitals and physicians with secure, web-based access to NBS results.

Practitioner manuals were updated and posted on the Northwest Regional NBS Program website.

The CDRC Metabolic Dietician promoted a national third party reimbursement policy for medical foods for treatment of metabolic conditions by: 1) submitting medical food cost estimates to the Congressional Budget Office in collaboration with Genetic Metabolic Dietitian International, students enrolled at USC and the National PKU Alliance; 2) submitting a request to CMS to change HCPCS codes to reflect the clinical purpose of medical foods in collaboration with Genetic Metabolic Dietitians International and medical food manufacturers; and 3) advocating for medical foods being included as essential benefits in the insurance exchanges established through the Affordable Care Act.

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

c. Plan for the Coming Year

The NBS panel will continue to include the 29 Core conditions recommended by the American College of Medical Genetics and the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and adopted by the Secretary of HHS.

The NBS program is striving to add Severe Combined Immunodeficiency to the screening panel by July 2013.

The CDRC Metabolic clinic will continue process WIC vouchers and dispense medical formula for WIC eligible children under age 5 who have inborn errors of metabolism.

The CDRC Metabolic Dietician will continue to promote a national third party reimbursement policy for medical foods for treatment of metabolic conditions detected by NBS through activities that involve 1) advocacy and data collection that supports passage of the Medical Foods Equity Act, 2) inclusion of medical foods as essential benefits for the state insurance exchange established through the Affordable Care Act, 3) establishing HCPC codes that better reflect the clinical purpose of medical foods that in turn will impact appropriate rate schedules for medical food products required for the treatment of inborn errors of metabolism.

The OHSU/CDRC Metabolic clinic will continue to be offer assistance and follow-up to primary care providers of all children with metabolic conditions requiring treatment or monitoring. In addition, the primary care providers of infants with hemoglobinopathies, endocrinopathies, and cystic fibrosis detected by NBS will continue to be offered assistance and follow-up through the OHSU's pediatric hematology, endocrinology, and pulmonology programs.

Children with metabolic conditions will continue to be offered visits to the OHSU/CDRC Metabolic Clinic and new information on the children seen in the OHSU/CDRC Metabolic Clinic detected by tandem mass spectrometry will be added to the Long-Term Newborn Screening Follow-up Database.

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

NBS information for the public, parents, and health care providers will continue to be maintained on the OSPHL NBS program website at www.oregon.gov/DHS/ph/ph/. These educational materials will be updated to meet plain language criteria for parents.

The NBS program will transition from the in-house WebRad tool to the Natus-Neometrics Remote Secure Viewer for providing hospitals and physicians the ability to obtain NBS test results for their patients via the Internet.

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

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by	45238
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Occurrence:						
Reporting Year:	2011					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	45238	100.0	1	0	0	
Congenital Hypothyroidism (Classical)	45238	100.0	378	29	29	100.0
Galactosemia (Classical)	45238	100.0	1	1	1	100.0
Sickle Cell Disease	45238	100.0	0	0	0	
Cystic Fibrosis	45238	100.0	36	9	9	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	45238	100.0	4	0	0	
Citrullinemia	45238	100.0	1	1	1	100.0
Isovaleric Acidemia	45238	100.0	1	1	1	100.0
Carnitine Uptake Defect	45238	100.0	1	1	1	100.0
3-Methylcrotonyl-CoA Carboxylase Deficiency	45238	100.0	3	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	45238	100.0	27	2	2	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	45238	100.0	5	4	4	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	45238	100.0	1	0	0	
3-Hydroxy 3-Methyl Glutaric Aciduria	45238	100.0	1	1	1	100.0
Short Chain Acyl-CoA Dehydrogenase Deficiency	45238	100.0	1	1	1	100.0
Malonic Aciduria	45238	100.0	2	0	0	
Hyperphenylalanemia	45238	100.0	2	0	0	
Arginase Deficiency	45238	100.0	1	1	1	100.0
2-methylbutyryl CoA dehydrogenase deficiency	45238	100.0	3	0	0	
Carnitine palmitoyl transferase	45238	100.0	4	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	55	56	57	57	57
Annual Indicator	55.5	55.5	55.5	55.5	69.7
Numerator					
Denominator					
Data Source		NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	70	72	74	76	78

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Similar to national estimates (57.5 percent), slightly more than half of Oregon families of CSHCN (55.5 percent) indicate they are partners in decision making at all levels and are satisfied with services they receive.

a. Last Year's Accomplishments

OCCYSHN partnered with several family-driven organizations to bring family insights and expertise to program and policy development, implementation and evaluation activities, and to illuminate unmet needs of families of CYSHN.

OCCYSHN was awarded a MCHB grant to fund a Family to Family Health Information Center (F2FHIC) to provide peer-to-peer information and resources and to strengthen statewide support for families of CYSHN. The F2FHIC has increased collaboration with family-driven organizations and individual families across the state.

OCCYSHN's Family Involvement Network (FIN) continued to support Family Liaisons as members of Community Connections Network (CCN) multidisciplinary teams. The FIN coordinator provided ongoing training and support to Family Liaisons as well as consultation to OCCYSHN's community-based programs -- CCN and CaCoon.

OCCYSHN worked in close partnership with the Child Development and Rehabilitation Center (CDRC) Specialty Clinics to assure to patient and family-centered quality care. CDRC hired a new family navigator to support families in specialty clinics. The FIN coordinator provided training and mentoring for a new family navigator and served as the administrative manager for the family navigator as well as the Family Consultant who works in CDRC's Autism clinic.

OCCYSHN staff partnered with Leadership Education in Neurodevelopmental and related Disabilities (LEND) program to provide training and education to a cohort of short and long term students. The FIN coordinator served as the LEND family discipline director and managed the Family Mentor program to match LEND trainees with families of CYSHN. The FIN coordinator and OCCYSHN evaluation staff worked with the LEND family trainee to evaluate family comments captured in OCCYSHN's 2010 Needs Assessment Family Survey. Qualitative data from family comments was linked with quantitative data from the survey. Results were shared with key stakeholders and summarized into a technical report.

OCCYSHN partnered with Oregon Office on Disability and Health, OHSU UCEDD, and Adolescent Health at the Office of Family Health to convene the Oregon Youth Health Forum on February 2, 2011. Families and youth were involved in planning the forum as well as presenting the family perspective and sharing their expertise on a family/youth panel.

Family staff participated on several statewide quality improvement initiatives including the Oregon Pediatric Improvement Project (OPIP), the Assuring Better Child Development III Project and the Oregon Pediatric Society's Screening Training and Referral (START) Advisory Committee and the Early Childhood Council - Health Matters Committee. OCCYSHN supported an AMCHP Family Scholar. The Family Scholar is also a Family Liaison on one of the CCN teams and attended the AMCHP national conference. This leadership opportunity has increased her skills and participation in several state level initiatives.

OCCYSHN was awarded a grant from AMCHP to develop a family navigation tool for families of children (birth to age 8) with Autism Spectrum Disorder and other Developmental Disabilities (DDs). A family consultant was hired to work closely with the Oregon Commission on Autism Spectrum Disorders (OCASD) to develop and pilot the tool with families across the state. Five focus groups were held with families from across the state. Families reviewed the navigation tool and provided feedback regarding the tool's format, content and usefulness. Feedback collected was utilized in the finalization of the navigation tool.

OCCYSHN, in partnership with Office of Family Health, sponsored training from the Catalyst Center on national health care reform issues, including the Affordable Care Act. Training was available to professionals and providers through a grand rounds presentation on June 2, 2011. Family Liaisons participated in a small group session addressing state and national policy and health care finance issues with the Catalyst Center at the OCCYSHN's Family Gathering on June 3-4, 2011. The Family Gathering was a leadership training opportunity for Family Liaisons. The purpose of the training was to enhance linkages and communication among Family Liaisons and families working in OCCYSHN and CDRC clinics; provide training and information on health care finance and the Affordable Care Act, obtain input for the block grant and other upcoming OCCYSHN activities.

An attachment is included in this section. IVC_NPM02_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Families are on OCCYSHN staff and active partners on state committees, initiatives, activities and leadership.				X
2. Families are involved in community-based activities.		X		X
3. OCCYSHN staff partner with state agencies, organizations and family-driven organizations to provide family perspectives, identify issues and share information.				X
4. OCCYSHN partners with other areas of CDRC including the LEND program and UCEDD to promote family-centered care and family leadership.				X
5. OCCYSHN disseminates information and provides education to assist families in decision-making.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OCCYSHN hired a new FIN coordinator. This position provides oversight, training and support to FLs as well as servings as the LEND family discipline director. A F2FHIC Coordinator (also a parent of CYSHN) was hired to coordinate project activities including the development of information, materials, and trainings. F2FHIC launched its website and toll-free line Fall 2011 and continues to update resources and information.

OCCYSHN supports 10 FLs across the state. This year, OCCYSHN focused efforts on increasing training and support for FLs through monthly topical webinars. Topics included guiding families through the mental health system, understanding public and private insurance, inclusive childcare and Autism resource navigation. OCCYSHN convened a family gathering to bring together FLs and CDRC family staff for sharing ideas, standardizing program processes and training in family support.

Family staff participate on the OPIP Executive Committee, ABCD III Advisory Committee, Autism Treatment Network Advisory Group and Health Matters. Family staff are partnering with Mental Health family leaders to reach families of CYSHN with mental health concerns. CDRC family staff initiated a Family Advisory Committee to advise the Autism program in family-centered care, quality improvement and program development.

OCCYSHN partnered with the OCASD to disseminate the navigation tool to families of children with ASD and DDs statewide as well as other partners across systems of care.

c. Plan for the Coming Year

OCCYSHN is committed to promoting and sustaining family involvement at all levels of participation and decision making. OCCYSHN seeks to assure families receive information that can impact their ability to care for their children, especially in light of current economic conditions, budget cutbacks, and significant changes felt at the local, state and national levels. OCCYSHN will track systems and policy changes relative to the implementation of Oregon's Coordinated Care Organizations (CCOs) and health care reform and evaluate how these changes impact families.

Oregon F2F HIC's family-driven activities will continue under OCCYSHN's administration this year. The F2FHIC will develop and disseminate information to help guide families through the

new CCO model and explore models of sustainability beyond the 2012-2013 project year.

OCCYSHN will explore ways to expand family involvement in decision-making at both the state and local level. Most immediately, OCCYSHN will explore the possibility of expanding Family Liaison/Family Navigator roles within the CaCoon program as well as within primary and tertiary care settings.

OCCYSHN is partnering with three counties statewide to implement CaCoon for Youth -- a project focused on expanding CaCoon services to YSHN and their families. The FIN Coordinator will bring family-perspective to the project as well as provide technical assistance around family-involvement to each of the participating counties.

OCCYSHN will continue to support family leadership development and involvement on state level committees, in ongoing program activities and initiatives, and in developing and enhancing family leadership opportunities. Family staff will continue to serve on the OPIP Executive Committee, ABCD III Advisory Group, the Autism Treatment Network Family Advisory Group and Health Matters. OCCYSHN will appoint family staff as opportunities for involvement are identified.

OCCYSHN will continue partnerships and collaborative activities with OHSU/CDRC partners including LEND, to assure family participation in decision-making, family-centered and culturally competent services and systems of care. OCCYSHN's FIN coordinator will continue her role as the family discipline director for the LEND program. The FIN coordinator will have one family-discipline fellow as well as facilitate opportunities for LEND trainees to work/partner with CYSHN families.

OCCYSHN's FIN will continue a focused effort on training and support for Family Liaisons and CDRC family staff through topical monthly trainings as well as an annual family gathering. FIN will also be developing a formal Family Liaisons/Family Navigators Core Competency Curriculum.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	53	53	48	50	52
Annual Indicator	47.4	47.4	47.4	47.4	41.1
Numerator					
Denominator					
Data Source		NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	42	44	46	48	50

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009

Nearly half of Oregon CSHCN (47.4 percent) received coordinated, ongoing comprehensive care within a medical home. This is nearly identical to the percentage of CSHCN nationally who were estimated to have received care in a medical home (47.1 percent).

a. Last Year's Accomplishments

In the spring of 2010, OCCYSHN initiated a new work effort addressing NPM #3. OCCYSHN's Medical Home Initiative (OMHI) identified two primary goals: 1) Ensure that the needs of the CYSHN population are integrated into state medical home policy and 2) increase medical home practices that meet the needs of this population. Objectives are to incorporate the needs of CYSHN into: a) the definition and recognition of medical homes, b) improved purchasing and reimbursement policies, and c) local practice change. To ensure issues of importance to both pediatric and adult care providers are addressed, the OMHI focused on transition from pediatric to adult health care for 3 specific groups of the CYSHN population including individuals with intellectual disabilities including autism spectrum disorders, with complex mental health conditions and with rare chronic health conditions.

OCCYSHN participated in the Oregon Patient Centered Primary Care Home Standards (PCPCH) Advisory Group - Pediatrics which resulted in recommendations on the implementation of medical home to be applied statewide. OCCYSHN continued to participate on the Oregon Pediatric Improvement Partnership's (OPIP) Executive Committee. The goal of the OPIP is to develop and improve quality of care for children, youth and their families. As a member of OPIP, OCCYSHN participated with other state leaders to set standards for implementing and measuring Medical Homes for Oregon's children.

OCCYSHN participated on the Oregon's Assuring Better Child Development (ABCD) III Project Advisory Group. The goals of the ABCD III are to improve: 1) identification of children with developmental/behavioral delays, 2) referral to Early Intervention and other community-based services and 3) care coordination between primary care and community-based services. The Project is coordinated through the OPIP and the Division of Medical Assistance Programs (Oregon Medicaid).

OCCYSHN and the Children's Health Alliance explored opportunities for collaborating on a medical home demonstration project in pediatric clinics. Due to timing and budget constraints, the collaborative efforts were redirected to the OPIP ECHO medical home learning collaborative.

OCCYSHN's Medical Consultant partnered with the Oregon Pediatric Society (OPS) to redesign

the Committee on Children with Disabilities (CCwD). OCCYSHN developed an online discussion group to engage CCwD members and other physicians in policy development and educational opportunities.

OCCYSHN's community-based programs, CaCoon and the Community Connections Network, continued to link CYSHN to a medical home through coordination with local primary care providers. The number of primary care providers participating on CCN teams increased over the previous year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate resources to support medical home care coordination for CYSHN, including chronic condition management and medical home			X	X
2. Develop and deliver education and training programs on ongoing comprehensive management of chronic conditions within a medical home			X	X
3. Promote medical home implementation with an emphasis on care coordination, including effective communication among PCPs, families and other community-based programs and providers		X		X
4. Ensure OCCYSHN's CaCoon and Community Connections Network programs' CYSHN are linked to a medical home		X		
5. Participate in collaborative efforts to build PCP capacity to implement medical home, increase recognition of medical homes and inform practice and policy change				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OCCYSHN collaborates with OPIP to develop and implement quality improvement projects; provide support to practices; and support efforts in the identification of CYSHN and their care coordination. OCCYSHN is collaborating with OPIP and ORPRN to implement the "Enhancing Child Health in Oregon Primary Care Learning Community" (ECHO). ECHO assists primary care practices implement medical home concepts as part of Oregon Patient Centered Primary Care Home (PCPCH) Standards. OCCYSHN/OPIP shared a position this fiscal year to support ECHO implementation. OCCYSHN supported two ECHO Learning Collaborative Sessions to address identification of CYSHN and care coordination.

OCCYSHN is partnering with ABCD III to improve cross system referrals and care coordination. OCCYSHN has developed a universal CaCoon Referral Form for health care providers to refer children to local CaCoon programs.

OCCYSHN expanded its medical home webpage to include a care coordination Toolkit. The Toolkit links to the Oregon PCPCH Standards (found at www.occyshn.org).

OCCYSHN initiated "Coffee Consultations"- webinars that focus on clinical issues for CYSHN. Each session focuses on a specific topic and is presented by a physician with clinical expertise. Four sessions have occurred this year.

OCCYSHN hosted Dr. Carl Cooley - national expert on medical home. Dr. Cooley provided two live webinars on medical home and care coordination and a luncheon consultation with key stakeholders around healthcare transition.

An attachment is included in this section. IVC_NPM03_Current Activities

c. Plan for the Coming Year

OCCYSHN will continue to advocate for a medical home model which supports the needs of CYSHN through state policy work, partnerships and advocacy. OCCYSHN will identify system and practice needs in implementation of medical home and determine feasibility of three potential efforts: supporting practice-based quality improvement teams with family involvement, building the capacity of CCN teams to provide autism evaluation, and using lessons learned from CCN to develop a curriculum, briefs and technical assistance materials to support the development of local CYSHN Health Teams.

OCCYSHN will continue to work in collaboration with OPIP and the ABCD III Initiative to support efforts to improve care coordination and comprehensive quality healthcare for CYSHN. Although the OCCYSHN/OPIP shared position will be retired, OCCYSHN will continue to collaborate with OPIP and ORPRN on the ECHO project. OCCYSHN will participate in the 3rd ECHO Learning Collaborative session in November 2012 on the topic of mental and physical health integration within the medical home. OCCYSHN will support family involvement in the third session specifically sharing the family perspective on working with children with physical and mental health conditions.

The CaCoon and CCN program will continue to assure CYSHN and their families are linked to a medical home in their community and to support that linkage through ongoing communication with primary care providers.

OCCYSHN will build the capacity of primary care providers to address the PCPCH standards by providing them with resources for linking CYSHN and their families to community based resources.

OCCYSHN is partnering with three counties statewide to implement the CaCoon for Youth project (C4Y). The goal of the project is to expand the reach of the CaCoon program to an increased number of youth (12 to 21 years) with special health needs in support of a successful adolescent transition to adult healthcare. This next year, C4Y will focus on increasing its outreach to adult-oriented providers. OCCYSHN partners, OPIP, ORPRN, OPS and a new partner, the Oregon Academy of Family Physicians, will assist C4Y in identifying adult-oriented healthcare providers/practices. OCCYSHN will and support these practices in identifying YSHN and implementing elements of medical home.

OCCYSHN will disseminate the CaCoon universal referral form to health care providers and other partners statewide. An electronic version of the referral form was created and posted on the OCCYSHN website in early summer.

OCCYSHN will continue monthly "Coffee Consultation" webinars September through June. Webinars will focus on a specific clinical topic related to CYSHN and will offer time for case discussion and questions/answers. All webinars will be archived on the OCCYSHN website.

OCCYSHN will continue to disseminate medical home research, best practices, information on state activities, and opportunities for local and state involvement.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	56	62	62	65	64
Annual Indicator	61.5	61.5	61.5	61.5	55.8
Numerator					
Denominator					
Data Source		NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	58	60	62	64	66

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

Almost two-thirds of families of CSHCN in Oregon indicated they have adequate public and/or private insurance to pay for needed services (61.5 percent). In comparison, the percentage of families indicating adequate public or private insurance was nearly identical (62.0 percent).

a. Last Year's Accomplishments

OCCYSHN participated in discussions with families, providers, policy makers and partners to identify track and provide information on health care access, health care reform and finance issues impacting CYSHN.

OCCYSHN strengthened linkages with managed care plans and DMAP in order to track coverage limitations and identify successful strategies for accessing services for CYSHN. OCCYSHN's collaboration with DMAP and the Oregon Health Services Commission (HSC) improved CYSHN access to appropriate genetic services. Through this collaboration OCCYSHN gained access to data on the use of genetic testing by Medicaid recipients.

OCCYSHN partnered with the Office of Family Health's State Genetics program in 2010 to complete a statewide assessment of genetic services. The assessment concluded that there is a critical need to improve access to genetic counseling; that the state's genetic counselors (with one exception) and medical geneticists supported licensing genetic counselors; and that licensing genetic counselors would improve access to genetic services. To support licensure of genetic counselors, OCCYSHN collaborated with OHSU government relations to draft legislation. However, legislation was not submitted for the 2011 short session due to Oregon's fiscal climate and lack of designation of a state agency or office to administer the licenses.

OCCYSHN provided webinar training and consultation to Community Connections Network teams and CaCoon PHNs regarding access to insurance and community financial resources for CYSHN and their families. Trainings were posted on the OCCYSHN website. Updates were also made to the website and CCN Toolbox to include resources and strategies for maximizing health benefits, finding financial resources, and limiting financial hardship on families. In addition, OCCYSHN family staff identified information and supports for families and provided consultation to Family Liaisons about financial resources and health insurance coverage.

OCCYSHN facilitated CDRC medical consultations to CCN community-based teams and local health care providers of CYSHN and their families, especially in rural areas. Two developmental pediatricians participate regularly on CCN teams.

OCCYSHN staff tracked health reform efforts and initiatives within the state and nationally. OCCYSHN disseminated information related to health reform and its impact on CYSHN and their families to key stakeholders.

In partnership with Office of Family Health, OCCYSHN sponsored two webinar trainings to a statewide audience presented by Catalyst Center staff on national health care reform, including the Affordable Care Act and its impact on CYSHN. The first training was a grand rounds presentation available to professionals and health care providers; the second training focused on state and national policy and health care finance issues and targeted Family Liaisons participating on community-based CCN teams.

OCCYSHN was awarded an MCHB grant to support the Oregon Family to Family Health Information Center (OR F2FHIC) which will increase dissemination of health care information to families of CYSHN, including the Affordable Care Act and health care reform within Oregon.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer the Zetosch fund to support the purchase of adaptive equipment for low-income CYSHN.		X		
2. Health care finance (HCF) education and advocacy activities.				X
3. Strengthen partnerships with families, providers, insurers, and legislators to address the concerns of HCF.				X
4. Partner with CDRC clinics to support and sustain unreimbursed services critical to CYSHN at the tertiary and community level.		X		X
5. Partner with Division of Medical Assistance Programs and the Health Services Commission to address genetics services coverage on OHP.				X
6. Track and monitor health reform efforts, legislative initiatives, emerging policy concepts, and related HCF activities.				X
7.				

8.				
9.				
10.				

b. Current Activities

OCCYSHN continues to track and disseminate information about health reform efforts, legislative initiatives, and emerging policy concepts as they relate to CYSHN both at the national and state level.

OCCYSHN participated in the Gubernatorial appointed Coordinated Care Organization (CCOs) Criteria Workgroup in fall 2011. The workgroup charge was to provide input on the statement of work and certification criteria for CCOs to assure delivery system innovation and transformation as guided by the Oregon Health Authority's Triple Aim.

Genetics staff served on the Health Services Commission - Genetics Advisory Committee. Recommendations were developed regarding coverage of genetic services under the Oregon Health Plan. OCCYSHN partnered with the OFH Genetics Program to educate managed care directors about coverage of genetic services.

OCCYSHN continues to collaborate with a workgroup of genetic counselors and OHSU government relations to explore opportunities to support legislation for the licensure of genetic counselors.

OCCYSHN continued to administer the Zetosch fund to support the health-related educational needs low-income CYSHN. Equipment was purchased for 79 CYSHN residing in 19 Oregon counties.

The F2FHIC collaborated with the Oregon Insurance Division to produce a webinar on state regulated employer or individual insurance coverage for CYSHN. The webinar educated families on how to navigate the insurance system, file appeals, understand insurance policies.

c. Plan for the Coming Year

This summer OCCYSHN, OHSU Government Relations, and the genetic counselors work group will reevaluate submitting the Genetic Counselor Licensure legislation for the 2013 legislative session.

Oregon CCOs are being approved for implementation. CCO Advisory Committees are being established and will begin implementation August 2012. OCCYSHN will seek opportunities to inform CCOs about the needs of CYSHN and their families.

OCCYSHN and the OFH are working together to jointly identify a replacement for the Public Health Genetics Specialist who has retired. OCCYSHN genetics staff will continue to serve on the HSC Genetics Advisory Committee to provide recommendations around genetic services covered by Medicaid.

OCCYSHN will continue to support the administration of the Sidney and Lillian Zetosch funds. Plans are underway to improve the application process by offering an electronic application form on the OCCYSHN website.

The Oregon F2FHIC will continue to highlight and disseminate information on access to healthcare, including the Affordable Care Act and health care reform within Oregon utilizing the F2FHIC website, email, newsletters, telephone lines, training and meetings.

Evaluation staff will continue to conduct further analyses on data from OCCYSHN's 2010 Needs Assessment Family Survey and the 2010 National Survey of Children with Special Health Care

Needs for items specific to health care finance and adequate coverage. A report and/or issue brief will be developed summarizing key findings.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	74	90	90	92	92
Annual Indicator	88.3	88.3	88.3	88.3	63.4
Numerator					
Denominator					
Data Source		NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	65	67	70	72	74

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009

Nearly 90 percent of families of CSHCN in Oregon (88.3 percent) and nationally (89.1 percent) reported that community-based systems are organized for ease of use.

a. Last Year's Accomplishments

OCCYSHN continued to administer two community-based programs, CaCoon and Community Connections Network (CCN), throughout Oregon. These community-based programs provided infrastructure that enables communities to more effectively care for CYSHN. Through CaCoon and CCN, OCCYSHN provides gap-filling and care coordination services for CYSHN and their families. The two programs worked together to increase the coordinated and comprehensive care of CYSHN.

OCCYSHN provided training and resources to CaCoon and CCN providers statewide. The use of web technology allowed OCCYSHN to provide an increased number of trainings on a wide variety of topics relevant to caring for and serving CYSHN and their families.

The CCN program's online toolbox was also expanded to include more statewide and community-based resources to support the CCN teams in their work with families and children/youth with complex conditions

CaCoon nurse consultants conducted annual site visits in each CaCoon county, oriented new public health nurses (PHNs) to the CaCoon program and provided training and technical assistance to CaCoon PHNs around topics related to CYSHN and care coordination. The CaCoon program promoted care coordination with local Exceptional Needs Care Coordinators (ENCCs) in their managed care groups to ensure coordinated care of CYSHN, worked to increase Targeted Case Management (TCM) reimbursement to LHDs for care coordination, and examined ORCHIDS data system relative to reporting of medical home assessments and capacity for reporting care coordination. In addition, the CaCoon program worked with NICU's and Relief Nurseries to improve communication and referral-linkages to the CaCoon program.

OCCYSHN was awarded a modest grant from AMCHP to develop a navigation tool for families of children with Autism Spectrum Disorder and other Developmental Disabilities per recommendations of the Oregon Commission on Autism Spectrum Disorder (OCASD). OCCYSHN partnered with the OCASD's subcommittee on community Services for Children and Families to develop, test and disseminate the navigation tool and assure the tool meets the needs of families of children with ASD.

OCCYSHN applied for a HRSA grant to implement the CaCoon for Youth Project, a project focused on increasing the number of youth (ages 12 to 21) served by the CaCoon program.

OCCYSHN and the Office of Family Health (OFH) collaborated with state and local partners to redesign the Home Visiting system in Oregon. The Oregon Home Visiting Steering Committee (HVSC) As the leadership group to oversee and direct the system design work. OCCYSHN is a member organization on behalf of its CaCoon program along with the OFH's Babies First and Maternity Case Management, the Oregon Commission on Children and Families which administers Healthy Start, Early Head Start, Head Start, and the Department of Education on behalf of Early Intervention. OCCYSHN partnered with the Oregon Home Visiting Steering Committee to conduct a home visiting needs assessment as well as to develop the application, assessment and plan for Oregon. Work on the Oregon HVSC has increased understanding and coordination across state agencies providing home visiting programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OCCYSHN and family partners participate in state level program and policy planning groups to assure CYSHN priorities and cultural needs are addressed.				X
2. CaCoon public health nurses provide care coordination to	X	X	X	X

CYSHN and their families.				
3. CCN and local Family Liaisons work to identify local resources, fill service gaps, develop strategies to meet needs of CYSHN in local communities.		X		X
4. Identify/develop/disseminate resources about services and systems of care for families and providers.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OCCYSHN continues with level funding to the CaCoon program in 35 counties and CCN in 9 communities. OCCYSHN is evaluating program data to identify needs/gaps and areas of program improvement. Focus groups are being conducted with families of CaCoon clients to assess satisfaction and opportunities for service improvement. OCCYSHN engaged CCN stakeholders to assess core components essential to the CCN model.

CCN teams continued to meet monthly to provide multidisciplinary team care coordination for CYSHN and their families. OCCYSHN provided TA and training to teams.

OCCYSHN conducted presentations on the CaCoon program to primary care practices and managed care plans. Presentations highlighted opportunities for building community-level partnerships with CaCoon.

OCCYSHN partnered with OHSU's Department of Pediatrics to orient residents to the CaCoon program. As part of orientation, residents accompany CaCoon nurses on home visits.

OCCYSHN was awarded a HRSA grant to fund CaCoon for Youth -- a project to expand CaCoon to an increased number of YSHN (12 to 21 years). The project is implemented in 3 counties.

OCCYSHN participates on the Oregon HVSC to redesign the home visiting service structure statewide. OCCYSHN participated in the development of a universal entry form to streamline HV intake and referral processes.

The family navigation tool was piloted in 2 diagnostic sites and revised based on site feedback. The finalized tool was disseminated statewide.

An attachment is included in this section. IVC_NPM05_Current Activities

c. Plan for the Coming Year

There is a great deal of systems change happening in Oregon relative to the implementation of Coordinated Care Organizations (CCOs). The implementation of CCOs may have a significant impact on the community-based programs statewide. OCCYSHN will continue to track systems and policy changes relative to CCOs and health care reform and evaluate how these changes impact community-based programs as well as CYSHN and their families.

OCCYSHN will continue to be an active member of the Home Visiting Steering Committee as it maps the integrated home visiting system and develop pathways for referral and eligibility determination.

The CaCoon program will continue quality improvement efforts through monitoring of program

data, improved contract language with counties and technical assistance (TA) for meeting standards of care.

OCCYSHN will continue the implementation of CaCoon for Youth project in the three counties as well as explore opportunities to expand the project to other counties. OCCYSHN will support these counties as they expand CaCoon services to YSHN and engage community partners to collectively address the needs of YSHN. Over this next year, OCCYSHN will evaluate the project related outcomes and convene a work group to begin planning for sustainability and spread.

OCCYSHN will implement the final focus groups with families of CaCoon clients. OCCYSHN will conduct a qualitative analysis of the focus group data for themes related to family experience and satisfaction and opportunities for service improvements. A report of key findings will be generated and shared with key stakeholders.

OCCYSHN will continue to support CCN teams in 9 communities. This fall 2012, the CCN program will bring together CCN core team members (physicians, family liaison and professional adjuncts) from each community to address quality improvement through a working meeting. The goal of the meeting is to increase participation of the family liaison as a partner on the team and to increase the family-centeredness of team processes.

OCCYSHN will assist CCN teams in identifying members (e.g. Family Liaisons, Cultural Brokers, etc.) that add value to the team. Several web-based and in-person trainings are planned for the next year to increase knowledge of the role of Family Liaison and Cultural Brokers as aids to supporting families of CYSHN.

OCCYSHN will partner with the Department of Pediatrics to train and orient residents to the CaCoon program as well as other Title V MCH activities.

OCCYSHN will explore options to improve, sustain and spread care coordination programs for CYSHN. Such efforts will include disseminating models for community-based care coordination, including CaCoon and team-based models such as CCN. OCCYSHN will increase linkages with OHSU and CDRC community outreach efforts to assure greater coordination of community-based systems of care.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	6	45	45	48	46
Annual Indicator	43.7	43.7	43.7	43.7	35.6
Numerator					
Denominator					
Data Source		NS- CSHCN	NS- CSHCN	NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2012	2013	2014	2015	2016
Annual Performance Objective	36	36	36	40	40

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009

Over 40 percent (43.7) of CSHCN youth in Oregon between the ages of 12 and 17 were estimated to have received services needed for transition to adulthood. National estimates for this performance measure indicate a similar percentage (41.2 percent).

a. Last Year's Accomplishments

OCCYSHN, OHSU University Center of Excellence in Developmental Disabilities (UCEDD), LEND program, and other OHSU entities worked toward sustaining youth involvement and emphases on Youth Transition (YT), including seeking funding and opportunities for shared activities and training.

OCCYSHN continued as a participant of the Emerging Leaders Northwest (ELNW) consortium and helped to add health care transition to the ELNW curriculum. OCCYSHN provided in-kind support through staff participation in ELNW and "Dream It, Do It" activities -- a youth leadership training program.

OCCYSHN sponsored two youth interns in partnership with the OHSU UCEDD. One of the interns conducted a youth survey regarding their transition experiences which was subsequently presented at a statewide conference. The youth intern has completed his baccalaureate and is planning for graduate work.

On February 2, 2011, OCCYSHN convened in the Oregon Youth Health Forum in collaboration with the OHSU University Center of Excellence in Developmental Disabilities (UCEDD), Oregon Office on Disability and Health and the Office of Family Health-Adolescent Health Section. The OYHF brought together policymakers, state and local agencies, families and youth to discuss and address the opportunities and challenges facing YSHN as they transition to adulthood. Participants heard from a high-level federal officials, youth leaders (including Mallory Cyr from the MCHB National Center on Youth Transition), learned about available data describing the experiences of youth with special health care needs/disabilities, explored the strengths and gaps in the systems serving youth, and worked in small groups to identify solutions to system

challenges. OYHF participants identified key issues, offered solutions, and prioritized action steps for improving services and systems.

In preparation for the OYHF, OCCYSHN developed a resource document describing Oregon services and supports available to YSHN transitioning to adulthood. All information was confirmed with the agency or organization sponsoring the service or support prior to dissemination. Considered a "living document," it will be updated and expanded to reflect a more comprehensive compendium of Oregon services and supports touching YSHN as they transition into adulthood.

OCCYSHN's medical consultant served on the Oregon Commission on Autism Spectrum Disorder (OCASD) and its Transition Subcommittee to assure health inclusion in transition planning including encouraging health care providers and public health professionals, to participate in local councils on youth transition.

The CaCoon program collaborated with the Office of Family Health to revise the State Plan Amendment (SPA) to expand Targeted Case Management (TCM) payments for CaCoon services to CYSHN up to age 21. CaCoon nurse consultants provided ongoing technical assistance to CaCoon PHNs around YT.

OCCYSHN's community-based program, the Community Connections Network and CaCoon, worked closely with School-Based Health Centers and Educational Service Districts to address youth transition issues and exchange best practice information. OCCYSHN sustained emphasis on youth transition in trainings and education offered to CaCoon PHNs, CCN teams and Family Liaisons.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate information and strategies for successful youth transition.		X	X	
2. Support CaCoon nurses and Community Connections Network (CCN) teams in addressing transition needs throughout the life cycle.				X
3. Partner with communities, families, schools and providers in addressing Youth Transition (YT) health care concerns.				X
4. Promote YT issues and Youth Involvement within program, agency and policy arenas.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OCCYSHN provides information and resources to health care providers about transition for YSHN. An online care coordination toolbox includes a chapter on health care transition and is available on OCCYSHN's Medical Home webpage.

OCCYSHN was awarded a HRSA grant to expand CaCoon services to an increased number of YSHN, ages 12 to 21, to support adolescent transition and assure access to a medical home. The project, CaCoon for Youth, is being implemented in 3 counties and has made considerable progress in identifying and serving YSHN.

OCCYSHN hosted Dr. Carl Cooley to provide training and consultation on Medical Home and YSHN transition. Dr. Cooley presented on health care transition to health care providers, community-based service providers and families across the state.

OCCYSHN developed a report highlighting key issues and actions steps identified at the OYHF. A follow-up survey was sent to OYHF participants to understand the contribution the forum is having on program, policy and system changes. OCCYSHN convened a meeting with Dr. Cooley, OYHF collaborators, counties participating in CaCoon for Youth and other key partners to discuss action steps from the OYHF and opportunities for further progress in Oregon's efforts to support transition to adult healthcare.

OCCYSHN supports youth involvement in meetings and conferences. YSHN participated in the OYHF meeting and provided a youth perspective on healthcare transition during Dr. Cooley's presentation on transition

An attachment is included in this section. IVC_NPM06_Current Activities

c. Plan for the Coming Year

Ongoing education and information dissemination will continue regarding youth transition to adult health care and its importance to the lives of emerging adults. Dissemination efforts will target youth and family groups, health care providers, and educators through direct mail, email and other dissemination pathways.

Additional educational opportunities are presented in relation to the CCO's. As the CCO's become established they will become a focus of education/dissemination efforts to support them in their efforts to meet the healthcare needs of their entire population, including children and youth with special health needs.

The OR F2FHIC will provide information to families and their youth regarding youth transition through their newsletters and website.

OCCYSHN will explore opportunities for Youth Involvement in conjunction with other CDRC efforts, including UCEDD activities, OHSU Adolescent Health, Shriner's Hospital, partnership efforts with ELNW and the CDRC Adolescent Transition Committee. In partnership with the OODH, OCCYSHN will develop a Youth Needs Assessment Survey to be conducted statewide. YSHN will be involved in the development, planning and implementation of the survey. With YSHN and family input, OCCYSHN will identify effective methods to disseminate the survey to YSHN across Oregon.

OCCYSHN will work in partnership with OYHF collaborators, CaCoon for Youth counties and other key partners to reflect on and advance the action steps identified at the OYHF to improve transition for YSHN. The priorities and action steps will be reviewed through the lens of Oregon's health care reform, recognizing that the context in which healthcare transition occurs is quickly changing. Additionally, input and reflection from the luncheon discussion with Dr. Carl Cooley about adolescent transition provided opportunity for additional insight and input into methods for effective change in practice relative to transition.

OCCYSHN will continue its implementation of the CaCoon for Youth Project in three counties as well as explore opportunities of expanding the grant to a fourth county. OCCYSHN will continue to provide support, technical support and training around serving YSHN to each of participating counties. In addition, OCCYSHN evaluation staff will assess outcomes related to the CaCoon for Youth project. Several datasets and data collection methods will be employed. Findings will be utilized in planning for the sustainability and spread of the CaCoon for Youth project.

The Community Connections Network will continue to serve YSHN and their families through the

convening of multi-disciplinary care coordination teams. OCCYSHN will continue to provide training and technical assistance to CCN teams around the topic of YSHN and transition.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	75	79	79	77	73
Annual Indicator	72.4	72.3	64.8	69.3	69.3
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	73.5	74	74	75	75

Notes - 2011

Source: National Immunization Survey, CDC. 2010 data for vaccine series 431331 carried over. 2011 data will be available Fall 2012 (e.g.: Sept).

In 2008 and prior years, the NIS rates for both series 4:3:1:3:3, and 4:3:1:3:3:1 (4 Diphtheria/Tetanus/Pertussis, 3 Polio, 1 Measles/Mumps/Rubella, 3 Hib, 3 Hepatitis B, 1 Varicella) were reported on NIS web tables, but starting in 2009 the web tables excluded the data for series 4:3:1:3:3. For Title V report, year 2009 data was updated from series 43133 (66.9%) to series 431331 (64.9%), which the Oregon Immunization Program also reports on. Data for year 2009 and subsequent years will be for vaccine series 4:3:1:3:3:1 because it is more complete by containing Varicella vaccine. Due to switch in reporting of using vaccine series 431331, shortage of Hib in 2009 and 2010 NIS samples, and changes in current reporting method for Hib, comparison of data with 2008 and prior years is limited.

The NIS rates for vaccine series 431331 for years 2007 to 2010 were 70.5%, 71.1%, 64.8%, and 69.3%. The drop in 2009 could be correlated to the national wide shortage of Hib vaccines during 2009. There was an increase in 2010, but confidence intervals range plus or minus 6 points for 2009 and 2010 rates. Overall, Oregon's 4:3:1:3:3:1 series rate are stagnant. Rates among specific antigens are generally strong and meet Healthy People 2020 goals. Confidence intervals continue to be too large to assess significant change in this immunization series rate.

Note: The 2006 data for vaccine series 43133 (no longer visible in TVIS) was reviewed and should be 78.8% (and not 78.4%).

Notes - 2010

Source: National Immunization Survey. Final 2008 and 2009 data for vaccine series 43133. 2010 data will be available Spring 2012, so 2009 data carried forward.

There was a minor decrease in 2008. The drop in 2009 (66.9%) could be correlated to the national wide shortage of Hib vaccines during 2009. A review of NIS 2010 half year data shows that 2010 data might not be for series 4:3:1:3:3, but for a new series which would limit comparison with 2009 and prior years data.

Overall, Oregon's 4:3:1:3:3:1 series rate are stagnant. Rates among specific antigens are generally strong and meet Healthy People 2020 goals. Confidence intervals continue to be too large to assess significant change in this immunization series rate. Usually, confidence intervals range plus or minus seven points. This is true in many states, rendering state ranking largely irrelevant.

Notes - 2009

2008 and 2009 data not available. 2007 data carried forward.

Interpretation integrated into year 2008 data.

a. Last Year's Accomplishments

Oregon's 431331 series rate have improved in 2010, now that the effects of the Hib vaccine shortage from 2008 have largely resolved. Rates among specific antigens are generally strong and meet Healthy People 2020 goals.

Confidence intervals continue to be too large to assess significant change in this immunization series rate. Usually, confidence intervals range plus or minus seven points. This is true in many states, rendering state ranking largely irrelevant

In 2010, a minimum of 890,976 doses of vaccine valued at \$34,570,589 were shipped to public and private providers statewide.

Several thousand health care and school professionals use Oregon's two Immunization Information Systems (IIS) -- ALERT the statewide registry and IRIS the public-sector electronic record. Both have a direct impact on Oregon's ability to improve immunization practices and avoid costly duplicate doses.

ALERT sent monthly recall reports to over 350 Oregon clinics for children 22 months of age, who were overdue for shots. Oregon's Immunization Program used ALERT data to create comprehensive reports about immunization practices for private and public clinics, and immunization quality improvement measures.

Recall postcards were sent to children statewide who were not up-to-date on immunizations from ALERT and IRIS data systems.

The Oregon Immunization Program provided Immunization Practice Assessments (AFIX -

Assessment, Feedback, Incentives, and eXchange) to over 100 providers in 2010. Interventions are focused on assessment of immunization rates and encourage use of recalls for past-due clients.

Oregon Partnership to Immunize Children (OPIC) and Immunization Program co-hosted two Roundtable meetings in Fall 2010 that focused on vaccine management, Medicaid fraud, achieving clinical confidence, and school law. These meetings were well attended and received high evaluation marks.

The Immunization Program developed immunization rates for counties that are population-based and client-based to support the program efforts in DMAP and WIC who assist in improving immunization series completion. Rates can be found at <http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Pages/research.aspx>

The OPIC Health Disparities Workgroup led development of statewide partnerships and measures to monitor and respond to changes in access to immunizations during the economic downturn.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. School immunization laws in place to assure all children in children's facilities are up-to-date annually			X	X
2. Vaccines for Children and the 317 Programs provide vaccines for eligible populations		X		
3. Outreach about immunization disseminated through training, consultation, and health education				X
4. Immunization information systems (IIS) track immunization status and recall individuals				X
5. AFIX assessment for public and private providers monitors clinic rates and identifies gaps and needs for providers		X		X
6. WIC screens and refers any participants aged 3-24 months for immunizations		X		X
7. WIC and Immunization programs collaborate and coordinate services at the state and local levels				X
8. FamilyNet client data system links immunization and WIC client data				X
9. County-specific immunization rates produced annually and shared with local partners to improve targeting of population-based strategies			X	X
10.				

b. Current Activities

Produce and disseminate 2010 population-based immunization rates by ethnicity, race, county of residence, WIC enrollment, Babies First enrollment, and DMAP enrollment for use by DHS, local health departments and community partners.

Continue AFIX activities to improve immunization coverage rates across the state with healthcare providers and health systems.

Provide technical support to tribal health clinics and to assure that all American Indian and Alaskan Native children have access to recommended immunizations. Develop plan for assessing coverage rates among tribal populations, using ALERT IIS, to compare to rates

generated using the RPMS system used by participating tribal sites.

Continue annual funding performance-based contracts to thirty-four LHDs supports their direct and population-based services to communities.

Develop immunization rates by census tract and providing counties with maps of coverage rates to enhance their understanding of local geographic pockets of need related to immunization coverage levels.

Initiated a statewide social marketing campaign to reach vaccine-hesitant parents.

Complete roll out of the new Immunization Information System that has combined ALERT and IRIS registries into one comprehensive system, ALERT IIS.

Co-host two roundtable meetings in Fall 2011, with Oregon Partnership to Immunize Children (OPIC), that will focus on vaccine management, one of which will be tailored specifically for family practitioners who practice in rural areas.

c. Plan for the Coming Year

Produce, publish, and share population-based immunization rates by county and partner program status for 2011 with local partners, to include assessments of missed shots and late starts at the county-level.

Complete assessments of tribal sites and provide summary of coverage levels to participating tribes and the Northwest Portland Area Indian Health Board.

Provider education will continue to promote the Vaccines for Children (VFC) program to eligible populations, the need for reasonable administration fees, and appropriate client billing.

VFC will offer technical assistance and consultation to support partnerships between public and private immunization providers.

Develop partnerships with OB/GYN provider community to increase vaccination rates among pregnant women, post-partum women and household contacts of newborn infants, as well as providers who come in close contact with pregnant women and newborns.

Introduce state-based reminder/recall letters (rather than postcards) to five age groups (children turning 5 months, 13 months, 20 months, 26 months, and 37 months of age) and conduct assessment of UTD status following use of R/R letters.

Initiate pilot project focused on decreasing vaccine hesitancy in schools with high exemption rates; in partnership with VaccNW. Participate in evaluation of pilot project. Continue to work on education and materials to address vaccine hesitancy within the social marketing workgroup.

Assess impact of billing for vaccine at the local health department level; work on ways to improve capacity of LHDs to bill for immunization services.

Provide funding for LHDs to increase partnerships focused on efforts to vaccinate adults with influenza and Tdap vaccines.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	15	15	17	15	14
Annual Indicator	16.6	17.5	15.3	12.8	11.5
Numerator	1228	1314	1150	969	834
Denominator	73997	75054	75370	75466	72806
Data Source		Oregon Center for Health Statistics	Oregon Center for Health Statistics & OPR	Oregon Center for Health Statistics & OPR	Oregon Center for Health Statistics & OPR
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	11	11	11	11	11

Notes - 2011

Numerator: Oregon Center for Health Statistics. 2010 data updated and is now final. 2011 data is preliminary as of 4/2012. Denominator: Oregon Annual Population Report (PSU).

Birth rate among teenagers aged 15 to 17 years old appears to be decreasing. The trend since 2008 seems to be heading in the right direction. The data trend should be interpreted with caution as provisional data does not include teen births that are out of state, which takes 2 or more years to incorporate the out of state births.

Notes - 2010

Numerator: Oregon Center for Health Statistics
Denominator: Oregon Population Research Center

The preliminary 2010 birth rate among teenagers aged 15 to 17 years old appears to be decreasing; the trend since 2008 seems to be heading in the right direction. The data trend should be interpreted with caution as provisional data does not include teen births that are out of state, which takes 2 or more years to incorporate the out of state births.

Notes - 2009

Numerator: Oregon Center for Health Statistics
Denominator: Oregon Population Research Center

The birth rate for teenagers (15-17) went back up between 2005 (15.8) and 2006 (17.7), but then dipped in 2007 (16.6), went back up in 2008 (17.5) and then down again in 2009 (15.3). The three year average from 2007 to 2009 shows a reduction to 16.4 per 1,000 teens, from the high of 17.7 in the single year 2006. Oregon rate is only about one-third of the HP 2010 objective to reduce pregnancies among females aged 15-17 to no more than 46 per 1,000 females aged 15-17 years.

a. Last Year's Accomplishments

The Adolescent Sexual Health (ASH) Program Coordinator served as co-chair of the Oregon Youth Sexual Health Partnership (OYSHP, formerly known as the Teen Pregnancy Prevention-Sexual Health Partnership) through July 2011 and continued to be an active member. OYSHP is a public-private partnership - membership includes: Oregon Department of Education, Oregon Commission for Children and Families, Department of Human Services Youth Services Program, Oregon Public Health Division (Family Planning Services, HIV/STD Prevention, Adolescent Health), Planned Parenthood Affiliates, Cascade AIDS Project, local health departments, the Attorney General's Sexual Assault Task Force, and the Oregon Teen Pregnancy Task Force (OTPTF). OYSHP meets monthly to assess and evaluate statewide teen pregnancy prevention work, including promotion and support of the Oregon Youth Sexual Health Plan.

In April 2011, the Adolescent Sexuality Conference was held in Seaside Oregon. Approximately 275 youth service providers and youth attended sessions on pregnancy prevention, STI prevention, healthy relationship promotion and ways to outreach to youth. The Adolescent Health Section provided funding and staff support for this conference.

In April 2011, The Rational Enquirer was distributed at the Adolescent Sexuality Conference and via direct mail to 3,000 Oregonians. The Rational Enquirer, a youth-focused magazine addressing sexual health, is an annual publication of the Oregon Teen Pregnancy Task Force in collaboration with Office of Family Health. Distribution includes adolescent pregnancy prevention agencies, youth service providers and youth themselves. Feedback from youth focus-groups was considered when developing the publication.

The ASH Program Coordinator served on the My Future My Choice and WISE (Working to Institutionalize Sexuality Education) Advisory Boards. My Future My Choice (MFMC) is a comprehensive sexuality education curriculum developed in Oregon. WISE is an effort to assist school districts to develop strong sexuality education programs in kindergarten- 12th grade.

Two Adolescent Health staff served on the Oregon School Based Health Care Network's EC Brown Grant Advisory Committee. EC Brown Grant funds are provided to School-Based Health Centers to improve partnership activities in support of sexual health of youth.

OFH's Adolescent Health and Women's Health Managers continued to participate in the AMCHP Action Learning Collaborative on Preconception Health for Young Adults with Disabilities.

The ASH Program Coordinator assisted with the state application for federal Office of Adolescent Health Pregnancy Assistance Funds. The application was successful. Funds are being used to support pregnant and parenting women, including teens, who are dealing with intimate partner violence access an array of services, including family planning.

The Adolescent Health Program in collaboration with many partners, developed the application for the federal Family Youth Service's Bureau Personal Responsibility Education Program (PREP) Teen Pregnancy Prevention Funds.

Using PREP funds, the Adolescent Health Program hired two additional staff (one program coordinator and one research analyst) and awarded funding to four county health departments to implement ¡Cuídate!, an evidence-based Latino-focused HIV-prevention program that encourages behaviors to prevent unintended pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with other agencies to implement teen pregnancy prevention strategies				X
2. Provide technical assistance to county health departments and other organizations working toward teen pregnancy prevention goals				X
3. Implement, support and coordinate actions to meet objectives of the Oregon Youth Sexual Health Plan			X	
4. Teen pregnancy prevention media campaign to raise awareness of adolescents, parents and other adults.				X
5. Collaborations with schools and other programs, such as Coordinated School Health				X
6. Collaboration with Title X family planning providers to assure youth-friendly reproductive health services.				X
7.				
8.				
9.				
10.				

b. Current Activities

Contracts to four local public health authorities to implementation of ¡Cuídate, a Latino-specific HIV and teen pregnancy prevention program were in place in December 2011. All funded agencies will implement in 2012.

The ASH Coordinator serves on four statewide groups working to improve sexual health outcomes for youth.

The Adolescent Health Section provided funding and staff support for the April 2012 Adolescent Sexuality Conference. There were 278 people attending, including 65 youth or young adults (under 25).

The 2012 Rational Enquirer was released. Over 3,000 copies were distributed in April 2012.

The Adolescent Health Section focused efforts on addressing disparities. In partnership with Portland State University, a research review on the sexual health disparities of disenfranchised youth was published and shared with partners.

The ASH Program sponsored a workshop on Framing Disparities in Adolescent Sexual Health on April 19, 2012. Fifty community partners attended. Another workshop for state-level programs, held on April 20, 2012, served as a starting point for partnering across state programs to address both service and outcome disparities.

All PREP-funded counties received professional development training in June 2012. Training focused on evaluation measures, implementing to fidelity, and connecting youth to health care services.

c. Plan for the Coming Year

Major activities of the year will be supporting county health departments with their outreach, recruitment and implementation efforts of ¡Cuídate! with a goal of reaching 1,000 youth per year.

State-level staff will collect, input and analyze program data to determine effectiveness of implementation.

The Adolescent Sexual Health program will continue to provide support and technical assistance in implementation of the Oregon Youth Sexual Health Plan. Activities will focus on how state agencies and partners are messaging and addressing sexual health disparities.

A document highlighting the accomplishments related to the objectives of the Oregon Youth Sexual Health Plan will be prepared and shared with policy makers.

The Adolescent Health Section will continue to provide support for The Adolescent Sexuality Conference to be held in April 2013 at Seaside, Oregon.

The Adolescent Health Section will continue to closely monitor teen pregnancy and birth rates.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	52	52	44	44	44
Annual Indicator	42.7	42.7	42.7	42.7	42.7
Numerator	1261	1261	1261	1261	1261
Denominator	2953	2953	2953	2953	2953
Data Source		Oregon Smile Survey	Oregon Smile Survey	Oregon Smile Survey	Oregon Smile Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	44	55	55	55	55

Notes - 2011

Source: Oral Health Program’s Smile Basic Screening Survey, Oregon Health Authority. 2007 data carried forward. The sample of 3rd graders is representative of 3rd graders in Oregon public schools that have at least 10 students in 3rd grade. If there were no 1st or 2nd grade, feeder school was used (feeder school is defined as schools that feeds a particular high school). The 2012 Smile survey is in progress as of 4/2012. Data collection is expected to be completed by Fall 2012, with data available 3 months after.

Data in 2002 and 2007 shows that less than half of third grader students in Oregon received dental sealants. In comparison with other states, Oregon’s dental sealant rate is significantly lower than Washington State (51.2%, from Smile 2009-10) and significantly higher than California (27.6 %, from Smile 2004-05). Oregon and Illinois have similar dental sealant rates. (Source:

National Oral Health Surveillance System:
<http://apps.nccd.cdc.gov/nohss/IndicatorV.asp?Indicator=1>, as of 1/4/2011).

Notes - 2010

2007 data carried forward. Reviewed 2009 data and corrected it from being provisional to final. Next Smile survey data will be available Fall 2012.

Notes - 2009

Data for this measure is available only every five years through the Oregon Smile Survey. 2007 data carried forward. Next SMILE survey year is 2012.

a. Last Year's Accomplishments

The survey for this measure is available every five years through the Oregon Smile Survey. 2007 data are carried forward into 2012. In 2002 the percent of third graders with dental sealants was 51%. By 2007 the rate had dropped to 43%. Both percents are below the Healthy People 2010 goal of 50%. There are multiple factors that may have contributed to the decrease, including differences in sampling methodology between the two surveys. What is important to highlight is that several changes occurred in 2007 that greatly improved the Oral Health Unit's capacity for providing school-based dental sealants. It is expected that this data point will show a sharp increase in the 2012 Smile Survey.

The Oral Health Unit in the Office of Family Health served about 7,000 students in 140 schools. 16,000 dental sealants were placed. The Unit implemented a Lean Daily Management System and created several metrics to streamline processes and pinpoint areas for improvement. For example, one of the metrics shows that the estimated number of children to be screened compared with actual number screened is high. This is reflected in the lower than expected parental permission form return rates. Additionally, the actual number of dental sealants provided to second graders is lower than estimated sealants in place, reflecting the effectiveness of outreach and placement of sealants on the teeth of first graders. The Oral Health Unit began implementation of a retention check protocol, comparing the results of children served as second graders with their results from when they were served as first graders. The school-based dental sealant program is maintaining a greater than 90% retention rate, well above the expected 80% national average.

The Oral Health Unit leveraged state general funds that support expansion of the school-based dental sealant program. The Unit contracted with a few regionally based dental hygienists to coordinate the program locally and recruit more volunteers to provide the services to more schools.

The Oral Health Unit received a HRSA grant for workforce development. The project, called First Tooth, trains medical pediatric providers to incorporate early childhood cavities prevention strategies into the well-child visit and trains general dentists to access the young child by the first birthday. First Tooth is a critical piece of creating a continuum of care as Smile Survey 2007 showed that many children have decay by the time they enter school, 10% have never had a dental visit by the time they entered school, and the prevalence of decay in permanent teeth is high.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Community-based and school-linked partnerships are supported through statewide technical assistance from the Oral Health Unit				X
2. Smile Survey provides assessment data to monitor status of			X	

sealants				
3. Dental sealant promotion campaign to raise awareness of the benefits of sealants			X	
4. Statewide sealant Unit partnering with schools for outreach to children who need services			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oral Health Unit is providing the dental sealant programs in 140 schools, serving over 8,000 children and providing more than 15,000 dental sealants. The total number of schools that qualify for the program has increased by 10% from the previous year. Budget constraints limit the number of schools that can be served. The Oral Health Unit has applied for a workforce grant pilot using Expanded Practice Dental Hygienists to deliver dental sealant services and establish an efficient reimbursement mechanism.

Additionally, data analysis showing the 9-year caries averted rate demonstrates the amount of decay prevented over one and half year increments. This data is being analyzed locally with screening data in 6th and 7th grade dental sealant programs. Smile Survey 2012 is being implemented in early 2012 with results expected in fall 2012.

c. Plan for the Coming Year

Schools participating in the dental sealant program in the previous year will continue to participate in the Sealant Program. Since overall oral health status is dependent on numerous factors it is impossible to project the impact that the school-based dental sealant program will have on dental sealant rates when the 2012 Smile Survey is completed. The Smile Survey results will be available in fall 2012.

The Oral Health Unit will be coordinating with state and local partners through the school-based dental sealant program screening process to assure children identified with urgent needs are referred for treatment. Additionally, we will be also working to utilize existing systems to assure children with treatment needs (non-urgent) identified through the screening process are referred into dental care. Coordination with local programs will include establishing a standardized protocol for providing school-based dental sealants, including providing data and results to the Oral Health Unit.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	2.8	2.8	3	1.3	1.3
Annual Indicator	1.4	1.4	1.8	1.8	1.8
Numerator	10	10	13	13	13
Denominator	724681	724681	730991	730991	730991

Data Source		CDC- WISQARS	CDC- WISQARS	CDC- WISQARS	CDC- WISQARS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	1.7	1.7	1.7	1.7	1.6

Notes - 2011

Sources: WISQARS -- Fatal Injury Reports, 1999-2009, for National, Regional and State (RESTRICTED file). Denominator: Oregon Annual Population Report (PSU), 2008 and 2009 populations for age 0-14 years old. The most current and available 2008 and 2009 data were reviewed and updated, and are now considered final. The 2008 rate is 3.1 per 100,000 (23/730,360), but can no longer be entered into TVIS. Data for 2010 and 2011 are unavailable, so 2009 data carried over.

Notes - 2010

Numerator: WISQARS, 2007 data -- the most currently available data. Denominator: Oregon Population Report (PSU), 2007. Data for 2008-2010 unavailable, 2007 data carried forward.

Annual indicator based on overall motor vehicle crashes among 0-14 years old, age-adjusted to the standardized year 2000. The 2007 rate for Oregon is 1.4 in comparison with the national rate of 3.20 per 100,000 (number of deaths =1,960).

Notes - 2009

2009 not available, 2007 data carried forward.

a. Last Year's Accomplishments

The Children's Injury Prevention Program/Safe Kids Oregon (CIPP/SKO) state office is housed in the Injury Prevention & Epidemiology Section and funded by Title V Block Grant. The Section has identified four top injury priorities: suicide, motor vehicle traffic, falls, and poisonings. Between 1999 and 2007, 223 Oregon children under 15 died as a result of motor vehicle traffic injuries. This translates into a rate of nearly 3.3 per 100,000 children in 1999 to 1.4 per 100,000 children in 2007--a decrease of 58%.

The CIPP/SKO works through local coalitions implementing the Safe Kids Buckle Up program to ensure children are fully protected in vehicles. Coalitions provide education on the proper use of child safety seats to caregivers, screen and provide child safety seats and booster seats to families in need at a reduced cost, and sponsor or volunteer at free child safety seat clinics throughout Oregon. Key partners in this program are the Alliance for Community Traffic Safety (ACTS Oregon) and ODOT's Transportation Safety Division's Occupant Protection Program.

CIPP/SKO provided technical assistance and support to 12 coalitions statewide on registering child passenger safety events and seat check clinics throughout the state. Additionally, each coalition developed a Safe Kids Buckle Up proposal for 2011 on what they would accomplish on the local level. Together, more than 4,000 car seats were checked at child passenger safety events, and more than 1,000 child safety seats were distributed to families in need in one year.

Through a grant from ODOT's Transportation Safety Division, CIPP/SKO partnered with ACTS

Oregon to increase the number of Senior Checkers by 20%. This was accomplished by ACTS Oregon and other CPS Instructors implementing independent CPS Technician assessments, and identifying highly-skilled CPS Technicians that qualified as a Senior Checker. Senior Checkers are required at registered Safe Kids clinics. Additionally, the grant allowed staff oversight and training to community members on filling out the checklist correctly, and increased the percentage of accurately complete child safety seat clinic forms to 98 percent.

CIPP/Safe Kids Oregon also participated in the rollout of the teen pre-driver education program, Countdown to Drive, a web-based program designed to bring parents and young teens together to talk about the key safety issues teens will face when riding as passengers or as they prepare to drive.

In September, six Safe Kids coalitions participated in Safety Seat Check Saturday, a national event sponsored by the National Highway Transportation Safety Administration. This annual, nationwide event raises awareness on proper car seat installation. On this day alone, 328 seats were checked throughout the state.

CIPP/SKO hosted a day at the Capitol in January 2011 educating legislators on pediatric window falls, childhood poisonings, and spoke with legislators about a bill that would update Oregon's child occupant protection law. The child occupant protection bill passed and aligns the law with new products on the market to allow children to remain in a 5-point harness up to the upper weight limits of the seat before moving into a booster seat until age 8 or 4'9". The bill went into effect on January 1, 2012.

Teaching children and adults how to share the responsibility of safety on the road is a key effort in the Safe Kids Walk This Way program. The program has several components from sponsoring schools to participate in International Walk to School Day, to pedestrian visibility during Halloween, to developing school and community task forces to improve safe routes for children to take to school. Several local coalitions provided safety information and safety incentives for walking and biking events at local schools. Most local coalitions are also engaged in distributing helmets for biking, and providing education to motorists and bicyclists on sharing the road and following the rules of the road.

Oregon's home visiting network and public health home visiting nurse programs counsel families on injury prevention and send families to local Safe Kids coalitions and other partners for identified safety items.

Other injury prevention efforts outside of motor vehicle safety included efforts in fire and burn safety, prevention of pediatric window falls, and safe sleep for infants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote motor vehicle safety for children through Safe Kids Oregon, the state office for Safe Kids USA.			X	X
2. Collaborate with ODOT Transportation Safety Division (ODOT-TSD), ACTS Oregon, Safe Kids USA and NHTSA on national Child Passenger Safety Week promotion.			X	
3. Provide support and technical assistance in the development of local child passenger safety efforts via coalitions			X	
4. Support Public Health Nurse home visiting programs in providing anticipatory guidance and health education to parents about child passenger safety.	X			
5. Collaborate with ACTS Oregon on training for certified child				X

passenger safety technicians throughout the state				
6. Support safety seat inspections by local certified technicians assures correct use of car seats	X			X
7. Oversee the Safe Kids Buckle Up program and provide technical assistance on correct use of child safety seat forms statewide, and compliance oversight for quarterly reports				X
8. Support coordination between local Safe Kids coalition partners to screen and refer low-income families needing child safety seats to the seat distribution site.		X		
9.				
10.				

b. Current Activities

Oregon was awarded one of 20 CDC Violence and Injury Prevention Program Core grants. A major focus for the next several years will be integrating motor vehicle, suicide, poisoning, and falls prevention efforts with early childhood educators and home visiting nurses. As part of this effort, the MCH program in the Office of Family Health (Title V) and the Injury Core Grant manager will collaborate in collecting baseline health impact measures for injury prevention priorities, as well as outcome and impact measures related to the MCH program. Grant requirements also include implementation of at least two effective prevention strategies in the four injury priority areas and developing and implementing a policy plan with in-service policy activities to educate stakeholders.

With Oregon in the top five states for high seat belt use, statewide collaborative efforts in motor vehicle traffic safety will involve targeting selected populations and messages. Efforts include: continuing public education about booster seat use, provide traffic safety materials to Hispanic population, encourage pediatricians to adopt the new A.A.P. guidelines on child passenger safety, address DUI and drug-impaired driving issues in partnership with ODOT, and promote Oregon's recently changed child passenger safety law that allows children to remain in harness systems in forward-facing child safety seats past 40 pounds.

c. Plan for the Coming Year

In 2012, Oregon continues to be one of the top states for high safety belt use with a reported 97% use rate. The ODOT-Transportation Safety Division goal is to increase the safety belt use rate to 98% by 2014. However, trauma data from 2010 showed that 16% of occupants injured in motor vehicle crashes were not wearing seat belts or using child safety seats at the time of the crash. And, according to the 2010 ODOT-TSD observed use survey, 40% of children aged five to eight were not riding in booster seats as required by Oregon law. Continuing to partner with ODOT on increasing belt and child restraint use will be a priority.

The use of a bicycle and walking as transportation modes has also increased. According to the 2009 National Household Travel Survey (NHTS), biking and walking make up 11.9 percent of all trips made in the US. This increase in use has also resulted in an increase in bicyclist and pedestrian injuries. Oregon bicyclist injuries increased from 636 in 2007 to 877 in 2010, a 40.1 percent increase. According to the 2010 Intercept Bicycle Helmet Use Observational Study, 41 percent of middle school students were observed to have no helmet present. Percent of helmet use by children was 57 percent in 2010. The ODOT-TSD goal is to reduce the number of bicyclists' age 0 -- 19 injured in motor vehicle crashes from the 2008 -- 2010 average of 202 to 196 by December 2013. Of the 710 pedestrian/motor vehicle patients injured in the trauma system in 2010, the frequency and rate of pedestrian injuries peaked among patients in the 11-20 year old age group. The ODOT-TSD goal is to decrease fatalities to children under 14 to 38 by 2015. Safe Kids will support these goals and increase efforts to address pedestrian safety.

In 2013, Oregon Safe Kids will promote statewide collaborative efforts in motor vehicle traffic safety. With the decrease in funding available through ODOT -- TSD to support child passenger

safety, the coming year will present challenges and new opportunities. As a CPS Technician, the Safe Kids Oregon Director will be focusing efforts with the local coalitions to assist in maintaining their programs, including those for occupant safety, bicycle safety and pedestrian safety.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	58	60	63	63	64
Annual Indicator	62.1	62.1	63	62.2	62.5
Numerator					
Denominator					
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	64	65	65	65	65

Notes - 2011

Source: Breastfeeding Report Card 2011, National Immunization Survey, CDC. Provisional NIS data available at <http://www.cdc.gov/breastfeeding/pdf/2011BreastfeedingReportCard.pdf>. The 2011 report is for the 2008 births. Numerator and denominator values remain unavailable.

Data from the 2011 Breastfeeding Report Card (2008 birth cohort) finds that Oregon women breastfeed their infants to the age of 6 months at rates that exceed those of other states, and surpass the national rate (44.3%) and the breastfeeding goals outlined in Healthy People 2020 (60.6%).

Breastfeeding rates among Oregon women enrolled in the WIC program mirror Oregon's position as a top state for breastfeeding. Data from the 2011 Pediatric Nutrition Surveillance Survey finds that 91.2% of Oregon WIC mothers initiate breastfeeding compared to 63.2% of WIC participants nationally. Likewise, 42.3% of Oregon WIC mothers breastfed at six months, a rate lower than the general Oregon population but still significantly higher than the WIC national average of 25%.

Note: The WIC national average is for year 2010 data.

Note: NIS data will be continued to be used for 2012 data and onward for comparability across states.

Notes - 2010

Source: CDC-Breastfeeding Report Card 2010, available at <http://www.cdc.gov/breastfeeding/data/reportcard2.htm>. Numerator and denominator values remain unavailable.

Data for the 2010 and 2009 Report Cards are considered provisional (references: <http://www.cdc.gov/breastfeeding/pdf/BreastfeedingReportCard2010.pdf> and <http://www.cdc.gov/breastfeeding/data/reportcard.htm#OutcomeIndicators>)

In 2010, 62.2 % of infants were breastfed for at least 6 months and 91.5% were ever breastfed; the high breastfeeding prevalence puts Oregon above the Healthy People 2010 objective of 50% (reference: <http://www.cdc.gov/breastfeeding/pdf/BreastfeedingReportCard2010.pdf> .

Notes - 2009

Source: CDC - Breast Feeding Report Card, www.CDC.gov/breastfeeding/data.

a. Last Year's Accomplishments

Oregon continues to have among the highest breastfeeding rates in the U.S. The CDC Breastfeeding Report Card demonstrates that Oregon exceeds the national average for all indicators. (<http://www.cdc.gov/breastfeeding/data/reportcard.htm>)

The Office of Family Health's (OFH) "Breastfeeding Think Tank" continued promotion and distribution of the Surgeon General's Call to Action to Support Breastfeeding, and the Breastfeeding Mother Friendly Employer project. The Breastfeeding Coordinator in OFH provided updated breastfeeding information in the Newborn Handbook, utilized the statewide SafeNet hotline to track breastfeeding questions, and participated in World Breastfeeding Week.

The breastfeeding pages on the Public Health website were updated to improve user-friendliness. Collaboration continued with the Department of Medical Assistance Programs (DMAP -- Oregon's Medicaid Agency) to assess lactation services and care offered through their contractor programs. OFH Nutrition Consultant staff continued involvement with the Breastfeeding Coalition of Oregon and participated in their regional and state meetings as well as participated in Oregon Hospitals Partnering for Evidence-based Infant Nutrition Summit.

The MCH Nutrition Consultant served on two child care grant projects with outside partners, providing technical expertise about breastfeeding support and child care. Also the state and local Child Health Collaborative project that focuses on healthy weight and development birth to eight years of age included breastfeeding as part of the overall strategic plan. Partnerships were established with the Healthy Communities program to engage in work related to breastfeeding support and accommodation. As part of the CDC Communities Putting Prevention to Work grant, Wellness at Work, expertise for an online breastfeeding module was provided.

The law, Employee Rest Periods for Expression of Breast Milk (ORS 653.077), has been in effect since January 1, 2008. This law in conjunction with the federal law covers most of the Oregon workforce. Partnership with the Bureau of Labor and Industries continues in order to implement the law. Support is provided to mothers and employers needing help to implement the law and WIC has developed material to inform all women about the law.

OFH continued to promote the 1999 Executive Order/SB 744, which affirms a women's right to breastfeed in public. Business cards explaining the law continue to be available in English and Spanish.

WIC continued to promote and support a breastfeeding pump project which includes provision of pumps and provider training. WIC encourages and supports local staff to receive their International Board Certified Lactation Consultant credential. WIC received Breastfeeding Performance Awards for high breastfeeding rates which were used to support all local agencies in media outreach as well as fund a competitive grant process to enable local agencies to address strategies in the Surgeon General's Call to Action to Support Breastfeeding.

TANF (Temporary Assistance for Needy Families) and WIC partnership continues to support working breastfeeding mothers. TANF continued to implement their breastfeeding policy that assures mothers are encouraged to breastfeed and are referred for services especially WIC. Every new TANF employee continues be trained on the importance of breastfeeding and the policy.

Public health nurses provide anticipatory guidance, health education, assessment and support for parents after birth to assure and support optimal health through breastfeeding for clients enrolled in Maternity Case Management and Babies First.

OFH is continuing efforts to improve data quality from breastfeeding surveillance by monitoring NIS data, PRAMS and PRAMS-2 data, and WIC data to determine breastfeeding initiation, duration, and exclusivity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Breastfeeding surveillance includes state level data from PRAMS and PRAMS-2				X
2. Resources and technical assistance provided to women and employers through the Oregon Breastfeeding Mother Friendly Employer project to assure breastfeeding support in the workplace			X	
3. Continue to implement the Governor's 1999 Executive Order requires all state agencies have a location for breastfeeding				X
4. Breastfeeding education and resources provided through the Newborn Handbook which is distributed through community partners to all pregnant women and new mothers				X
5. WIC, Perinatal, and home visiting programs provide education, support & referrals to all pregnant women about benefits, legal protections and available resources for breastfeeding		X	X	X
6. Support and collaborate with Breastfeeding Coalition of Oregon			X	X
7. Engage partnerships to support population-based planning and policy development that promotes, protects and supports breastfeeding, in work place and child care settings			X	X
8. Provide technical assistance and collaboration in the implementation of rest periods for expression of milk law (ORS 653.077)				X
9. Collaborate with TANF/WIC supporting working mothers		X	X	X
10.				

b. Current Activities

The MCH Nutrition Consultant is providing technical expertise for two grant projects with outside partners, about breastfeeding promotion and support in child care, and engagement with the child care workforce about best practices related to breastfeeding. Promotion and technical assistance of worksite support for the breast milk expression and return to work law (ORS 653.077) in partnership with Healthy Communities, Wellness and Work, and the Bureau of Labor and Industries will continue. Provide support to Breastfeeding Coalition of Oregon in promotion and support of activities, including speaking at the annual conference. Promote the Oregon Breastfeeding Mother Friendly Employer program, and through Wellness at Work. Continue to engage the Child Health Collaborative around healthy weight and development to include breastfeeding promotion and support action steps.

Continue dialogues with DMAP about increasing coverage for lactation care and services through Oregon Health Plan programs in order to provide breastfeeding support for all low-income women.

WIC supports all local agencies in media outreach about breastfeeding successes as well as fund 23 local agencies in a competitive grant process to address four strategies in the Surgeon General's Call to Action to Support Breastfeeding. The four strategies include local coalition development, baby friendly initiatives, lactation support at work, and breastfeeding friendly child care.

c. Plan for the Coming Year

The Breastfeeding "Think Tank" of the Office of Family health will continue work on improving breastfeeding initiation and duration rates by implementing activities that raise awareness, provide breastfeeding education, improve breastfeeding web presence, continue worksite wellness breastfeeding support effort, address maternity care practices in hospitals, promote National Breastfeeding Week and promote Surgeon General's Call to Action to Support Breastfeeding. Implementation of the Child Health Collaborative healthy weight and development plan will continue.

To continue to implement ORS 653.077, breastfeeding support pieces will continue to be distributed and promoted using HRSA's "Business Case for Breastfeeding" and "Oregon's Breastfeeding Friendly Employer Project."

The WIC breastfeeding pump project, peer counselor project, Fathers Supporting Breastfeeding, implementation of project recommendations of TANF population, and implementation of local agency performance awards will continue.

Continue to develop assessment, planning, and implementation of breastfeeding policies for the Division of Medical Assistance Programs (DMAP/Medicaid) perinatal regulations.

OFH will continue to partner with the Oregon Public Health Institute, Breastfeeding Coalition of Oregon, Nursing Mother's Council, and Oregon Department of Education, and serve on advisory councils addressing child care environments, specific to breastfeeding support.

Maternity Case Management and Babies First nurse home visiting programs will support public health nurse practice guidelines for breastfeeding support at the population-based individual level of practice based on nursing standards.

Continue education for health professionals in breastfeeding management across the state for a three-day Breastfeeding Basics course, a five-day Advanced Breastfeeding course and sponsorship of WIC staff to take the International Board of Lactation Consultants Exam.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	99.7	99.5	99.5	99.5	99.5
Annual Indicator	97.6	96.4	93.4	93.3	93.3
Numerator	48205	46455	44845	42697	42292
Denominator	49373	48190	47999	45786	45341
Data Source		EHDI and Oregon Center for Health Statistics			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	99.5	99.5	99.5	99.5	99.5

Notes - 2011

Source: Oregon Vital Events Registration System (OVERS) - Center for Health Statistics (CHS). The preliminary 2011 data (as of March 2012) is from the OVERS EHDI tracking system. The denominator is all Oregon births, including those that occurred outside the hospital setting. The numerator is the number of infants who received a hearing screen within the first 30 days of life.

The 2010 data was reviewed and updated to be consistent with reporting methods for 2011 data, and is the final data that was sent to CDC on February 2012. Starting in 2010 the numerator is all infants with a completed screening within the first 30 days of life (not all infants screened were born in the hospital setting) and the denominator is all Oregon births.

Comparisons before 2010 are limited due to the change in data system. Beginning in 2010 the data includes all births, not just hospital births. This results in a lower overall screening rate since out-of-hospital births have a lower screening rate than hospital births. Data in 2010 and 2011 held steady at 93.3% of all Oregon infants receiving a newborn hearing screen within the first 30 days of life.

Notes - 2010

Source: Oregon Vital Events Registration System (OVERS) - Center for Health Statistics (CHS). Denominator: in 2008 and 2009 is defined as all births (including still born and births born out of

state); starting in 2010 is defined as births with Oregon as mom's resident state following predefined definition from CHS.

Screening data (numerator) is defined as screenings completed before being discharged from the hospital and 8 hrs after delivery, and screenings result submitted to EHDI program within 10 days from the screening date.

2009 data reviewed and corrected (screening prevalence revised from 93.4% to 94.4%). However, data issue still exist with 2009 data – such as 15% duplication of data, and missing data related to inability to match all screening data from Hi-track with births data and vice versa.

2010 data are from a pilot to test the implementation of OVERS involving 6 hospitals from Jan.- June 2010; Jan-June data from Hi-Track (EHDI's old tracking system); and July-Dec 2010 data from OVERS. Due to the multiple ways in which 2010 data was obtained, and implementation of the new EHDI tracking system (OVERS) in 2010, comparison across years is limited until year 2011.

Provisional 2008-2010 data indicates an increasing trend in new born hearing screening.

Notes - 2009

2007 -2009 data: numerator: Early Hearing Detection and Intervention Program (EHDI)

For 2009, 93.4% of newborns in Oregon were screened for hearing before hospital discharge. This shows a decrease from 2008 (96.4%). The decrease is probably more of a data issue due to EHDI's tracking system (used up to 2009) that may have contributed to the numerator being under counted. Comparison across years is limited due to lack of information on how the numerator and denominator were defined in 2007 and earlier.

As of June 2010 EHDI is no longer using Hi-Track and has switched to using the Vital Statistics (Oregon Center for Health Statistics) tracking system which should result in more accurate numbers starting in 2010.

a. Last Year's Accomplishments

The Office of Family Health (OFH), Early Hearing Detection and Intervention (EHDI) Program, in collaboration with the Newborn Hearing Advisory Committee and other partners, continued to strive to assure that all Oregon births are screened by one month, infants needing diagnostic evaluation are seen by three months, and children diagnosed with hearing loss receive early intervention by six months. EHDI monitored and tracked newborn hearing status for Oregon births, provided technical assistance and support to hospital newborn screening programs, diagnostic centers and early intervention providers, educated families about the importance of hearing screening, mobilized partnerships to address gaps in the EHDI system, developed policies and plans, and evaluated our effectiveness in assuring early identification and intervention for children with hearing loss.

Following the successful transition in July 2010 to a web-based surveillance system based on the Oregon Birth Certificate Registry, Oregon EHDI continued to monitor status and performed follow-up for any infant at risk of missing the 1-3-6 milestones. EHDI supported excellence in screening and reporting through on-going technical assistance and annual trainings for hospital screening staff, audiologists and other partners. EHDI provided trainings and workshops with information on best practices and an overview of Oregon's protocols for screening, diagnosis, and reporting.

EHDI partnered with Hands & Voices of Oregon to assure a Parent-to-Parent mentoring program for parents who have newly identified children with hearing loss. Upon diagnosis of loss, Parent Guides contacted families and provided information, support, and linkages to community programs. Parent guides also performed follow-up phone calls for children at risk of not meeting the three month diagnostic audiology milestone.

EHDI continued to partner with Portland State University and a local birth center to provide free hearing screening for out of hospital births.

The EHDI Program disseminated informational brochures and resources for providers, partners and families.

EHDI staff made a number of presentations to health care providers, local public health departments and Early Intervention staff about the program and opportunities to collaborate and work together more effectively.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement laws requiring all hospitals with 200 or more annual births to conduct newborn hearing tests (ORS 433.321)			X	X
2. Newborn data linking project includes diagnostic and early intervention data for children				X
3. Public education materials, such as the Perinatal Resource Guide and Newborn Handbook, provide information about hearing screening			X	X
4. Advocacy for policies and legislation to assure screening and referral access for all newborns				X
5. Technical assistance and consultation to screening and diagnostic facilities				X
6. Parent-to-Parent Support program for families of newly identified children with hearing loss		X		
7. Free Hearing Screening Clinics for out-of-hospital births.	X	X		
8. Established Diagnostic Testing Facilities and Auditory Brainstem Response diagnostic training		X	X	
9.				
10.				

b. Current Activities

The EHDI Program hosted the annual hospital newborn hearing screening workshop in November 2011, and a follow-up webinar in May 2012.

The Program also conducted outreach to midwives to promote hearing screening, including emails, providing electronic brochures, and two presentations to the Oregon Midwifery Council.

Revisions and improvements to the EHDI Information System includes adding a public health nurse tab, the Guide By Your Side tab, National Early Childhood Assessment Project (NECAP) data, task lists, the automated letter module, implementation of new hearing loss levels for degree of loss, incorporating early intervention data, and improvements related to the EHDI-EI pilot. An evaluation of Guide By Your Side Program data was conducted, which is leading to subsequent improvements to data collection and training based on findings;

EHDI initiated Medicaid data matching project to evaluate use of Medicaid data for reducing loss to follow-up and identifying medical home provider;

Early Intervention (Part C) and EHDI are discussing ways to include enhanced data sharing, transparency, communication, and partnership opportunities;

c. Plan for the Coming Year

Oregon EHDI will continue to advance program efforts to assure that children with hearing loss are identified early and that we have a robust, coordinated system of care for children identified with hearing loss. Key focus areas are: enhance partnership with midwives to improve screening rates, reduce loss to diagnostic follow-up rate, revise the Memorandum of Agreement with Early Intervention (Part C) and continue efforts to improve the referral and reporting process, support EI providers with best practice knowledge to support a family's choice of communication mode, improve coordination with ENTs, and connect to medical homes.

EHDI will continue to follow-up strategies, including letters to parents, public health nurse efforts, and parent mentor phone calls for all infants at risk of not meeting the National 1-3-6 milestones. Efforts will continue to reduce loss to follow-up in regions with highest economic and geographical barriers.

Advance adoption of best practices in systems of care for children who are deaf or hard of hearing, though mobilizing partnerships among government leaders, community experts and families of children with a hearing loss.

Collaborate with the BEST project through the University of Oregon to test methods of improvement to the statewide EI referral system.

The Oregon EHDI Program is participating in the National Early Childhood Assessment Project.

A training plan will be developed to strengthen connection with the medical home community, including increasing representation on the EHDI Advisory Board and communicating EHDI data through the Immunization ALERT system.

Develop and implement a decision support tool algorithm that provides individualized information to determine appropriate follow-up facility for EHDI stakeholders to direct families.

The EHDI program is continuing a pilot of direct audiology referral process to Early Intervention services.

Oregon EHDI will participate in the "Improving Hearing Screening & Intervention Systems Learning Collaborative".

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	12	12	12	11	11.5
Annual Indicator	12.2	12.2	11.6	11.9	10.4
Numerator	104057	104057	102720	105205	90105
Denominator	854842	854842	885516	884078	866397
Data Source		Natl. Survey Child. Health	CPS and OPRC	CPS and OPRC	CPS and OPRC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	10	10	9	8	8

Notes - 2011

Source: Percentage of children without insurance is from U.S. Census Bureau, Current Population Survey, 2011 Annual Social and Economic Supplement, Table HI05, at: <http://www.census.gov/hhes/www/cpstables/032011/health/toc.htm>. Denominator: 2011 Oregon Population Report (PSU) for 0-17 years old. Number uninsured (numerator) was computed from indicator data point and denominator. Note: CPS data are reported for age group 0-17 years old.

There appears to be a decreasing trend in percentage of children without any kinds of health insurance throughout the years.

Notes - 2010

Indicator: U.S. Census Current Population Survey (2010 Annual Social and Economic Supplement), Table HI05: Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2009. Available at http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm.

Denominator: 2010 Oregon Population Report (PSU) for 0-17 years old. Numerator was calculated using percent from CPS and estimated population from OPR. CPS defines children as “under 18 years” old.

Beginning 2009 uninsured data for children 0-18 years old is no longer available from Oregon Health Insurance Survey, so data from U.S. Census (i.e.: CPS) are reported for years 2009 and 2010. Please note the CPS survey year 2009 is for data year 2008, and CPS survey year 2010 is for data year 2009; however, the CPS survey year is used to report data here.

Since 2007, there is a decreasing trend in percentage of children without any kinds of health insurance throughout the years.

Notes - 2009

Sources: Percentage of children without insurance (indicator point) is from Current Population Survey (2009 Annual Social and Economic Supplement) (CPS), at: www.census.gov/hhes/www/cpstables/032009/health/h05_000.htm. Denominator = Population estimates of 0-17 years old from Oregon Annual Population Report (OPR), PSU. Numerator was derived with data from CPS and OPR. Note: In CPS children are defined as <= 18 yrs old.

Any trends or differences between years should be interpreted with caution. Variability in the data sources could contribute to differences.

a. Last Year's Accomplishments

As of September 30, 2011, a total of 363,474 children were enrolled in Medicaid or the Children's Health Insurance Program (CHIP), known collectively in Oregon as the Healthy Kids Program. In December 2010, Oregon was awarded a federal performance bonus based on enhancements that streamline enrollment for children and a Medicaid enrollment increase of 19% over the 2010 baseline. The enhancements included 12 month continuous eligibility, elimination of asset tests for most children, a shortened un-insurance period of 2 months, expanded income limits for children from 185% to 200% FPL, expanded Medicaid and CHIP eligibility to documented immigrant children who have been in the US for fewer than 5 years, and premium assistance on a

sliding scale for children in families with incomes from 200% to 300% FPL. In addition, Express Lane Eligibility was initiated with the Supplemental Nutrition Assistance Program (SNAP). July 2011, the Oregon Health Authority announced findings from the Oregon Health Insurance Survey indicating that the child uninsured rate has dropped from 11.3% in 2009 to 5.6% in 2011.

Since 2009, the Office of Healthy Kids (OHK) within the Oregon Health Authority has spearheaded the effort to reach, enroll, and retain eligible children in coverage through outreach support, administrative policy changes, and marketing campaigns.

Outreach activities include:

- partners throughout the state working to reach and enroll eligible children;
- a statewide media campaign, including transit wraps, bus benches, billboards, theatre ads, newspaper and radio promotions, and through social media such as Facebook, Twitter, and YouTube;
- revision of the insurance application available in seven or more languages;
- training for enrollment assisters and partners, retraining of State eligibility workers and staff; and
- contracts with individuals and community based organizations to assist families in applying for coverage.

Title V funded programs and services assure that clients and families are informed about health insurance coverage options, and assist families with referrals and application assistance as needed. Efforts include:

- Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) Community Connections Network multidisciplinary teams assist uninsured children with special health needs access, enrollment in health insurance, and referrals to benefit counseling.
- Public health nurse home visiting services in Maternity Care Management (MCM), Babies First!, and CaCoon (Care Coordination) assess a child's insurance status and help families access and enroll in health insurance programs. Once enrolled, PHNs continue to assist families in the coordination of a child's care and in navigating the system of care.
- OCCYSHN disseminates information around health insurance and related legislation to health care providers, public health nurses, community service providers and families across the state.
- Oregon School-Based Health Centers offer a variety of OHP enrollment programs based on local resources, including school-based outreach workers and health department employees that facilitate bilingual and expedient enrollment.
- Oregon MothersCare (OMC), a statewide initiative to improve access to early prenatal care, provided services in most counties in an effort to link women to health insurance enrollment and health care providers. Both unborn and born children benefit from the assistance provided through the OMC initiative.
- OFH's Immunizations Program partnered with OHK to produce a postcard mailing about health insurance coverage.
- WIC has initiated efforts to partner with OHK for outreach and referrals to application assisters.

OFH was the recipient of a two year grant through CMS to support 6 safety net provider grantees working in 15 counties to reach and enroll citizen children of mixed status families. From April 2010 to September 2011, 6,072 target children were enrolled into coverage as a result of the project. During this time, state Title V staff conducted bi-monthly conference calls and focus group interviews with three grantees to better understand the complexity of barriers that families face in accessing health insurance coverage for their children and the myriad of services and supports provided by our grantees that surmounted those barriers. The project was presented at the Western MCH Epidemiology Conference in 2011.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Outreach and application assistance through local health department programs and home visiting programs		X	X	
2. Information and referral through toll-free number, SafeNet.		X	X	
3. Coordination and collaboration in MCH programs to simplify application.				X
4. Policy advocacy to sustain eligibility levels for Oregon Health Plan for children 0-18.				X
5. Collaboration to strengthen early childhood linkages with healthcare coverage initiatives.				X
6. Policy advocacy to maximize third party reimbursement for developmental screening, assessment, promotion and prevention services, and care coordination.				X
7. Oregon Title V MCH programs promote universal comprehensive insurance and healthcare for expectant parents, children, adolescents, children and youth with special health needs, and their families				X
8.				
9.				
10.				

b. Current Activities

Title V staff continue to participate in quarterly Oregon Healthy Kids (OHK) Advisory Committee meetings, and cross-agency Healthy Kids Evaluation Workgroup meetings. Staff identify collaborative and coordination opportunities with OHK.

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

The Office of Family Health received a no-cost extension from CMS to continue to support outreach and enrollment to citizen and legal resident children of mixed status families. From October 2011 to March 2012, an additional 1,013 target children were enrolled into coverage as a result of project efforts. Grantees have dedicated funding for community health workers to provide culturally and linguistically appropriate outreach and enrollment services targeted to eligible children from mixed status and undocumented families until December 30, 2012. State Title V staff continues to host bi-monthly conference calls with grantees, and are currently working to create a series of communication pieces to illustrate the importance and effectiveness of the project in an effort to identify sustainable support. An abstract for the project has been accepted for poster presentation at Academy Health Annual Research meeting in June 2012.

c. Plan for the Coming Year

Oregon continues to develop strategies for marketing, outreach, and enrollment, as well as strategies to improve the State systems.

Local Title V funded maternal and child health programs and services will continue to assure that clients and families are informed about health insurance coverage options, and assist families with referrals and application assistance as needed. They will continue to work with community partners and stakeholders to assure awareness of the Healthy Kids Program.

OFH will continue cross-office collaborations to promote universal comprehensive insurance and healthcare for MCH populations through programs, policy development, collaborative leadership, and other activities across state and local programs.

State Title V staff will continue to participate in monthly Healthy Kids Advisory Committee meetings and cross-office Healthy Kids Evaluation Workgroup meetings, as feasible.

Efforts will continue to secure additional funding and support for community health workers to provide culturally and linguistically appropriate outreach and enrollment services in targeted communities. The evaluation of the CHIPRA outreach and enrollment project will be completed by OFH staff and findings disseminated through presentations and publications. An abstract for the project has been accepted for poster presentation at American Public Health Association meeting in October 2012.

OFH will continue to collaborate with the Office of Healthy Kids and their Targeted Outreach Grantees, and seek opportunities to promote healthcare for all MCH populations in Oregon.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	33	33	32	32	31
Annual Indicator	32.1	32.3	32.8	32.8	32.4
Numerator	14613	15638	17290	17761	17598
Denominator	45525	48415	52713	54150	54316
Data Source		WIC	WIC	WIC	PedNSS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	30	30	30	30	30

Notes - 2011

Source: The 2011 calendar year (final) data are from the national Pediatric Nutrition Surveillance System (PedNSS), CDC. The prevalence (32.4%) is a summation of the percentages of overweight (17.5%) and obese (14.9%).

The percentage of children between 24 and 59 months of age, who were classified as overweight (17.5%) or obese (14.9%) has remained fairly stable in the last several years, with 32.4% of Oregon WIC being placed in one of these two weight categories. The Oregon WIC program's rate of childhood overweight is slightly higher than the national WIC rate of 30.5%.

Notes: The PedNSS and Pregnancy Surveillance System (PNSS) are potentially going away, and the real-time WIC database called TWIST will be used to provide data for WIC related measures. Relevant procedures from PedNSS and PNSS will be used to clean and report TWIST data. Data will no longer be comparable with other states due to difference in methodology across states. Up to 2011, data from TWIST were submitted to CDC to be cleaned and reported back to the WIC program; this direct support will no longer be available beginning 2012.

Notes - 2010

Source: WIC, Public Health Division. Based on data reported to the Pediatric Nutrition Surveillance System (PedNSS). Based on calendar year for 2010 data and previous years data.

In keeping with the national trend, the percentage of Oregon WIC participants between the ages of 2-5 years classified as overweight has stabilized. As slightly less than one-third of Oregon WIC preschoolers have a BMI above the 85th percentile, Oregon ranks 37th (worst) out of 55 state and territorial WIC programs.

Notes - 2009

Nearly a third of Oregon WIC clients between the ages of 2-5 years have a BMI above the 85th percentile. Compared with other states for the most recent data reported in TVIS (primarily 2008), Oregon’s percentage is among the highest (worse) half of states

a. Last Year's Accomplishments

The FFY 2010-2011 Oregon WIC Program Nutrition Education Plan was designed to support and promote a comprehensive approach in the delivery of WIC services. This structure involved a three-year strategy focusing on quality nutrition services and enhanced participant centered services to improve the health outcomes for all WIC participants. The plan reflects the Value Enhanced Nutrition Assessment (VENA) philosophy and continued to support breastfeeding promotion, the Nutrition Services Standards and MCH Title V National Performance Measures.

As part of the FFY 2010-2011 NE Plan, local agency WIC staff completed the new eLearning online Child Nutrition course to increase the understanding of the factors influencing health outcomes for the WIC population.

WIC continued to partner with other USDA Food and Nutrition Services programs through the Supplemental Nutritional Assistance Program (SNAP) to plan and implement physical activity and fruit and vegetable promotions. WIC partnered with the Nutrition Council of Oregon Nutrition Education Subcommittee and is involved with their Family Meals initiative.

Local WIC agencies continued to distribute the Sesame Workshop Healthy Habits for Life kits to WIC families in Oregon. These kits were also shared with other programs including Head Start and the First Tooth project to reach additional families. Local agencies had the opportunity to distribute children's educational materials from the Texas WIC Program that are designed to promote healthy eating and physical activity. WIC participants were able to access online nutrition education courses on a variety of topics including ways to increase fruit and vegetable consumption and physical activity.

WIC developed participant-centered group sessions and resources on Infant Feeding Cues and Screen Time Awareness. These materials were shared with local agencies across the state during regional training sessions.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess and monitor weight status for all WIC clients between 2-5 years of age	X	X		
2. Provide counseling to all parents on ways to promote healthy weight in families; refer clients at highest risk to Registered Dietitians, their own medical provider and/or other resources in the community.	X	X		
3. Collaborate with state nutrition programs and groups in identifying best practices for promoting healthy weight in families across Oregon using a Life course approach.		X	X	X
4. Improve the health outcomes of clients in the local agency service delivery areas through technical assistance and training for implementation of local Nutrition Education Plans			X	X

5. Promote and support a participant-centered approach when working with WIC families to identify their concerns and priorities around addressing and preventing overweight in children.	X	X		
6. Develop a Three Year Breastfeeding Strategic Plan for the Oregon WIC Program.				X
7.				
8.				
9.				
10.				

b. Current Activities

The FFY 2011-2012 Oregon WIC Program Nutrition Education Plan focuses on enhancing breastfeeding education, promotion and support by incorporating specific participant centered skills and strategies in breastfeeding counseling.

WIC is partnering with the Supplemental Nutritional Assistance Program (SNAP) program to plan and implement physical activity and fruit and vegetable promotion. The WIC Breastfeeding Peer Counseling (BFPC) expanded to 11 agencies with the potential to reach about 60% of pregnant women in WIC. The state WIC program received a Breastfeeding Bonus award funds from USDA in recognition of Oregon's high rates of exclusive breastfeeding. The award was distributed as a one-time Breastfeeding Bonus Award to all local agencies to for breastfeeding promotion efforts. In addition, 22 breastfeeding support projects were funded through a competitive grant process targeting WIC and Healthy Communities Coalitions, using the Surgeon General's Call to Action to Support Breastfeeding as guidance. The remaining bonus funds will expand the Farm Direct Nutrition Program to provide benefits for all eligible WIC participants and will be used to develop a three-year strategic plan for breastfeeding support.

WIC is part of the Office of Family Health Child Health Collaborative Obesity Workgroup and assisted with the development of the action plan. WIC has identified new concepts in infant feeding and development which will be incorporated into staff training materials

c. Plan for the Coming Year

The FFY 2012-2013 Oregon WIC Program Nutrition Education Plan is designed to support and promote a comprehensive approach in the delivery of WIC services. This structure involves a three-year strategy focusing on providing quality nutrition services and enhancing participant centered services. The multi-year plan will reflect the Value Enhanced Nutrition Assessment (VENA) philosophy and continue to support Breastfeeding Promotion, the Nutrition Services Standards and MCH Title V National Performance Measures.

The focus of the Nutrition Education Plan will include developing community partnerships with other organizations, providing health promotion and support. Activities involve updating relevant referrals in the community and identifying partners to strengthen collaborations. The intent is to improve the health outcomes for WIC families in Oregon.

WIC will continue to work as a partner with other USDA FNS programs through the Supplemental Nutritional Assistance Program (SNAP) collaboration. WIC will continue to partner with the Nutrition Council of Oregon Nutrition Education subcommittee Family Meals initiative.

WIC will continue to work with the Office of Family Health Child Health Collaborative Obesity Workgroup in planning and developing activities. As of July, 2012, all the chronic disease and MCH obesity and healthy weight work will be merged under the Center for Prevention and Health Promotion and most of the staff on the Workgroup will be in the same office, under the Title V Director.

WIC plans to incorporate the new nutrition messages from FNS supporting the 2010 Dietary Guidelines and My Plate into resources for WIC families.

WIC plans to review the Institute of Medicine recommendations, strategies and actions steps for preventing obesity to determine which ones may be implemented in local WIC agencies.

WIC will implement a three-year Breastfeeding Strategic Plan.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	12	10	10	11	11.8
Annual Indicator	10.3	11.1	12.1	10.1	10.1
Numerator	4883	5225	5412	4376	4376
Denominator	47614	46882	44579	43266	43266
Data Source		PRAMS	PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	10	10	10	9	9

Notes - 2011

Source: PRAMS weighted (final) 2010 data – from the most currently available PRAMS survey. There is no 2011 PRAMS survey yet, so 2010 data carried over.

The 2010 PRAMS data showed that the percentage of women who smoke in the last three months of pregnancy has went down after 2008 (11.2%) to what was observed in 2007 (10.3%).

Notes - 2010

Source: PRAMS weighted 2009 data. 2010 PRAMS unavailable, 2009 carried forward -- the most currently available PRAMS survey.

Preliminary 2009 PRAMS data showed that the percentage of women who smoke in the last three months of pregnancy has gone up after 2008 to what was observed in 2005 (12.1%).

Notes - 2009

After declines from 2005 to 2007, 2008 data shows a slight rise (11.1%) from 10.3% in 2007.

2009 not yet available, 2008 data carried forward.

a. Last Year's Accomplishments

The Perinatal Health Program continued cessation screening and counseling in county services for family planning, prenatal care and Maternity Case Management (MCM), nurse home visiting for high risk infants, and WIC. The 5-As brief intervention for smoking cessation is now a required component of the Maternity Case Management (MCM) program and is included in the current

MCM Oregon Administrative Rules, OAR 410-130-0595. All MCM programs receive training and technical assistance in conducting the 5-As. Local public health nurses around the state delivered tobacco education and 5-A's quitting support to pregnant women through home visiting maternity case management visits.

PRAMS and PRAMS 2 collected and analyzed surveillance data on tobacco use in pregnant women as well as mothers with a 2-year-olds.

The Office of Family Health, MCH Program, worked with the Office of Disease Prevention and Epidemiology on an ARA grant (The Tobacco Control Improvement Project) to ensure that cessation messages are included in all MCH materials that clients receive. This includes print and electronic media. Tobacco messages were included in WiseWomen Screening Materials, Oregon MothersCare materials, and on the Oregon MothersCare website. The Oregon Tobacco Quitline provided a special protocol to assist pregnant women to quit smoking. The service includes a stage-appropriate Quit Guide with specialized materials for Hispanic/Latino, pregnant women, smokeless tobacco users, youth, and proxies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide training and technical assistance to local Maternity Case Management (MCM) providers on the Five A's Intervention and motivational interviewing for pregnant women.		X		X
2. Strategic planning for sustaining outreach to private prenatal care and other services to screen clients and implement 5 A's cessation practice				X
3. Health education and social marketing about smoking during pregnancy through Family Planning, maternity case management, and Babies First home visiting program services			X	
4. Screening and referral in Babies First, maternity case management, WIC and Family Planning client services		X		
5. PRAMS-2 (2-year old PRAMS follow up) data surveillance to assess prevalence of tobacco use during the postpartum period and up to two years after the infant's birth.				X
6. ORCHIDS (Oregon Child Health Information Data System) state and local level data reports on reported tobacco exposure during pregnancy and home visitor interventions to evaluate trends and level of intervention provided in MCH programs.				X
7. Increase collaborative activities between MCH programs and Oregon Tobacco Control Program				X
8. Develop strategies and activities regarding pregnant women as a priority population for Oregon Public Health Tobacco Priority.			X	X
9.				
10.				

b. Current Activities

Cessation screening and counseling are continuing to be offered through county services for clients of family planning, prenatal care, and nurse home visiting for high risk infants, WiseWomen, and WIC. Partnerships will continue with Oregon's Medicaid agency, Division of Medical Assistance Program (DMAP), local providers and agencies to train and educate providers about perinatal tobacco issues and the 5 A's protocol for smoking cessation in local MCM and perinatal care services.

Surveillance of perinatal tobacco use and cessation continues through PRAMS and PRAMS 2 surveys.

Monitoring and evaluation of county client data reports from ORCHIDS county client database is being used to provide quality improvement for nurse home visiting services related to tobacco use in pregnancy, and to plan future programming by state and local partners.

The Oregon Tobacco Quitline continues to provide a special protocol to assist pregnant women to quit smoking. The service includes a stage-appropriate Quit Guide with specialized materials for Hispanic/Latino, pregnant women, smokeless tobacco users, youth, and proxies.

c. Plan for the Coming Year

Partnerships will continue with Oregon's Medicaid agency, Division of Medical Assistance Program (DMAP), local providers and agencies to train and educate providers about perinatal tobacco issues and the 5 A's protocol for smoking cessation in local MCM and perinatal care services.

Cessation screening and counseling will continue in county services for family planning, Oregon MothersCare Services, prenatal care and Maternity Case Management, Babies First nurse home visiting for high risk infants, and WIC Programs. OFH will also assess children's exposure to second and third hand smoke, with associated counseling and referrals as appropriate.

Tobacco Control has become a primary priority throughout the entire Public Health Division. It is expected that the MCH Program will become more involved in tobacco control policies that affect the MCH populations over the coming year. Through reorganizations and strategic planning, the program is poised to work closer with Oregon's Tobacco Control Program. In addition, reduction of tobacco use in pregnant women and women planning to be pregnant (18-25) are included as a specific priority measure throughout the Public Health Division.

Evaluation of county client data reports from ORCHIDS client data system will improve surveillance and monitoring on tobacco exposure during pregnancy and provider interventions. The information will be used by the Perinatal Title V Program to plan for strategies in program services delivered by county health department partners.

Surveillance of perinatal tobacco use and cessation will continue through PRAMS and PRAMS-2.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	7	7.5	9.5	8	7
Annual Indicator	8.4	11.3	6.8	6.7	6.7
Numerator	21	28	17	17	17
Denominator	248780	247556	251785	254860	254860
Data Source		Injury and	Injury and	njury and	njury and

		Violence Prevention Program	Violence Prevention Program	Violence Prevention Program	Violence Prevention Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	6.5	6.5	6.5	6.5	6.5

Notes - 2011

Source: State Injury and Violence Prevention Program, Oregon Violent Death Reporting System, Oregon Health Authority. Year 2010 data is final as of 5/2012. There is 2 years of lag time in reporting data (the 2011 data will be available May 2013), so 2010 data carried over.

The suicide rates vary from one year to another. Overall the suicide rates among ages 15 to 19 have remained at same level since 2004. There is not a statistical difference on the rate between 2008 and 2010. Note: Two to three years of data isn't sufficient to do trend analysis.

Notes - 2010

Source: Injury and Violence Prevention Program, Oregon Violent Death Reporting System for 2008 and 2009 data. Source for preliminary 2010 denominator is 2010 Oregon Annual Population Report (PSU).

2008 data updated and is final. 2009 data entered is final. 2010 count and rate are preliminary.

The suicide rates vary from one year to another. Overall the suicide rates among ages 15 to 19 have remained at same level since 2004. There is not a statistical difference on the rate between 2008 and 2009.

Notes - 2009

Oregon Violent Death Reporting System data. Complete 2009 data not available, 2008 data carried forward.

Suicide deaths among young people aged 15-19 years of age seems to be raising steadily since 2006, reaching a high of 11.3/100,000 in 2008. However, trending should be interpreted with caution due to the 2008 data being provisional and differences in computation for 2007 and earlier. Reliability is also a concern with the population dropping dramatically in 2008 (247, 556) compared to 2007 (248,780).

a. Last Year's Accomplishments

The Youth Suicide Prevention (YSP) program was in year two of grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) for a Garrett Lee Smith Memorial Act Youth Suicide Prevention grant (GLS) during this period. Six counties were added to the GLS grant for years 2 and 3 of the grant, for a total of 20 county sites participating statewide. The program also funded the Confederated Tribes of Umatilla Indians to host a 4-day

summer youth camp and for the Siletz Tribe to hold a conference integrating traditional Native arts and crafts with positive mental health.

In the second year of the GLS grant 15 Oregonians became ASIST trainers and 37 became QPR trainers, for a total of 39 ASIST and 64 QPR trainers trained in the last 2 years, several of whom are bilingual in Spanish. RESPONSE was implemented in over 39 schools. In total, over 5800 Oregonians were trained in suicide prevention awareness and intervention skills through last year's grant project. Since grant inception, approximately 7800 people have received suicide prevention training through our grant, representing 26% of all people trained by the 18 federally funded GLS grantees.

The RESPONSE program was approved for listing on the Suicide Prevention Resource Center's Best Practice Registry. The comprehensive, high-school based program requires schools to develop procedures and guidelines for interacting with suicidal students or in the case of a suicide.

The Youth Suicide Prevention Coordinator (YSPC) collaborated with NARA (Native American Rehabilitation Association) and Oregon tribes on youth suicide prevention activities.

Epidemiologists in Injury Prevention and the Oregon Violent Death Reporting System worked to discover trends and use data to inform planning and activities.

The YSPC attended the Oregon's Child Fatality Review Team bi-annual meetings to provide information on youth suicides and suggest prevention strategies.

A Latino Outreach Project was initiated in April within 5 GLS counties to address suicide prevention within the growing Latino population. Activities included focus groups, interviews, and surveys to assess current attitudes and beliefs about youth suicide prevention, inform future directions, and make recommendations for program activities. Recommendations included training bilingual/bicultural (in Spanish) QPR trainers, training parents and other adults to recognize signs of suicide and be able to get help for their youth; working with parents and youth to increase communication and to bridge the cultural divide between first-generation immigrant parents with American-raised youth; and increasing access to appropriate services. Bicultural/bilingual public mental health professionals worked with youth and parents.

The YSPC facilitated monthly webinars for the county GLS grantees, administered the YSP Network listserv and an ASIST Network listserv for Oregon ASIST trainers. She worked with the Oregon chapter of the National Association of Social Workers to enable Oregon ASIST trainers to offer continuing education credits for ASIST trainings. She also obtained continuing education credits for first responders who take ASIST.

The YSPC made presentations for an Oregon VA conference on suicide prevention, a conference for children's first responders, the annual GLS grantees meeting, and an ASIST trainers' conference. She was a speaker for a national webinar through the Suicide Prevention Resource Center.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Focus state and local efforts on best practice and evidence-based practices described in the State Suicide Prevention Plan.			X	X
2. Provide and facilitate training for providers, counselors, educators, and others on youth suicide prevention strategies.		X	X	X
3. Assess and monitor trends in youth suicides and suicide				X

attempts through surveillance and participation on the State Child Fatality Review Team.				
4. Train school teams to implement RESPONSE in high schools as part of the Garrett Lee Smith Memorial Act (GLS) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA).		X		X
5. Increase capacity in suicide intervention skills training throughout Oregon to crisis responders, clinicians, school staff, parents, and lay people as part of the GLS grant.		X	X	X
6. Encourage and support Bereavement Support activities.				X
7. Provide a medium for exchange of research findings, trainings, collaboration, news, and local events through a statewide listserv.			X	X
8. Educate the media on prevention and provide nationally-developed guidelines to increase safe reporting of high-profile suicides.			X	X
9.				
10.				

b. Current Activities

The findings from the Latino Outreach Projects in five GLS counties are being implemented to increase participation in youth suicide prevention among their Latino populations. Oregon Tribes were funded to host 2 youth summer camps.

Counties offer ASIST and QPR trainings to increase awareness that suicide is preventable and teach skills so that participants will be able to intervene with a suicidal person. They engage new schools in the RESPONSE program and work with schools who have implemented it. They are also building program sustainability into their agency systems and program planning

Data from the Adolescent Suicide Attempt Data System was analyzed and the program epidemiologist wrote a report, Suicide, Suicide Attempts, and Ideation among Adolescents in Oregon that will help us enlist hospitals for follow-up and collaboration. He also developed a new report, Violent Deaths in Oregon: 2010. Both reports help inform our program priorities.

Collaborations with the Adolescent Health Section, the Addictions and Mental Health Division, the Tribal Liaison, the Children and Families Division, and the Oregon Youth Authority support goals to increase awareness about youth suicide prevention and to collaborate on population-based strategies.

The Oregon Public Health Division leadership named suicide prevention as an agency priority for the next 5 years. A two-day Open Space Technology meeting will be held to revise the state Youth Suicide Prevention plan at the end of September.

c. Plan for the Coming Year

Two consecutive GLS grants from SAMHSA have provided \$2.288 million in funding for youth suicide prevention in Oregon since 2005; that funding ends September 2012 and we will not have another opportunity to apply until 2014. The YSPC is funded through state general funds so the position will remain, but with little funding. Regardless, work with counties will continue with webinars, the YSP Network listserv, the ASIST trainer listserv, program collaboration, sharing resources and other means as possible. Technical support will be provided to QPR and ASIST trainers with data, brochures, CEUs, resources and other means.

The YSP plans to work with hospitals to encourage follow-up with youth who made suicide

attempts; assist professionals to counsel patients and parents about removing access to lethal means; and develop a training to demonstrate the relationships between suicide and alcohol and drug use.

The reorganization of the Public Health Division will provide new opportunities to broaden the focus of the YSP to upstream prevention by protecting youth and families from numerous high risk factors such as child maltreatment, family violence, onset of depression, disruptive school behaviors, alcohol and drug use, and others. A CDC injury prevention grant will support work on child maltreatment; the Adolescent Health program is engaged in work on positive youth development; and the MCH program has a large grant to implement the Nurse Family Partnership program. These efforts present a life course approach to preventing youth suicide.

The injury epidemiologist who works on the Oregon Violent Death Reporting System will continue to provide meaningful data and reports to inform suicide prevention work and respond to the frequent requests for data from Oregon cities and counties.

The youth suicide prevention program has worked with the GLS grant counties to build sustainability into our programs and we will continue to do so. ASIST trainings will continue in Oregon, as the trainings have become mandated for county crisis line workers, behavioral and mental health clinical staff, and community mental health agencies in several counties. Schools have developed protocols and guidelines for suicidal students, and in doing so, set up collaborative systems with other local systems. ASIST trainers who staff schools and agencies make ASIST trainings an ongoing part of their job requirements. The majority of county youth suicide prevention coordinators are funded primarily through the state Addictions and Mental Health Alcohol and Drug Prevention grants. That funding will continue, while youth suicide prevention activities have become part of their coalition and community activities. Continued support and resources will be provided to local coordinators, schools, and agencies.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	81	99	99.5	99.8	99.8
Annual Indicator	99.2	99.4	99.8	99.4	99.5
Numerator	491	484	471	477	428
Denominator	495	487	472	480	430
Data Source		Oregon Center for Health Statistics			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	99.8	99.8	99.8	99.8	99.8

Notes - 2011

Source: CHS, 2011 preliminary data. The 2010 data was reviewed and updated, and is now considered final.

As mentioned in field notes from previous years: Starting in 2007, reporting for this measure was based on very low birthweight infants born in hospitals, so the prevalence for years 2007 and onward are higher compared to 2006 data. Comparison of data across years is limited due to the different reporting method. The data for this measure does not implies that approximately 100% of very low birthweight infants are being delivered at birthing centers designed for high risk infants.

Since 2007, about 99% of very low birth weight infants were delivered at hospitals or birthing centers designed for high risk infants.

Note: As part of quality improvement for this indicator, next year’s report will refine the numerator to being “very low birth weight infants born in 7 NICUs” (see narrative section for the list of the 7 hospitals with NICUs). The 2011 will be used as the baseline.

Notes - 2010

Source: CHS, 2007-2010 data from hospitals in general and not NICUs.

As mentioned in field notes from previous years, 2006 data was based on data from 6 Oregon hospitals with NICUs. Starting in 2007, reporting for this measure was based on very low birthweight infants born in hospitals, so the prevalence for years 2007 and onward are higher compared to 2006 data. Comparison of data across years is limited due to the different reporting method. The data for this measure does not implies that approximately 100% of very low birthweight infants are being delivered at birthing centers designed for high risk infants.

Notes - 2009

Oregon Vital Statistics Data. Oregon does not have designated high risk facilities. Data since 2007 is based on very low birthweight infants born in hospitals.

Interpretation of data for this measure is limited due to change in methods of between 2006 and 2007.

a. Last Year's Accomplishments

In Oregon, there is no regulated designation for a Neonatal Intensive Care Units; 56 hospitals in Oregon provide obstetric care, 7 with NICUs. The NICUs are staffed with Neonatologists and are Level III by the AAP Perinatal Levels of Care. There are three NICUs in the Portland Metro area: Providence St. Vincent's Hospital, Randall Children's Hospital at Legacy Emanuel, and Doernbecher Hospital (OHSU). The NICUs in the rest of Oregon include Salem Hospital in Salem, Sacred Heart Medical Center in Eugene, Rogue Valley Medical Center in Medford, and St. Charles Medical Center in Bend. There are no NICUs in Oregon's eastern rural and frontier areas.

Oregon providers agree that women in pre-term labor should be transported to the nearest facility, not to a facility that is experienced in the care of very low birth-weight neonates that often requires long distance travel to the urban center (Portland or Eugene).

The OCCYSHN/Title V program at the Oregon Health and Science University provides

consultation to providers caring for high risk deliveries and neonates.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Advocacy for assuring systems in place to appropriately care for VLBW infants				X
2. Assessment and surveillance of status of VLBW infants among all population groups			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OCCYSHN CaCoon Nurse Consultant attends weekly rounds in the OHSU Hospital's NICU to discuss cases being discharged from the NICU. The CaCoon nurse consultant also communicates with discharge coordinators from other NICUs around Oregon to assure infants are linked to CaCoon care coordination services in their community.

OCCYSHN invites NICU nurses to participate in CaCoon sponsored webinar trainings. All webinar trainings are archived on the OCCYSHN website and shared with NICU staff.

OCCYSHN developed a universal CaCoon referral form to streamline the referral process from health care providers, clinics and hospitals to local CaCoon programs around the state. The referral form captures key intake information about the client/family and the client's health condition. The universal referral form was shared with the OHSU NICU and NICU follow-up clinic.

OCCYSHN developed an on-line resource for public health nurses to access information on the care of premature and high risk infants in the community.

c. Plan for the Coming Year

Collaboration and coordination with NICU and NICU follow-up clinics will continue to assure CYSHN and their families are linked to CaCoon services. OCCYSHN will continue to disseminate the universal CaCoon referral form to hospitals and NICU follow-up clinics around the state. An electronic writable version of the referral form will be available summer 2012.

OCCYSHN will continue to invite NICU staff to participate in Title V sponsored webinar and in-person trainings.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	82	82	80	72	74
Annual Indicator	78.4	70.2	71.5	73.3	74.9
Numerator	38484	34143	32584	33101	32754
Denominator	49078	48612	45560	45167	43732
Data Source		Oregon Center for Health Statistics			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	75	75	78	78	78

Notes - 2011

Source: Center for Health Statistics (CHS), 2011 preliminary data. Year 2010 data was reviewed and updated, and is now final. Percentages are calculated by excluding missing cases in the denominator following CHS's computation method.

There is an increase trend of infants born to pregnant women who received prenatal care in the first trimester.

Notes - 2010

Source: Center for Health Statistics (CHS). 2010 preliminary data available at <http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/birth/Pages/index.aspx>. 2009 and 2007 data reviewed and are now finalized. Percentages are calculated by excluding missing cases in the denominator following CHS's computation method.

Since 2008, the implementation of the new CHS tracking system, there has been an increase in percentage of infants born to pregnant women who received prenatal care in the first trimester (from 70.2 % in 2008 to 73.2 % in 2010).

Notes - 2009

Vital statistics data, available: www.dhs.state.or.us/dhs/ph/chs/data/finalabd/09/birthpc.pdf.

Oregon implemented the use of the 2003 US Standard Birth Certificate of Live Birth in 2008, resulting in a change in how prenatal care begin month is calculated. Several variables were

used to determine whether a pregnant woman had received “adequate prenatal care” in the first trimester care or not. The Oregon Center for Health Statistics has not finalized this computation. Due to change in tracking method and difference in computation, rates from 2008 and onward are not comparable with those from 2007 and earlier. 2008 data will be used as baseline.

a. Last Year's Accomplishments

In 2009 (most recent data), Oregon ranked 25rd in the nation for adequacy of prenatal care as defined by the Kotelchuck Index (United Health Foundation America's Health Rankings, 2011). However, the OHSU/NWLC Women's Health Report Card shows a decrease in first trimester prenatal care from 81.2 in 2007 to 79.2 in 2010). Oregon still has no system of presumptive eligibility for Medicaid for pregnant women. Women in Oregon often cannot see a prenatal care provider until the source of payment for care is determined because providers are reluctant to initiate care without having Oregon Health Plan (OHP) or other coverage confirmed. As of 2012, presumptive eligibility was the Medicaid practice in 30 states and the District of Columbia (Kaiser Family Foundation, 2012). Despite advocacy within OHA and from public health advocates, budget constraints and other barriers have precluded Oregon's implementing presumptive eligibility for pregnant women.

Oregon MothersCare (OMC), a statewide initiative to improve access to early prenatal care, provided services at 27 sites in an effort to link women to health insurance enrollment and health care providers, and is funded by Title V, along with local funds.

The OMC program has developed partnerships among public and private agencies to streamline, coordinate, and promote access to prenatal services. Project components include the MCH toll-free hotline (SafeNet), a referral and support system for prenatal services, including dental services, and an ongoing public awareness, outreach, and education campaign. During 2011, the program assisted 4,336 women in gaining access to prenatal services.

The Office of Family Health (Title V Program) continued to provide funding and administered Maternity Case Management (MCM) and home visiting services through local health departments as part of an effort to increase access and effective utilization of prenatal care and other services for high risk pregnant women. In 2010, MCM services were delivered to a total of 5,763 pregnant women in 28 counties. An additional 2,496 women received other maternity services through Title V agencies around the state.

Title V and Medicaid (Division of Medical Assistance Program -- DMAP) have worked in partnership with local public health departments to increase the reach of the Prenatal Expansion Project (PEP). The PEP uses SCHIP funding to provide undocumented women with prenatal and dental coverage through the Oregon Health Plan. Initially a pilot project in two counties, the program has now expanded 15 counties.

The Oregon Healthy Kids (OHK) insurance program implemented a simpler Medicaid application process that should decrease barriers to first trimester prenatal care. Pregnant women under age 19 with incomes up to 200% FPL are now eligible for Medicaid. Approximately 200 OHK application assisters provide outreach and application assistance to families to enroll children and families in the Oregon Health Plan.

The Title V also funds and administers the SafeNet contract to provide and MCH warm-line to assist pregnant women to access prenatal care services in their community.

Throughout 2011, OFH continued to administer and analyze the PRAMS survey of post-partum women to collect information related to prenatal care access for surveillance and program planning.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach and link women to early and adequate prenatal care		X	X	
2. Maternity case management and home visiting services for high risk pregnant women		X	X	
3. Reproductive health and family planning services provide education about optimal prenatal care		X	X	
4. ORCHIDS client data system provides data to assess status of client risk factors and needs				X
5. PRAMS surveillance provides information about utilization, access, and quality of prenatal care				X
6. Policy change advocacy for early prenatal care system and quality improvements				X
7. WIC and Family Planning programs refer women who screen positive for pregnancy to prenatal care		X	X	
8. Prenatal Expansion Program (Medicaid) provides prenatal health coverage for undocumented women.		X		
9.				
10.				

b. Current Activities

Oregon MothersCare (OMC) continues to link pregnant women to prenatal services in 27 sites serving 26 counties. Staff is currently conducting a Robert Wood Johnson Foundation CQI project that will help streamline the data submission and entry process using a web-based data entry tool for OMC Coordinators.

Oregon was awarded both formula and competitive Maternal and Infant Home Visiting (MIECHV) grants. The formula grant is enhancing access to both clinical and home visiting services in 3 Oregon counties through expansion of Healthy Families America/Healthy Start and Early Head Start home visiting services. The competitive is establishing Nurse-Family Partnership in 5 counties. These resources are establishing a team of specialists to help implement the statewide home visiting system at the local level. Title V will continue to work to knit together a comprehensive system of home visiting services that enhances pregnant women's access to early prenatal care.

The Title V program is collaborating with Oregon Healthy Kids to continue enrolling all children in public or private health insurance. MCH continues to work with the Office of Healthy Kids to decrease barriers to Medicaid enrollment for all populations, including pregnant women.

c. Plan for the Coming Year

With the initiation of the Coordinated Care Organizations, the Public Health Division will be monitoring closely how the required outcome for improved birth outcomes is being addressed by each CCO. With all Medicaid dollars moving to the CCOs, this may impact the Maternity Case Management program. It may also impact the need for the Oregon Mothers Care (OMC) and the Prenatal Expansion Project. We anticipate these will be positive changes. Title V will also be working closely to coordinate access to prenatal care and other MCH priorities with the emerging healthcare transformation initiative and the Governor's Early Learning Collaborative.

In the meantime, OMC will continue implementing the RWJR CQI project to improve the program's data collection. MCH plans to work with local health departments to assure that the funding formula and quality assurance structure for OMC maximizes the reach of the program to

assist pregnant women to access early prenatal care.

The Title V Program will continue to provide funding to administer Maternity Case Management (MCM) and home visiting services through local health departments. MCH will continue working with local public health partners to revise the home visit nursing programs to prioritize evidence-based prenatal services, and to coordinate public health home visiting services with the MICHV funded services.

The redesigned Oregon Maternal, Infant and Child Home Visiting (MICHV) program will continue to enhance access to both clinical and home visiting services in the 8 funded Oregon counties as well as statewide. The implementation team will begin rolling out the home visiting system at several sites deemed ready. Title V will continue to support this work to knit together a comprehensive system of home visiting services that enhances pregnant women's access to early prenatal care.

The Title V supported SafeNet contract will be revised to place 2 MCH specialists on the SafeNet staff to better provide assist pregnant women and families to access prenatal care and other MCH services in their community.

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

D. State Performance Measures

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					12.4
Annual Indicator		14.0	13.2	12.4	16.4
Numerator		24891	23261	26691	27184
Denominator		178381	175689	214735	165815
Data Source		Region X Ahlers Family Planning database			
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	14	16	18	20	20

Notes - 2011

Source: Ahlers Family Planning Client Data-Clinic Visit Record (CVR), Women's & Reproductive Health Program. Data are based on calendar year. The Clinic Visit Record (CVR) is an

encounter form used for all publicly-funded family planning clients statewide. Clients must be of reproductive age to receive services. The measure is defined as any visit/encounter (not necessary the first encounter) with a relationship safety component within the report time period (numerator). This is not unduplicated client-level data; and it is possible that one client could have had more than one visit/encounter within the report time period.

In 2011, 16.4% of visits/encounters included counseling on relationship safety. There are fluctuations between 2008 and 2011, and it is too early to assess if these changes indicate a real trend. Demographic characteristics of the population who received relationship safety information are: 98.6% female, 67.9% aged 20 years old or more (compared to 32.1% being 19 years old or younger), and 84.7% white.

Notes - 2010

Source: Ahlers Family Planning Client Data-Clinic Visit Record (CVR), Women's & Reproductive Health Program. 2008-2010 data based on calendar year.

The Clinic Visit Record (CVR) is an encounter form used for all publicly-funded family planning clients statewide. Clients must be of reproductive age to receive services. In 2008, 14% of reproductive age clients received counseling on relationship safety, 13.2% in 2009, and 12.4% in 2010. Demographic characteristics of the population who received relationship safety information are: 98.4% being female, 86.1% white, and 66.5% being aged 20 years old or more (compared to 33.5% being 19 years old or younger).

a. Last Year's Accomplishments

Systems and Partnerships Accomplishments:

The OFH/Title V Women's Health Program collaborated with the Oregon Department of Justice (DOJ) and Department of Human Services to implement a DHHS Office on Adolescent Health grant. The focus of the grant is to address Intimate Partner Violence among Pregnant and Parenting Adolescents. The grant supports 15 Domestic and Sexual Violence advocates that are stationed in child welfare, TANF, or public health offices. Local coordination to improve screening and support services for victims of domestic violence between public health, child welfare, and domestic violence agencies is the foundation of this work. Women's Health staff is on the advisory committee for the grant. In addition, the OFH now has an interagency agreement in place with DOJ to implement the grant's training plan.

In November 2010, the Women's Health Program in OFH participated in a full-day United Way Summit on domestic violence to develop strategic plans for addressing DV in the four-county area surrounding the Portland Metropolitan Area and a follow-up Prevention Mobilization Team meeting to develop recommendations on primary prevention initiatives.

In response to a growing concern and apparent increase in domestic violence related murder suicides, stakeholders, advocates, public health, and child welfare, and the Department of Justice came together to organize a planning meeting to create Oregon's first statewide Domestic Violence Fatality Review Team. The fatality review team model has been used by communities by involving a team of experts from a wide variety of disciplines including public health, law enforcement, victim services, medical examiners, clergy and mental health, to review fatalities after the fact with the purpose of identifying systems changes and prevent additional deaths. The Oregon Domestic Violence Fatality Review Team, is convened by the Public Health Division, Office of Family Health, and the co-chairs are from the Department of Human Services and the Department of Justice.

Training and Education Accomplishments:

In August 2011, OFH staff provided in person training to DV Advocates and DHS child welfare workers on how to work with local public health and improve DV referrals.

In October 2011, the Local Health Department, Family Planning Coordinators received in person

training on health affects of DV, screening best practices, and how to work with your local DV advocate to better support clients who are victims of DV.

OFH co-sponsored a training and webinar presentation with Dr. Elizabeth Miller in Portland, Oregon: 1) "Intimate Partner Violence, Reproductive Coercion and Unintended Pregnancy", March 22, 2011 in partnership with the Center for Health Training (over 55 attendees) (March 22, 2011).

The Public Health Department sponsored "Making the Connection: Intimate Partner Violence and Public Health," during Oregon Public Health Week in partnership with the DHHS Office on Women's Health-Region 10 (over 60 attendees) (April 5, 2011).

The State Family Planning Nurse and a local family planning provider attended an Office of Adolescent Health Training on preventing intimate partner violence and "rapid repeat pregnancies" among pregnant and parenting teens (March 2011).

Legislative Accomplishments:

During the Oregon 2011 Legislative Session OFH Staff spent considerable time providing consultation and information on a "Teen Dating Violence Bill". The intent of the bill was to ensure education and accountability in the school around teen dating violence. The bill did not pass in this session.

Baseline data is being collected from family planning client visit data and from the public health surveys BRFSS, PRAMS, PRAMS-2, Oregon Healthy Teens Survey, and the CDC National Intimate Partner Violence, Sexual Violence & Stalking Surveillance System (NISVSS).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase family planning providers' capacity to document and implement domestic and sexual violence (DSV) screening, assessment, and referral through provider training and strengthening screening policies.				X
2. Increase home visiting nurses capacity to document and implement DSV screening, counseling and referral through training and skill building and strengthening program policies.				X
3. Identify requirements and develop best practices for public health screening and response to DSV. Provide training and technical assistance to providers and advocates in improvement of the referral and systems response.				X
4. Provide training and technical assistance to providers and advocates to support collaboration and systems coordination between local public health and DSV advocates.				X
5. Support state and local DSV primary prevention initiatives in Oregon through legislative and policy work (For example: Teen Dating Violence legislation) and building upon on the work of the Rape Prevention Education program grant.				X
6. Surveillance of data sources to measure screening and counseling clients through Family Planning programs, including Ahlers Family Planning client data and population-based surveys such as PRAMS, PRAMS2, BRFSS, Nat'l DV Survey, OHT).				X
7.				
8.				

9.				
10.				

b. Current Activities

The Women's Health program is implementing the training plan for the "Intimate Partner Violence among Pregnant and Parenting Adolescents" federal grant. Training was provided to: local & state Family Planning Coordinators and Oregon MothersCare staff on IPV Screening tools, techniques, the health effects of IPV before and during pregnancy, and working with local DV advocates; Public Health Nurse Supervisors on the health effects of IPV on mother and child, vicarious trauma, and screening techniques at their annual meeting. Additionally, developed and distributed an on-line resource for on-line training.

The Domestic Violence Fatality Review Team (DVFRT) held meetings to develop membership, provide training, and put the protocol in place. The Team also conducted its first fatality review and developed its first set of recommendations in May.

Title V/OFH Staff provided consultation and information on the Teen Dating Violence bill during the 2012 Legislative Session. The bill, now signed into law, requires that dating violence is incorporated into school curriculum and someone accountable at every school to address reported abuse.

The Public Health Division identified Family Violence prevention as one of its priority goals for the next five years. This complements the Title V priority to prevent Domestic and Sexual Violence. A stakeholder meeting was held in May, which was the first step in developing a strategic plan for the agency on preventing family violence.

c. Plan for the Coming Year

The Women's Health Staff will continue to collaborate with the Oregon DOJ and Department of Human Services to implement a the "Intimate Partner Violence among Pregnant and Parenting Teenagers" grant. Women's Health staff will continue on the advisory committee for the grant. Some of the major pieces of the work on the grant in 2013 will be: 1) implementing a Domestic and Sexual Violence (DSV) provider training plan for local health departments, TANF and Child Welfare providers, and DSV Advocates in collaboration with the DOJ; the focus will be on improving agency and community linkages to strength the screening and referral system for victims. 2) Review the results of a training needs survey of local public health, child welfare, and DV advocates. 3) Develop and implement a training to provide skill building on assessing and strengthening their local DV referral system. 4) The on-line training resources that were developed for all project staff will continue to be promoted. 5) Work with WIC State staff to develop IPV training for the Oregon WIC Association members to be held at their annual meeting in Fall of 2012.

Women's Health will provide consultation with the Nurse Home Visiting Program and other Title V programs to review training curriculums for IPV screening and advocacy. OFH will assess the feasibility of applying for a Project Connect funding opportunity to strengthen the health care response to domestic violence (due out Fall 2012).

In addition, Oregon recently passed HB 5030 which will place DV advocates in DHS self sufficiency and child welfare offices. This comes with \$3 million in new funding which will provide resources to place DV advocates in DHS offices and coordinate community referrals, including public health, statewide. DHS is forming a steering committee to implement this program. Public health has been invited to be at the table to ensure that local public health will be part of this systems approach to screening and assuring victims receive services and ensure their safety.

The Oregon Domestic Violence Fatality Review Team, will continue to be convened by the Public

Health Division, Office of Family Health, and the co-chairs are from the Department of Human Services and over the summer work will be done to pick the next case and in the Fall the DVFR will meet twice to review it's second case. The goal is to review two cases a year. The Women's Health program will continue to participate in strategic planning for the Public Health Division's goal to prevent family violence.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					43
Annual Indicator		47.5	43.5	43.5	40.1
Numerator		14554	16892	16892	15272
Denominator		30644	38864	38864	38063
Data Source		Oregon Healthy Teens (OHT)	OHT	OHT	OHT
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	43	42	42	40	40

Notes - 2011

Source: 2011 Oregon Healthy Teens survey, Oregon Health Authority. Weighted counts and percentages. Unweighted counts and weighted percentages for years 2008 & 2009 available at <http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Page/s/ohtdata.aspx>.

Weighted counts do not represent the actual number of students who were surveyed, but the estimated number of 8th grade population attending public schools, not counting charter or private schools.

Fewer 11th grade youth reported having their first sip of alcohol before age 14 in 2011 (40.1%) than in 2009/10 (43.5%) and 2008 (47.5%), continuing a slight downward trend. While the downward trend in the data are encouraging, single-year fluctuations should be interpreted with caution. The survey only captures one point in time, and changes could be due to differences in the survey sample from previous years or other secular trends. This trend will continue to be closely monitored, as the Addictions and Mental Health Division roll out a statewide media campaign to address norms around drinking and the Public Health Division implements strategies to increase provider awareness and screening of alcohol use among youth.

Notes - 2010

Weighted counts and percentages. 2010 data unavailable because there was no OHT survey; 2009 data carried forward. Due to another statewide survey (SWS -Student Wellness Survey), which is conducted in even numbered years, as of 2011 OHT will be conducted in odd numbered years contingent on available funding. Unweighted counts and weighted percentages for years 2008 & 2009 available at <http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Page/s/ohtdata.aspx>.

Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 8th grade population attending public schools, not counting charter or private schools

More 11th grade youth had at least one sip of alcoholic drinks in 2008 (47.5%) than in 2009 (43.5%). Provisional 2009 data indicates a decreasing trend.

a. Last Year's Accomplishments

Addictions and Mental Health Division, to begin long-term planning to address this priority. Long term planning included a review of related project goals and objective, resources, and capacity to jointly address this priority.

The OFH continues to focus on preconception health issues, including alcohol use and dependency. The OFH defines preconception health as interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management, emphasizing those factors which must be acted on before conception or early in pregnancy to have maximal impact. Alcohol use, abuse, and dependency is one of those factors.

Oregon's lead agency for alcohol and drug treatment programs, is a Strategic Prevention Framework Incentive Grant (SPF-SIG) grantee from the Substance Abuse and Mental Health Services Administration (SAMHSA). Their goals, which are similar to our MCH Priority, include:

- Prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking.
- Reduce substance abuse-related problems in communities.
- Build prevention capacity and infrastructure at the state and community levels.

While the Office of Family Health was not the lead agency on this project, a strong partnership was developed with OFH's partnership on the workgroup. MCH is now a participating member of the SPF-SIG Task Force. MCH staff and the SPF-SIG staff, along with other prevention staff from Oregon's alcohol and drug office, consult quarterly with each other regarding projects, strategies, and goals for alcohol prevention in Oregon.

In addition, the MCH Program supported two county public health departments in their application to CityMatch to participate in alcohol prevention in pregnancy learning collaborative. Multnomah County Health Department, was awarded the collaborative, and the State program provides support to them regarding alcohol use, binge drinking and pregnancy at the State level.

Throughout FY 2011, an environmental scan of programs, policies, and activities in Oregon around the performance measure was conducted. The scan identified populations for which alcohol prevention services in Oregon were being conducted.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct a statewide environmental scan to assess interventions, strategies and policies currently in place that aim to reduce early initiation of alcohol use and increase awareness and education of binge drinking among reproductive age adults				X
2. Develop a database of alcohol policies in Oregon				X
3. Identify survey instrument to assess: parent knowledge of dangers of early initiation of alcohol use; binge drinking among reproductive age adults				X
4. Ensure that Oregon pediatric providers are trained in the START Expansion Module; Encourage the use of the CRAAFT screening instrument by School-Based Health Centers in Oregon.		X		
5. Encourage appropriate tracking of alcohol measures and				X

outcomes by CCO's and providers.				
6. Conduct parental focus groups to understand their knowledge around early initiation of alcohol use for further message development of promotional materials		X		
7. Develop and distribute an Oregon Health Authority promotional message to young women regarding binge drinking		X		
8.				
9.				
10.				

b. Current Activities

In November, 2011, an educational presentation was developed and disseminated for use with other public health departments and providers.

The environmental scan conducted in 2011 will be used in strategic planning and development of the alcohol use priority policy database.

In October and November, the OHA developed and distributed an Oregon Health Authority CD summary to educate providers on early initiation of alcohol use and lifetime dependency and provider use of screening tools.

Title V/OFH staff is researching different models to educate providers on the importance of early identification of alcohol use and abuse and training on the use of evidence-based screening tools (such as the CRAAFT). The Oregon Pediatric Society's Screening Tools and Referral Training (START) Program provides training, support and resources to providers and clinic staff in screening and referral methods. Evaluation outcomes include: provider/staff knowledge, beliefs and attitudes; referral data; chart review data on screening rates; claims data and participant feedback. START has provided a preliminary budget to develop an adolescent alcohol module, and OFH will continue exploring this model in the next fiscal year.

OFH is providing technical assistance to Multnomah and Marion Counties regarding substance-exposed pregnancies, under-age alcohol use; binge drinking by young adults; increasing parental knowledge regarding risks of alcohol use by youth; and provider screening.

c. Plan for the Coming Year

By March, 2013, an alcohol and other drug statewide policy database will be developed to understand the range of existing policies and needed policies to include in strategic planning. A policy database is an inventory of policies that may use an ecological model regarding a specific issues or topic, such as prevention of alcohol dependence. Continued development of the alcohol and other drug Statewide policy database will occur throughout the year, along with making the database available to partners and counties as a way to review policy discrepancies by county and encouraging local and statewide partners to strengthen alcohol use/misuse policies.

By December 2012, OFH will contract with the Oregon Pediatric Society to develop a START module for adolescent alcohol use screening. The contract will include module development, training materials, provider training, and evaluation.

By June 2013, School-Based Health Centers in Oregon will have received training and information regarding the CRAAFT screening instrument. OFH will provide technical assistance to SBHC staff regarding the CRAAFT.

By September 2013, the OFH will contract for parental focus groups to assess parent knowledge of the dangers of early initiation of alcohol use and assess knowledge of the dangers of binge

drinking among reproductive age adults.

By September 2013, collaborate with alcohol prevention partners to promote provider knowledge of alcohol use and SBIRT (Screening, Brief Intervention, Referral, and Treatment) screening among providers and CCO's.

By June 2013, encourage provider and health plan implementation of the IOM Preventive Health Services Recommendation regarding screening for alcohol use.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					76
Annual Indicator			76.0	77.5	77.5
Numerator			33615	33278	33278
Denominator			44234	42950	42950
Data Source		Developmental	Pregnancy Risk Assessment Monitoring System (PRAMS)	PRAMS	PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	76	76	76	77	77

Notes - 2011

Source: Pregnancy Risk Assessment Monitoring System (PRAMS), Oregon Health Authority. PRAMS 2010 weighted (final) counts and percentage. The data entered for 2011 is considered preliminary because 2010 data was carried over.

Based on the following survey question that was incorporated into PRAMS starting 2009 (question #23) and was asked among women who gave births in 2009: During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? A dichotomous (No/Yes) response category: What to do if I feel depressed during my pregnancy or after my baby is born. 2009 is the first year of data for this measure. The survey question is not specific to being screened for depression during pregnancy; however, it provides information about whether the woman received depression education during her most recent pregnancy.

Seventy-seven percent of women who gave births in 2010 reported having received education on depression during prenatal care visits for that pregnancy. This is slightly higher women who gave birth in 2009 (76.0%).

Notes - 2010

Source: Pregnancy Risk Assessment Monitoring System (PRAMS), Office of Family Health, Public Health Division. Final PRAMS 2009 weighted counts and percentage. 2010 data will be available Fall 2013, so 2009 data carried forward.

Based on the following survey question that was incorporated into PRAMS starting 2009 (question #23) and was asked among women who gave births in 2009: During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? A dichotomous (No/Yes) response category: What to do if I feel depressed during my pregnancy or after my baby is born. 2009 is the first year of data for this measure. The survey question is not specific to being screened for depression during pregnancy; however, it provides information about whether the woman received depression education during her most recent pregnancy.

Seventy-six percent of women who gave births in 2009 reported having received education on depression during prenatal care visits for that pregnancy.

a. Last Year's Accomplishments

The Office of Family Health's maternal mental health work is conducted with the goal of improving Oregon's systems and services to:

- Identify, treat and support women's perinatal mental health; and
- Prevent the negative consequences of maternal mental health disorders on women, infants, children, and families.

The Oregon Maternal Mental Health Work Group's findings and recommendations to improve Maternal Mental Health in Oregon were published and presented to legislature in September 2010. In November 2010, OFH convened 150 maternal mental health providers and advocates convened in Salem in to launch implementation of HB 2666 Report recommendations. Throughout the subsequent year, OFH staff and partners delivered presentations to disseminate and promote the work group's recommendations both within Oregon and nationally. The partnership and policy development process and resulting recommendations were presented at AMCHIP in February 2011, and at the Western States MCH Epidemiology conference in June 2011, and at the Postpartum Support International conference in September 2011, and in the PRAMS Data to Action reports.

Throughout this time, Title V staff continued to develop partnerships and support maternal mental health activities and policy initiatives with partners in medical and mental health, early childhood services, advocacy groups, and state and local government agencies.

In July 2011, the Oregon Legislature passed HB 2235, the Maternal Mental Health Patient and Provider Education Act. This legislation is based on recommendations contained in the HB 2666 Maternal Mental Health Work Group report. It requires the Oregon Health Authority-OFH to develop a website and materials for provider and patient education, and to seek funding to expand maternal mental health awareness and provider training opportunities around the state.

Title V staff began work to implement HB2235 in September of 2012. These included: identifying a source of grant funding to support the work; initiating development of a patient and provider education website and materials, and contracting with content experts to develop pilot maternal mental health training webinars.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Address system barriers that limit Oregon Health Plan providers' ability to identify and treat maternal mental health				X

disorders.				
2. Coordinate with Oregon Health Authority and across state agencies to develop trainings and integrate maternal mental health education, screening, assessment and/or treatment into existing state programs serving women and children.				X
3. Develop tools and provide TA to local health departments and other partners to assess local needs and resources for maternal mental health; and to develop screening, assessment and referral systems in their communities.				X
4. Develop and maintain the Oregon Health Authority's maternal mental health patient and provider education website.				X
5. Seek funding to support the new legislatively created maternal mental health patient and provider education program.				X
6. Develop and support training for public health, human service providers, as well as medical and mental health providers in perinatal mood and anxiety disorders.				X
7. Facilitate work with public and private partners to increase availability and access to community-based social and parenting support.				X
8. Collaborate with 211-Info/SafeNet (MCH Toll-free line) and other partners to improve the state MCH hotline's capacity to make referrals for maternal mental health needs				X
9. Initiate partnerships and identify new system integration opportunities.				X
10. Conduct ongoing surveillance of maternal mental health status and needs through Oregon PRAMS and PRAMS 2.				X

b. Current Activities

Collaborate with 211-Info/SafeNet (MCH Toll-free line) and other partners to improve their capacity to make referrals for calls about maternal mental health needs.

Assist local health departments to refine and pilot tools to assess local needs and resources for maternal mental health; and provide TA to local communities to develop screening, assessment and referral systems in their communities.

Outreach and facilitate partnerships with other state agencies serving women to integrate maternal mental health education, screening, assessment, referral, and/or treatment into existing state programs serving women and children; and decrease barriers for maternal mental health within the changing healthcare delivery system in Oregon.

Develop the OHA patient and provider education website and supporting materials in compliance with the requirements of HB 2235, the Oregon Maternal Mental Health Patient and Provider Education Act.

Develop and piloting a maternal mental health training module for local MCH and WIC staff to enhance understanding of perinatal mental health issues and integrate support, education, screening, assessment and/or treatment into their work as appropriate.

Conduct ongoing surveillance of maternal mental health status and needs through Oregon PRAMS and PRAMS-2.

c. Plan for the Coming Year

Collaborate with 211-Info/SafeNet (MCH Toll-free line) and other partners to improve the capacity to make referrals for calls about maternal mental health needs.

Disseminate the local needs and resource assessment for maternal mental health tools beyond the pilot counties and provide technical assistance to local communities to develop screening, assessment and referral systems in their communities.

Develop partnerships with other state agencies to integrate maternal mental health education, screening, assessment, referral, and/or treatment into existing state programs serving women and children and decrease barriers for maternal mental health within the changing healthcare delivery system in Oregon.

Refine and maintain the OHA patient and provider education website and supporting materials in compliance with the requirements of HB 2235, the Oregon Maternal Mental Health Patient and Provider Education Act.

Develop and pilot a maternal mental health training module that can be used by state and local agencies to train staff to understand perinatal mental health issues and integrate support, education, screening, assessment and/or treatment into their work as appropriate.

Conduct ongoing surveillance of maternal mental health status and needs through Oregon PRAMS and PRAMS 2 surveys.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					18
Annual Indicator		15.7	17.6	17.2	17.2
Numerator		14654	17608	18190	18190
Denominator		93291	100253	105892	105892
Data Source		Medicaid data	Medicaid data	Medicaid data	Medicaid data
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	18	20	20	21	21

Notes - 2011

Source: DMAP, calendar year 2010 final data. As with HSCI #2, 3, 7A and 7B, data will be available after Fall 2012 so 2010 data carried over.

Among children 4 years old and under, there is an increasing trend in having received preventive dental services from dental provider. Between 2009 and 2010, 17.6% to 18.7% children received preventive dental services. This is for children enrolled for at least one day (ever enrolled) in Medicaid, and includes SCHIP.

Notes - 2010

All data provisional. 2010 data will be available Fall 2011. 2009 data carried forward.

Among children 4 years old and under, there is an increasing trend in having received preventive dental services from dental provider. In 2007 (data not entered in TVIS) to 2009, about 14% to 16% of children among this age group received preventive dental services.

Note: Before 2010, dental claims billing form was not available at 3 unique clinics (documented on file) that had dental providers performing dental services. Procedure codes used for dental services were put on medical claims form, so 2009 data included CDT codes from medical claim forms from those 3 clinics type. This will no longer be true starting with 2010 data due to the existence of appropriate dental claim forms.

Notes - 2009

Baseline data using reporting year 2009:

Percent: 16.5%

Numerator: 16,501

Denominator: 100,253

a. Last Year's Accomplishments

This was year two of the First Tooth grant, a workforce development project that trains pediatric medical providers to incorporate early childhood cavities prevention strategies into the well-child visit, trains general dentists to access children under age three, and creates a collaborative relationship between pediatricians and dentists to ensure continuity of care. The training is in-person and will eventually be available as a web-based training.

Major accomplishments include development of a comprehensive curriculum for medical and dental providers each and implementation of face-to-face training statewide. Forty sites received training. Development of the web-based training began. A new project coordinator was hired when the previous coordinator took a new position.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train medical pediatric providers to provide oral health risk assessments, screenings, interventions, and anticipatory guidance.				X
2. Train general dentists on serving the very young child for routine and preventive care.				X
3. Provide messaging and outreach to partners that served children under the age of three.			X	
4. Collaborate with DMAP to make policy changes regarding reimbursement for early childhood cavities prevention services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Data collection and analysis of pilot site data was developed in collaboration with the Assessment & Evaluation Unit in the Office of Family Health, Maternal & Child Health Section. Pilot site training participants were asked to complete a training feedback survey at the end of each

training (see section e. evaluation and impact). The pilot site First Tooth trainings were very well-received, as indicated by high satisfaction rates and satisfaction with the instructor and teaching methods. To date, satisfaction in all categories ranges from 92.4%-99.5%. Since the project began, over 1,000 providers have been trained, representing 21 counties. The project was also presented at the National Oral Health Conference and was very well received.

An outreach plan has been created and is being implemented statewide. The primary focus is to promote the web-based training. The grant is set to end August 2012 and a transition plan is in place that will move the First Tooth Project into the work of the Oregon Oral Health Coalition.

c. Plan for the Coming Year

The First Tooth Project grant will end in August 2012. The project is moving into the the Oregon Oral Health Coalition (OrOHC). The Oral Health Program will continue to collaborate with OrOHC on the First Tooth Project by providing technical assistance and support with the evaluation plan and data collection and analysis, maintaining the web-based training site, and fulfilling requests for First Tooth Project materials. An abstract was submitted for the fall 2012 APHA conference and was accepted; staff will present the project results. The Oral Health Program will collaborate with the newly established Coordinated Care Organizations to implement First Tooth as a model for providing preventive dental services to members.

State Performance Measure 5: *Using benchmarks develop a Public Health Action Plan for improving parenting skills and education within MCH policies, programs, and outcomes.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					1
Annual Indicator			0.0	0.0	2.5
Numerator		0	0	0	2.5
Denominator			6	6	6
Data Source			None	None	Benchmarks
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	4	5	6	6	6

Notes - 2011

As a new measure in 2010, no data available prior to 2011.

Calculation: A ratio. Self-evaluation of the progress for each step of the benchmark. Each step is valued at 1.0, and may be scored at .5 if only part of a benchmark has been completed.

1. Complete an inventory of existing parenting resources, unmet parenting needs, and opportunities.
2. Select a framework for assessment and planning that aligns with the statewide early childhood health and education policy initiatives and programs.
3. Participate and engage with parent and stakeholder groups working on parenting skills and early childhood policies and programs
4. Develop goals and outcomes for the Public Health Action Plan that are identified by and aligned with parent and stakeholder groups for early childhood initiatives and programs such as the state’s Early Learning Council, LAUNCH grant, and MIECHV (home visiting) grant.
5. Select parenting skills, knowledge and behavior needs that are feasible for action by public health and Title V agencies.

6. Complete the Public Health Action Plan, which will include an evaluation process, for improving parenting skills and education by September, 2015.

Notes - 2010

As a new measure in 2010, no data available prior to 2011.

Calculation: Each of the following Benchmarks is equivalent to 25% and will be cumulative over five years.

1 - An MCH workgroup including local and state partners is convened to define the role of MCH in building parent resources for desired child health outcomes (as identified by Title V and Early Childhood Matters Council and Committees)

2 - Existing planning efforts and parent resources are identified in relationship to the desired child health outcomes

3 - A statewide needs assessment is conducted to supplement existing knowledge tied to identified child outcomes and further define the role MCH can play in developing better resources for parent education and skill development.

4 - MCH in collaboration with the Early Childhood Matters and ECCS develop a strategic plan that clearly defined roles/responsibilities for MCH programs and staff related the specific child health outcomes and performance measures tied to parent resource development.

Notes - 2009

No data prior to 2011.

a. Last Year's Accomplishments

As part of the new parenting priority a small internal work group continued to refine the benchmarks to align them more closely with current state system efforts that are addressing parenting skills across Oregon. This workgroup reviewed the role of parenting through two perspectives: the need for skills and resources to improve overall parenting and the impact that parenting has on child development and health outcomes.

The first step for this goal was to identify the role that public health would serve. In order to do this staff completed an inventory of existing parenting resources, unmet parenting needs and potential parenting opportunities across the state. One parenting asset in many of the communities and/or regions across the state is the Parenting HUB grants that the Oregon Community Foundation is funding and supporting. These parenting HUBs are providing parenting education and services. Unfortunately, these Parenting HUBS are not in all the counties throughout the state. Nonetheless, parenting skills and resources are being offered within many other programs such as home visiting, WIC, School Based Health Centers, Early Care and Education Programs, Addictions and Mental Health Services, Child Welfare Services, Community Based Organizations and Community Colleges.

To further expand upon the information included in the inventory the results from the parent survey (conducted as a requirement for the Affordable Care Act for the Maternal, Infant and Early Childhood Home Visiting, MIECHV, Grants) were reviewed. Respondents included WIC and Home Visiting Programs and 4,328 respondents completed the survey. The parenting needs that were expressed during this survey included information about how to play/read and teach children, general parenting, child growth and development, family nutrition, child safety and injury prevention. A second category that parents expressed in this survey were many basic needs for the family and child including assistance with food, housing, transportation, cash, translation and child care.

Thus, the results of this survey mirrored many of the needs that were expressed during the Title V

community engagement needs assessment.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Complete an inventory of existing parenting resources, unmet parenting needs, and opportunities.				X
2. Select a framework for assessment and planning that aligns with the statewide early childhood health and education policy initiatives and programs.				X
3. Participate and engage with parenting groups that are working on early childhood programs and policies.				X
4. Select parenting skills, knowledge and resources that are feasible for action by public health and Title V agencies.				X
5. Develop goals and outcomes for the Public Health Action Plan that are aligned with parent and stakeholder groups for early childhood programs such as the state's Early Learning Council, LAUNCH grant, and MIECHV (home visiting) grant.			X	X
6. Complete the Public Health Action Plan for improving parenting skills and education, which will include an evaluation process, by September, 2015.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Title V program made adjustments to this benchmark to include all the actions needed to result in a strategic plan by the end of the five-year cycle.

The internal workgroup researched frameworks that had a public health perspective that could address many of these parenting and basic family needs identified in the assessment. The small internal work group reviewed different models of parenting support and skills, looking for things that addressed not just parenting education but models that could meet broader parenting and family needs overall.

After reviewing the available evidence-based programs, models and frameworks the workgroup chose the "Strengthening Families" framework, developed by the Center for Study of Social Policy, as a potential state guiding framework to guide the title V programs across the state.

This framework was then taken to a broader group of Maternal and Child Health local county health partners for input and approval. Simultaneously the public health division is consulting with agencies and organizations across the state to see if and how they are implementing this framework. This outreach and continual update of the inventory is a dynamic process.

c. Plan for the Coming Year

In the coming year the emphasis of the parenting priority will continue to update the parenting resources inventory as the educational and healthcare systems continue to transform. However, a primary focus will be on participating and engaging with parenting stakeholder groups that are working on early childhood programs and policies. This participation will help to shape the knowledge, skills and resources that public health can develop, which will ultimately help to

determine the goals and outcomes for the Public Health Parenting Action Plan.

The framework and work will align with early childhood policy efforts across the state. The Governor's Early Learning Council is developing the direction and focus of the Oregon Early Learning System. This council has multiple work groups that are developing recommendations around database systems, developmental screening tools and community based family organizations. These family organizations will have family resource navigators who will refer and connect families to the needed services and/or systems. The selected "Strengthening Families" framework will help with public health contribute to these statewide planning efforts.

Many other early childhood system efforts are underway in Oregon that the parenting priority intends to align with, as well. These system efforts include the Oregon Parenting Education Collaborative (OPEC) Oregon Home Visiting System, two Linking Actions for the Unmet Needs of Child Health (LAUNCH), grants, Oregon Public Health strategic planning, the Help Me Grow System work and Coordinated Care Organizations (CCOs).

Much of this system work is in its infancy and therefore the role that the Title V parenting priority will have in the overall Oregon Early Learning System and within the Coordinated Care Organizations is yet to be determined. By January 2013 greater clarity will be established in both of these transformative efforts, and therefore it will be easier to determine what goals and outcomes to focus on as the basis for the Title V/Public Health Parenting Action Plan.

State Performance Measure 6: *Percent of 8th grade students with a BMI below the 85th percentile*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					73.5
Annual Indicator		74.2	73.4	73.4	77.9
Numerator		26218	27277	27277	28817
Denominator		35357	37142	37142	36971
Data Source		Oregon Healthy Teens (OHT)			
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	74	74.5	75.5	76	76

Notes - 2011

Source: 2011 Oregon Healthy Teens survey, Oregon Health Authority. Weighted counts and percentages. Unweighted counts and weighted percentages for years 2008 & 2009 available at <http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Page/ohtdata.aspx>.

Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 8th grade population attending public schools, not counting charter or private schools.

Since 2007 the number of 8th grade students with a BMI below the 85th percentile has stayed

relatively constant with minor fluctuations. This is true not only for students whose BMI falls below the 85th percentile, but also for those with a BMI in the 85th < 95th percentile (overweight) and those with a BMI in the > 95th percentile (obese) category. The increase in the proportion of 8th grade students below the 85th percentile in 2011 is encouraging, but should be interpreted with caution. The survey only captures one point in time, and changes could be due to differences in the survey sample and other secular trends. Reducing overweight and obesity has been identified as a priority for the Oregon Public Health Division, and this trend will be closely monitored in the coming years as it forwards new strategies and activities. Note: the terminology for childhood overweight and obesity has changed. In the past, childhood overweight BMI > 85th percentile was referred to as "at risk of overweight" (now "overweight") and a BMI > 95th percentile was referred to as "overweight" (now "obese").

Notes - 2010

Weighted counts and percentages. 2010 data unavailable because there was no OHT survey; 2009 data carried forward. Due to another statewide survey (SWS -Student Wellness Survey), which is conducted in even numbered years, as of 2011 OHT will be conducted in odd numbered years contingent on available funding. Unweighted counts and weighted percentages for years 2008 & 2009 available at

[http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Page s/ohtdata.aspx](http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Page%2Fs/ohtdata.aspx).

Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 8th grade population attending public schools, not counting charter or private schools.

Since 2007 the number of 8th grade students with a BMI below the 85th percentile has stayed relatively constant with minor fluctuations. This is true not only for students whose BMI falls below the 85th percentile, but also for those with a BMI in the 85th < 95th percentile (overweight) and those with a BMI in the > 95th percentile (obese) category. With the school nutrition standards policy in place and improvements to the school lunch program and additional environmental supports, the population-based BMI of 8th grade Oregon students should trend towards a greater percentage of students with a BMI below the 85th % in the coming years. Note: the terminology for childhood overweight and obesity has changed. In the past, childhood overweight BMI > 85th percentile was referred to as "at risk of overweight" (now "overweight") and a BMI > 95th percentile was referred to as "overweight" (now "obese").

Notes - 2009

Baseline and objectives for the new State Performance Measures will be forthcoming in September, 2010.

a. Last Year's Accomplishments

The OFH Nutrition and Physical Activity (NPA) workgroup began collaborating with the Oregon Health Promotion and Chronic Disease Prevention (HPCDP) Program's Healthy Communities work. The focus is to provide a life course approach and integrate the MCH work that is also occurring within those communities. The MCH Childhood Collaborative reviewed survey results from counties to inform with future planning and activities. Work continued on obesity prevention strategies around breastfeeding, child care, and food access issues. The NPA workgroup has adopted the phrase "Healthy Weight and Development" to replace "obesity prevention" as a way to reframe our efforts and make them more inclusive and less threatening to the public.

The OFH Oral Health program is planning to include a Healthy Growth Survey in conjunction with their Smiles Survey which is conducted every five years. A coordinator will oversee both surveys which will take place in the spring of 2012. The Healthy Growth Survey will consist of 1st, 2nd and 3rd grade schools in randomly selected schools being weighed, measured and their BMI's calculated. The survey will be done for surveillance purposes only, and no student information will be identified or shared. This will provide Oregon with baseline data on elementary student weight.

The OFH continues to work in collaboration with statewide nutrition and obesity prevention efforts.

Areas of collaboration include Farm to School, Walk and Bike to School, School Wellness Policies, Breastfeeding, Screen time and Childcare. The OFH continues to use Oregon Healthy Teens to monitor weight status (BMI) and eating and physical activity habits of adolescents.

During FFY 2011, trainings on how to talk to clients about weight-related issues were presented to School-based Health Providers and Family Planning Providers. Resources were also provided.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate obesity prevention efforts within the Office of Family Health to integrate nutrition and physical activity within all maternal, child and school-based programs				X
2. Collaboration with Oregon Dept. of Education and school-based organizations to provide education and support implementation of school wellness policies and the Farm to School/ School Garden efforts		X		
3. Collaborate with Oregon's Health Promotion and Chronic Disease Prevention Program on priority setting and implementation of obesity prevention strategies			X	
4. Provide obesity prevention resources and training for public health staff and health care providers		X		
5. Collaborate with state-wide nutrition organizations and agencies in Oregon to share resources and support implementation of obesity prevention strategies and promoting healthy weight using a Lifecourse approach				X
6. Support state-wide walk and bike education and infrastructure building				X
7. Use surveillance data to monitor child and adolescent BMI rates and adolescent nutrition and physical activity behavior				X
8. Inform and educate families, educators, policy makers about healthy eating and active living		X		
9. Support research and demonstrations to gain insight into effective obesity prevention and weight management strategies				X
10. Collaborate with local and statewide agencies and organizations around screen time awareness and breastfeeding, education and capacity building				X

b. Current Activities

A Public Health Division-wide screening of "The Weight of the Nation" is being shown over several months.

Beginning in July 2012, the MCH and health promotion and disease prevention sections are housed in the Center for Prevention and Health Promotion. In preparation, the healthy weight/obesity prevention policy staff has been working on some strategic planning around obesity prevention goals and strategies. A life-course approach, breastfeeding, and a focus on healthy weight and development, are three top objectives that family health has brought to the strategic planning process. Obesity prevention was identified as one of the five Public Health Division goals to address over the next five years.

The Oregon Healthy Growth Survey is currently underway and being done in conjunction with the Oregon Smiles Survey. At this point, screening has been done in about 45 schools, with a target number of 75 schools. We are currently looking at continuing our screening into the fall of 2012.

The OFH continues to work in collaboration with statewide nutrition and obesity prevention efforts.

Areas of collaboration include Farm to School, Walk and Bike to School, School Wellness Policies, Breastfeeding, Screen time and Childcare. New areas under exploration include expanding the garden and food offerings at a woman's correctional facility and implementing the farm to school concept in other settings.

c. Plan for the Coming Year

Integration and collaboration between the maternal child health programs and the disease prevention programs will be the focus of obesity prevention efforts in the coming year. The new Center for Prevention and Health Promotion will provide opportunities to develop and plan an approach, resource allocation, and obesity prevention efforts in a more comprehensive scope for counties and public health partners.

The Healthy Growth Survey screenings are scheduled to be complete by November 2012, and the data report should be complete by winter 2012.

Obesity prevention efforts will continue to depend on partnerships with agencies and organizations throughout the state. We will continue to promote efforts around school food and PE, Farm to School and School Gardens, Walk and Bike to School, School Wellness Policies, Breastfeeding, Screen time and Childcare. OFH will be active in implementing a statewide Family Meals Campaign in conjunction with statewide public health nutrition partner organizations throughout the state.

In addition, Worksite Wellness activities will also be a focus of our work, as a means of creating healthy environments and positive health habits that will trickle down to family members and be one more influence in shifting the cultural norm towards healthy eating, active living which leads to healthy weight and development/obesity prevention.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					44
Annual Indicator		47.4	45.1	45.1	56.7
Numerator		17943	18266	18266	23151
Denominator		37878	40524	40524	40856
Data Source		Oregon Healthy Teens (OHT)			
Is the Data				Provisional	Final

Provisional or Final?					
	2012	2013	2014	2015	2016
Annual Performance Objective	44	46	46	48	48

Notes - 2011

2011 Oregon Healthy Teens survey, Oregon Health Authority. Weighted counts and percentages. Unweighted counts and weighted percentages for years 2008 & 2009 available at <http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx>.

Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 8th grade population attending public schools, not counting charter or private schools.

Based on the following OHT survey question among 8th graders: When did you last go to a doctor or nurse practitioner for a check-up or physical exam when you were not sick or injured?

More 8th graders saw a doctor or a nurse practitioner for a check-up or physical exam when they were not sick or injured in 2011 (56.7%) than in 2009/10 (45.1%) or 2008 (47.4%). The increase could be attributed to the State's increased focus on expanding insurance coverage among this population through programs like Healthy Kids, and increasing access points through School-Based Health Centers. However, changes in the data should be interpreted with caution, as the survey only captures one point in time, and changes could be due to differences in the survey sample and other secular trends. This trend will be closely monitored as the State forwards efforts to transform the delivery of Medicaid services through Coordinated Care Organizations in the coming years.

Notes - 2010

Weighted counts and percentages. 2010 data unavailable because there was no OHT survey; 2009 data carried forward. Due to another statewide survey (SWS -Student Wellness Survey), which is conducted in even numbered years, as of 2011 OHT will be conducted in odd numbered years contingent on available funding. Unweighted counts and weighted percentages for years 2008 & 2009 available at <http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx>.

Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 8th grade population attending public schools, not counting charter or private schools.

Based on the following OHT survey question among 8th graders (question #12 in 2008, and #13 in 2009): When did you last go to a doctor or nurse practitioner for a check-up or physical exam when you were not sick or injured? Question remains same in both years.

Fewer eighth graders saw a doctor or nurse practitioner for a check-up or physical exam when they were not sick or injured in 2009 than in 2008.

a. Last Year's Accomplishments

Oregon's School-Based Health Centers (SBHCs) provided approximately 52,000 children from grades K through 12 with access to preventive health care and mental health services.

Seven new centers were established with planning grant funds dispersed in FFY 2010; three in high schools, one in a middle school, one in an elementary school and two in combined school campuses. Of the seven new centers, one opened in a county with no previous SBHCs.

SBHC State Program Office hosted three SBHC Coordinator's Meetings, which included state updates and trainings on relevant topics.

The Adolescent Health Section (AHS) contracted with a youth consultant who partnered with the Oregon School-Based Health Care Network's (Network) statewide Youth Advisory Council to develop a tool kit to help establish youth advisory councils (YACs) in school-based health centers to engage youth in quality improvement and utilization of health care services.

The SBHC State Program aligned the Patient Satisfaction Survey to meet the requirements of Tier 1 Patient-Centered Primary Care Home (PCPCH) Standards, a central component of health care transformation. Centers were also provided with technical assistance and guidance to adopt Bright Futures (American Academy of Pediatrics) Preventive Guidelines.

The SBHC State Program provided technical assistance and support for communities to apply for Federal HRSA SBHC capital planning grants. Fourteen organizations in Oregon were awarded over \$4.8 million.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve youth education and involvement in accessing preventive health services.		X		X
2. Increase the availability of check-ups and physical exams to the target population.		X		X
3. Increase provider education and awareness of the need for preventive physical and mental health services.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Youth consultants completed a pre-publication draft of the tool kit for Youth Advisory Councils YACs. They provided a framework of duties for a permanent young adult health education position in the Section. Current work is focused on preparing the tool kit for dissemination and working with Division leadership and Human Resources to develop a feasible position description for a young adult health education position.

SBHC State Office hosted training on the AAP Bright Futures Guidelines which was attended by fifty-three clinics.

SBHC State Program partnered with OCHIN (Oregon County Health Information Network) to develop an electronic health record (EHR) system based in Bright Futures Guidelines that better meet the needs of providing preventive care to adolescents in school-based settings.

SBHC State Program collaborated with Network and PCPCH Program staff to host a summit to support clinics to apply for PCPCH Tier 1 standards.

AHS developed survey questions to assess provider knowledge and use of recommended guidelines and evidence-based screening tools for children and adolescents. AHS is working with the Division of Medicaid Assistance Programs to determine how the assessment can dovetail with

metrics under development for Coordinated Care Organizations (CCOs).

AHS is exploring training models for provider education in the use and adoption of Bright Futures guidelines and evidence-based screening tools, specifically tools to identify early alcohol abuse or dependence.

c. Plan for the Coming Year

AHS will publish and disseminate the SBHC youth advisory council development tool kit and will continue working to establish a youth health educator position.

AHS will conduct a literature review and develop a study plan to determine the cost-effectiveness and outcomes of delivering preventive physical and mental health services in the school setting.

The SBHC State Program plans to analyze health outcomes from SBHC EHR pilot site data to assess the costs and benefits of delivering preventive and mental health services in the school setting, and the financial impact of EHR systems in SBHCs.

AHS will confirm and implement provider survey of awareness and use of recommended guidelines and evidence-based screening tools. Continue to explore models for provider outreach and education.

SBHC State Program will undergo a comprehensive review of all aspects of the program including site certification standards, data collection requirements and funding formula to continue its alignment with health care transformation.

SBHC State Program will award 3-5 planning grants to county health departments based on a competitive proposal review process.

State Performance Measure 8: Among CYSHN who needed mental health care or counseling in the past 12 months, percent of CYHSN who received all needed care.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					85
Annual Indicator				81.0	72.0
Numerator				81	72
Denominator				100	100
Data Source				NS-CSHCN	NS-CSHCN
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	85	85	85	85	74

Notes - 2011

Data for this Performance Measure are from the 2009/2010 National Survey of CSHCN. This is the most current data available for progress toward this indicator. The specific items used to compute this information are C4Q05_6 – Needed mental health or counseling in the past 12 months and C4Q05_6A – Received all needed mental health or counseling in the past 12 months.

Notes - 2010

Data for this Performance Measure are from the 2005/2006 National Survey of CSHCN. This is the most current data available for progress toward this indicator. The specific item used to compute this information are C4Q05X06A - Oregon CYSHN who received all needed mental health care or counseling during the past 12 months.

Notes - 2009

Baseline and objectives for the new State Performance Measures will be forthcoming in September, 2010.

a. Last Year's Accomplishments

OCCYSHN conducted an environmental scan to collect information on existing activities, resources and partnerships. Additionally, evaluation staff analyzed data from OCCYSHN's 2010 Need Assessment surveys and the 2007 National Survey of Child Health and 2005-2006 National Survey of Children with Special Health Care Needs to evaluate access to mental health services for CYSHN. Information from the environmental scan as well as national and state data was instrumental in helping OCCYSHN outline objectives and action steps to improve linkages to mental health.

OCCYSHN educated providers and families about appropriate linkages to mental health services. A webinar training was offered to health care providers and other professionals on effective navigation, referral and utilization of the mental health system. The webinar was archived on the OCCYSHN website and continues to be accessed as a resource for educating health care providers about Oregon's mental health system.

OCCYSHN partnered with the state's Addictions and Mental Health section to enhance collaboration and communication around this measure. OCCYSHN presented at a statewide children's mental health coordinator meeting to introduce OCCYSHN's community-based programs and discuss opportunities for improving linkages with local mental health programs.

OCCYSHN explored the use of the Early Childhood Service Intensity Instrument (ECSII) and the CASII as potential assessment tools to be utilized within the CaCoon program. These two tools are utilized within the mental health system and it was anticipated that usage of a common shared screening tool would assist in improving linkages and care coordination with mental health. With the advent of Oregon 's health care reform efforts, this work was put on hold as the integration of Oregon's mental health organizations into local Coordinated Care Organizations (CCOs) began to be implemented.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess the extent of need and access to mental health services.				X
2. Contribute to statewide capacity to improve linkages between health care and mental health				X
3. Educate health care providers and families about appropriate linkages to mental health services in Oregon				X
4. Promote integration of physical and mental health		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OCCYSHN track systems and policy changes related to the integration of physical and mental health through the implementation of CCOs to assess the impact on CYSHN with mental health needs.

OCCYSHN conducted a survey of professionals who participated in the webinar training on mental health. The survey goal was to understand the training impact on professional practice as well as identify difficulties/barriers in referring and linking with mental health. Survey results are being analyzed.

OCCYSHN is supporting the development and implementation of the F2FHIC through its administration of the grant and the shared resources available through its established infrastructure. F2FHIC provides information and navigational support to CYSHN families including those with mental health needs. Parents of CYSHN with mental health needs are identified and trained as Family Liaisons.

OCCYSHN's FIN and F2FHIC strengthen linkages with Oregon Family Support Network, an organization for families of children with mental health concerns. FIN and F2FHIC staff attended the Addictions and Mental Health (AMH) family leadership conference and have subsequently joined a AMH family leaders group. FIN/F2FHIC partner with AMH family leaders to increase outreach to CYSHN families with mental health needs.

F2FHIC Coordinator participates on the Oregon Mental Health Taskforce to represent the needs of CYSHN.

FIN/F2FHIC sponsored a training for Family Liaisons on navigating the mental health system.

c. Plan for the Coming Year

OCCYSHN staff will continue to track and monitor efforts related to health care transformation and the creation of a health insurance exchange to assure that CYSHCN mental health needs are included. OCCYSHN will work its partners through the the Office of Family Health and Addictions and Mental Health to assure the mental health needs of CYSHN are addressed as well as the challenges accessing mental health care.

Through the leadership and consultation of a new CDRC Child Psychiatrist, OCCYSHN will increase it efforts at a systems level to address issues pertaining to CYSHN with mental health concerns and their access to care.

OCCYSHN continue to strengthen its linkages with the Oregon Family Support Network, National Alliance for the Mentally Ill, Native American Rehabilitation Association and others to better provide families with information and navigational support as well as explore opportunities to collaborate on advocacy and policy work related to CYSHN with mental health needs.

OCCYSHN will continue to provide information and education to families of CYSHN on the effective navigation, referral and utilization of the Oregon mental health system. The CaCoon and CCN programs will work collaboratively to identify and address mental health issues of CYSHNN throughout Oregon. All information and education materials will be posted to the OCCYSHN website family page and/or the F2FHIC website.

OCCYSHN will continue to work towards building capacity and infrastructure needed to improve linkages between health care and mental health. OCCYSHN plans to continue outreach and partnership activities with key stakeholders including partnering with OHSU Child Psychologists and the Oregon Pediatric Society to disseminate OPAL-K (psychiatric consultation) for primary care providers.

The Community Connections Network will continue to provide community-based care coordination and problem solving CYSHN and their families. OCCYSHN plans to expand representation from mental health providers on CCN multidisciplinary teams as well as explore opportunities for collaboration with local mental health wrap-around teams.

State Performance Measure 9: *Among CYSHN who needed specialty care in the past 12 months, percent of CYHSN who received all needed care.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					81
Annual Indicator				78.0	90.0
Numerator				78	90
Denominator				100	100
Data Source				NS-CSHCN	NS-CSHCN
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	81	81	81	81	91

Notes - 2011

Data for this Performance Measure are from the 2009/2010 National Survey of CSHCN. This is the most current data available for progress toward this indicator. The specific items used to compute this information are C4Q05_2 – Needed specialty care in the past 12 months and C4Q05_2A – Received all needed specialty care in the past 12 months.

Notes - 2010

Data for this Performance Measure are from the 2005/2006 National Survey of CSHCN. This is the most current data available for progress toward this indicator. The specific items used to compute this information are C4Q05X01A - C4Q05X014A - Oregon CYHSN with no unmet needs for any of 15 specific health care services or equipment during the past 12 months.

Notes - 2009

Baseline and objectives for the new State Performance Measures will be forthcoming in September, 2010.

a. Last Year's Accomplishments

OCCYSHN analyzed data from the 2010 Needs Assessment Surveys to identify specific barriers to specialized services among underserved populations including CYSHN living in rural/frontiers areas of the state.

One goal related to this performance measure is to address issues related to coverage and reimbursement for specialized services. OCCYSHN collected information about Medicaid and other third party payer coverage of genetic services.. OCCYSHN and the Office of Family Health collaborated with the Oregon Health Services Commission, now the Health Evidence Review Commission (HERC), and DMAP to provide staff time to chair the Genetics Advisory Committee to these agencies. Denials for coverage of pediatric clinical genetics evaluation, genetic counseling, and genetic testing were reviewed; DMAP genetic testing utilization data were analyzed; and the medical literature was researched. The committee recommended evidence-based revisions to the Oregon Health Plan (OHP) non-prenatal genetic testing guidelines which were adopted by the commission. Technical assistance was provided to HERC staff.

OCCYSHN worked with OHSU government relations and a workgroup of genetic counselors to draft legislation for genetic counselors licensure. The bill was not submitted for the 2011 session due to the state's fiscal climate.

OCCYSHN partnered with the Oregon Commission on Autism Spectrum Disorder (OCASD) to promote state recommendations on Autism screening and assessment. OCCYSHN submitted a HRSA grant to support the development of community-based teams for the purpose of screening and diagnosing ASD and other Developmental Disabilities. OCCYSHN was not awarded the HRSA grant.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve the availability and quality of data about needs and access to specialized services				X
2. Identify and address issues related to insurance coverage and reimbursement of specialized health and related services				X
3. Educate providers and families about accessing specialized health and related services				X
4. Integrate public health and clinical activities to increase capacity to provide specialized health services to CYSHN across Oregon		X		X
5. Promote the development of policy and system changes that improve access to specialized health services				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OCCYSHN is tracking and monitoring efforts related to health care transformation for the inclusion of CYSHN.

OCCYSHN is partnering with CDRC on efforts to provide specialty care in rural areas by sending CDRC physicians out to underserved communities as well as increase consultation to providers in rural areas. To further address challenges to accessing specialized services, OCCYSHN is also exploring alternative models for CCN. OCCYSHN explored opportunities to leverage existing CCN teams to increase their capacity to also serve as community-based Autism screening, evaluation and diagnostic teams in select rural communities.

Information collected (in the prior program year) about Medicaid and other third party payer coverage of genetic services is currently being analyzed to better understand coverage and coverage denials for pediatric clinical genetics evaluation, genetic counseling, and genetic testing.

OCCYSHN and the OFH continued to support staff time to serve on the HERC's Genetics Advisory Committee. This year, the committee recommended additional revisions to OHP genetic testing guidelines which were adopted with minor modifications. Resources for OHP Managed Care Plan Medical Directors for deciding coverage of genetic tests based on the guidelines were presented and disseminated.

CCN collaborated with the LEND program to provide a series of trainings on treatment and

management of ADHD to multidisciplinary CCN teams and other community-based providers.

c. Plan for the Coming Year

OCCYSHN will continue efforts to identify and address insurance coverage and reimbursement issues related to specialized services, including access to specialty services for families who live in rural communities where there no, or limited, specialty care providers.

OCCYSHN will continue to track and monitor changes related to health care transformation and the implementation of CCOs statewide. Assurance of appropriate referrals and access to specialty care and/or the adequacy of panels is of great concern to families with CYSHN. OCCYSHN will explore opportunities to assess the impact of CCO's on access to specialty care for CYSHN.

Ongoing budget cuts and resulting limitations to available therapies are of serious concern to families of children with special health needs. OCCYSHN will explore avenues by which impact on families and their children can be assessed, as well as the adequacy of therapy/therapy visits received in relation to best practice.

OCCYSHN will continue to promote the development of policy and system changes that improve access to specialized health services. This fall OCCYSHN, OHSU Government Relations, and the genetic counselors work group will reevaluate submitting the legislation for the 2013 legislative session. If the bill is introduced in the 2013 session, OCCYSHN will begin coalition building as well as developing materials to educate stakeholders.

OCCSYHN will explore the development of a statewide nutrition network. Based, conceptually, on a nutrition network implemented in Washington state, OCCYSHN will determine the feasibility and need of a state level systems effort around nutrition services to CYSHN.

OCCYSHN plans to develop an "issue brief" highlighting the need for specialized services among Oregon CYSHN. This brief will include data findings from OCCYSHN's 2010 Need Assessment Surveys. OCCYSHN plans to develop and disseminate information to primary care providers and families about specialized services available around the state. Information on Medical Home with an emphasis on care coordination with specialty care providers will also be disseminated.

OCCYSHN will partner with the Oregon F2FHIC to provide information to CYSHN and their families on how to access specialized health and related services, especially in rural/frontier areas. OCCYSHN will work with the F2FHIC to identify ongoing needs of families regarding access to specialty care and therapies as evidenced through the OR F2FHIC data.

State Performance Measure 10: *Progress in developing an Action Plan to improve access to family support services for families of children with special health needs statewide*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance					1

Objective					
Annual Indicator				0.0	1.5
Numerator				0	1.5
Denominator				4	4
Data Source				OCCYSHN Benchmark Checklist	OCCYSHN Benchmarks
Is the Data Provisional or Final?				Provisional	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	2	3	4	4	4

Notes - 2011

The data source for this measure is a benchmark checklist developed by OCCYSHN (Oregon's Title V CSHCN program). The checklist includes specific action steps for each benchmark. OCCYSHN monitors the checklist and determines when each benchmark has been completed. Documentation includes: benchmark checklist, work plans, timelines, meeting minutes, and completion of work products and activities.

Notes - 2010

The data source for this measure will be a benchmark checklist developed by OCCYSHN (Oregon's Title V CSHCN program). The checklist will include specific action steps for each benchmark. OCCYSHN will monitor the checklist and determine when each benchmark has been completed. Documentation will include: benchmark checklist, work plans, timelines, meeting minutes, and completion of work products and activities.

Notes - 2009

Baseline and objectives for the new State Performance Measures will be forthcoming in September, 2010.

a. Last Year's Accomplishments

As part of Oregon's 2010 Title V Needs Assessment, OCCYSHN conducted a Family Survey and a Provider Survey to assess the needs of children and youth with special health needs (CYSHN) and their families as well as those of community-based providers who serve this target population. The Family and Provider Survey results identified greatest needs of families of CYSHN to include Family Support Services (e.g. information, navigational assistance, parent-to-parent support, respite). This finding was largely consistent with those identified by the Child Health Collaborative and Advisory Group.

In response to this need, OCCYSHN developed State Performance Measure (SPM) #10 -- Increase access to family support services for families of CYSHN. No reliable data sources were identified for this measure. OCCYSHN developed a benchmarks checklist to track and monitor activities as well as progress towards meeting this performance measure. OCCYSHN conducted an environmental scan to evaluate internal/external activities, partnerships and resources and how they contribute to the development and implementation of this performance measure. Information collected from the scan was utilized in the development of a benchmark checklist and other planning activities.

OCCYSHN was awarded a MCHB grant to fund the Oregon Family to Family Health Information Center (F2FHIC). The F2FHIC provides peer to peer information and resources and works to strengthen statewide support for families of CYSHN. Because both OCCYSHN and the F2FHIC actively contribute to the MCHB's six core performance outcomes, the placement of the F2F within OCCYSHN serves to enhance the capabilities and achievements of both programs including work accomplished on behalf of this performance measure. F2FHIC grant activities commenced July 2011. OCCYSHN and the F2FHIC collaborate to identify and evaluate family support needs; identify and link to existing family support entities; establish and strengthen a

network of Family Liaisons; assist in providing training for families and/or Family Liaisons; and develop strategies and recommendations to meet family support needs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Gather information related to family support needs, availability and accessibility of family supports across the state				X
2. Strengthen statewide network of Family Liaisons/Family Navigators, family-driven organizations and other family support resources		X		X
3. Develop, disseminate and share information and materials around family support resources and services			X	X
4. Identify and develop strategies for increasing access to family support to families of CYSHN across the state including families in rural/frontier areas				X
5. Partner with key stakeholders including families, state and local agencies and other to develop action plan for implementing strategies for increasing access to family support to families of CYSHN statewide				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OCCYSHN finalized the benchmark checklist to track activities, outputs and outcomes. This year OCCYSHN focused its activities on meeting benchmark #1 - Gather information related to family support needs, availability and accessibility of family supports across the state. To meet this benchmark, OCCYSHN completed the following activities: 1) analyzed Family Needs Assessment Survey to further evaluate family support needs; 2) convened an internal workgroup to analyze/examine family support needs; 3) convened a series of family listening sessions around the state to collect information on family support needs; 4) developed a database of contacts including family-driven organizations and programs serving CYSHN; 5) developed a "map" of family-driven organizations/groups around the state.

OCCYSHN began work on benchmark #2 - Strengthen statewide network of Family Liaisons/Family Navigators, family-driven organizations and other family support resources. OCCYSHN worked to closely link Family Liaisons (FLs) working with its FIN to the F2FHIC. FLs are located around the state and work with local multidisciplinary teams. FLs expanded their role to work with the F2FHIC to receive and respond to calls from families needing information and navigational support. In addition, OCCYSHN established a listserv of FLs, family-driven organizations and individual families and a listserv of agencies that support families. Listservs served as a method for establishing a virtual statewide network.

c. Plan for the Coming Year

OCCYSHN will continue to monitor the benchmark checklist to track activities and determine when each benchmark has been completed. An internal workgroup of key OCCYSHN staff will be convened monthly.

OCCYSHN will continue to develop, maintain, and support a statewide network of family liaisons

under the rubric of Benchmark #2. OCCYSHN will continue to explore opportunities for expanding Family Liaisons including the expansion of Hispanic Family Liaisons to increase outreach to Latino communities. To assure Family Liaisons are prepared to receive and respond to the family support needs of families of CYSHN, FLs will receive monthly training on key topics including Oregon's new health delivery system and care-coordination efforts, accessing services of exceptional needs care coordinators within managed care plans, Oregon's Positive Behavior and Intervention Support in public schools, and Oregon's Assistive Technology programs. In addition to these activities, OCCYSHN will continue to build on and utilize its listerves as a method for strengthening a virtual statewide network and sharing information with network entities.

OCCYSHN will begin work under the rubric of Benchmark #3 -- Identify and develop strategies for increasing access to family support to families of CYSHN across the state including families in rural/frontier areas. Planned activities include: exploring methods/strategies for expanding family liaisons in rural/frontier areas around the state; explore opportunities for implementing family liaisons/family navigators in tertiary care settings as well as within local health departments to partner with public health nurses serving CYSHN through the CaCoon program; and exploring opportunities to partner with family-driven organizations and state agencies to collectively address the support needs of families. Information, data and lessons learned from these activities will be utilized in the development of a comprehensive Action Plan (Benchmark #4) to increase access to family support to families of CYSHN statewide.

OCCYSHN plans to develop an issue brief highlighting family support needs among families of CYSHN. The "issue brief" format has been very positively received by OCCYSHN's stakeholders. In addition, information and data on family support needs will be shared with Department of Human Services, legislators, brokerages, disability organizations and others.

E. Health Status Indicators

Demographic information and data from vital statistics, including poverty levels, describe the Oregon population at large and reflects changes in the proportion of population subgroups. The information allows the Title V programs to identify those areas that need assessment or further analysis. Population changes drive the ability of the Title V programs to serve a specific population with health disparities or inequities. In Oregon, the major population changes continue to be among the Hispanic population, including those who are citizens or are undocumented. The service requirements for this population group require specific cultural competencies among providers and access to care not covered by Medicaid. More information about Oregon's demographic changes are described in the narrative in "Agency Overview" Section III.A. Data for Health Status Indicators can be found in Form 20, in the Forms section of the Block Grant.

Low birth weight (HSI #1A and 1B):

Low birth weight percentages have gradually risen in Oregon at similar rates to the rest of the country. Low birth weight for singleton births in Oregon has been steady at about 4.7% since 2005.

A preventable reason for the low birth weight proportion is elective cesarean deliveries. Another way in which low birth weight could be decreased is in decreasing third trimester smoking among pregnant women. Oregon had an active program to teach prenatal care providers to use The 5 A's; the lessons from that program have been incorporated into work that is now done by local health departments. Additional funding for smoking cessation (including advertising, increased access to the Oregon Quit Line and increased education of prenatal care providers in the use of The 5 A's) could further decrease maternal smoking and therefore low birth weight. Oregon PRAMS has asked about several components of The 5 A's. Analysis of that data on prenatal care providers doing optimal smoking cessation counseling led to the discovery

that many prenatal care providers are not providing optimal smoking cessation counseling. The work was published in the American Journal of Public Health ("Racial/Ethnic Disparities in the Receipt of Smoking Cessation Interventions During Prenatal Care." Tran ST, Rosenberg KD, Carlson NE. Maternal and Child Health Journal, 2009)

/2013/ The MCH Epidemiologist and staff from the Title V Program office are working on a research project with the local chapter of the March of Dimes and the Evidence-Based Center at the Oregon Health and Science University to conduct "hard stops" to elective inductions prior to 39 weeks. //2013//

Very low birth weight (HSI #02A and #2B):

Very low birth weight in Oregon has been steady at 1.0% since 2005 and very low birth weight for singleton births in Oregon has been steady at 0.7-0.8% since 2005. Oregon has no programs in place to decrease very low birthweight.

Pre-pregnancy nutrition may be an important factor in determining birthweight. For example, in World War II, women were exposed to similar famines in the Netherlands ("the Dutch famine") and Leningrad ("the siege of Leningrad"). Birthweights of both groups of women decreased during the famines but the birthweights of the Dutch women decreased more because they had better nutrition before the famine. (Thomson AH. Technique and perspective in clinical and dietary studies of human pregnancy. Proc Nutr Soc. 1957;16:45-51.)

Dr. David Barker is located at the Oregon Health and Sciences University and continues to consult with the Title V epidemiologist and program staff about the impact of events before and early in pregnancy on a variety of outcomes, including adult cardiovascular disease.

/2013/ The Oregon Title V Program is working on a collaborative project with local health departments to promote better preconception health. The collaborative developed a preconception action plan, through an Action Learning Collaborative team supported by AMCHP to develop preconception recommendations for young women with disabilities. Additionally, a HRSA-funded grant helped create a social marketing campaign to raise awareness of preconception health among Latinas and their providers, called "Amor Y Salud." //2013//

Deaths due to injuries: HSI #03A and #03B:

The leading causes of unintentional injury death to children aged 14 years and younger remain 1) motor vehicle crashes/occupants, 2) drowning, 3) suffocation, 4) motor vehicle crashes/pedestrians, and 5) fire/flame. Local health departments are encouraged to screen families for child safety seat needs and send them to local coalition members that can provide the seat with education on installation and use. A focus statewide has been to identify certified Child Passenger Safety Technicians that are bilingual or work with families that speak another language than English.

A statewide effort is to increase the percentage of children ages 4-8 observed riding in a booster seat. Currently, about 60% of the children this age are riding in a booster seat. For drowning safety, mini-grants are provided to local coalitions to erect Lifejacket Loaner Kiosks at rivers and lakes in order to promote the use of lifejackets while swimming. For suffocation, a task force was created to develop a statewide plan for reducing sleep related suffocation and SIDS/SUIDS deaths to children under age 1. For pedestrian and bike safety, mini-grants are provided to local coalitions to support walking and bicycling to school and teaching pedestrian safety. We partnered with the Office of the State Fire Marshal to launch a train the trainer program with Head Starts statewide on a new Start Safety fire safety education program.

Oregon law requires children to remain in a booster seat until age 8 or 4'9". About 20 (out of 36) county health departments participate in screening families for child safety seats. Local

departments are referred to local coalition members that can provide the seat with education on installation and use. Federal funds for child safety seats and booster seats are available to all counties in Oregon and most low-income families are accessing low-cost seats.

/2013/ Updates for injury data will be provided in the September 2012 update. //2013//

Deaths due to unintentional injuries (HSI #03C and #4C):

Title V Child Injury Prevention staff participate on the Advisory Committee to the Youth Program and Occupant Protection Programs with Oregon Department of Transportation. A focus of the Youth Program efforts has been to increase the availability of Driver's Education instruction and classes in Oregon. A program to engage pre-drivers and their parents was launched. This program encourages parents and pre-drivers to take a web-based quiz that helps both navigate and understand the costs and consequences of teen driving and build a contract on safe passenger behaviors.

/2013/ Updates for injury data will be provided in the September 2012 update. //2013//

Nonfatal injuries HSI #04A and 4B:

The leading cause on nonfatal injuries to children aged 14 years and younger is falls. Leading causes of falls include those that occur: on playgrounds, in the home (stairs, chairs, beds), out of buildings, scooters/skateboards/skiing, and one level to another. Safe Kids is holding a public Window Falls Summit Nov. 9 to encourage community discussion on how best to promote window safety. We partner with home visiting nurses to identify home fall hazards, and encourage helmet use while in wheeled or snow sports. A statewide campaign to prevent window falls was launched in 2012 and includes a website, www.stopat4.com.

Oregon law requires children to remain in a booster seat until age 8 or 4'9". About 20 (out of 36) county health departments participate in screening families for child safety seats. Local departments are referred to local coalition members that can provide the seat with education on installation and use. Federal funds for child safety seats and booster seats are available to all counties in Oregon and most low-income families are accessing low-cost seats. A major effort is ongoing to increase the percentage of children ages 4-8 riding in booster seats.

/2013/ Updates for injury data will be provided in the September 2012 update. //2013//

Chlamydia among women (HSI #05A and #5B):

Since July, 1987, Oregon has had a rule that all providers and laboratories must report all confirmed cases of cases of Chlamydia to their local health department. The local health departments report these cases to the state health department, which keeps the reports in the Sexually Transmitted Disease Management Information System (STDMIS).

The data are organized to count more than one case of Chlamydia in a year for an individual, but multiple reports on the same case of Chlamydia are de-duplicated.

Starting in March 2010, the STDMIS data was moved to a new database, known as ORPHEUS (Oregon Public Health Epidemiology User System). From 2006-2010, there was a significant increase in cases of Chlamydia among women 15-19 years old; from 18.0 to 24.7 per 1,000. Two mostly likely reasons for this increase are more sensitive lab methods and increased screening, especially targeting screening to women age 25 years old and younger. Oregon labs have recently moved to using nucleic acid amplification testing, which is more sensitive than previous technologies. More women are being screened each year for Chlamydia in Oregon. There is increasing interest among Managed Care Organizations and other provider groups in the HEDIS measure for Chlamydia screening among women age 15-25 years old, a potential motivator to screen more women more often (every year) than in previous years. National Chlamydia screening guidelines recommend screening sexually active females under age 26 at least annually for Chlamydia infection.

New strategies being made by the HST Program to reduce Chlamydia cases includes encouraging sex partner services such as expedited partner therapy (EPT) among females who

are already positive for Chlamydia to prevent re-infection after treatment.

/2013/ Updates for Chlamydia rates will be provided in the September 2012 update. //2013//

DEMOGRAPHICS (RACE/ETHNICITY):

Health Status Indicator #06A and #6B: Infants and children aged 0-24 by race, ethnicity; Oregon Center for Health Statistics.

The total estimated population of infants and children aged 0 through 24 years in Oregon accounts for approximately 32% of the total Oregon population. Within this population age group, 86.4% were White, 2.8% were Black, 2.0% were American Indian/Native Alaskan, 4.0% were Asian, 0.4% were Hawaiian or Pacific Islander, 17.9% were Hispanic/Latino and 82.1% were non-Hispanic/Latino. Overall, the largest youth groups were White and Hispanic/Latino.

/2013/ The total estimated population of infants and children aged 0 through 24 years in Oregon accounts for approximately 32% of the total Oregon population in 2010. Within this population age group, 76.3% were White, 2.3% were Black, 1.7% were American Indian/Native Alaskan, 4.0% were Asian, 0.5% were Hawaiian or Pacific Islander, 19.2% were Hispanic/Latino and 81.0% were non-Hispanic/Latino. Overall, the largest youth groups were White and Hispanic/Latino. //2013//

Health Status Indicator #07A and #7B: Live births by maternal age, race and ethnicity.

Data source: Oregon Center for Health Statistics.

The overall racial makeup in Oregon shows a shift toward increasing racial diversity. In 2010, 81.5% of births were to White mothers. There is a trend towards an increasing percent of Hispanic children. In 2010, Hispanics comprise 20.2% of infants 0-1.

/2013/ The overall racial makeup in Oregon shows a shift toward increasing racial diversity. In 2011, 82.9% of births were to White mothers. There is a trend towards an increasing percent of Hispanic children. In 2010, Hispanics comprise 19.3% of infants 0-1. //2013//

Health Status Indicator #08A and #8B: Deaths of infants and children by age, race and ethnicity.

Data Source: Oregon Center for Health Statistics

In 2010, white children accounted for 81.5% of deaths to children age 0-24, Blacks 4.4%, American Indians 2.2%, Asians 3.2% and Hawaiian/Pacific Islanders 0.8%. Those with more than one race accounted for 3.5% of deaths and others/unknown for 4.4%. Latino/Hispanic children comprised 16.4% of deaths to children age 0-24

/2013/ Death data is not available for 2011. //2013//

Health Status Indicator #09A and 9B: Infants and children aged 0 through 19 years in miscellaneous situations, by race and ethnicity; Data available from various sources.

Household percentages:

In 2009, there were 863,803 children aged 0-17 in Oregon; 29.6% (n=257,877) of those lived in families where there was only a male or female as head of household. Blacks (63.5%), American Indian (43.6%) and Pacific Islander (49.0%) were much more likely to be living in a household headed by a single parent than Whites (27.8%). Both the NSCH and ACS identify children as 0-17 years of age.

/2013/ In 2010, there were 884,078 children aged 0-17 in Oregon; 29.9% (n=264,339) of those lived in families where there was only a male or female as head of household. Blacks (65.0%), American Indian (47.4%) and Hispanics or Latino (36.0%) were much more likely to be living in a household headed by a single parent than Whites (29.9%). Both the NSCH and ACS identify children as 0-17 years of age. //2013//

TANF percentages:

In 2009, Blacks were much more likely to receive TANF (25.3%) than other racial/ethnic groups

(second highest was Hawaiian/Pacific Islander: 13.7%, followed by Hispanics: 11.4%). There seems to be a decrease in percentage of children aged 0-19 on TANF between 2007 (6.7%) to 2009 (5.9%); however, such comparison should be with caution due to different methods in reporting TANF data.

/2012/ The number of individuals on TANF during 2010 indicates a small increase of not more than 10%. //2012//

/2013/ In 2011, Blacks were much more likely to receive TANF (34.7%) than other racial/ethnic groups (second highest was Hawaiian/Pacific Islander: 15.5.7%, followed by American Indian (12.8%), and Hispanics: 12.6%). There seems to be an increase in percentage of children aged 0-19 on TANF between 2007 (6.7%) to 2011 (9.9%); however, such comparison should be with caution due to different methods in reporting TANF data. The number of individuals on TANF during 2011 indicates a small increase of not more than 10%. //2013//

Food Stamp enrollment:

In 2009, Blacks were more likely to be recipients of food stamp (60.0%, n=16,894) than any other groups. Next highest were Hawaiian or Pacific Islander (54.8%, n=2,056) and Hispanics or Latino (45.9%, n=86,132).

/2013/ In 2011, Blacks were more likely to be recipients of food stamp (79.0%, n=17,726) than any other groups. Next highest were Hawaiian or Pacific Islander (55.0%, n=2,623) and Hispanics or Latino (50.0%, n=99,668). //2013//

Medicaid and SCHIP enrollment:

In 2010, about 236,282 children aged 0-18 were on Medicaid/Oregon Health Plan. A total of 935,241 children were in Oregon during 2010 (Oregon Annual Population Report). This indicates that 25.0% of children received Medicaid that year. Notes: Number of children with un-identifiable race/ethnicity could belong in any of the 5 racial groups making the numbers for the 5 groups unstable (i.e.: White, Black, American Indian, Asian, and Hawaiian/Pacific Islander). Interpretation of Number in SCHIP is integrated in Number enrolled in Medicaid.

/2013/ In 2011, about 251,241 children aged 0-18 were on Medicaid/Oregon Health Plan. A total of 918,372 children were in Oregon during 2011 (Source: 2011 Oregon Annual Population Report). This indicates that 27.4% of children received Medicaid that year. Notes: Number of children with un-identifiable race/ethnicity could belong to any of the 5 racial groups making the numbers for the 5 groups unstable (i.e.: White, Black, American Indian, Asian, and Hawaiian/Pacific Islander). Interpretation of Number in SCHIP is integrated in Number enrolled in Medicaid. //2013//

Foster care:

/2012/ In 2010, there were more White children (9,084) and children with 2 or more races (4,421) living in foster care arrangements. //2012//

/2013/ In 2011, there were more White children (8,905), children with 2 or more races (2,063), and Hispanics or Latino children (1,862) living in foster care arrangements. //2013//

WIC enrollment:

/2013/ The Pediatric Nutrition Surveillance Survey data (2011) provides age, race and ethnicity data for 110,442 de-duplicated infant and child Oregon WIC participants. Approximately 20% of child WIC participants are under 5 months of age, with another 11% falling between 6-11 months of age. Nineteen percent are between the ages of 1 and 2. Half are between the ages of 2 and 5. Fifty-two percent of child participants were White, with 37.5% of participants reporting their ethnicity as being Hispanic. Two percent each reported their race as either Asian/Pacific Islander or Black/African American. Three

percent reported more than one race. //2013//

Juvenile crime rates:

In 2008, the juvenile crime rate among Blacks was substantially higher than that of other racial/ethnic groups. **/2013/ The 2010 rates continue to show the same disparity among all races and ethnicities. //2013//**

High school dropout percentages:

2009-2010 school year data showed that Blacks (6.2%), American Indian/Alaskan Natives and Hispanics (6.7%) and Hispanics (4.7%) had dropout rates that were substantially higher than the state average (3.4).

/2013/ The 2010-2011 school year data showed that Blacks (5.6%), American Indian/Alaskan Natives and Hispanics (5.9%) and Hispanics (4.7%) had dropout rates that were substantially higher than the state average (3.3). This pattern is consistent with school year 2009-2010 data where Blacks (6.2%), American Indian/Alaskan Natives and Hispanics (6.7%) and Hispanics (4.7%) were the three groups with highest drop-out rate. //2013//

Health Status Indicator #10: Geographic living area for all children aged 0 through 19 years. Data Sources: U.S. Census, American Community Survey, and Oregon Population Report.

The majority of Oregon children ages birth through 19 (91.3%) live in metropolitan areas. Most (73.1%) live in urban areas, and the rest live in rural (25.7%) or frontier (1.1%) areas.

/2013/ Updated and corrected data show that the majority of children in Oregon (85.0%) reside in metropolitan areas. The rest (15.0 %) live in non-metro areas. Most Oregon children (79.4%) live in urban areas, and the rest live in rural (18.3%) or frontier (2.5%) areas. //2013//

Health Status Indicator #11 and #12: Percent of the State population at various levels of the federal poverty level.

A very small percentage of the overall Oregon population is below 50% of poverty (0.6%). However, for children, this percentage is much higher (7.0%). Similarly, children are more likely to be below 100% and below 200% of poverty than the general population.

/2013/ In comparison with 2009 and 2010 poverty data, there is an increase for those Oregonians living with poverty level below 50%: about 4.6% of Oregonians were below 50% of poverty in 2009 (source: 2010 CPS), and this number jumped to 7.2% in 2010. For children, this percentage is much higher (9.5%). Similarly, children are more likely to be below 100% and below 200% of poverty than the general population. Overall, the percentage of Oregonians living under poverty is similar with national rising trend (source: 2010 American Community Survey). //2013//

F. Other Program Activities

MCH Toll-Free Line: 1-800-SafeNet is Oregon's statewide MCH Information and referral line. It was established in April 1991, and is funded jointly by Title V, Title X, WIC, and Immunization and Oregon Food Stamps Programs. SafeNet's information and referral services are provided through a contract with the agency 211Info and the Office of Family Health. 211info owns the 211 National Social Service number for the state of Oregon, however they are not yet statewide.

The 211info and SafeNet call lines link low income Oregon residents with health care services in their communities; assist in identifying and prioritizing needs of callers with immediate, multiple health care concerns; match provider callers with appropriate information concerning options; track and document service gaps. Outreach for SafeNet occurs through Medicaid card messages

and inserts (WIC, prenatal, flu, and dental), state public health and social services brochures, community networking and presentations, websites, DHS offices, local health departments, private providers, managed care plans and social service agencies. Special advertising campaigns designed to move particular target audiences to call SafeNet for particular time-sensitive information is conducted periodically. SafeNet is utilized as a part of other nutrition and food assistance programs such as in Food Stamp Outreach and Summer Food site information. At present eleven staff members are fully trained in taking Oregon SafeNet calls.

As Oregonians move more toward using the internet to look for services and find information, 211info and SafeNet developed websites where the public can search for particular services and their location. <http://www.oregonsafenet.org/>

A Prenatal and Newborn Resource Guide for Oregon Families is the third version over the years. The booklet has content in Spanish on the left page and English content on the right page. The book was originally designed and disseminated to hospitals and birthing centers to distribute to new mothers, and included content specific to health and care of newborns and early childhood. The current version adds prenatal content and is distributed to providers of prenatal care services instead of hospitals and birthing centers. The guide is available on http://www.oregon.gov/DHS/ph/ch/newborn_resource_guide.shtml

Cultural Competency:

Juntos Podemos, a family support organization, connect families with the resources they need to better support their children. Through Family Liaisons in Lincoln and Marion Counties, OCCYSHN's collaboration with Juntos Podemos and its parent organization, Human Services Research Institute, has lead to increased referrals of Latino families to CCN and CaCoon and to development of family support groups for Latino and other families whose children have disabilities and/or chronic conditions in Lincoln County.

/2012/ The Community Connections Network (CCN) has increased outreach to Latino families and materials were translated into Spanish. One CCN Team has initiated increased cultural competency by adding a cultural broker to the local CCN team. This practice will be evaluated in the future and shared with other CCN Teams around the state to increase cultural competency. CCN partnered with the Oregon Pediatric Society's START program to increase awareness of CCN among primary care providers. This outreach effort has increased engagement of local primary care providers in CCN activities, including referral to CCN and attending CCN team meetings. //2012//

/2013/ OCCYSHN partnered with Juntos Podemos to submit a grant to the Providence Community Foundation to support Latino families better meet the needs of their CYSHN through increased family support, care coordination, and access to health and medical resources. Juntos Podemos was not awarded the grant and has since closed its doors. OCCYSHN is exploring other opportunities to expand outreach and support for Latino families of CYSHN. OCCYSHN contracted with an independent consultant who previously worked for Juntos Podemos. In addition to being a family member of a CYSN, she has a close working relationship with many Latino families with children with disabilities and special health needs. Additionally, OCCYSHN has been invited to participate in a national learning collaborative sponsored by the Association of Maternal and Child Health Programs addressing increasing "ease of use" of community-based services for families of CYSHN of the Latino community. //2013//

Family Consumer Participation:

OCCYSHN has developed a relationship with Swindell's Family Resource Centers in two communities. This partnership leverages the CCN and Swindell's resources and impact through a shared position in one community (Lincoln County) and a common employee in another (CCN Family Liaison who is also a Resource Center coordinator in Marion County).

Assessments and Evaluations:

OCCYSHN conducted a survey of CCN providers to assess the strengths and weaknesses of current CCN operations as well as evaluate the impact of CCN on CYSHN, their families and the local community. CaCoon, OCCYSHN's public health care coordination program was submitted and approved by AMCHP as a promising practice. OCCYSHN is continuing efforts to improve and evaluate the program to elevate the program to an evidence-based best practice.

//2012/ OCCYSHN improved several assessment and evaluation practices during FY11. The ORCHIDS client database for CaCoon program services was updated with additional fields to measure outcomes, such as client's issues identified, interventions delivered, and outcomes achieved. These were improved to ease reporting and facilitate time series analysis. The CCN database was modified to improve reporting of child and collaborative team level activities for use by local CCN team's quality improvement. Annual reporting methods for both programs were improved to better monitor site and county/community level activities. //2012//

Other OCCYSHN Activities:

OCCYSHN has been highly involved with the Oregon Commission on Autism Spectrum Disorder (OCASD) and its efforts to improve services and the system of care for individuals with Autism Spectrum Disorders. OCCYSHN's medical consultant was selected to serve on the OCASD in 2008. Dr. Nickel also chaired the Health Services subcommittee and served on the Screening, Identification and Assessment subcommittee. OCCYSHN Director also served on the Community Services for Children and Families subcommittee. Work of and with the Commission and subcommittees led to OCCYSHN submission of a grant request to assist in implementing components of the OCASD plan.

OCCYSHN continues strong partnership with the CDRC LEND program. OCCYSHN staff present Interdisciplinary Forums on Title V and systems of care for CYSHN, Family Centered Care, and assist the LEND program in finding parent speakers and presenters. OCCYSHN FIN Manager also works with the LEND Family Mentoring Program to match students with Parent Mentors and as Family Faculty. LEND Family Faculty helps to identify and mentor a Family Trainee to participate in the 10 month training program and provides family perspectives in LEND activities.

OCCYSHN collaborated with the Autism Treatment Network to expand services in rural Oregon for children newly diagnosed with autism. OCCYSHN coordinated and implemented a series of webinars for professionals using a train-the-parent model. The program trains professionals to teach parents how to increase social communication with their children in the course of day-to-day to activities.

G. Technical Assistance

- Region X Title V programs (Alaska, Washington, Idaho, Oregon) request assistance to sponsor a National Association of Chronic Disease Directors (NACDD) Regional State Academy on Life Course & the Chronic Disease Model in 2013. In Region X, two of the four states have merged Chronic Disease Programs with Maternal Child and Adolescent Health programs, leveraging the opportunity to implement Title V efforts according to a life course framework. Additionally, an "Academy" structure for learning, sharing, and applying knowledge to these structures is available with a partnership with the National Association of Chronic Disease Directors and the Association of Maternal and Child Health Programs.

Purpose: To develop a shared learning experience for MCAH and Chronic Disease epidemiology, evaluation and policy staff in our state programs.

Issue Category: General Systems Capacity Issues

Proposed Consultants: NACDD & AMCHP
Estimated Costs: Meeting rooms and associated costs
Estimated Dates: About Jan 2013-June 2013

- The Public Health Division has recently adopted new goals and objectives. Many of these are linked to the Title V priorities, such as family violence, obesity, suicide, and excellence in epidemiology and surveillance. Additionally, the Title V programs and the Chronic Disease and Injury programs have recently merged into the Center for Prevention and Health Promotion. During 2013, the Center will need to work on aligning program and policy priorities and strategies, including integration of the life course approach.

Purpose: To develop framework for policy development and program evaluation that aligns with the PHD goals and evidence-based/best practices for life course approach to public health interventions.

Issue Category: Other

Proposed Consultants: Professional Facilitator familiar with public health

Estimated costs: Consultant stipend and associated meeting costs

Estimated Dates: About October 2013-December 2013

- The Public Health Division has adopted a goal to support Oregon's new Coordinated Care Organizations (like Accountable Care Organizations) in achieving community health goals. The CCO model is community-oriented, using local needs and assessments to build the delivery system for populations enrolled in the CCOs. A need exists to build a set of best and evidence-based practices, along with quality metrics, for the maternal, child and adolescent populations that aligns with the mission and goals of the Oregon Health Authority, the Public Health Division, and the Title V priorities.

Purpose: Learn about nationally accepted best /evidence-based practices feasible for implementing through Oregon's CCOs

Issue Category: Other

Proposed Consultants: National experts in public health strategies for

Estimated budget: Stipend and travel costs

Estimated dates: January -- June 2013

- The Title V needs assessment identified parenting education and skills resources priority in 2010. Simultaneously the Oregon Public Health Division has recently adopted new goals and objectives that include the prevention of family violence. An important first step in this process is to identify the role that public health can offer in a state system approach to developing parenting resources capacity. The state and local Public Health Maternal and Child Health Sections supported using the "Strengthening Families Approach" as a guiding framework to align parenting and family goals across multiple child and family serving systems.

Purpose: To develop a shared learning experience with statewide and local partners interested in strength based and based on evidence-based practices for improving skills and resources for parents of young children.

Issue Category: State Performance Measure 5

Proposed Consultants: Consultant from the Center for the Study of Social Policy (CSSP)

Estimated Costs: Consultant stipend and travel

Estimated Dates: About October 2012

- Community Based Services are Easy to Use.

As changes occur within health care and maternal and child health arenas at the federal level, Oregon is undergoing significant changes in its health care delivery and organizational structures. Realignment under the Oregon Health Authority, creation of Coordinated Care Organizations and a Health Care Exchange, reorganization toward a statewide system of home visiting, and continuing reductions in funding are all impacting Oregon families of CYSHCN as well as professionals who serve them. Specific expertise in serving CYSHCN and in providing education on quality care and services is often prioritized at a low level when considering and implementing change for the entire child and adult population of the state.

Purpose: Technical assistance in applying the Ease of Use Framework (and its guiding domains of Universality, Access, Value, and Affordability) to assist OCCYSHN's work to assure state health reform: addresses CYSHCN issues, incorporates measurements of quality of care for CYSHCN and their families, and assures that community-based services meet the needs of CYSHCN and their families and are easy to use.

Performance Measure: National Performance Measure #5: The percent of children with special health care needs age 0 to 18 whose families report community-based service system are organized so they can use them easily.

Proposed TA source: National Center for Ease of Use of Community-Based Services (<http://www.communitybasedservices.org/>)

Estimated budget: \$2500 for travel, lodging, consultant fees

Estimated dates: February 2013 through April 2013

- Public Health Nurse Care Coordination for CYSHCN -- Curriculum Development Consultation
OCCYSHN's CaCoon program is seeking to formalize, evaluate and validate a training curriculum to address the training needs of public health nurses. This is to insure that public health nurses are prepared and supported in their role of providing community-based care coordination for children with special health needs. The CaCoon program has been implemented for 20 years and is becoming ever more important within the current environment of healthcare reform. Referrals from healthcare providers are increasing and CaCoon public health nurses are assisting children with complex conditions that require coordination with several providers. Expert consultation on curriculum development, implementation, evaluation and validation would support this effort.

Purpose: Consultation on formalizing the CaCoon Training Program -- including further training program development, implementation, evaluation, and validation -- leading toward certification

Performance Measure: NPM #3

Proposed TA source: MCHB Training Program, University of Washington LEND Training

Program estimated budget: \$2500 for travel, lodging, and consulting

Estimated dates: September 2012 -- December, 2012

- Outcomes Measurement of Community Health Teams

The OCCYSHN Community Connections Network (CCNs) program is evolving within the larger context of Oregon's health care transformation -- including the development of Coordinated Care Organizations (like Accountable Care Organizations). CCNs have for nearly 20 years provided a point of "wrap-around" of health and health related services for children living in rural communities who have "ongoing complex and unresolved issues." Additionally, CCN teams become the mechanism by which each participating community has amassed a "CYSHN team" with expertise and connections that serve a larger population beyond the children who are referred to CCN. The outcomes of the community teams have been challenging to measure. OCCYSHN seeks assistance in developing an evaluation plan that will measure intended and unintended outcomes of this model of community health team. This may also support OCCYSHN in its efforts to assess the capacity of communities to continue with the CCN model within the larger changing context of healthcare transformation.

Purpose: Assess and evaluate OCCYSHN's CCN Teams for outcomes, sustainability, and future positioning within Oregon's healthcare transformation

Performance Measure: Outcome Measurement

Proposed TA source: Expert in health outcomes measurement

Estimated budget: \$2000 for outcomes measurement consultation and planning

Estimated dates: November 2012-March 2013

- Medical Home Provider Training and Implementation

Background: The OCCYSHN program is exploring the establishment of a formal program of training and technical assistance to address the rapidly growing need for trained office-based care coordinators within the context of a medical home resulting from the passage and implementation of Oregon health care reform legislation. OCCYSHN already has a strong infrastructure related to training our CaCoon (Care Coordination PHNs) nurses who reside in

each Oregon county. OCCYSHN believes there is a need to provide consultation, training, and hands-on technical assistance to support practice change for practices that provide primary care to CYSHN and are faced with providing comprehensive care coordination and linkages with community-based resources. OCCYSHN is seeking assistance in the development of this program of training and technical assistance.

Purpose: Development of formal program of consultation, training and technical assistance addressing office-based care coordination.

Performance Measure: NPM #3

Supports: General System Capacity

Proposed T.A.: Jeanne W. McAllister, BSN, MS, MHA, Center for Medical Home Improvement

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	6225530	6155398	6148111		6100000	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	13202453	29466033	12694490		12894577	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	7788590	7658349	8123706		10810637	
6. Program Income <i>(Line6, Form 2)</i>	0	0	0		0	
7. Subtotal	27216573	43279780	26966307		29805214	
8. Other Federal Funds <i>(Line10, Form 2)</i>	62540357	44793166	65973783		66858842	
9. Total <i>(Line11, Form 2)</i>	89756930	88072946	92940090		96664056	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	1309862	1986040	1271647		1249764	
b. Infants < 1 year old	9359857	15747726	8883779		11975091	
c. Children 1 to 22 years old	10745784	20946122	10610292		10869562	
d. Children with	3262598	3244698	3242513		3205032	

Special Healthcare Needs						
e. Others	660877	464076	569062		569062	
f. Administration	1877595	891118	1927240		1936703	
g. SUBTOTAL	27216573	43279780	26504533		29805214	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	440000		440000		140000	
b. SSDI	94664		94664		94664	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	18544041		23552977		20998460	
h. AIDS	0		0		0	
i. CDC	9200881		8801520		7838308	
j. Education	0		0		0	
k. Home Visiting	0		0		3459202	
k. Other						
FP Waiver/Med Match	0		0		29374901	
SNS, SAMHSA, CMS	0		0		2535721	
Title X Family Plan	0		2219906		2417586	
ACYF, EPA, HRSA, SNS	0		2824572		0	
CCare (FPEP) Waiver	0		28040144		0	
FPEP Waiver	31016826		0		0	
Other Fed Funds	1012945		0		0	
Title X, Family Plan	2231000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	5778726	2667761	5653845		1262762	
II. Enabling Services	9511350	13481573	9269085		10544219	
III. Population-Based Services	1721976	4124183	1620125		2439539	
IV. Infrastructure Building Services	10204521	23006263	9961478		15558694	
V. Federal-State Title V Block Grant Partnership Total	27216573	43279780	26504533		29805214	

A. Expenditures

Oregon's expenditure and budget report represent the totals from both Title V Agencies -- Office of Family Health and the Oregon Center for Children and Youth with Special Health Needs. The totals include all those funds under the direction of the Title V Director in OFH and OCCYSHN, which include Federal Funds, State General Funds, and Other Funds. Each of these funds is on different cycles which make for some estimates in some cases. The expenditures are final for a federal fiscal year (October-September) or a state fiscal year (July-June) for the same general time period. Oregon is on a biennial budget so the projection is generally half of the Legislative Approved budget or, in a Legislative year, a pending Governor's budget. Notes about the sources for the expenditures and budget are included in the Forms.

The Federal/State Partnership expenditures report on Forms 3, 4 and 5 for 2008, include all Title V Block Grant Funds, state General Funds not used as match for other federal programs, and Other Funds, that are typically private foundation grants (not used for match for other federal programs). The 3:4 Title V match includes expenditures or revenues in local health departments that are not used for match for Targeted Case Management and Medicaid Administrative Match, including fees, County General Fund and other Third Party payments. There can be fairly wide variations on Forms 3, 4, and 5 between the budget projection and the expenditures, which follows two years later. Variations are generally caused by differences between the state and county budget amounts and actual expenditures funded by revenue generated by federal payments for eligible services, such as the Family Planning Expansion Project (counting clients under age 21) and Babies First home visiting programs. Other match is calculated from county program expenditures using revenue sources that are non-federal (client fees, county general fund) and that is not used for federal match.

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 count as Direct and Enabling Services. Funds that are used at the State level, in the Office of Family Health, are distributed between Population-Based and Infrastructure, prorated according the type of activities occurring in the state-level programs.

The Oregon Center for Children with Special Health Needs reports its expenditures into the Federal/State Partnership expenditures report (Forms 3, 4 and 5 for 2009) and includes all of its 30% federal funds transferred from the Office of Family Health to OCCYSHN along with matching state General Funds. OCCYSHN community --based programs (CaCoon, Community Connections) are allocated approximately 30% in Enabling services and the remainder in Infrastructure services.

The Oregon Title V Expenditures are generally based on reports from the Office of Family Health, Oregon Center for Children and Youth with Special Health Needs, and from county health department reports submitted to the Public Health Division. In each annual report, the expenditures are based on actual expenditures at the time of the preparation of the Title V report (around May of each year).

/2012/ Assumptions for Expenditures for both OFH and OCCYSHN are the same as above.
//2012//

/2013/ There was no change in the expenditure assumptions during FY 2011. //2013//

B. Budget

Oregon's budget and expenditures report represent the totals from both Title V Agencies -- Office of Family Health and the Oregon Center for Children and Youth with Special Health Needs. The totals include all those funds under the direction of the Title V Director in OFH and OCCYSHN, which include Federal Funds, State General Funds, and Other Funds. Each of these funds are on different cycles which makes for some estimates in some cases. The expenditures are final for a federal fiscal year (October-September) or a state fiscal year (July-June) for the same

general time period. Oregon is on a biennial budget so the projection is generally half of the Legislative Approved budget or, in a Legislative year, a pending Governor's budget. Notes about the sources for the expenditures and budget are included in the Forms.

The Federal/State Partnership budget includes all Title V Block Grant Funds, state General Funds not used as match for other federal programs, and Other Funds, that are typically private foundation grants (not used for match for other federal programs). The budget does not include anticipated expenditures from revenues generated by match or new grants in the Title V Offices or local health department MCH programs.

The Office of Family Health, Title V Program, meets its 30-30 minimum requirement by transferring 30% of the Oregon MCH Block Grant appropriation to the OCCYSHN for serving the children with special health care needs. No administrative or indirect is retained by OFH prior to transfer. The required Maintenance of Effort for Oregon is \$3,950,427 and the Title V Offices assure this minimum through funds generated at the state and local levels that benefit the maternal and child health population. The 3:4 Title V match in the budget are projected revenues from state general funds and county local funds, including patient fees, local general funds, and non-Medicaid 3rd-party payments, that are not used for match for other federal programs. The Oregon Legislature appropriates the state funds on a biennial basis and the state appropriates funds for local grants on an annual basis.

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 count as Direct and Enabling Services. Funds that are used at the State level, in OFH are distributed between Population-Based and Infrastructure prorated according the type of activities occurring in the state-level programs.

The OCCYSHN budget includes the required 3:4 Title V match from state general funds through a state budget line item for the Child Development and Rehabilitation Center. The Oregon Legislature appropriates the state funds on a biennial basis. OCCYSHN programs are allocated approximately 30% in enabling services and the remainder in infrastructure services.

/2012/

Sources of Other Federal Grants reported in Forms 2 and 3 (see Form Notes for details):

SPRANS

Early Childhood Comprehensive Systems Planning (ECCS)
Universal Hearing Screening

CDC

Breast and Cervical Cancer Prevention (BCCP); Early Hearing Detection Intervention (EHDI); Genomics; Immunization -- various program grants; PRAMS (Pregnancy Risk Assessment and Monitoring System); Rape and Prevention Education (RPE); WISEWOMAN

OTHERS

Health Resources and Services Administration (HRSA): MCH Home Visiting; OCCYSHN -- Family to Family; Oral Health - Workforce Activities

Substance Abuse and Mental Health Services Administration (SAMSHA): Project LAUNCH -- Linking Actions for Unmet Needs in Children's Health

Centers for Medicaid and Medicare Services (CMS): CHIPRA Outreach Grant; Medicaid Administration for Children and Families (ACYF) - PREP - Personal Respon. Edu. Pre. - ACYF

Strategic National Stockpile (SNS): Immunization

Environmental Protection Agency (EPA): Building Capacity

Office for Population Affairs:
Family Planning - Title X

Medicaid Waiver: Family Planning Expansion Project (FPEP in previous years) renamed to
CCare -- Contraceptive Care

Other Medicaid Match: Maternity Case Management, home visiting, School-Based Health
Centers, Oral Health, Immunization //2012//

//2013/ The Title V Office does not anticipate new funding sources in 2013. //2013//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.