



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

**State Narrative for
Oregon**

**Application for 2009
Annual Report for 2007**



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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.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurance 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; expires May 31, 2009.

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.

//2008/ The Title V program created a website was created to encourage comments, suggestions and ongoing input into the priorities to improve health for the MCH population. (<http://www.oregon.gov/DHS/ph/ofhs/mch/mch.shtml#mch>)

Other opportunities for public input occurred through public meetings and sessions with stakeholders and local partners, such as Conference of Local Health Officials- MCH Committee and local Nursing Supervisors. Input into the priorities OCCYSHN family consultants provide input on program and policy development in both OCCYSHN and in OFH, and links other family consultants to participate in planning activities beyond Title V program areas. //2008//

//2009/ The OFH reviewed the Title V budget with MCH-CLHO in Fall 2007 to solicit input on the linking of the budget with goals and performance measures. Shared priority setting and strategic planning to improve perinatal health status engaged the public health nurses and the Title V program. //2009//

//2009/ In June, 2008, OCCYSHN provided an educational and feedback session with 8 families of children/youth with special needs, from rural communities and small urban communities, and Family Liaisons in the Community Connections Network. The session provided overview of OCCYSHN and asked families about their priorities in their communities for CYHSN, how well programs were addressing those needs, and suggestions and recommendations for improvement. Families identified health care access and need for mental health services as primary concerns and priorities throughout the state. They also emphasized the needs of non-English speaking families and families who are non-readers or have lower literacy levels. Both of OCCYSHN's community based

programs, CaCoon and Community Connections are considered very helpful to families. However, this group indicated that additional marketing was needed to assure that families and providers are aware of the programs and know how to access them. //2009//

//2009/ In addition to the emphasis on sharing the block grant with families, OCCYSHN also interacted with its partners through the local public health departments and local community teams through the end of year reflection and evaluation meetings to secure input regarding unmet and emerging needs of CYSHN. Repeatedly issues related to behavioral and mental health and oral health are cited as areas of growing unmet need. OCCYSHN relies on this local input to help shape its priorities for the coming program year. //2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Oregon Title V Needs Assessment priorities are focused on capacity building and leadership to better address current and emerging issues for the MCH population. Summarized below are the ongoing assessment activities in 2008-09.

Population assessment:

- In 2007, the Title V Program completed a comprehensive, in-depth look at the health status of pregnant women and birth outcomes in Oregon to explore priorities and needs. This information was published as the Oregon Perinatal Data Book. The Data Book is comprised of leading perinatal health indicators that describe the overall picture of perinatal health in Oregon, with data obtained from Vital Statistics, PRAMS, and the National Immunization Survey. The Data Book was instrumental in a priority setting function shared between local public health nurse supervisors and the Title V Program in OFH. The result was two priorities for which action plans have been developed -- preconception/inter-conception care and perinatal depression.

- In Summer 2008, an intern is conducting an in-depth look at the Oregon results of the National Survey of Children's Health. The outcome of this study will help to provide direction about priorities in child health status that will help shape program priorities and provide some basis for the next Title V needs assessment.

- The Adolescent Health Program is working in ongoing needs assessment and priority setting by incorporating Youth Action Research methods to identify needs, priorities and goals based on the input of youth. The information from this research will be used to the development of strategies and policy recommendations for the new teen pregnancy prevention/adolescent sexual health State Plan.

- A School Based Health Center Mental Health Needs Assessment online survey was completed by each of the SBHCs to assess in detail their mental health staffing and capacity in order to understand where gaps exist. This information will be used to provide technical assistance and training to SBHCs in having better organization of existing mental health services, as well as serving as a capacity baseline when planning for future mental health services.

- OCCYSHN designed a question for the Oregon Healthy Teens Survey to better understand behaviors of adolescents with special health needs

- OCCYSHN evaluated qualitative data and information to assess the need to improve program services on behavioral health, family involvement, access and adolescent transition

Evaluation capacity improvement:

- OFH has instituted its planned Evaluation and Epidemiology Unit within the newly restructured MCH Section in the Office of Family Health. Development of this unit was one of the highest priorities identified in the MCH Capacity Assessment conducted as part of the needs assessment.

- ORCHIDS -- the MCH client data system in development for many years -- finally rolled out in 2008 and will provide much needed information to evaluate local MCH program delivery.

- OFH is conducting a small study to ascertain whether Medicaid citizenship verification laws, implemented in 2006, were associated with any delay in Medicaid eligibility determination for

pregnant women in Oregon. If the data indicate that a delay occurred, we will examine the effect of this delay on timeliness and quality of prenatal care.

Leadership capacity building;

- OCCYSHN is collaborating with private groups and public agencies to explore the health access concerns for CYSHN as related to insurance coverage, training for providers and assessing capacity of nursing groups (school nursing, home health nurse and public health nurses) to address care coordination needs.

- Office of Family Health annually conducts a series of informational sessions for public health staff to share their work and outcomes, assisting in the professional development of staff. This series has taken on a different framework each year and in 2008, the theme is "Lessons Learned in Program Evaluation and Design."

- OFH and OCCYSHN staff and managers are attending both Public Health Leadership and MCH Leadership programs. During 2007-08, two of the new MCH managers MCH attended the National MCH Leadership Academy, two staff completed a DHS Leadership Academy, and others attended the national Program Evaluation Association meeting held in Portland in late 2007.

III. State Overview

A. Overview

Oregon's Title V Program provides the leadership and direction for state and local programs and partners to identify issues affecting the health of Oregon's maternal and child health population. The Title V Program functions across agencies in the Office of Family Health (OFH) in the Department of Human Services, Public Health Division, and in 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 Title V Administrators from both these agencies assure a comprehensive, cross-agency approach to understand and plan activities supporting Oregon's MCH population issues and needs. Activities include jointly reviewing epidemiological data and information from stakeholder and public input activities, assuring state and local staff are adequately trained in MCH program and policy development, partnering to develop client services data systems and quality assurance for service delivery, and communicating regularly to manage the Title V program at the operational and population-health level. The Title V programs utilize the framework for public health core functions, public health essential services, and Title V pyramid of services in developing and promoting strategies and recommendations to stakeholders and policy makers.

OCCYSHN utilizes an array of needs assessments and data sets to frame priorities for its activities. These include national surveys, community needs assessments, and input from families, community providers, and state partners. Alignment with OHSU and its teaching and research centers benefits OCCYSHN's commitment to provide high quality leadership on behalf of Oregon's children and youth with special health needs, as well as education of families and in-service training for Oregon's providers.

1. Oregon Environment

Oregon is located in the Pacific Northwest with a population of 3.5 million living in 96,545 square miles. Oregon is primarily a rural state, with a population density of 37 people per square mile. Portland is the major urban center, with approximately 1.5 million people in a tri-county area. There are 43 member tribes of the Northwest Portland Area Indian Health Board and other urban health facilities located in Oregon, Washington and Idaho. Other urban areas include Salem, the state capital, Eugene, in the mid-Willamette Valley, and Medford, in Southern Oregon. Oregon has many state parks and national forests with an abundance of outdoor recreational opportunities, from windsurfing to backpacking and fishing to walking or biking on Portland's 40 mile-loop.

/2008/ The 2007 Oregon Shines report, an analysis by the Oregon Progress Board of 91 "Oregon Benchmarks" measures the state's well-being and this year shows Oregon is making strong progress in terms of economic growth, public safety and livable communities, while challenges remain in other areas, including education, civic engagement, social support and the environment based on established state goals. The seven biggest improvements occurred in: 1) net job growth; 2) third-grade math; 3) feeling of community; 4) national ranking for hunger; 5) juvenile arrests for property crime; 6) state road condition; and 7) invasive species. Areas that raised concerns are: 1) continuing fall of per capita income in relation to other states; 2) worker training; 3) public library service; 4) homelessness; 5) high school students carrying weapons; 6) housing affordability (also a concern in the 2005 report); and 7) carbon dioxide emissions (<http://www.oregon.gov/DAS/OPB/>)

/2008/ Oregon's population continues to increase overall according to the 2006 Population Survey (<http://www.oregon.gov/DAS/OEA/popsurvey.shtml>). The rate of people migrating to Oregon in the past five years grew from 17 percent in 2004 to 23 percent in 2006. An increase occurred in all regions but Region 4 (five counties in southwest Oregon), which remained the same as in 2004. Region 1, generally rural (three north coast counties plus Columbia County), saw a 10-percentage point increase; Region 2, primarily urban (Clackamas, Multnomah, Washington and Yamhill counties), experienced a 9-percentage point increase. In rural central Oregon, Deschutes County reported a 29% increase in their population and neighboring Crook

County reported a 20% growth in population. A shift in the ethnic diversity is also occurring, best demonstrated in Washington County where in the town of Hillsboro the population has more than doubled since 1990 with the Latino population increasing more than fourfold (from 11% in 1990 to 21% in 2005% //2008//

/2009/ Oregon's population grew by 1.5% between July 2006 and July 2007, to reach 3,745,455, a slower growth than the 1.6% of 2005-2006. This is the first year of decline since 2002, when growth was under 1.% at the time of recession. However, Oregon is ranked 11th fastest in the nation in 2007. (Oregon Employment Dept. Article, April, 2008; <http://olmis.emp.state.or.us/olmisj/ArticleReader?itemid=00005899>). Oregon's housing market, compared to other areas in the country, has help up well comparatively well. //2009//

/2009/ The 2006 American Community Survey ranks to other states for median household income and in percentage of people in poverty. Median household income for Oregon overall is \$46,230, a significant increase of 4.3%, ranking 27th in the U.S., between 2005 and 2006; the U.S. overall was \$48,451, a 1.6% increase. Oregon income-to-poverty ratio less than 100% is 13.3% or 480,613 persons, ranking 32nd in the U.S. in the in the 2006 ACS survey, where the U.S. ranks 30th overall compared to other states. (U.S. Census Bureau, 2006 American Community Survey). //2009//

/2009/ The 2008 Oregon Benchmark Race and Ethnicity Report (Oregon Progress Board, May 2008) remarks that, while Oregon continues to become a more diverse state, it is less racially and ethnically diverse than the U.S. as a whole. From 2006 Census population projections, 86.1% Oregonians classify themselves as White, compared to 73.9% in the U.S. African Americans are the least represented group in Oregon, at 1.7% compared to 12.4% in the U.S. overall. Asian/Pacific Islanders have increased slightly to 3.9% of the population while the U.S. API population is at 4.4%. American Indians are more represented in Oregon than the U.S., at 1.8% and 0.8% respectively. Oregon experienced an increase in the Hispanic population between 2000 and 2006, from 4% to 10.2% in that time period, though is lower than the 14.8% in U.S. overall.//2009//

2. Economic Environment

The median income for Oregon for a family of 4 is \$36,157 (2005). The total population making 100% or less of the federal poverty level (2002-2003) is 16%, with a total of 35% of the population is considered low income (Kaiser Foundation, State Health Facts: www.statehealthfacts.kff.org). The unemployment rate (May 2005) remains at 6.5 percent, less than 2004, but still higher the U.S. 5.1 percent. The fastest growing industries are business administrative and business support services and health service industries: ambulatory health care, hospitals, and nursing and residential care. Health services are likely to continue to grow along with the population due, in part, to the increasing demands of the aging baby boom population.

/2007/ Unemployment rates reached a peak of 8.5 in Summer 2003, but has steadily improved since then. The rate fell to 5.5 in April 2006, though this is still higher the national rate for that month which was 4.7. /2008/ Oregon's unemployment rate was 4.7 in May 2007 (5.0 seasonally adjusted), much improved but slightly higher than the national rate of 4.3 (4.5 seasonally adjusted). (<http://www.employment.oregon.gov/employ/budget/ui/index.shtml>) //2008//

/2009/ The unemployment rate for May 2008, was 5.6% up slightly from April 2008 at 5.4%. the U.S. rate was 5.5% in May an 5.0% in April, 2008. Although Oregon's rate has been higher than the U.S. rate for many years, the gap has been narrowing and now the difference between the two is not statistically significant. (Oregon Employment Department, May, 2008 http://www.oregon.gov/EMPLOY/COMM/news/may_2008_unemployment.shtml) //2009//

/2007/ The annual report card published by Children First of Oregon in September 2005, reports that the rate of child poverty increased from 17.5% to 19.1% or approximately 160,000 children. The poverty rates for the total population show disparities for specific populations: White: 24% in Oregon compared to 33% nationally; Black 24% in Oregon compared to 33% nationally; Hispanic

is 34% in Oregon compared to 29% nationally; and "other" is 21% in Oregon and 19% nationally (2003-04; Kaiser Family Foundation, www. Statehealthfacts.org) //2007//

/2008/ The Oregon Population Survey for 2006 found Oregon's median household income increased from \$40,569 to \$42,021 between 2003 and 2005. Adjusted for 1989 dollars, income decreased from \$26,220 to \$25,813 during that period. (<http://www.oregon.gov/DAS/OEA/popsurvey.shtml>) //2008//

/2008/ Oregon struggles with its tax revenue structure that assure sufficient funding for schools, public safety, and health care. The 2007 Legislature made steps to improve this by creating a Rainy Day fund that would direct the 2007-2009 Corporate Kicker (previously returned to taxpayers) and the Education Stability Fund, one percent of the state's general fund balance into the reserve, providing full protection for education, public safety, and human services during future economic downturn. Oregon was one of six states without a general fund rainy day fund.

At the federal level, a multi-year reauthorization of the Secure Rural Schools and Community Self Determination Act, which technically expired in September 2006 and extended for one year, is threatening the infrastructure of Oregon's counties who relied on the timber industry to support local services. The Rural Schools Act provided \$1.6 billion to 33 of 36 Oregon counties in payments to compensate for lower revenues from reduced timber harvests on federal land. Without these funds, 23 counties face losses of more than 20% to their county general or road funds. In three counties, the revenue amounted to 60% of their county general funds, and in other counties 70% of their county road funds. With the expiration of these payments, counties have already begun to cut services, such as law enforcement, public safety and public health services. Counties that relied heavily on General Fund timber revenue have low permanent property tax rates, as set by a state property tax limitation, Measure 50, rates. "One effect of these low rates is that counties cannot simply grow out of the financial crisis they now face. A stark example is Curry County. With fewer than 12,000 homes at a median assessed value of \$225,000, the county will need 33,000 new homes assessed at \$350,000 each to replace the lost PL 106-393 general fund revenue." (Presentation on Federal Forest Payments and County Services, by Association of Oregon Counties, January 23, 2008; http://www.aocweb.org/aoc/Portals/0/Content_Managers/FFP%20Generic%20Package.pdf). Some counties will try for tax levies to begin shifting costs locally, however, even if levies are passed, the collection and transition from one revenue source to another will be result in a reduction of services and will not be at the same level as the timber tax revenues. Oregon state and local public health officials are making strategic plans to assure public health services continue in the county, even if by a contractor other than the county health department. //2008//
/2009/ Currently, the Rural Schools Act, the "Timber Tax," has been in and out of Congressional Appropriations Bills, creating a roller coaster of unknown futures for Oregon counties. Limited success in one year extensions of the tax give these counties a reprieve, however, those extensions are not sufficient for long-term problems. In 2007, Gov. Kulongoski appointed a task force to review Oregon's tax revenue system to determine ways to provide support for local services in the counties that are hardest hit. The Task Force report will be released sometime in summer, 2008, and is expected to provide recommendations for flexibility for counties to levy property taxes, currently limited in Measure 50, or allow use of lodging taxes for basic services. //2009//

3. Health Insurance Access

Health care services are accessed through private providers and hospitals, paid through private hospitals and managed care plans, including the Oregon Health Plan, a Medicaid waiver program, a safety net system that is linked through community health care and partnerships with private health care providers. Systems to link private and public health care services exist through medical associations, the medical and dental directors on the Oregon Health Plan, Office of Rural Health, medical, nursing and dental academic and training programs.

There are approximately 229,000 children enrolled in the Oregon Health Plan, but it is estimated

that another 66,000 remain uninsured. Children and families may encounter barriers when attempting to access publicly funded insurance programs such as Medicaid and the State Children's Health Insurance Program (SCHIP). When OHP reduces enrollment or benefits, parents may find it difficult to discern that their children may still qualify for benefits. It is difficult in many areas to find providers who will accept the patients covered by OHP due to perceived low reimbursement rates. Language and cultural differences can be barriers to enrolling in publicly funded insurance programs. African-American, Native American and Hispanic children are less likely to be insured than white, non-Hispanic children both locally and nationally. (Office for Oregon Health Policy and Research http://egov.oregon.gov/das/ohppr/rsch/doc_rep_present.shtml).

/2007/ In March, 2006, the Office for Oregon Health Policy and Research released a report, "Profile of Oregon's Uninsured--2004." (<http://www.oregon.gov/das/ohpr>). In 2004, the national uninsured rate was 15.7%, and during the same time, 17% of Oregonians are without health insurance coverage, an increase from 14% in 2002. This represents more than 609,000 individuals of all ages, 117,725 who are children under the age of 19. Over half (53%) of the currently uninsured children may qualify for SCHIP, which offers coverage for incomes up to 185% of the federal poverty level, or \$34,873 for a family of four in 2004. A statewide survey of parents, conducted in 2005 through the Office for Oregon Health Policy and Research found that the required period of uninsurance, the 6-month enrollment periods and a fairly complicated application all contributed to breaks in coverage for low-income children. The Profile reports that: young working-age adults (18 to 24) are very likely to be without coverage. Approximately 62% of the uninsured 18 to 24 year olds had household incomes of less than 200% of the federal poverty level, and 64% are working. The disparities among Oregon's largest minority population, Spanish, Hispanic or Latino, are twice as likely to be uninsured (34.2%) as the general population. The Profile reports that over 15% of those who are uninsured reported that they have a lasting physical (24%), mental (24%), developmental or learning (11%). (from the Oregon Population Survey, 2004, reported in the Profile of the Uninsured, Office for Oregon Health Policy and Research <http://www.oregon.gov/das/ohpr>).

The condition of the uninsured in Oregon, especially for children, has received increasing media attention in front page reports and editorials, and from the the Governor, who is running for re-election. Organized efforts are in existence to improve access to health care for Oregonians, including the Archimedes Movement led by former Governor Kitzhaber, and a petition for a ballot measure to make health care a right in Oregon. The issue is the highest priority among candidates for the Legislature and for the Governor. //2007//

/2009/

The 2006 survey of the Oregon Health Policy study of insurance shows 12.6% of children under the age of 19 (116,000) lacked health insurance coverage last year, compared to 13% in 2004.//2009//

/2007/ Past legislation that will affect the availability of care of children with special needs is Oregon Senate Bill 1, the Mental Health Parity bill to take effect January 2007. The intent of this legislation is to require insurance companies to offer as much coverage for mental illnesses as they do for physical ailments. There is concern however, as the rules are being written, that limits on the coverage for treatments such as communication will limit the access to those children with special needs that require these treatments for optimal growth and development. OCCYSHN will continue to partner with advocacy and providers group to advance the parity of services in all areas for children and youth with special health needs. //2007//

/2008/ Legislative summary for health insurance access:

SB 3, Healthy Kids Plan: This legislation was introduced by the Governor under several bills, all of which created a Healthy Kids Fund to provide resources for increased coverage by Medicaid to family income of 250% of Federal Poverty Level to pregnant women and children up to age 24. The Private Health Partnership is created to provide support for families up to 250% FPL and

ineligible for the Oregon Health Plan, to purchase health insurance. With bipartisan support for the Healthy Kids Plan, the funding mechanism to raise taxes on tobacco sales to 84.5 cents per pack stalled the bill. The final legislation referred the Healthy Kids Plan to the voters in Fall, 2007, as a constitutional amendment that will dedicate tobacco tax revenues to provide health care to children, low-income adults and other medically underserved Oregonians and to tobacco use prevention and education.

House Bill 2406 directs the DHS to apply for a Medicaid Waiver for medically-involved children to allow families to move their children out of institutions and back home with the more comprehensive services that Medicaid provides. Approximately \$3 million was allocated through the DHS Seniors and Disability Division to fund this bill.

HB 2918, the insurance parity bill for children with pervasive developmental disabilities passed, as well. This measure requires a health benefit plan to cover treatment of a child under 18 who has been diagnosed with pervasive developmental disorder subject to the same conditions as treatment of physical illness. It also directs the Health Resources Commission, which is the body responsible for the OHP prioritized list, to conduct a review of available medical and behavioral health evidence on treatment of pervasive developmental disorders and to report findings and recommendations to the next legislative assembly. For purposes of the legislation, a pervasive developmental disorder means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or mental retardation.

Approved budget increases in DHS for payment of services included a \$3.8 million biennial increase for the Family Planning Expansion Project to continue covering reproductive health services for all women in Oregon.

SB 329 Creates Healthy Oregon Act, establishes Oregon Health Fund program, and establishes Oregon Health Board to administer program; key directives include developing a comprehensive plan and proposal for financing Oregon Health Fund program and identifying health services to be provided by program, that support principles of equity, public priorities, effectiveness, efficiency, collaborative, coordinated, family-centered, and financially sustainable. Recommendations and a plan are to be reported to the 2009 Legislature. //2008//

//2009/ Oregon Health Fund Board and task forces have been meeting over the last year to develop a comprehensive plan to ensure access to health care for all Oregonians. The Board is expected to provide recommendations that contain health care costs and address issues of health care quality. Gov. Kulongoski has reiterated his commitment to ensuring affordable health care coverage for children and low income adults in a letter to the Health Fund Board in June, 2008 (<http://www.oregon.gov/OHPPR/HFB/index.shtml>). In his letter, he requests the Board to consider revenue options, including tobacco taxes, to support these priorities. The Governor's 2009 Budget Request will include funding requests for health care access improvements based on the Health Fund Board's recommendations. //2009//

4. Health Care and Safety Net Access

Populations facing barriers to primary or preventive health services include people living in frontier and rural areas, Hispanics, migrant farm workers, and resident uninsured adults ineligible for the Oregon Health Plan.

Oregon's health care safety net is comprised of a broad range of local non-profit organizations, government agencies, school-based health centers, and individual providers who share the common mission of delivering health care to persons who experience barriers to accessing the health care services they need. Health care safety net clinics in Oregon are staffed by physicians, nurse practitioners, physician assistants, nurses, dentists, social workers, community health workers, other health care providers, and volunteers.

Oregon's health care safety net clinics include:

32 Federally Qualified Health Centers (some at county health departments)

30 Rural Health Clinics

10 Indian/Tribal Health Clinics

40 School-Based Health Centers

35 County Health Departments
15 Community Clinics
7 Migrant Health Centers

These clinics vary in terms of size, number/types of professionals employed, client characteristics, service area population density and demographics, diversity and stability of revenue sources, as well as sophistication in practice and business management practices. Primary care services provided by the safety net include, but are not limited to: urgent care, acute and chronic disease treatment, services based on local community need (mental health, dental, and vision), preventive care, well child care, and enabling services (translation/interpretation, case management, transportation and outreach).

Migrant and seasonal farmworkers support a multi-billion dollar agricultural industry. According to the Oregon Migrant and Seasonal Farmworker Enumeration Profiles Study completed by Alice Larson, Ph.D., September, 2002: The Migrant and Seasonal Farmworker population is estimated at 174,484, including 14,558 Migrant Children and Youth, 44,905 Seasonal Children and youth. Commonly reported health problems among Migrant Farmworkers and their children include: lower height and weight, respiratory disease, parasitic conditions, skin infections, chronic diarrhea, vitamin A deficiency, accidental injury, heat-related illness and chemical poisoning. Non-resident pregnant women are not eligible for Oregon Health Plan covered prenatal care and must rely on federal (Title V) and state funds and public clinics for that care.

2007/ Targeted Case Management: A collaboration and agreement with the Title V Programs in OFH and OCCYSHN, the Dept. of Education and Developmental Disability Services established a priority billing system for Targeted Case Management (TCM). This agreement will allow improved ability to address the care coordination and service delivery needs, avoid duplication of services, optimize resources and ultimately improve access to care for families. //2007// /2008/ The focus has shifted to find and establish other financing for home visiting/high risk infant case management, as the limitations and proposed changes in TCM may reduce the capacity of the services. //2008//

/2009/ The billing priorities resulted in unanticipated risks for loss of services to at-risk children and were therefore discontinued. SPA revisions are being drafted that more accurately define public health nursing program target populations. OFH and OCCYSHN continues to pursue other funding strategies to decrease public health dependence on TCM resources. //2009//

/2007/ The Oregon School-Based Health Centers seek to improve adolescent health through prevention, primary care, and mental health services delivered in an accessible, developmentally appropriate framework that helps support the educational mission. In Oregon, there are 45 Centers in 17 Counties, 28 High Schools, 8 Elementary Schools, 1 K-12 School, 8 Middle Schools; 39,249 students had access to SBHCs at their school and Oregon SBHCs served 17,702 clients in 56,633 visits; 53% of SBHC's clients were uninsured and 71% of SBHC clients reported they were unlikely to receive care outside of the SBHC. //2007//

/2008/ The 2007 State Scorecard on Health System Improvements, published by the Commonwealth Fund, ranks Oregon as 34th in overall health system performance. Oregon ranked in the bottom quartile in access and equity, ranked second in hospital use and costs, and in the second and third quartiles in quality and healthy lives. (http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=4945) //2008//

/2009/ The Commonwealth Fund's 2008 State Scorecard in Child Health System Performance shows Oregon is lagging behind other states in several indicators. Oregon ranks 43 in overall child health system performance. This includes a ranking of 26th for access, 29th for quality, 24th in costs, and 47th in equity. Oregon ranked 24th in the potential for children to lead healthy lives. The Title V program is concerned about these rankings and will be taking steps to understand and assess the low ranking in equity

(children without medical homes and children without both a medical and dental preventive care visit in the past year). //2009//

/2008/ In 2007, OFH developed a system to allocate Title V funds to any of the nine tribal governments in Oregon. To assist in start up and to equitably include the tribes in the existing funding formula for county health departments, OFH has set up a planning mini-grant fund to support development of the program, data and a triennial plan. To date, two tribes have applied for these mini-grants and will be included in annual allocations by next year. Both of these agencies are planning to enhance their ability to improve oral health among pregnant women.
//2008//

//2009/ To date, two tribes, Cow Creek and Coquille, have been awarded MCH funds and are pursuing systems building and services related to prevention of early childhood caries. The tribe with the largest membership in Oregon, Confederated Tribes of Warm Springs, have applied for planning funds to plan for prenatal women's health promotion, continue "Back to Boards classes, and home visits for breastfeeding education and early childhood health education. //2009//

/2008/ To implement the requirement from the Deficit Reduction Act (DRA) to verify citizenship and identity, Oregon used a unique approach for clients applying for the family planning Medicaid waiver, Family Planning Expansion Project (FPEP). When a client presents for family planning services at one of the participating clinics and does not have proof of citizenship with them, they are allowed a one-time only visit. Using State General Funds, the one-time only visit assures that the provider will be paid for services as long all eligibility criteria are met with the exception of citizenship documentation. The client then can be using a birth control method, with time to bring back the necessary documentation. Since implementing the citizenship verification requirements, visits provided through Oregon's family planning waiver have decreased by 18%. Without the one-time only visits there would have been a 38% decrease. //2008//

/2008/ Legislative summary for health services access:

HB 2867 provides easier access to dental services for patients enrolled in the Women, Infants and Children (WIC) program, the Oregon pre-kindergarten program and Head Start by allowing dental hygienists with specialized training to apply sealants and fluoride without the supervision of a dentist.

HB 2700 is the ABC - Access to Birth Control - Bill. This bill has two parts: contraceptive equity, which prohibits insurance plans from excluding family planning in prescription medication benefits package; and emergency contraception, which requires hospitals to inform victims of sexual assault about emergency contraception and treatment options and to provide emergency contraception upon request.

HB 3516 Directs Oregon Department of Administrative Services and Department of Human Services to collect data and report to appropriate interim legislative committee regarding citizenship or legal residence requirements for Department of Human Services assistance programs; public assistance as defined in ORS411.010, benefits and services for persons with disabilities, publicly funded or government subsidized housing, food or nutrition programs and unemployment insurance benefits.

SB 362 to expand the Oregon Prescription Drug Program to include the private sector, labor unions, and all underinsured Oregonians who lack full prescription drug coverage. The Oregon Prescription Drug Program was created in 2003 to help low-income uninsured Oregonians over the age of 54 afford the high cost of prescription drugs, through bulk purchasing and pooling resources for the state to negotiate lower prices than what individuals and businesses normally could negotiate. In November 2006, the program was expanded under Ballot Measure 44 to allow all Oregonians without prescription drug coverage to access the program.

HB 2371 requires certain health and child care facilities to adopt emergency plans that provides for safety of persons receiving services from facilities when faced with threat of imminent danger.

SB 571 expands prohibition of smoking in public places and places of employment, with certain exceptions and allowances.

Not passed: HB 3099 requires that water suppliers serving more than 10,000 persons add

fluoride to water; delays implementation until water suppliers have sufficient capital to purchase fluoridation equipment; preempts local government regulations that prohibit or restrict use of fluoride. SB 617 to create a traumatic brain injury registry and SB 873 to create a birth defect registry. //2008//

Budget increases in DHS that support health care access (relevant to SPM #6), the 2007 Legislative Approved Budget includes \$2 million biennially in expansion of SBHCs to open up to 13 new centers, implement a new quality improvement program, and expand state program office staff in the areas of clinical nursing and health care economic analysis and modeling. //2008//
/2009/ The 2008 Oregon Benchmark Race and Ethnicity Report gives a negative rating for decreasing disparities for Native Americans and Hispanic populations in their category for Health and Safety. The report indicates little progress in decreasing the gap of health insurance rates of Native Americans at 28.5% and Oregon's rate overall at 15.5%, in 2006. The gap among Hispanics is 32.7% compared to 13.7% of non-Hispanics. (Oregon Progress Board, May 2008). //2009//

5. Pregnancy, Births and Infants

In 2003, there were 45,935 births, of which 18% were Hispanic. The birth rate for Oregon is 13 per 1,000 population and the infant death rate is 5.6 per 1,000 live births. The teen pregnancy rate in 2003 for ages 15-19 was 49.3 per 1,000 live births. Approximately 57% of deliveries were paid by private health insurance, while approximately 37% were paid by the Oregon Health Plan. Eligibility for the Oregon Health Plan includes children ages 0-18 and pregnant women up to 185% of federal poverty level, while all other adults are eligible up to 133% of federal poverty level, with a co-pay requirement. Dental care is covered for children and pregnant women but not for adults. (Oregon Center for Health Statistics, 2003; <http://oregon.gov/DHS/ph/chs/data/annrep.shtml>). In Oregon, SCHIP is seamlessly integrated with the Medicaid program (OHP), making it difficult for the public to distinguish between the two programs.

//2007/ Total births and race/ethnicity of births continues at the same rates. Oregon's low birthweight rates and infant mortality rates are slightly increasing, though still remains less than the national rate. The percentages of women receiving adequate prenatal care is decreasing, though percentages for first trimester prenatal care continue at the same rate. Outreach efforts to enroll pregnant women early in pregnancy are expanding through the Oregon MothersCare Program. //2007//

//2008/ Office of Family Health conducted a full review of perinatal health data and trends to publish a "Perinatal Data Book." A discussion of the findings is in Section IV.B., State Priorities. //2008//

/2009/ In general, however, Oregon's trends in low birthweight, infant mortality and early and adequate prenatal care are worsening at the same rate as the rest of the U.S. (see HSCI 05). The disparities between Medicaid populations and the non-Medicaid populations for these indicators show a widening and are concerning to the Title V program as well as Oregon's Medicaid providers. The analysis of perinatal data published in the Perinatal Data Book showed results that highlight the need to focus on disparities and inequities to improve birth outcomes. Though the Hispanic population is about 10.2% of the overall Oregon population, the birth rate is about 25 per 1000 women compared to almost 26 per 1000 are Hispanic for all births. Indicators show that Hispanic births are less likely than the state overall to receive early or adequate prenatal care, while African-American births are more likely to be preterm or low birthweight than the state. The infant mortality rates for African Americans (10.5 per 1,000 live births in 2004) and Native Americans (12.8 per 1,000 live births in 2004) are almost double the rate of the state overall (5.4 per 1,000 live births in 2004). //2009//

//2008/ Legislative Summary for pregnant women and infants:

HB 2372 requires employers with 25 employees or more to provide unpaid rest periods for breastfeeding women to express milk through the day, including requiring employers to provide a reasonable, quiet private location for breastfeeding women.

SB 244 removes the "sunset" clause from the Oregon law statute that states that those involved in criminal/corrections proceedings have the right to request DNA testing to support their innocence. SB 244 also aligns the pieces of Oregon's Genetic Privacy Act that address how genetic information can be retained and disclosed with the federal health information protection law, HIPAA. It eliminates an unintended administrative burden for health care providers, health systems, and patients while leaving in place genetic discrimination protections. These modifications to a portion of the Oregon Genetic Privacy law make it more useable for clinicians and health care systems while still protecting the public from potential genetic discrimination. //2008//

/2009/ The Regional Nurse Team in Oregon's Title V Program collaborated with the Oregon Association of Public Health Nurses, to identify leading priority health issues and develop strategic plans to address these issues. The collaborative identified preconception health and maternal depression as the areas to focus resources and activities over the next couple of years. The outcome is an action plan to address both issues, taking a life-span approach for both issues. The Preconception Work Group used the MMWR Recommendations for preconception health and identified four areas to work on in Oregon: consumer awareness, preventive visits, public health programs and strategies, and monitoring improvement. The Perinatal Depression Work Group developed strategies to work on over the next two years. The areas this group recommends are: partnership development, provider education, screening and referral, research, funding and resource development, mother/infant interventions and programs, and community support services. //2009//

/2009/ The Division of Medical Assistance Programs (DMAP) is launching a pilot program that will cover prenatal care to women in two Oregon counties who do not currently have access to these services under Medicaid. The 2007 Legislature approved using federal funds and "other" funds to implement a pilot under the state's SCHIP program. State/county partnerships were established to put together the required financial match to acquire federal SCHIP funds for the project: 73% federal funds, 25% state funds, and 2% county funds. The pilot is for pregnant women residing in Multnomah or Deschutes Counties who are not eligible for any Medical Assistance coverage other than CAWEM (Citizen-Alien Waived Emergent Medical), usually undocumented immigrants, or immigrants with documentation who have not completed their 5 year US residency. When the pregnancy ends, the mother will return to CAWEM status and the newborn child will be covered for up to a year before eligibility will be re-determined. The pilot is for 15 months, ending June 30, 2009. //2009//

6. Children and Adolescents

/2008/ The Oregon Health Policy Commission in coordination with the Public Health Division, including OFH and the Chronic Disease Program, prepared a Childhood Obesity Study in coordination to report to the 2007 Legislature. The issue was discussed extensively and number of bills were introduced relevant to reducing both obesity and childhood diabetes. The significant legislation that passed included a ban on junk food in schools, a requirement for employers to have a quiet and private place for breastfeeding mothers, and requirement for a long-term study by the Dept. of Education to recommend and implement changes in physical education requirements by 2011. //2008/

/2008/ Legislation summary for child and adolescent health:

HB 2650 specifies minimum standards for food and beverages sold in public schools during the school day and allows school district boards to adopt more restrictive standards.

HB 2188 expands the ALERT immunization registry from 0 -- 18 to lifespan to age 23 in Phase 1 with current resources and further expansions to take place once funding was secured.

HB 3486 directs DHS to develop a strategic plan to slow the rate of diabetes caused by obesity and other environmental factors in Oregon; to identify actions to be taken to reduce morbidity and mortality from diabetes by the year 2015; and include recommended statutory changes and funding needed for presentation at the 2009 Legislative Session.

SB 480 requires persons who are under eight years of age or are under certain height to use child safety system in motor vehicle and requires persons under one year of age to use rear-facing child safety system.

Dental sealants program was approved with a \$300,000 General Fund increase to provide sealants to children statewide. This is the first time state General Funds have supported oral health prevention program. //2008//

/2008/ Governors Executive Order 07-04 created the Children's Wraparound Steering Committee and to develop a statewide plan to provide integrated care for children with, or at risk of developing, significant emotional, behavioral or substance abuse problems. The plan is intended to prevent involvement with foster care and the juvenile justice system; increase academic achievement; provide family and child based services across the public system of care, and maximize availability of resources for appropriate access to behavioral and other support services. //2008//

/2009/ Oregon participated in the ABCD-3 Early Childhood Screening Academy facilitated by the National Academy of State Health Policy, and sponsored by the Commonwealth Fund. The Title V Program at the Office of Family Health, provided leadership and project management in partnership with the Oregon Pediatric Society and the Division of Medical Assistance Programs (Medicaid agency) and the Oregon Center for Children and Youth with Special Health Needs. Within the last year, the Oregon ABCD Coalition has created recommendations for standardized screening tools for development, behavioral and psychosocial screening; improved the placement of the screening CPT code 96110 in the Oregon Health Plan to encourage its use in conjunction with screening, and is improving the referral communication between providers and early intervention services. In the Fall, 2008, the Initiative is supporting a demonstration site at Kaiser Permanente Northwest pediatric clinics to integrate standardized developmental screening tools in well child visits. Additionally, efforts are underway to spread the practice of standardized screening through partnerships with a managed care organization, CareOregon, and the Northwest Early Childhood Institute to implement a train-the-trainer curriculum on screening, and more providers are interested to learn and implement screening in their practices. //2009//

/2009/ Oregon developed a booklet aimed at promoting the comprehensive adolescent well visit. The booklet is aimed at (1) parents of youth ages 11 -- 15; and (2) the youth themselves. It provides information about how providers can be helpful to parents in discussing health risks (substance use, sexual activity, etc.) at the well visit, and can be a time for youth themselves to bring up health issues of concern to them. The piece also provides information on adolescent brain development and Oregon is in the middle of an evaluation to see if the booklet had any effect on well visit rates in an Independent Physician Association's practice where the booklets were mailed to all eligible parents. //2009//

7. Services to Children with Special Health Needs

It is estimated that 13% to 18% of Oregon children under the age of 21 years have special health needs. The prevalence of chronic illness and disability continues to increase due to advances in science and technology. More youth and young adults with disabilities are living longer and assuming productive lives. Fewer than 30% of young adults with special health needs are employed. They may have no experience managing their own health and are unaware of resources that could help them.

In Oregon, it is estimated that 116,364 children have a special health need, and 5,818 of these children have a condition so severe that it significantly interferes with day-to-day function. Children with cerebral palsy, autism, arthritis, Down syndrome, ADHD, rare metabolic disorders, spina bifida and cleft lip and palate are examples of the children and conditions that are served by

the Title V program.

/2007/ The total number of children in Oregon age 0-17 years dropped slightly in 2005 to 865,613. Based on the National Survey of CSHCN the estimated number of children with special needs in Oregon is 115,473, and of these 6%, or 6,928 children would have a disability significant that impacts their ability to function at an age appropriate level. //2007//

/2009/ Based on the 2005/2006 National Survey of CSHCN the estimated number of children with special health needs in Oregon is 116,988 and of these 30.3% report their condition affects their activities of daily living.//2009//

The most recent accessible data reports available indicate the following regarding the status of Oregon CYSHN.

- In 2007, CDRC provided 57,664 services to 8,966 children and young adults through specialty clinics in Eugene and Portland and by OCCYSHN's community-based programs. In addition, 692 families received financial assistance for services and supplies.. These data represent 8,845 unduplicated clients.
- As of March 2008, 80,826 pre-school and school age children receive special education services. Approximately 8% are diagnosed with Autism.
- The number of children enrolled in Early Intervention and Early Childhood Special Education, 0 - 5 years of age, has increased from 7,800 (as of March 2003) to 9,387 as reported March 2008.
- 2003 data indicated that Oregon's Early Intervention Program (Part C) provides services to only 1.4% of the 0 - 3 year-old population. 4.86% of Oregon children age 3 -- 5 receive Early Childhood Special Education Services. (Oregon Department of Education).

/2008/ In 2006, the Department of Education estimates that the total number of children in special education is 64,085, in ECSE ages 3-4 5,889 and Early Intervention age 0-3 was 3,265 for a total of 73,239. This number does not reflect those children with chronic medical conditions who require a 504 plan. //2008//

- In previous years we have known that approximately 19% of the 73,887 received services for a severe, low incidence disability including vision and hearing impairments, orthopedic and health impairments, autism, dual sensory impairments and multiple disabilities.
- Tandem mass spectrometry technology adds approximately 23 additional metabolic conditions to the newborn screening panel. In 2003, a total of 62 infants were detected to have a clinically significant metabolic, endocrine, or hemoglobin disorder by newborn blood spot screening, including those detected using MS/MS technology. The program added congenital adrenal hyperplasia (CAH) to the screening panel early in 2004.
- According to the NS-CSHCN, 13.34% of Oregon children and young adults have a special health need. More recently, the NCHS reports that the estimate for CYSHN may be closer to 18%.
- In 2002, 576 (1.3% of the 45,190 births) were reported on the birth certificate as having a congenital anomalie(s). Malformed Genitalia (14%), cleft lip/palate (12%) and heart malformations (12%) were reported as the highest incidence.
- Families in poverty experience a higher rate of disabilities.
- Families of color experience a disproportionate rate of disabilities.

/2008/ Fifty percent of the children with disabilities who receive services from Early Intervention come from families who are Medicaid eligible. Although poverty is not the cause of poor outcomes for children, it produces a constellation of risk factors. 13% of children who receive Early Intervention are currently living in foster care. A 2% increase in children with Autism served in Early Intervention over the last several years has been noted, increasing from 5% to 7% of total children. //2008//

It is estimated that the Hispanic population in Oregon has increased 12% since the 2000 Census. OCCYSHN recognizes the impact this growth has on community based services and has responded with continued support of Promotoras in the CaCoon Program, Spanish translation of materials and inclusion of interpreter services in outreach forums in FISHS grant and the Oregon

Medical Home Program, and a bi-lingual Spanish support staff in the Title V Office. In some counties more than 50% of the families followed by the nurses are of Hispanic origin.

- The number of children enrolled in the Oregon Health Plan is 224,529 (birth to 18 years of age). During 2004, 229,000 children, 0-20 years of age, were enrolled approximately 10% or 2,290 of those children are reported to be blind or disabled or in foster homes.

- During 2003, 74% of the services provided by CaCoon were to children insured through Medicaid. According to the Social Security Administration December report 7,508 children under 18 years of age received SSI and were eligible for Medicaid. CDRC continued the agreement with DDS to provide evaluations to determine SSI eligibility. The Portland CDRC provided 54 assessments to 48 children. Evaluations included 26 pediatric, 9 psychology, 9 special education, 7 speech, 1 ENT, 1 audiologist and 1 occupation therapy. The Eugene CDRC provided 49 evaluations to 44 patients: 21 speech, 11 pediatric, and 17 psychology.

//2007/ In 2005, 6,832 children under the age of 16 received federally administered SSI payments. The majority of these children lived in their parent's household, and according to the Office for Seniors and Developmental Disabilities Services, up to 50 children receiving SSI benefits resided in a long-term care facilities or Medicaid institutions. In 2005, the total number of Oregon children, age 0-21, in special education is 79,913.

//2007//

B. Agency Capacity

The Title V Agency for Oregon is the Office of Family Health (OFH) in the Department of Human Services, located in Portland, Oregon. The Title V Program for Children with Special Health Needs (CYSHN) is administered through the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN), at the Child Development and Rehabilitation Center (CDRC), in the Oregon Health and Science University (OHSU). Oregon Revised Statutes (ORS) 444.010, 444.020 and 444.030, designates CDRC as the authority to administer services for children with special health needs. CDRC is a division of OHSU, a tertiary care clinical program and the Oregon Institute on Disability and Development (OIDD) which is one of 61 University Centers for Excellence in Developmental Disabilities (UCEDD).

The Title V Program in Public Health and the Title V Program for CYSHN have an interagency agreement to document the roles of each agency and to directly transfer 30% of the Title V allocation (without indirect costs). The two organizations strive to have a seamless collaboration and coordination to provide state and local services for whole Title V population.

The mission of the DHS, Office of Family Health is to provide leadership for improving health outcomes for women, children, and families through:

1. Collecting and sharing data to assess the health of women, children, and families;
2. Developing and implementing public health policy based on these data;
3. Assuring the availability, quality and accessibility of health services and health promotion; and,
4. Providing technical assistance, consultation, and resources to local health departments, and other community partners.

The OFH programs provide the capacity to provide primary and preventive care to the Oregon's MCH population. Program activities typically include systems development, infrastructure, technical assistance, training, and resources to local and state organizations working to improve health of the MCH population. The programs are organized into sections that report directly to the Title V Director/OFH Administrator.

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, advocacy and assessing levels of care and services;

- 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.

Capacity for Preventive and Primary Care for Women, Children and Adolescents:

Office of Family Health, Public Health Division

Title V Coordination

- MCH Program Specialist: provides technical assistance, consultation and coordination for MCH policy and assessment issues and activities, including local MCH program assessment, planning, and evaluation, legislative analysis and development, and coordination of the Title V Block Grant.
- Medical Consultant: provides medical consultation, expertise, and on family health issue, disease prevention, and genetics to professional staff on specific services and program components related to the identified areas, and serves as the Office of Family Health's liaison with the State's primary care providers.

Womens and Reproductive Health Section: The Reproductive Health Program assures reproductive health services are available across the state; provides funding and technical assistance to local family planning clinics that offer contraceptive services and screening for breast and cervical cancer, infections, anemia, and other conditions; administers a family planning benefit program for low-income Oregonians, Family Planning Expansion Project (FPEP), under a HCFA 1115 waiver; and promotes awareness of women's health issues among the public and health providers. Title X and Title V funding supports family planning services to individuals not eligible for FPEP. Women's Health Program: A systems development program to raise awareness, engage stakeholders, and improve resources for women's health concerns across the lifespan.

- The Women's Health Program includes three major efforts: A Women's Health Initiative funded by Office of Women's Health in HRSA is being used to 1) expand the information and referral capacity of the MCH Toll-Free line (SafeNet) and improve the information and referral resources for the public and for providers, 2) identify gaps in services and data identified by SafeNet call data, and 3) create a statewide women's health coalition.

- A CDC Rape Prevention and Education Grant supports the Oregon Sexual Assault Task Force to provide funding and technical assistance to local agencies around primary prevention of sexual assault. //2007/ Two statewide plans were released in May, 2006. The first, "Recommendations to Prevent Sexual Violence in Oregon: A Plan of Action," was a joint effort between Women's Health and the Attorney General's Sexual Assault Task Force; the second, "The Oregon Violence Against Women Plan," was produced by the Injury Prevention Program. //2007//

- Fetal Alcohol Syndrome (FAS) Prevention Project is a CDC grant to prevent alcohol use among women of reproductive age. The FAS Project has three parts: 1) Design and implement an intervention to identify women who are at high risk for having a child with FAS and refer them to appropriate services in family planning, university, and Indian health clinics, 2) Use surveillance techniques to identify the prevalence of FAS children in Oregon, and 3) Develop systems to improve the referral of children with FAS and their families to appropriate services.

//2009/ The Oregon Breast and Cervical Cancer Program moved to the Women's and Reproduction Health Section in 2007, from the Office of Prevention and Epidemiology. The BCC Program helps low-income, uninsured, and underserved women gain access to lifesaving screening programs for early detection of breast and cervical cancers. The Oregon BCC Program provides screening funds to promote early detection of breast and cervical cancer among Oregon's medically underserved individuals. Each year, approximately 7,000 eligible individuals receive services. Funding is from Centers for Disease Control and Prevention and the Susan G. Komen for the Cure Oregon and SW Washington Affiliate. //2009//

Maternal and Child Health Section:

//2009/ New section beginning October, 2008, merging previously stand-alone programs in

Office of Family Health including perinatal health, child health, EHD, oral health and nutrition. Added an evaluation and assessment unit to support program evaluation in the section. //2009//

Perinatal Health Programs seek 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. This section uses Title V resources to develop statewide policy and funding for improving the health of periconceptual and pregnant women. Activities include: supporting local health departments to plan, manage and deliver perinatal services including outreach, advocacy, systems development, the Maternity Case Management program, community-based health education; early prenatal care and insurance coverage through the Oregon MothersCare program; and administering the Pregnancy Risk Assessment Monitoring System (PRAMS).

Perinatal health programs include:

- Maternity Case Management (MCM) program is administered through county health departments either by direct service or by contract. Services are reimbursed through the Oregon Health Plan (Oregon's Medicaid Waiver Health Plan) serving women up to 185% of federal poverty level. Services include screening for risk factors, referrals for supporting health care and services, smoking cessation counseling and follow up, and ongoing support and advocacy prenatally and two months postpartum.
- Oregon MothersCare (OMC) program is an information and referral resource for all pregnant women and providers. By streamlining state and local systems, OMC facilitates enrollment in the Oregon Health Plan, the scheduling of the first prenatal care appointment with a local provider as early as possible in the pregnancy, and referral to MCM, WIC, and other services as indicated. The program is funded through Title V funds in addition to local funding.

Child Health Programs promote optimal health, safety, and well-being of all infants and children in Oregon through preventive practices and strategies along a developmental continuum of growth and development from birth to adolescence. This section uses Title V resources to develop statewide policies and programs for child health improvement including: coordinating local public health nurse home visits through the Babies First! Program; providing statewide training and technical assistance for promotion of nutrition, breastfeeding, and physical activity; developing integrated data systems for services for children and children with special health needs; and promoting healthy child care practices. Programs in the Child Health Section include:

- Early Hearing Detection and Intervention Program: This program promotes early detection of hearing loss among newborns through follow-up and referral to early intervention services, funded by a HRSA-SPRANS grant. State laws adopted in 2000 mandates all hospitals with more than 200 live births per year to provide hearing screening tests to all babies born in their hospitals. A hearing registry, hi-track system and recall system is functional as of 2007.
- Babies First! Program: A high-risk infant nurse home visiting program delivered through county health departments which assures healthy growth and development of infants and children up to age 5. The Office of Family Health allocates state general funds and counties are reimbursed through target case management billing. Title V funds support these services for activities and individuals not eligible for Babies First! services.
- Child Care Health Consultation Program: A program that educates and trains certified facility and family-based child care providers in health and safety practices, nutrition promotion, communicable disease prevention, physical, social and emotional growth and development screening, and community resources. This program is funded through a combination of funding from the State Child Care Division and Title V funds. **//2009/Program is fully operating in four sites with planning underway to expand into four regions and will strengthen the mental health consultation component.//2009//**
- Regional Nurse Consultation: The state nursing staff provide technical assistance, consultation and training to local public health nurses in implementation of MCM, OMC and Babies First! programs.
- Children with Heritable Conditions: A HRSA-SPRANS funded project that will integrate client data systems with newborn screening and birth certificate data, in FamilyNet, Oregon's integrated data system that includes WIC, Immunization, Prenatal, High Risk Infant programs, CaCoon (Oregon's CSHCN home visiting program), newborn screening, and birth certificates. **//2009/As**

of May 2008, the ORegon Child Health Information Data System, Maternal and Child Health Data Entry (ORCHIDS-MDE) system is being used in all but 1 county. ORCHIDS data is being integrated into the existing FamilyNet data warehouse. //2009//

- Oral Health Program seeks to improve the oral health status of all Oregonians through statewide planning, policy and program development, data surveillance system, and to make progress on the oral health status of Oregonians. A State Oral Health Coalition is implementing the State Oral Health Plan (rolled out in 2006), addressing five focus areas across the lifespan: oral health education/promotion, prevention, access, workforce, and infrastructure, including special populations and optimal water fluoridation. The Oral Health programs include oral health 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 fluoride supplement program. Funding from HRSA provides for dental sealant projects across Oregon and a CDC cooperative agreement is funding oral health infrastructure planning and implementation.

- Early Childhood Systems Planning: Oregon's Early Childhood Comprehensive Systems Initiative coordinates integration of early childhood policies and strategies within existing activities and programs. The project works closely with all Title V programs in OFH and OCCYSHN, and the Commission for Children and Families, the Oregon Mental Health and Addiction Services, Child Care Division, Child Protective Services, and Early Intervention services in the Oregon Dept. of Education. /2007/ The State Early Childhood Plan sets out priorities to strengthen overall infrastructure and capacity in each of the five critical components of the early childhood system. In 2006-2007, Oregon will begin to implement strategies in six action areas and facilitate development of a public-private partnership. //2007//

/2009/ In 2007-08, the ECCS attained new levels of partnership and momentum for comprehensive systems development. Governor Kulongoski health a Governor's Summit on Early Childhood in March, 2008, and launched " Early Childhood Matters: Oregon's Framework for A Birth through Five Early Childhood System." This framework was based on the state's ECCS plan and reframes that plan into three core elements: Health Matters; Early Learning Matters; and Family Matters. The state ECCS Program will continue involvement with the Early Childhood Council, co-sponsor of the Health Matters sub-committee, and facilitation of the system indicators workgroup. The OCCYSHN Program participated in the Governor's Summit and will participate in the "Early Childhood Matters" activities. //2009//

/2008/ Evaluation and Epidemiology: In 2007, OFH piloted use of program evaluation consultation through with the state public health Program Design and Evaluation Services. The AMCHP-Data Grant helped support this activity, and the products include guidelines to program evaluation specific to OFH programs. Below is a summary of this new section in OFH. //2008//

A consultation group provides leadership, systems building, and technical assistance to OFH and CSHCN Title V state and local programs. Includes:

- MCH Epidemiology: provides consultation and surveillance to OFH programs and state and local organizations; conducts research and studies of PRAMS to determine trends and gaps in the health status of pregnant women and newborns.

- MCH Data Coordinator /2008/ Position changed to MCH Informatics//2008//: provides statistics and epidemiologic consultation, technical assistance and leadership in developing the integrated/linked client data system, FamilyNet, and its Family and Child Module. This position also creates, monitors performance and outcome measures for Title V, OFH, DHS, programs, and provides consultation and training to state and local organizations on using of data in policy and program development and evaluation.

/2009/ The MCH Evaluation Unit Manager began in May, 2008, with the primary activity to organize and build a viable program evaluation and epidemiologic unit over the next few years. //2009//

/2009/ In the summer of 2007 The Office of Family Health released a new data system designed to gather data for Oregon's public health home visitation programs. OFH

successfully partnered with county health departments to assure uniform data collection state-wide. Over 100 Oregon nurses have been trained in uniform data collection. Data analysis from Oregon's Maternal Child Health Data System (ORCHIDS) is underway and the completion of a report is projected for January 2009. This data will be used to evaluate the current home visiting continuum and will help inform future program evaluation and planning. For the first time in Oregon history, Oregon's public health home visitation program data is collected in one uniform data base. This same data base is linked to Oregon's WIC and Immunization program databases. //2009//

Adolescent Health and Genomics Section: The goal of the adolescent health section is to maximize the health and functioning of Oregon's adolescent population. The section includes teen pregnancy prevention, nutrition & physical activity, school-based health centers, and coordinated school health programs. Title V funds are directed at 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.

- Adolescent Health is a working member of Oregon's Department of Human Services Teen Pregnancy Prevention Program/ Sexual Health Partnership that provides technical assistance to public and private partners and local coalitions working on a statewide Teen Pregnancy Prevention Action Agenda. The Title V Abstinence Education program is administered through TANF in the Children, Adult and Families Services Division in DHS as one strategy within the state Action Agenda

- The School Based Health Center (SBHC) Program coordinates the development of SBHCs through county health departments as a component of the state's safety net system of care for school-aged youth. The program provides technical assistance to local communities for planning, operating, and certifying SBHCs and maintaining a statewide database on services. School-Based Health Centers are funded through a combination of state general funds, Title V and local funds. The SBHC program supported a successful application to the Kellogg Foundation from the State SBHC Coalition for a 5-year organizational grant to advance community level sustainability and advocacy efforts. //2007/ The Governor is supporting expansion of school-based health centers in the number in existing counties and in 5 new counties in the 2007-09 budget. //2007//. //2008/ The Legislature approved \$2M in SBHC expansion. More information is in SPM #6 narratives. //2008// **//2009/ The SBHC expansion began in Fall 2007 and continues. See more information in State Performance Measure #6 narratives. //2009//**

- The Healthy Kids Learn Better (Coordinated School Health) Program, funded by CDC represents a key state-level partnership with the Oregon Department of Education that supports implementation of the coordinated school health systemic change model and framework at the local school level to address health-related barriers (e.g. nutrition, physical activity, tobacco) to learning and educational success. There are 22 individual projects in development at the state level combined with the external supports for local and state policy changes through the statewide Healthy Kids Learn Better Coalition representing over 40 statewide organizations. //2007/ In 2006, 13 new sites will be planned, 5 of which will focus on tobacco, physical activity & nutrition, 4 on asthma. A new HRSA funded initiative provides resources for schools to apply for funding to focus on mental health issues in their school using the Coordinated School Health model and will add 4 additional projects. //2007// //2008/ A mental health component was added to the Coordinated School Health program for the first time in the 2006-07 school year. A school mental health self-assessment and planning tool was modeled after the CDC School Health Index, piloted during the 2006-2007 academic year. //2008// **//2009/ The CDC did not fund Oregon for the next Cooperative Agreement for this project. The Public Health Division is committed and is continuing as the lead agency for HKLB and is restructuring support in partnership with the Office of Disease Prevention and Epidemiology. The mental health project is continuing with leveraged funds from the Addictions and Mental Health Division in DHS to continue development of the innovative approach to include a mental health as a topic area in the Coordinated School Health program. The loss of funding for the Physical Activity and Nutrition program is also impacting the CSH program**

planning within public health. The tobacco program and state general funds are funding the HKLB program for now. //2009//

Genomics Program: Oregon's Genomics Program is completing the second year of a 5 year CDC implementation based on the development of the Oregon Strategic Plan for Genetics & Public Health. Activities include: a Public Health Genetics Symposium; support for revisions to Oregon genetics privacy statute through staffing of the state Advisory Committee on Genetics Privacy and Research; establish and expand surveillance questions on key state surveys; initiate two projects related to family history & genetics; complete research synthesis on Genetics and Diabetes and Genetics and Obesity; include genetics in statewide chronic disease prevention plans and health communications. /2007/ In 2005, revisions were made (SB1025) in Oregon's genetic privacy and research laws that went into effect in 2006 that required the Genetics program to write administrative rules and development health communications for providers, consumers, IRB members and researchers that allows an 'opt-out' provision for anonymous and coded genetic research. //2007// /2008/ The 2007 Legislature made modifications to Oregon Genetic Privacy law make it more useable for clinicians and health care systems while still protecting the public from potential genetic discrimination. //2008//

Immunization Section: The Immunization program provides leadership in preventing vaccine-preventable diseases by reaching and maintaining high lifetime immunization rates. Activities include implementing Oregon's school immunization law; administering funding to local health departments and migrant health centers for child immunizations; operating Oregon's Immunization ALERT registry to track vaccinations provided in public and private health provider settings; providing free vaccines to public and private providers for children aged birth through 18 in certain population groups; coordinating a WIC-Immunization integration project for low income infants and children; providing technical assistance to private and public providers through AFIX, a continuous improvement method for improving clinic practices to achieve high immunization levels; promoting and providing technical assistance to increase immunizations to adolescents and adults. /2008/ A new information system will be purchased to combine functionality of two existing registry systems, to streamline state and local work and improve capacity to respond to special reports and recalls. //2008// ***/2009/ More information about the Immunization Program can be found in the reports and plans for National Performance Measure 7 and State Performance Measure 4. //2009//***

Women, Infants and Children (WIC) Section: The Oregon Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a public health nutrition program funded by the US Department of Agriculture (USDA) designed to improve health outcomes and influence lifetime nutrition and health behaviors in a targeted, at risk population. The 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 to promote fresh fruits and vegetables. ***/2009/ WIC is also the recipient of two national research grants from USDA to test strategies to increase duration of breastfeeding and consumption of fruits and vegetables. The 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. Both WIC research grant are progressing as planned. The breastfeeding grant is in its 3rd and final year and results should be available by the end of 2008. The fruit and vegetables research study is testing an educational approach using motivational interviewing three local agency sites. Early feedback indicates this technique to be highly popular and perceived by local staff as being a more effective way of counseling clients.//2009//***

Capacity for Preventive and Primary Care for Children with Special Health Needs:

Oregon Center for Children and Youth with Special Health Needs (OCCYSHN)
OCCYSHN-Title V Programs ensure a statewide system of services reflecting comprehensive, community-based, coordinated and culturally competent family-centered care. Programs include:

- Community Connections Network - in 14 primarily rural communities implement multidisciplinary teams of health, educational and social service professionals which evaluate and coordinate services for CYSHN and their families, develop care plans and participate in community planning activities to increase the organization and capacity of community based services and community based providers who provide services to CYSHN

- CaCoon (Care Coordination) Program - in all of Oregon's 36 counties, specially trained public health nurses help families and children develop management skills, (for example, feeding an infant with cleft lip/palate); work with health professionals and families to identify needs, gather resource information and refer to appropriate services; and participate on community planning groups, for example, Local Interagency Coordinating Councils for Early Intervention.

- Family Support Program -- limited funds available to CYSHN and their families who reside in Oregon to purchase supplies, equipment, and other needed services not covered by health insurance.

- Family Involvement Network (FIN) is a statewide network of CYSHN families who Provide parent perspectives across OCCYSHN and CDRC activities, family supports to CCN teams, train parents on working with health professionals and on multi-disciplinary teams. The OCCYSHN FIN program has 3 parent consultants, one of whom sits on the management team, and participates in planning and policy development across the Title V program in both offices.

- Grants and contracts focus on the development of training materials and provision of training events, development of model programs, and support for community-based activities.

- Office of Program Evaluation and Research (OPER) provides OCCYSHN's evaluation and epidemiology consultation. This supports OCCYSHN's commitment to continuous program improvement, assessment of program effectiveness and CYSHN population health monitoring. //2008/ OPER is staffed with a Program Evaluator/Director, Epidemiologist, Biostatistician, Database Systems Analyst, and Qualitative Research Methodologist who also serves as the Clinical Research Coordinator, a Research Assistant, and Graduate Research Assistants.

Additional consultation is accessible through the Child and Adolescent Health Measurement Initiative (CAHMI) housed within the OHSU Department of Pediatrics. CAHMI is nationally recognized for its work with the National Survey of Children and the National Survey of Children with Special Health Care Needs dataset and making it accessible through www.cshcndata.org.

//2008//

//2009/ Dr. Elizabeth Adams, MCH Epidemiologist, directs the Office of Program Evaluation and Research. It is staffed with a health systems researcher, an evaluation specialist, a database analyst and several research assistants. FY09 calls for increasing OCCYSHN's capacity in data management, analysis and reporting. //2009//

- Other agency capacity includes support for community professionals with best practice, resource and referral information; develop and coordinate training programs for community professionals; and work with key state partners, for example, major hospitals throughout the state to facilitate the referral of children and families to appropriate local services after hospital discharge.

The Oregon Institute of Developmental Disabilities, a University Center for Excellence in Disability and Development, 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). 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 is one of 16 centers nationally that receive funding from the Centers for Disease Control and Prevention (CDC) which supports activities to improve the health and wellness of people with disabilities. The Center on Self Determination exist to identify, develop, validate and communicate policies that promote the self-determination of people with disabilities.

Community Integration of the CYSHN Programs: A Community-based Service System Task Force, chaired by Dr. Dale Garrell, completed a report in 2004, "Toward a State-wide Community Based System of Care: An Integrated Approach to Care by the CDRC's Title V Services." The task force recommended the identification of a single point of referral for OCCYSHN services in the community and to integrate the supports provided to CaCoon nurses and CCN team members. County participation in the Universal Application System for Oregon (an activity of the FISH's grant) will allow for common eligibility for families for CSHN programs and direct them to a single point of contact in communities such as the local CaCoon program. /2008/ The Universal Application System was piloted in a few counties; however the response rate was too low to evaluate effectiveness. //2008//

- Videoconferencing is used extensively by the OCCYSHN and OFH to provide training, meeting access, and learning collaborative work.

- Coordination among CDRC Clinics and the OIDD includes tertiary care clinics in Eugene and Portland and outreach clinic sites in Medford, Klamath Falls and Roseburg. Interdisciplinary teams and individual clinicians provide diagnostic assessments, consultation, and management for children and youth with established or suspected disabilities. Some of the clinical programs are "unique" in the state such as the Metabolic program, and the services offered by other programs are partially duplicated at other centers. The clinical programs include the Metabolic, Genetic, Craniofacial, Spina Bifida, Neuro-developmental, Child Development and Autism programs. In 2005, 6452 CYSHN received 32056 services in these clinics. Relationships between the OCCYSHN and clinicians are critically important to the support provided to individual children and families. Joint quality improvement projects are conducted with the clinics and involved the specialists in needs assessment of direct services.

- /2008/ In 2006, 6,962 CYSHN received 37,414 services in these clinics. /2008/ CDRC will be named a University Centers for Excellence in Developmental Disabilities (UCEDD) as an agency, thus moving the UCEDD from a project to a program within CDRC. This change in organizational status will align the OCCYSHN to the mission and goals of excellence in education, research and service in the field of developmental disabilities as well as linked to a national network of centers. The UCEDD centers work with people with disabilities, their families, state and local government agencies, and community providers in projects that provide training, technical assistance, service, research, and information sharing, with a focus on building the capacity of communities to sustain all their citizens. These activities will further support and strengthen OCCYSHN's capacity to address the needs of children with special health needs and their families across Oregon. OCCYSHN will maintain its unique program identity, internal administrative and programmatic structure, and program budget. //2008//

- Relationships to Other OHSU Departments: OHSU faculty present at CDRC conferences and provide consultation to CCN community teams. School of Nursing faculty provide training for CaCoon home visiting nurses and participated in the development of the PHN training modules. Support for distance learning is available through the Biomedical Information and Communication Center (BICC) and the Information Technology (IT) office at OHSU. The BICC regularly transmits distance-learning activities of the School of Nursing and OHSU's Area Health Education Centers (AHEC). Work has begun with staff from the Oregon Rural-based Practice Research Network (ORPRN), the Office of Rural Health (ORH), and the Center on Health Care Disparities at the School of Nursing. The ORPRN includes 28 practices scattered throughout the rural areas of Oregon, and staff from the ORH have facilitated community-planning groups on health care issues in many of the same areas of the state.

- /2007/ Partnerships with the Leadership Education in Neurodevelopment and other Disabilities (LEND) has been strengthened with the agreement to incorporate the community-based services programs as training sites for LEND trainees. Disciplines of nursing, social work and psychology participated in the community-based teams and conducted family satisfaction survey as part of the Continuous Quality Improvement efforts. The LEND program has incorporated family professional partnership into its curriculum and partners with OCCYSHN's family staff to implement FPP and family centered care.

- Partnerships within the OHSU departments, including CDRC, provide an opportunity to bring specialty clinicians out to rural communities to provide training and clinical expertise to providers

in local communities.

- Partnerships with family-based organizations (Family Voices, FACT, Oregon Family Support Network, OrPTI, Swindells Center) through the Family Involvement Network facilitate family participation in the development of program activities, as well as a forum for advocacy to illuminate the unmet need of the CYSHN population and their families.

-New alliances with Oregon Advocacy Center and Oregon Health Action Campaign as well as the Oregon Insurance Commission have resulted in better representation for the CYSHN issues at the policy level. //2007//

Title V Program Cultural Competency Efforts

The Oregon Title V Program at OFH and OCCYSHN are aware of significant differences that can exist in issues of health care access and utilization across diverse communities based on geography, ethnicity, language, and socio-economic status. Activities in the Office of Family Health include analysis of program and population health data to identify disparities and engaging clients and population groups to understand the nature of those disparities. In Oregon, particular attention is focused on the Hispanic population, such as those needing family planning, preconception and perinatal care, early childhood care, and CYSHN care coordination. Efforts include creating culturally, linguistically appropriate program service models, health messages, and community engagement activities by Oregon's culturally diverse groups. OCCYSHN is exploring the National Survey of CSHCN data to determine the extent to which there are significant differences and/or trends in the results obtained from families in more urban environments versus those of rural areas.

//2009/ The Department of Human Services and the Public Health Division designed a cultural competency training curriculum that improves staff understanding and skills to approach their work, customers, and coworkers in sensitive to the origins and culture of each. //2009// A training curriculum for new local MCH leaders and staff includes a significant module on cultural and linguistic sensitivity skills. 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 partnered with the HRSA funded project on medical home with federally qualified health centers serving children with epilepsy.

The Oregon Title V Program allocates funds to county health departments and tribal governments using a formula weighted for those communities with higher rates of low birthweight, more women in need of contraception (family planning data), the childbearing population, and the number of persons living in rural and frontier communities. Local MCH leaders collaborate with diverse populations in their communities, such as Native Americans, Hispanics, African Americans, and both Asian and European nationals with specific cultural and linguistics needs. These populations exist in both urban and rural communities and require different approaches for each population. Minimum standards for county health departments include a requirement for culturally and linguistically appropriate services and the State PHD reviews for compliance with this standard every three years, through review of county policies and procedures.

Oregon's MCH Programs maintain resources and technical assistance for local providers to support the culturally appropriate service delivery. State regional nurse consultants are assigned areas to provide training, technical assistance, compliance reviews, and consulting on programs and services for the MCH populations. OCCYSHN conducted focus groups with Hispanic families from 3 Oregon communities about the extent to which they experienced a medical home approach to the care of their children with special health needs.

C. Organizational Structure

Oregon's Title V Agency is the Office of Family Health (OFH) in the Health Services branch of the Department of Human Services (DHS). The Director of DHS is appointed by the Governor and sits on the Governor's Cabinet. DHS Health Services includes offices the Division of Medical Assistance Programs (Medicaid -Oregon Health Plan), Division of Mental Health and Addiction Services (Substance Use and Mental Health Treatment and Services), and public health offices, including Office of Disease Prevention and Epidemiology, Office of Public Health Services, Office of the Public Health Officer, Oregon Public Health Laboratory. The umbrella Health Services organization allows for "seamless" activities and partnerships around policies and issues involving the broad health system.

The Office of Family Health is located in Portland, Oregon's largest city. Important partners of the OHD in carrying out the mission of Title V are the thirty-four local health departments (LHDs) and the Child Development and Rehabilitation Center (CDRC) at OHSU. The Public Health Director is Susan Allan, MD, JD, MPH and she sits on the DHS cabinet reporting directly to the DHS Director. **/2009/ Dr. Allan left her position in February, 2009. Recruitment is underway.** //2009// The Title V Director, Katherine Bradley, RN, PhD, serves as Administrator of the Office of Family Health and sits on the Executive Staff as Assistant Administrator of DHS. The OFH delivers its programs serving the MCH population through county health departments, other state and local partnerships, and in coordination with the CSHN program at the CDRC. /2007/ The public health section has been renamed "Oregon Public Health Division," still part of DHS and more visible image to the public.//2007// /2008/ The 2007 Legislature passed laws to establish the Public Health Director in statute and strengthen the public health capacity and authority in emergency situations. //2008//

The Federal/State Partnership programs and other federal grant programs administered by the Title V Director in the Office of Family Health:

/2008/ Organizational restructuring in the Office of Family Health will consolidate MCH programs along the lifespan range from preconception through young childhood for improved coordination and focus in program planning, development, and evaluation, policy analysis and development, epidemiology and research, consultation and technical assistance to local agencies. The MCH Section Manager, currently being recruited, will supervise Women's and Perinatal Health, Child Health, and Oral Health sections, and a newly created Epidemiology and Evaluation Section. Additionally, an MCH Emergency Preparedness coordinator is working in the Emergency Preparedness program to oversee planning and implementation for vulnerable populations. //2008//

/2009/ Below describes the current organization structure://2009//

- Women's and Reproductive Health Family Planning (Title X), Family Planning Expansion Project; women's health systems development project, rape prevention and education, sexual violence prevention state planning, fetal alcohol syndrome prevention; **/2009/ Oregon Breast and Cervical Cancer Prevention Program was shifted into the Office of Family Health from the Prevention and Epidemiology office. This program is directed under the Women's and Reproductive Health Section.** //2009//

- Maternal and Child Health Section: Perinatal and Early Child Health: periconception, maternity case management, Oregon MothersCare outreach, Smoke Free Mothers and Babies (/2007/ discontinued //2007//), PRAMS survey; High risk infant tracking, Early Childhood Comprehensive Systems Grant, EHDI-Early Hearing Detection and Intervention, breastfeeding promotion, Healthy Child Care America, public health nurse consultation, , FamilyNet/Orchids: Oregon Childrens Information Data System -- client-based data system; MCH Evaluation and Epidemiology; MCH Informatics; MCH Policy Analyst

- Adolescent Health: Adolescent health promotion, School-Based Health Centers, Coordinated School Health Program, Teen Pregnancy Prevention consultation, Healthy Teen Survey, nutrition and physical activity consultation

- Genetics: public health genomics planning and implementation, family history project

- Oral Health: Oral Health Systems Improvement Project, State Oral Health Plan, Sealant Program, fluoride supplement program, early childhood cavity prevention project, Smile Survey

- WIC: Nutrition Education and Supplemental Food Program, Farmers Market, Senior Farmers Market, Breastfeeding Promotion, and demonstration projects: Peer Counseling for Breastfeeding and Five-A-Day Fruits and Vegetables promotion.
- Immunization: Immunization Program, Vaccines for Children, ALERT Immunization Registry
- MCH Systems: Title V Coordination, medical consultation, program development and planning, community health improvement projects, special projects and grant development

/2007/ No significant changes in Office of Family Health, Title V Director's Office. Womens and Reproductive Health was restructured into Reproductive Health Section and the Womens and Perinatal Health Section, with the same responsibilities as described above. //2007//

The Federal/State Partnership programs and other federal grant programs administered by the Title V Children with Special Health Needs Director in the Child Development and Rehabilitation Center:

Oregon state statute designates Oregon Health & Science the responsible agency for Children with Special Health Needs (CSHN) programs and services. Oregon Health and Science University, under Oregon statutes 444.010, 444.020 and 444.030, is the designated entity to administer the program of services for disabled children with authority to administer services for children with special health needs. The Title V CSHN services are administered through the Child Development and Rehabilitation Center (CDRC), an independent division at OHSU. Dr Nickel, the OSCSHN Director, reports to Dr Brian Rogers who is the CDRC Director. Dr. Rogers reports directly to Dr. Peter Kohler, President of OHSU, and is a member of the OHSU Executive Committee. An application to change the name of the OSCSHN office to the Oregon Center for Children and Youth with Special Health Needs has been submitted and is still pending at the office of the OHSU Provost.

/2007/ The Office of Oregon Services for Children and Youth with Special Needs was granted a name change to Oregon Center for Children and Youth with Special Health Needs (OCCYSHN). As a long standing unit within the Child Development and Rehabilitation Center at Oregon Health & Science University, the "Center" designation clearly underscores the leadership role of OCCYSHN in addressing the needs of CYSHN in Oregon. OCCYSHN continues to be one of three main units within CDRC. The Director of OCCYSHN reports directly to the director of the CDRC and all program staff with the unit report, ultimately, to the director of OCCYSHN. OCCYSHN's functions and activities complements OHSU's mission to serve the citizens of Oregon.

In December 2005, Bob Nickel, M.D. stepped down as the director of the Oregon's Title V program for CYSHCN, but continued his role as Medical Consultant. James Ledbetter, M.D. began in January 2006 as Director. Dr. Ledbetter is a developmental pediatrician with extensive experience with the Colorado CSHCN program, acting as their Medical Consultant for the past 4 years. He brings a public health perspective to the OCCYSHN, and has worked extensively on the Medical Home and Fetal Alcohol Spectrum initiatives in Colorado. Currently, OCCYSHN employs 18 staff with 13.15 FTE. Grant and special projects provides funding for 3 staff at 1.65 FTE. //2007//

/2008/ In March 2007, Dr. James Ledbetter left the position of Director, to refocus his professional activities on health policy and health systems. Dr. Brian Rogers, Director of the CDRC, assumed the duties of Interim OCCYSHN Director. Dr. Ledbetter provides consultation to the CDRC through Dr. Rogers on issues related to health policy and children with special health needs. A search for a new Director will be initiated pending completion of a careful review of the program and its specific needs for future direction. CDRC is becoming a UCEDD as an agency, thus moving the UCEDD from a project within CDRC to applying to the entire CDRC. OCCYSHN will maintain its unique program identify, internal administrative and programmatic structure, and program budget. OCCYSHN currently employs 19 staff with 13.47 FTE. Grant and special projects provide partial funding for 10 staff at 2.42 FTE. //2008//

/2009/ On September 17, 2007 Marilyn Sue Hartzell, M.Ed. began her position as the

OCCYSHN Program Manager, assuming direct responsibility for the entire OCCYSHN program's management. In May 2008, it was announced that Ms. Hartzell was appointed Director of the Oregon Center for Children and Youth with Special Health Needs and would assume those duties effective July 1, 2008. Working collaboratively with Dr. Rogers, CDRC Director, an OCCYSHN Medical Consultant will be identified. The CDRC continues to adapt to the overarching UCEDD status of the organization. The CDRC has consolidated its efforts within the areas of public health, community outreach and policy. Charles Drum JD PhD is appointed as Assistance Director of CDRC for that area and will assume those duties effective July 1, 2008. OCCYSHN will reside within that area of focus. Marilyn Hartzell will report directly to Dr. Charles Drum. The announcement is attached. //2009//

When the Omnibus Budget Reconciliation Act of 1981 consolidated seven programs into the Maternal and Child Health Block Grant, the governor of Oregon designated the Oregon Health Division (OHD) (currently Office of Family Health) as the recipient of the Block Grant funds. OHD has contracted with CDRC for SCSHN since that time. In 1989, as a result of the OBRA 89 Amendments to the MCH Block Grant, states were required to use at least 30% of the funds on SCSHN, with not more than 10% on administrative costs. At that time, the mission of the state CSHCN program was revised to include a focus on the development of community-based systems of care for these children and their families that promote family-centered, community-based, coordinated care. /2009/ CDRC and OFH will be renegotiating their 5 year Inter-Agency Agreement prior to September 2008. // 2009//

The CDRC is a statewide service program that provides health and rehabilitative care for children with special health needs and their families and includes a tertiary clinical program, the Title V Oregon Services for Children with Special Health Needs (OSCSHN), and the Oregon Institute on Disability and Development. The CDRC has offices in Portland and Eugene. A variety of tertiary care clinics are offered at both the Portland and Eugene offices. These clinics are housed in Doernbecher Children's Hospital in Portland and at the Regional Service Center in Eugene in conjunction with the University Affiliated Program at the University of Oregon. The CDRC also administer two community-based programs for CSHN. The first, the CaCoon (CARE COordination) is an exemplary statewide care coordination program that provides public health nursing services in communities where families live. The second, Community Connections Network (CCN) coordinates community clinics in fourteen sites.

Attached are organizational charts for Office of Family Health, 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.

D. Other MCH Capacity

The Office of Family Health employs approximately 190 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.

The Oregon Children and Youth with Special Needs staff have expertise in public health nursing, special education, community engagement and development, evaluation and research, family involvement and family professional partnerships and rehabilitation services. The Center is comprised of 4 core program activities: the Community Connections Network (CCN), the CaCoon Program, the Family Support Program (FSP) and the Family Involvement Network (FIN). OCCYSHN maintains an ongoing relationship with the Office of Program Evaluation and

Research within CDRC from which it receives its evaluation and research services. OCCYSHN has a half-time Evaluation Specialist on staff, a new position to the OCCYSHN program.. At present, 18 staff (13.31 FTE) work in the OCCYSHN Title V office at CDRC. /2007/ The Medical Home Project is no longer funded and Learning Collaborative on Adolescent Transition has been completed with the project staff working on dissemination findings and 'spread'. //2007// /2008/ The Adolescent Transition Learning Collaborative was completed in the 6 participating counties. Lessons learned, tools and best practices were gleaned from each site and shared with other counties and programs in an effort to "spread" the information, including the sharing of a web page with additional information. The Youth Advisory group established as part of the AT Learning Collaborative continued to meet, developing leadership skills of youth with disabilities. //2008//

//2009/ OCCYSHN employs 19 part and full time staff in 4 core program activities. //2009//

The Oregon Title V Director is Katherine Bradley, RN, PhD and the Oregon CYSHN Title V Director is James Ledbetter, MD. The directors each have over 20 years experience directly serving women and children and participating in local, state and federal level policy and program development and decision making. /2008/ Dr. Brian Rogers, CDRC Director, has assumed the role of Interim Director for OCCYSHN until a replacement can be identified. Dr. Rogers bring 30 years of experience in the field of CYSHN. //2008//

//2009/ Dr. Ledbetter left his position Winter 2007. After remaining open for a year, the position was filled by appointment of Marilyn Sue Hartzell, M.Ed., previously the OCCYSHN Program Manager as of September 17 2007. Ms. Hartzell assumes her duties as Director effective July 1, 2008.//2009//

The lead management staff in the Office of Family Health includes section managers for **//2009/ Women's and Reproductive Health, Maternal and Child Health, Adolescent Health and Genomics, , Immunization and WIC. //2009//**

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. 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.

Local Title V Programs are delivered though 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: State Early Childhood Team, 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.

The Conference of Local Health Officials (CLHO) is an organization of county health department administrators and managers that advise state public health officials in matters of policy and programming. The CLHO-MCH Committee is an active partner with OFH and Title V programs in developing policy regarding services for the MCH populations in Oregon. CLHO-MCH meets monthly to discuss problems and issues common to county MCH programs, and to make decisions regarding funding and program implementation policies and to make recommendations to OFH/Title V Director and the CLHO Executive Committee.

All 36 counties have an Early Childhood Team to facilitate or conduct screenings of health and psycho-social risk in prenatal and postnatal health care settings; establish partnerships with the medical, public health, and social services community; and develop a process for connecting families to information, assessment, and services in the community. The OFH and the CDRC are primary partners in implementing the plan by providing expertise in nurse home visitation and data collection systems.

The CDRC employs people with disabilities and parents of CYSHN in a variety of roles. Persons with disabilities are employed in project evaluation, project coordination and as consultants. Parents of CYSHN are employed in project management, as family consultants, in grant planning and evaluation, administration of family support programs and gift funds and as consultants to grants, other projects and training initiatives. Through the Family Involvement Network (FIN), three family members hold part time positions specifically to assist the program with broad parent perspectives, to enhance connections throughout the state with parents of CYSHN, and to assist and arrange for training opportunities for both families and professionals. One of these parents is the first parent to participate in leadership training through the LEND program of the OIDD. The state Family Voices coordinator is the parent coordinator of FIN. Community-based liaisons and teams, and the Multicultural Task Force, CDRC continues to make family professional partnerships and participatory action initiatives a high priority. /2008/ The OCCYSHN parent consultant provides input to OFH (non-CYSHN) programs when needed. Plans to add a family consultant as part of OFH staff is identified in OFH capacity building plans. //2008//

/2007/ OCCYSHN was awarded a HRSA integrated services grant titled "SOCs: Strengthening Oregon Communities" making it possible to integrate the initiatives associated with the CSHN performance measures into the programs that are supported at the community level. Dr. Ledbetter assumed the role of Principle Investigator for the SOCs grant. Although addressing all six Title V National Performance Measures for CSHCN, this grant allows OCCYSHN to concentrate efforts on health insurance coverage for CYSHN, increased family participation in quality improvement planning at the medical practice level, continue our work in the area of Adolescent Transition, and improve developmental and behavior screening for children 0-5 years. The identification of local, culturally appropriate resources will be an effort to support the web-based Disability Compass Resource Guide. //2007//

/2008/ OCCYSHN served as a placement for a LEND trainee who was linked to experiences in the CDRC clinics and the resulting referral and follow-up to community based services. The LEND trainee studied referral practices and made recommendations for strengthening this linkage from clinic to community. A LEND psychology intern was supported to complete her LEND community rotation with OCCYSHN. She reviewed community mental and behavior health services available for children 0-8 years. Her work will be used to inform planning processes for improvement in meeting the behavior and mental health needs of CYSHN. //2008//

MCH EPIDEMIOLOGY CAPACITY:

The Office of Family Health has a maternal and child health epidemiology program that conducts surveillance of the population for use by OFH and other state and local organizations.

Ken Rosenberg, MD, MPH is the lead MCH Epidemiologist

James Gaudino, MD, MPH is the Immunization Registry Epidemiologist

Collette Young, PhD is the Immunization Program Epidemiologist

Julie Reeder, DrPH is the WIC Research Analyst

Amy Zlot, MPH is the Genetics Epidemiologist

/2007/ Laurin Kasehegan, PhD, is a CDC Fellow working on a number of projects across Title V programs including Child and Adolescent Health Status, outcome development for FamilyNet integrated data system, and MCH Performance Measure development; and. Jean Hutchinson, PhD, FAS Prevention Program Epidemiologist //2007//

/2008/ Dr. Kasehegan completed the following projects during 2006-07.

Conduct evaluation of state PRAMS questions; consulted with EHDl program coordinator to

rewrite analytic code and analyze data for annual progress report;
consulted on ORCHIDS client database development with regional nurse consultants and software developers to develop and design data collection instruments for Oregon MothersCare, Oregon Maternity Case Management, Oregon Babies First! and Oregon CaCoon programs;
served as FAS epidemiologist for start up of surveillance system and conduct of FAS surveillance; team member for development of the Perinatal Data Book. //2008//
/2009/ Dr. Kasehegan completed her CDC Fellow and is now at CityMatch. //2009//

/2009/ The new MCH Evaluation and Epidemiology Unit is now staffed and will provide supervisory and organizational development management to increase and improve the ability to provide program evaluation for quality improvement and more effective policy development. The Unit will be recruiting for a doctoral-level or equivalent program evaluator to provide technical expertise across OFH programs. //2009//

/2009/ The Perinatal Data Book is complete and is being used extensively to develop grant proposals and strategic plans, such as the shared state-local public health nurse planning described in III.A. Overview. The pdf of this book is attached to this Block Grant and can be found at: <http://www.oregon.gov/DHS/ph/pnh/databook.shtml> //2009//

Dr. Ken Rosenberg provides consultation and surveillance of MCH population health status to OFH programs and other local and state organizations. Dr. Rosenberg has been the Project Director of Oregon PRAMS (Pregnancy Risk Assessment Monitoring System) since 1998. Dr. James Gaudino provides consultation and surveillance of immunization in Oregon and consultation with Title V issues and activities as well.

//2008/ Elizabeth Adams, PhD is the MCH Epidemiologist for the CSHN population, providing consultation and analysis to the CSHN Title V program, and oversees special studies, conducted by the GSIP Intern and a LEND epidemiology trainee. The GSIP Intern used current population survey data to assess the prevalence of disability at the county level among children 5-15 years of age. Dr. Adams consults on measurement and monitoring activities using data sources such as NSCYSHCN and Oregon PRAMS 2. A Pediatrician-MPH student conducted an analysis of the CaCoon program in preparation for a focused program evaluation. OCCYSHN re-visited its work in the area of measuring and monitoring Oregon's progress toward achieving the National Performance Measures. A workgroup is comprised of key leaders within the OCCYSHN program, its evaluator and CAHMI as consultants. The project will identify data sources to support a more thorough examination of the status of Oregon's children relative to the performance measures, as well as identify special studies to pursue around those data sources. //2008//

/2009/ Dr. Liz Adams has been appointed Director of the Office of Program Evaluation and Research. She is the lead contact with the OCCYSHN program to provide ongoing program evaluation and epidemiological study consultation and studies. OPER has expanded its capabilities with the addition of a health services researcher. //2009//

Oregon PRAMS, which joined the CDC PRAMS system in 2002, has enhanced the ability to identify problems, and develop and track health status indicators and performance measures.

Survey results are posted on the OFH web site

<http://www.dhs.state.or.us/publichealth/pch/prams/index.cfm>. Dr. Rosenberg is leading a wide collaborative development turning PRAMS from a cross-sectional survey to a longitudinal survey. The "PRAMS-2" survey -- The Oregon Two-year-old Survey - will re-interview PRAMS respondents when their babies are 2 years old. The survey will begin in the fall of 2005. Among the topics will be well child care, chronic disease, immunization, breastfeeding, nutrition, physical activity, development, domestic violence, stress and social support, and tobacco and alcohol use. More information about PRAMS-2 can be found in III.F. Health System Capacity Indicator 09A.

//2007/ The PRAMS 2 survey for health of two year olds mothers who responded to the PRAMS surveys began implementation in 2005-06. First results should be available in 2007. //2007//
/2009/ Data from the first PRAMS-2, collected 2006 for 2004 births, has been weighted and

is ready for analysis. Several programs have access to the data set for analysis. //2009//

/2008/ OCCYSHN played a substantial role in designing a question included in the Oregon Healthy Teens Survey (the Oregon Youth Risk Behavior Survey). These data provide greater understanding Oregon youth with special health needs and the healthy behaviors that they engage in compared to teens who do not report having a special health needs. These questions began with the 2006 survey. //2008//

The Office of Family Health actively planned and participated in the 3rd Western MCH Epidemiology Conference was held in May 2005 with participation of 15 western states. Conference was attended by about 200 people, mostly tribal, state and local health department staff. Plenary presentations were on Health Disparities, Fetal Alcohol. /2008/ Attempts to raise resources for subsequent MCH Epidemiology Conferences have been unsuccessful since 2005. /2008/ Funding resources for a western states MCH Epidemiology Conference were unavailable in 2006 and 2007. //2008//

/2009/ OFH has presented methodology using PRAMS data to understand the magnitude of the problem of perinatal depression in Oregon and identify which women were at highest risk for perinatal depression. The outcome will be a report on Perinatal Depression in Oregon and will be used to develop a comprehensive approach to increase identification and treatment of depression through partnership development, provider education, screening and referral, enhanced infrastructure and services, and research. //2009//

An attachment is included in this section.

E. State Agency Coordination

State Title V Programs in OCCYSHN and OFH value the collaboration and coordination among partners, stakeholders, and between their respective programs. Family participation is highly valued and family liaisons are included in policy and program development and evaluation activities. 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 in order to create a kind of seamless representation of Oregon's Title V programs whenever appropriate.

The Office of Family Health extensively facilitates and promotes collaboration and coordination among state, local and non-profit agencies as ongoing development and maintenance of a system of care for the maternal and child health population. State level relationships among core health system agencies increase the ability of Title V to build collaborations and coordination around activities and programs addressing the health needs by population group.

The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) resides within the Child Development and Rehabilitation Center (CDRC) of the Oregon Health and Science University (OHSU). The Director of CDRC reports directly to the Vice-Provost of OHSU. The CDRC co-houses with the Department of Pediatrics and is beginning to integrate clinical operations to increase efficiencies.

1) EPSDT:

EPSDT in Oregon is administered and implemented through DMAP (Medicaid agency) and its contractual arrangements with managed care and other providers. Title V and its public health programs as well as the Early Intervention/Early Childhood Education 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. OFH and OCCYSHN with DMAP and

OPS partners have facilitated statewide efforts to increase the practice of developmental screening and to improve reimbursement processes for OHP providers. Emphasis on early screening and referral to appropriate follow up services is included in care coordination and home visiting programs (Babies First! And CaCoon). These programs are implemented through local health departments and are coordinated with community providers of services to young children. OFH is facilitating development and implementation of Oregon's Early Childhood Comprehensive Systems Plan and has engaged a large number of partners in the process (<http://www.oregon.gov/DHS/ph/ofhs/mch/docs/eccsplanexcsummary.pdf>). Components of the plan include access to health care, screening, and follow up care as part of efforts to assure that Oregon's children are healthy, safe and ready to learn. ***/2009/ Oregon's ABCD Early Childhood Screening Initiative made significant progress in the last year to clarify EPSDT program. The ABCD Initiative raised awareness about the CPT code 96110 for limited developmental screening and paired it with well child visits. Additionally, the ABCD clinician group has created recommendations for standardized screening tools, that are included in the Oregon Health Plan guidelines for preventive care. The ABCD project is working with the EI/ECSE office to create referral forms and methods that will increase communication between EI and providers, as a component of improving early childhood screening and referral. //2009//***

Public Screening Programs:

Babies First! High-risk infant tracking is a nurse home visiting program, administered by Office of Family Health that tracks the needs for infants and families with multiple risk factors, including developmental delays. The Oregon Care Coordination Program (CaCOON) provides a public health nurse presence on each LICC in every local county to represent the needs of CYSHN in early childhood services. It has contributed to the development of the statewide reporting system and supports its implementation through ongoing technical assistance to the local program. These Title V programs include joint training and coordination with county public health nursing staff.

Healthy Start, administered by Oregon Commission on Children and Families (OCCF) provides screening and referral for all first births in Oregon, with paraprofessional home visitors. The CDRC works with the Commission at the state and local levels to avoid duplication and to train the participants in home visiting programs. At the community level, these programs collaborate in unique ways to serve their communities, such as hiring a Healthy Start worker as a Promotora to provide services to the Latino community, and works with the CaCOON Nurse.

/2009/ Oregon is currently implementing a continuum of home visitation programs using Federal, State, local and private funding streams. Oregon's home visitation continuum includes a state infrastructure and a combination of proven and unproven models. Oregon's Public Health System has long recognized the importance of delivering proven home visiting models within a continuum that assures safety net services for families not eligible for proven evidence based models. //2009//

Other screening programs include:

- Early Hearing Diagnosis and Intervention Program (EHDI) is established in the OFH and reports 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.
- Metabolic Screening is administered by the Public Health Laboratory provides newborn metabolic screening to all Oregon infants. 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.
- Office of Family Health/CDRC Special Education, Education Service District and OCCYSHN partnered to develop a matrix of developmental screening tools for use by public health nurses and community providers, began discussion of reciprocity of test findings and established

protocol for referral feedback between provider and Early Intervention.

/2007/ OCCYSHN initiated exploration of a Universal Application System, "Oregon Clicks" which included extensive coordination and collaboration to develop and pilot with the Babies First! Program, the Division of Medical Assistance Program (DMAP), and ODE/ Early Intervention a web-based integrated application. Utah State University Champions for Progress staff provided technical assistance to the project. //2007//

2) Other federal grant programs -- WIC, developmental disability, family planning:

Immunization: The Immunization Program, funded primarily by CDC, works closely with the Local Health Departments and the Department of Education and the Employment Department to monitor and enforce school entry requirements for day care facilities and schools. The Oregon Partnership to Immunize Children (OPIC) and the Oregon Adult Immunization Coalition (OAIC) are private and public sector partnerships committed to improving immunization coverage rates in their respective populations. /2008/ DMAP is providing immunization assessment data and quality improvement strategies for Oregon Health Plan managed care plans. A new joint committee of OPIC and the Immunization Policy Advisory Team (IPAT) is working together to develop vaccine financing solutions to assured vaccines remain affordable. //2008//

Adolescent Health: The Coordinated School Health Program, a state-level partnership with the Oregon Department of Education, has continued to support development of the Healthy Kids Learn Better Coalition, which now represents over 40 statewide organizational-level partners to promote public policy and legislative agendas that support coordinated school health concepts and focal areas. /2008/ Adolescent Health participated in the DHS Mental Health-Primary Care Integration project and the Steering Committee for the EAST (Early Assessment & Support Team) Early Psychosis Screening Project with the Mid-Valley Behavioral Care Network. This project was the result of receiving a \$2 million Robert Wood Johnson Foundation grant to reduce the incidence of psychotic illness by intervening with youth showing early signs of psychosis. //2008//

Healthy Kids Learn Better (Coordinated School Health) Program: A key state-level partnership with the Oregon Department of Education that supports implementation of the coordinated school health systemic change model and framework at the local school level to address health-related barriers (e.g. nutrition, physical activity, tobacco) to learning and educational success. : /2007/ In 2006, 13 new sites are planned, 5 of which who will focus on tobacco, physical activity & nutrition, 4 on asthma. A new HRSA funded initiative was added to allow schools to apply for funding to focus on mental health issues in their school using the Coordinated School Health model and will add 4 additional projects. //2007//

Genetics: The Genetics Program collaborates with La Clinica del Cariño Family Health Care in Hood River, Oregon, to determine if the current methods of collecting family history information accurately and completely capture this information and with Kaiser Permanente on an assessment of family history tools. Information gleaned from these studies can be used to develop future prevention and intervention programs related to use of family history in the clinical setting.

---Title V programs collaborate and coordinate with 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. /2009/ **Breast and Cervical Cancer program is now located in the Women's and Reproductive Health Section in the Office of Family Health (Title V).** //2009//

- Title V programs collaborate and coordinate with SAMSHA funded programs located in the Division of Mental Health and Addiction Services. These OFH programs include the Mental Health Initiative in the Healthy Kids Learn Better Program (coordinated school health), Early Childhood Comprehensive Services, and FAS Prevention.

- WIC and Immunization have joined in a coordinated effort to refer WIC and perinatal clients to appropriate immunization services for mothers, infants and preschool children.

- The Breastfeeding Initiative is a program coordinated between WIC and Child Health nutritionists to improve the nutritional and healthy status of infants.

- Oregon's MothersCare is an initiative to streamline, coordinate and promote access to early

prenatal care through coordination of referral systems and linking women to the state toll-free hotline (SafeNet), pregnancy test sites, local health departments, OHP (Medicaid), Maternity Case Management, WIC and other agencies that provide prenatal services.

/2007/ The Oregon Title V Program collaborated with Oregon HRSA programs to participate in the HRSA State Strategic Partnership Review for Region X. The programs include: Office of Primary Care, Oregon Primary Care Association, Oregon Office of Rural Health, and the Ryan White Title II Program. The Strategic Partnership identified a common priority around "access to health care" and is investigating common performance measures appropriate across all programs. A joint planning meeting will occur in late 2006 with the five agencies and their key partners to develop strategies and outcomes around the priority goal. //2007//

/2008/ The joint meeting occurred in November 2006, and the final outcome recognized access to care as an overriding challenge. Interventions and activities targeted to each population are different enough to narrow the scope into a feasible and effective effort. The programs benefited from the discussions, enhancing future collaborations. //2008//

- The Title V and Title XIX agencies, with other private and public providers, participate on joint committees to facilitate the coordination of services with common clients, including a DHS-wide Medicaid Advisory Committee

WIC: WIC actively participates with the Oregon Hunger Relief Task Force in the created by the 1989 State Legislature to act as a resource within government and as a statewide advocate for hunger issues. WIC also 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 to provide fresh fruits and vegetables from farmers' markets and farm stand to eligible senior citizens and individuals eligible for WIC.

3) Providers of services to identify pregnant women and infants eligible for Medicaid and assist in applying for services

Early Child System of Services and Support: OFH and OCCYSHN staff participate with the Governor's Interagency Coordinating Team to implement an Early Childhood System of Services and Support in Oregon. /2008/ OFH and OCCYSHN staff participate on the Early Childhood Team, an interagency coalition of early childhood service agencies, on the development and dissemination of the comprehensive Early Childhood System Plan. Family consultants from OCCYSHN staff assisted the Early Childhood Team in developing a job description and guidelines for parent participation on the team. //2008// **/2009/ Early Childhood Team renamed to Early Childhood Council in response to the Governor's Summit on Early Childhood in March 2008. //2009//**

FamilyNet Data Integration: Agencies involved in development are Oregon Commission for Children and Families, Oregon Dept. of Education, OCCYSHN, Conference of Local Health Officials, county health departments, Oregon Healthy Start, public health offices of Public Health Laboratories (OSPHL) and Disease Prevention and Epidemiology (ODPE), and Early Intervention agencies. /2008/ The ORCHIDS data system (client master of FamilyNet) will be rolled out in counties beginning August 2007. //2008// **/2009/ ORCHIDS fully rolled out in every county as of June, 2008. //2009//**

Managed Care Organizations and Health Plans: Representatives of OHP managed care health plans participate in a number of advisory groups such as the group that developed practice-level definitions of CYSHN and the Medical Home advisory group. Title V staff and OCCYSHN staff have presented to the medical directors group OHP managed care organizations and begun to meet with the medical directors and care management staff of ODS, Care Oregon, Regence Blue Cross and Providence health plans to share information about community services and to collaborate on educational programs for providers and families. The SOCS grant will continue to support these activities. /2007/ OCCYSHN partnered with health care advocacy groups and health plans about health care financing in Oregon and provided a forum with Title V OFH participating to discuss next steps to benefits counseling and managed advocacy for families and children with special needs. //2007//

Children, Adult and Families Services Division (CAFD): Community-Based Application Assistance

project (to expand access to OHP and early prenatal care), Students Today Aren't Ready for Sex (STARS) Abstinence Program, Teen Pregnancy Prevention; Early childhood Division of Medical Assistance Programs: Lead Screening, Community-Based Application Assistance Project, Dental Health Services, Preschool and Adolescent Immunization, Vaccine for Children, Family Planning Expansion Project, School-Based Health Centers, VISTA Health Links, Oregon MothersCare, Maternity Case Management, Babies First! CaCoon; Childhood Cavity Prevention, definition of CSCHN, early child mental health; /2008/ ABCD Learning Academy technical assistance grant is a partnership between Title V, DMAP, and the Oregon Pediatric Society. //2008//

Partners for Children and Families: The PCF is a collaboration of social services, education, child care, public health, juvenile justice, and citizens. Early Childhood Comprehensive Systems Initiative (HRSA-CISS-SECCS grant) works extensively with this organization in developing its plan.

Division of Mental Health and Addiction Services: The Oregon Teen Health Survey is Oregon's Youth Risk Behavior Survey, and is implemented as a partnership between the Title V Adolescent Health Program and DMHAS. DMHAS and Title V collaborate on issues and workgroups around perinatal, early childhood and adolescent health, including the fetal alcohol syndrome prevention.

- The OFH has agreements with a variety of schools to provide a school fluoride rinse program. This includes the provision of fluoride supplies to schools and training programs for teachers, professionals, and volunteers.

- The Immunization Program contracts with DMAP to improve age-appropriate rates among Medicaid children to 90% by two years of age and implement a plan to promote adolescent immunizations. The Immunization Program also contracts to purchase vaccine to provide vaccines under the Title XXI, Children's Health Insurance Program.

4) Coordination with SSA, SDDS, VocRehab, and family leadership and support programs
County health departments, school districts, Educational Service Districts, hospitals or public health departments

CSHN Definitions: /2007/ OCCYSHN and the Office of Family Health are collaborating to develop a common definition for CSHN in Oregon, with DMAP, Regence BlueCross/ BlueShield, Kaiser Permanente and other health care plans, Providence Child Center, Oregon Department of Education, Oregon Commission of Children and Families, and parents. The workgroup developed and recommended two approaches and associated sets of tools to define CSHN. A validated list of diagnostic codes is recommended as a common method for identifying CSHN at the systems level and screening and complexity level tools are recommended for use at the practice level.

//2007//

/2009/ OCCYSHN plans to review and update these recommendations for currency. //2009//

- OCCYSHN and the Division of Medical Assistance (DMAP) have an interagency agreement to address reimbursement rates for services provided at tertiary clinics. DMAP Medical Director and staff participate on CDRC/OCCYSHN committees such as the Stakeholders group, on financing health care for CYSHN, the technical assistance provided to the OCCYSHN office and other agencies on the Universal Application System, and the COIT (Child Development and Rehabilitation Center and the Oregon Department of Education Interagency Team) on Child Find. Oregon Department of Education (ODE): Both OFH and OCCYSHNS 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 personnel preparation. For example, staff from the OCCYSHN office, the OFH and ODE are working together to revise the established risk criteria for EI/ECSE, consider provisional risk criteria for eligibility and to agree on common developmental screening tools. CDRC and the ODE update the interagency agreement on a yearly basis.

/2008/ - OFH staff and OCCYSHN staff 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 exploring use of a standard "universal referral form" for EI that includes feedback to referring providers.//2008//

/2009/ ABCD Screening Initiative is facilitating further development of the COIT

referral/feedback tool for referring providers. ODE is a collaborative partner in this process. //2009//

- Oregon Pediatric Society (OPS): Title V staff collaborate with OPS on a variety of issues. The OCCYSHN Medical Director, Dr. Nickel, is chair of the OPS Committee on Children with Disabilities (CCWD). This partnership has resulted in joint support of learning collaboratives on preventive care, chronic conditions, and other activities to support medical home improvement. The OPS and CDRC co-sponsored a survey of Oregon's pediatricians and health plans on coding and reimbursement. **//2009/ Oregon's ABCD Screening Initiative has furthered the strength of partnerships between Public Health, CYSHN, and private provider services. //2009//**

//2007/ Dr. Ledbetter, OPS Executive Member and Director of the OCCYSHN office, represents CDRC on the State Interagency Coordinating Council for Early Intervention/Early Childhood Special Education. CaCoon Nurses participate on the Local Interagency Coordinating Councils. **//2007// //2009/ Marilyn Hartzell, recently appointed as Director of OCCYSHN has assumed the representing role of OCCYSHN on the SICC and will identify a Medical Consultant who will also join the SICC.//2009//**

The Oregon Rural-based Practice Research Network (ORPRN) and the Office of Rural Health (ORH) at OHSU. OCCYSHN maintains collaborative relationships with ORPRN and ORH for activities in the SOCS grant. Twenty-eight primary care practices participate in ORPRN including 2 pediatric practices. Pediatricians in these 2 practices also participate in the CCN. The ORH staff conduct community planning and OCCYSHN has provided information to use with a number of community planning groups in rural Oregon.. The OCCYSHN office will work with 3 of these groups to establish the Health Watch committees of the SOCS grant. **//2009/ The Health Watch Committee approach did not develop as anticipated. Efforts to address health care finance turned toward legislative education and updates.//2009//**

Oregon Mental Health and Developmental Disabilities (MHDD): An MHDD staff member participates on the interagency team addressing adolescent transitioning, and the manager of the Family Support Program of the OCCYSHN office was appointed by the Governor to serve on the Oregon Council on Developmental Disabilities. In addition, a MHDD staff member who is also a parent of a CSHN is a member of the OCCYSHN Family Support Program advisory committee.

Vocational Rehabilitation Division (VRD) and the Social Security Administration (SSA): The CDRC, SSA and the Disability Determination Services (DDS) of 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 are participating on the 6 community teams of the youth transition learning collaborative. Staffs from both VRD and SSA have participated in previous Title V sponsored conferences.

Shriners Hospital for Children: 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, and the Title V OCCYSHN nurse liaison meets regularly with the care coordinators at Shriners Hospital to discuss ways to facilitate referrals to local public health nurses. OCCYSHN and Shriners Hospital co-hosted an interactive videoconference on Obesity Prevention and Treatment for Children with Special Needs.

- Hospital NICUs and Pediatric ICUs: Staff from the OCCYSHN office work with hospitals throughout the state to educate case managers, discharge coordinators and social workers about community-based programs for CSHNA brochure for parents of premature infants about community resources was developed, personalized by each hospital's NICU staff and distributed to families. In addition, a CD of county resources, in particular the CaCoon and CCN programs, was provided to hospital discharge coordinators.

- Family Organizations: The OCCYSHN supports the planning efforts to obtain and implement a parent-to-parent network for families with CYSHN. OCCYSHN family staff participate on various local task forces and committees such as Arc, United Cerebral Palsy (UCP), early intervention councils, community service clubs, and neighborhood meetings. Oregon Family Voices worked with the OCCYSHN Family Involvement Network in collaboration with the Oregon Parent Training and Information Center, the Family Action Coalition Team and other family organizations to submit a CMS grant for a family resource center.

/2009/ OCCYSHN Family Consultants continue to collaborate with additional groups, including Precious Beginnings, the IEP Partners project and the Oregon Family Support Network for families with children with mental health disorders. One of the parents in FIN program is a member of the OFSN.//2009//

- Oregon Regional Hemophilia Center: The Oregon Regional Hemophilia Treatment Center based at the CDRC has been the designated federal regional care center in Region X since 1976. Subcontractors are in each of the four Region X states and a satellite hemophilia program is in Spokane. Team members visit work sites, physicians' offices, emergency rooms, and local health departments.

- Providence Child Center (PCC) and the Swindells Family Resource Center: OCCYSHN staff including members of FIN meets regularly with Swindells' staff. Providence representatives were invited to the Universal Application System an activity of the SOCS grant, Health Care Finance initiative, and a stakeholders meeting to improve collaboration of agencies that maintain resource guides.

- Child Care and Respite Care: A representative from OCCYSHN has participated in the development of the Multnomah County Lifespan Respite Network and currently sits on the Inclusive Child Care committee of the Oregon Council on Developmental Disabilities. This project currently conducts 12 pilot projects to assist the families of CYSHN to locate appropriate child care and respite resources and provides funds to supplement child care costs.

Western States Genetic Services Collaborative (WSGSC): the Oregon WSGSC staff is collaborating to pilot a practice model to deliver genetic services to families living outside the Portland metro area. The partnership includes OCCYSHN staff, CDRC genetics and metabolic clinic staff, county public health nurses, and community hospitals. The WSGSC is working to determine how to provide genetic counseling for the parents of all infants with metabolic conditions, hemoglobinopathies, and CAH detected by newborn screening, in partnership with OPHL newborn screening program and public health nurses. The DMAP is working with the WSGSC to develop a method to make wise decisions about the genetic services to be paid by the Oregon Health Plan. //2007//

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	18.7	18.1	15.1	14.8	14.8
Numerator	428	414	346	342	342
Denominator	228681	228294	229032	230908	230908
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

Notes - 2007

Source: Hospital Discharge Data, 2006.

Notes - 2006

Source: Hospital Discharge Data

Notes - 2005

Narrative:

ICD-9 codes for hospital discharge data are readily available for the numerator and denominator to Oregon's MCH program. The program links with early childhood health programs in Office of Family Health such as Child Care Health Consultation and High Risk Infant Tracking home visiting program.

/2009/ Hospitalizations for asthma in Oregon children less than five has steadily decreased. A report on Oregon children with asthma on Medicaid in 2004 2005 showed that for every 100 children under five with asthma who were on Medicaid, there was an average of over 6 hospitalizations for asthma a year. The highest rates for hospitalization in this report were in mostly rural counties. Some 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 Asthma Program also works with Division of Medical Assistance Program contracted health plans to improve how health systems manage people living with asthma. Evidence based interventions with health plans focus on increasing use of controller medications by people with asthma, and ensuring that people who experience an asthma exacerbation that requires a trip to the 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. //2009//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	78.3	82.4	92.4	92.7	90.8
Numerator	16921	18390	28594	30132	26723
Denominator	21622	22307	30945	32491	29434
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

Notes - 2007

Source: Division of Medical Assistance Programs. Most recent data from CMS is 2006 . Oregon's SCHIP program is integrated into the Oregon Health Plan (Medicaid waiver). Data is not available separately.

Notes - 2006

Source: Division of Medical Assistance Programs, 2005. Oregon's SCHIP program is integrated into the Oregon Health Plan (Medicaid waiver). Data is not available separately.

Notes - 2005

Source: Division of Medical Assistance Programs. Most recent data from CMS is 2005. Oregon's SCHIP program is integrated into the Oregon Health Plan (Medicaid waiver). Data is not available separately.

Narrative:

Medicaid data is readily available from the Office of Medical Assistance Programs. SCHIP data is rolled into Medicaid data as a seamless Oregon Health Plan (waiver) program. The requirement for EPSDT was waived in Oregon with creation of the Oregon Health Plan so no consistent data are available on the number of children who receive periodic developmental and health screens. The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) has initiated a Learning Collaborative around developmental screening in five counties that will provide information about the strategies and need for early and periodic screening. This project will also evaluate the reliability of data sources used to create the numerator and denominator of this measure.

Medicaid data is readily available from the Office of Medical Assistance Programs. SCHIP data is rolled into Medicaid data as a seamless Oregon Health Plan (waiver) program. Data for Medicaid and SCHIP is not available separately to report the EPSDT rates. The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) has initiated a Learning Collaborative around developmental screening in five counties that will provide information about the strategies and need for early and periodic screening. This project will also evaluate the reliability of data sources used to create the numerator and denominator of this measure. The new ABCD Learning Collaborative sponsored by National Academy of State Health Policy, that Oregon is participating, will facilitate discussions and process to change how EPSDT is delivered and reporting to the state.

//2009/ The ABCD Learning Academy identified ways 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 efforts are ongoing to train pediatricians to integrate early developmental surveillance, screening and referral in their well-child visits. //2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	NaN	0.0	92.4	92.7	90.8
Numerator	0	0	28594	30132	26723
Denominator	0	1	30945	32491	29434
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

Notes - 2007

Source: Division of Medical Assistance Programs.

Notes - 2006

Source: Division of Medical Assistance Programs

Notes - 2005

Source: Division of Medical Assistance Programs

Narrative:

See HSCI 2. Data is not available for SCHIP separate from the Medicaid/Oregon Health Plan data.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	72.7	70.0	68.1	68.3	67.5
Numerator	33275	31828	31270	33157	33122
Denominator	45796	45501	45904	48513	49058
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

Notes - 2007

Source: Oregon Center for Health Statistics

Notes - 2006

Source: Oregon Center for Health Statistics

Notes - 2005

Source: Oregon Center for Health Statistics

Narrative:

The MCH Program has direct access to the vital statistics and calculator for the Kotelchuck indices relating to the amount and adequacy of prenatal care. The data shows a decrease in this measure over the past several years. The MCH program will investigate the statistical method for accuracy and the population-based factors that may influence this trend. This investigation will include evaluating the measure by various population factors, such as age, ethnicity, race, geographical location, Medicaid eligibility and continuous enrollment throughout pregnancy, and deliveries to undocumented mothers. For comparison, the statewide percentage for first trimester prenatal care, reported in National Performance Measure 18, is showing no change over the last five years.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	77.3	77.8	80.8	80.8	77.5
Numerator	247452	248562	242966	242966	233317
Denominator	319964	319433	300870	300870	300870
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

Notes - 2007

Sources:

Numerator = 2007 Annual EPSDT Participation Report, HCFA-416: "Total Individuals Eligible for EPSDT". Division of Medical Assistance Programs.

Denominator = 2007 Population Projects for ages 0-19. Population Research Center, Portland State University, March 2008.

Notes - 2006

Sources:

Numerator = 2007 Annual EPSDT Participation Report, HCFA-416: "Total Individuals Eligible for EPSDT". Division of Medical Assistance Programs.

Denominator = 2007 Population Projects for ages 0-19. Population Research Center, Portland State University, March 2008.

Notes - 2005

Sources:

Numerator = Annual EPSDT Participation Report, HCFA-416: "Total Individuals Eligible for EPSDT". Division of Medical Assistance Programs.

Denominator = Population Projects for ages 0-19. Population Research Center, Portland State University.

Narrative:

The data sources for this indicator are readily available from the Office of Medical Assistance Programs (OMAP) using the Medicaid Management Information System. Capacity to outreach potentially eligible children occurs through several linking mechanisms, such as SafeNet, the MCH Toll-Free hotline, local public health nursing programs, and Headstart and other child care programs. Application assistance is available for parents at county health departments and DHS Service Delivery Area sites. Application assistance for children with special health needs is available through the same sources.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	39.5	40.1	41.7	41.7	45.4
Numerator	20349	21010	22301	22301	23307
Denominator	51541	52349	53543	53543	51285
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	Final

Notes - 2007

Sources:

Numerator = 2007 Annual EPSDT Participation Report, HCFA-416: "Total Individuals Eligible for EPSDT". Division of Medical Assistance Programs.

Denominator = 2007 Population Projects for ages 0-19. Population Research Center, Portland State University, March 2008.

Notes - 2006

Sources:

Numerator = Annual EPSDT Participation Report, HCFA-416: "Total Individuals Eligible for EPSDT". Division of Medical Assistance Programs.

Denominator = Population Projects for ages 0-19. Population Research Center, Portland State University

Notes - 2005

Sources:

Numerator = Annual EPSDT Participation Report, HCFA-416: "Total Individuals Eligible for EPSDT". Division of Medical Assistance Programs.

Denominator = Population Projects for ages 0-19. Population Research Center, Portland State University

Narrative:

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, 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.

Health Systems Capacity Indicator 08: *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.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	7.0	1.3	0.0	0.0	0.0
Numerator	526	98	0	0	0
Denominator	7508	7508	6832	7077	7077
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
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Notes - 2007

OCCYSHN is exploring technical assistance to develop data sources for the numerator and denominator for Oregon. for this measure.

Notes - 2006

A reliable data source is still not available for this measure. As noted in prior year, in the past OCCYSHN has generated a list of children seen at the Child Development and Rehabilitation Center clinic for rehabilitation services and has that list compared to the list of children receiving SSI from the Oregon Department of Human Services. This strategy is no longer viable in light of HIPAA and time-restraints. A proxy measure was explored. OCCYSHN has finalized the letter which DHS-SSI Office has agreed to send out indicating to families their eligibility for OCCYSHN program services as the numerator to the total number of children under the age of 16 residing in Oregon. We anticipate the letter being implemented beginning FY2008 (July 1, 2007).

The source for our denominator is the Social Security Administration Supplemental Security Record, Table: Number of Children under the Age of 16 Receiving Federally Administered SSI Payments, December 06. When/if we the numerator, we will make the report final.

The program's ability to influence HSCI 8 is enhanced by the Oregon Medicaid Rules mandate that children who are SSI-eligible receive OHP Plus (Medicaid) coverage with no co-pay for services and the OCCYSHN Program partnership with the Oregon Children's Intensive In-Home Services (CIIS) and Oregon Seniors and People with Disabilities to inform families of the benefits available to them.

Notes - 2005

A reliable data source is not available for this measure at this time. In the past, OCCYSHN has generated a list of children seen at the Child Development and Rehabilitation Center clinic for rehabilitation services and was compared to the list of children receiving SSI from the Oregon Department of Human Services. This strategy is no longer viable in light of HIPAA and time-restraints. A proxy measure is being explored. We are exploring the possibly of reporting the number of notices sent by the DHS-SSI Office indicating to families their eligibility for OCCYSHN program services as the numerator to the total number of children under the age of 16 residing in Oregon.

The source for our denominator is the Social Security Administration Supplemental Security Record, Table: Number of Children under the Age of 16 Receiving Federally Administered SSI Payments, December 05. When we have obtained the numerator, we will make the report final.

The program's ability to influence HSCI 8 is enhanced by the Oregon Medicaid Rules mandate that children who are SSI-eligible receive OHP Plus (Medicaid) coverage with no co-ay for services and the OCCYSHN Program partnership with the Oregon Children's Intensive In-Home Services (CIIS) and Oregon Seniors and People with Disabilities to inform families of the benefits available to them.

Narrative:

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.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	payment source from birth certificate	6.6	5.8	6.1

Narrative:

The MCH programs have access to birth certificate data used to calculate the proportion of low birthweight infants born each year by payment source to evaluate disparities in healthy births. Low birthweight rates are increasing nationally for a variety of reasons, such as shortened gestational age, medical management of pregnancy, and multiple births. These are issues that are generally found in the population at large, not solely in the low income and uninsured population. While the disparity between Medicaid and non-Medicaid remains constant, further analysis will be conducted to determine the particular characteristics of the disparity to better understand areas to focus capacity building. ***/2009/ Oregon continues to have lower low birthweight rates than the rest of the U.S. However, rate among African Americans, Native Americans and Asian/Pacific Islanders are higher than Oregon overall. (Oregon Perinatal Data Book, 2007. <http://www.oregon.gov/DHS/ph/pnh/databook.shtml>) //2009//***

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2005	payment source from birth certificate	6.7	5.3	5.9

Narrative:

Oregon continues to have one of the lowest rates of infant mortality in the nation, though this trend is increasing along with the national trends in low birthweight rates. ***/2009/ Infant mortality rates in Oregon continues to be lower than the U.S. except for specific races and ethnicity groups. The rate has significantly increased among African Americans and Native Americans between 1993-95 to 2002-04, and slightly increased for Asians/Pacific Islanders. (Oregon Perinatal Data Book, 2007. <http://www.oregon.gov/DHS/ph/pnh/databook.shtml>) //2009//***

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

MCH populations in the State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	66	86.8	78.4

Narrative:

As mentioned in National Performance Measure 18, Oregon has a specific program and statewide strategy to link women to Medicaid and insurance for first trimester care. The disparity between Medicaid and non-Medicaid may be the same as low birthweight, though Oregon has a high number of undocumented women that are not included in this data. Further analysis of pregnancy and birth-related data will be conducted over the next year.

/2009/ First trimester prenatal care indicators have shown little improvement overall, and a worsening among Medicaid-covered women. While white mothers have the best rates for early prenatal care in Oregon, it is only slightly higher than that state average overall. Native Americans have the worse rate of first trimester care, with African Americans and Hispanic mothers with second worst rate of care. Approximately 8.2% of women who gave birth in Oregon reported having no insurance for the prenatal care services, while approximately 39% used the Oregon Health Plan/Medicaid. More than one-fourth of Hispanic women (28.7% in 2004) had no insurance for prenatal care, which is 3.5 times higher than the national average. Native Americans and African American women were significantly more likely to use the Oregon health Plan to pay for the prenatal care services than other race/ethnic groups. (Oregon Perinatal Data Book, 2007. <http://www.oregon.gov/DHS/ph/pnh/databook.shtml>) //2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	60.6	72.2	67.5

Narrative:

As mentioned in National Performance Measure 18, Oregon has a specific program and statewide strategy to link non-Medicaid and Medicaid eligible women to prenatal care. As described in HSCI 05C, the disparity between Medicaid and non-Medicaid may be influenced by high number of undocumented women with live births that are included in the non-Medicaid population to analyze adequacy of prenatal care visits for this population, however, further analysis of pregnancy and birth-related data will be conducted over the next year.

/2009/ The Oregon Perinatal Data Book provides analysis of the gap between first trimester initiation of prenatal care and adequate prenatal care. In 2004, white mothers had the

highest prevalence of both first trimester prenatal care initiation (84%) and adequate prenatal care (74%). Both Hispanic and Native American mothers were less likely to receive either first trimester care or adequate prenatal care compared to mothers of other race/ethnic groups, and approximately 40% of both groups did not receive adequate prenatal care. The trends for this indicator for 2007 shows these rates to be continuing to decline //2009//

Health Systems Capacity Indicator 06A: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	185

Narrative:

SCHIP is rolled into the Oregon Health Plan for the eligibility for all populations. Higher federal poverty rates are set for children under 5 years and for pregnant women, than for children 6-18 years and the rest of the adult population. The Oregon Title V Director participates in the state-level DHS Medicaid Advisory Committee that meets monthly for the purpose of discussion and recommendation of policy issues to the DHS Cabinet, and therefore has input into decisions regarding coverage and coordination of services for the MCH population.

The Oregon Health Plan (Medicaid waiver) was covered pregnant women and young children up to up to 185% FPL, until 2003. Budget reductions at the state and national level forced a reduction of these rates to Medicaid levels. The OHP benefit packages were split into two tiers -- OHP Plus and OHP Standard.

The former Basic package, renamed OHP Plus, covers the same services for categorically eligible clients. A new benefit package, OHP Standard, was created and offers reduced benefits, higher co-payments and requires premiums. Starting June 1, 2006, OHP no longer charges a premium to OHP Standard clients whose household income is 10% or less of the Federal Poverty Level (FPL). Clients on the OHP Standard benefit package whose income is above 10% FPL must now pay current and past-due premiums at the time of reapplication in order to remain eligible for continued OHP Standard coverage. Starting June 1, 2006, client eligibility for the CHIP program is extended from 6 months to 12 months.

The Centers for Medicare and Medicaid Services (CMS) granted Oregon another five-year waiver on October 15, 2002. Most Oregonians eligible for the Oregon Health Plan's Medicaid coverage now receive the OHP Plus benefit package. Clients receiving the Plus Benefit Package include children under 19, pregnant women, blind, aged, people with disabilities, and other special need populations. Individuals and families with income below federal poverty guidelines are eligible for OHP Medicaid coverage. Pregnant women and children under 19 in households with earnings up to 185 % FPL are also eligible.

The Family Health Insurance Assistance Program (FHIAP) subsidizes the purchase of health insurance for uninsured Oregonians in certain income ranges by paying a large part of their health insurance premiums. CMS approved the waivers for federal matching funds for FHIAP on October 15, 2002, and FHIAP implemented the waivers beginning November 1, 2002. Since then,

FHIAP new enrollments have qualified for either CHIP or Medicaid match rates. These savings help fund expansion of FHIAP over the five-year demonstration period. FHIAP subsidies range from 95% of the premium cost (for families up to 125% FPL) to 50% of the premium cost (for families up to 185% FPL).

Source: "The Oregon Health Plan: An Historical Overview"
http://www.oregon.gov/DHS/healthplan/data_pubs/main.shtml

These changes in the Oregon Health Plan over the last few years have created some confusion among families and health providers. In some families, the children qualify for OHP health insurance without a co-pay, but the parents do not qualify for their own health insurance, or must provide a co-pay. Outreach efforts are underway to raise awareness among families and health providers to assure all eligible children have access to health care and health insurance, especially those under 5 for the full 12 months.

/2009/ No changes in the coverage level for Medicaid-Oregon Health Plan. However, the DMAP set up a reservation list to add an average monthly enrollment in Oregon Health Plan-Standard plan of 24,000 by November, 2008. DMAP created a reservation list from which names would be drawn randomly to receive an application for OHP coverage. To date, 91,000 people submitted applications to be on the reservation list, and 15,000 have been drawn and sent applications. As a result, 3,084 have enrolled for medical coverage. (DHS News Release, July 7, 2008. <http://www.oregon.gov/DHS/news/2008news/index.shtml>) //2009//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2007	100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2007	185

Narrative:

Oregon's SCHIP program is combined with the Oregon Health Plan. Information is about SCHIP is included in HSCI #06A.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06	YEAR	PERCENT OF
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The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		POVERTY LEVEL Medicaid
Pregnant Women	2007	100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	185

Narrative:

Oregon's SCHIP program is combined with the Oregon Health Plan. Information is about SCHIP is included in HSCI #06A.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Oregon was approved but not funded by CDC for a Birth Defects Registry two years in a row. The Title V Program continues advocacy at the state level for creating and sustaining a Birth Defects Registry in collaboration with partners and stakeholders.

Oregon PRAMS-2 is administered by the Title V Program, began collecting data in 2005-06.

Narrative:

- Oregon's data capacity to measure the eleven indicators is contingent on access to a number of data sources. The OFH currently has access to data from FamilyNet client data including WIC client data ("TWIST"), Immunization client (IRIS) and registry (ALERT) data, EHDI (Early Newborn Hearing Detection Intervention) data, linked newborn screening and birth certificate data, Ahlers Family Planning client data, birth and death statistics, OMAP (Office of Medical Assistance Programs - Medicaid) data, hospital discharge data, PRAMS surveys, BRFSS surveys, and Oregon Healthy Teen (YRBS) Survey data. For children with special health needs programs, located at the Child Development and Rehabilitation Center at OHSU, Oregon Health Plan data is available to track early intervention, screening, diagnosis, referral and follow up for a variety of health and oral health issues. Oregon was approved but not funded by CDC for a Birth Defects Registry two years in a row, and will continue to submit applications.

- Vital Statistics-Public Health data warehouse: VistaPH is a web-based, user-friendly software package that allows the public health community in Oregon to access and analyze population-based health data on the county or state level. The program calculates rates of disease or other health events for specific age, gender and race groups with appropriate statistical measures: confidence intervals, case counts, and time trends. Oregon data sets currently available for analysis through VistaPH include birth, death, infant mortality, communicable disease and population estimates. Future plans for the initiative include making VistaPH available to additional counties, adding more data sets, and allowing analysis on sub-county geographic levels.

- Oregon's integrated data system, FamilyNet and ORCHIDS (Oregon Child Health Information Data System) is being developed to support and evaluate an integrated system of services in which all children, pregnant women, and families at risk are identified as early as possible, and services needed for optimal health and development are available and accessible. ORCHIDS will contain case based and aggregate, population, screening, follow-up, and care coordination data from seven different perinatal and child health programs. Programs included in FamilyNet the Early Hearing Detection & Intervention (EHDI); reporting and long term care coordination related to newborn dried blood spot screening (newborn metabolic, hemoglobin, and endocrine disorders screening); public health care coordination for children with special health needs (CaCOON and Community Connections Network); high risk infant follow up (Babies First!); prenatal care access (Mother's Care); care management for high-risk pregnant women (Maternity Case Management); and community support for families with social and economic risk factors (Healthy Start). ***//2009/ Full roll out and participation in ORCHIDS occurred in May 2008 //2009//***

//2009/ PRAMS_2: In September 2005, Oregon PRAMS began re-surveying PRAMS respondents when their child turned 24 months old. The survey includes questions on health insurance, chronic diseases, oral health, well child care, medical home, breastfeeding, smoking, domestic violence, family planning, child nutrition, immunization, early intervention, childcare, screen time, and reading to child. Up to two mailings of the PRAMS-2 surveys are sent for each mother, then a telephone follow-up to non-responders. The response rate is 57%. Data on 2006 surveys (for babies born in 2004) have been available since July 2008. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
P		

Notes - 2009

Oregon's YRBS is titled "Oregon Healthy Teen (OHT) Survey" and is conducted as one state-sponsored survey. The OHT is administered through a collaborative group of state agencies including the Department of Human Services, the Department of Education, the Governor's Commission on Juvenile Justice, the Commission on Children and Families and the Oregon Progress Board. The survey instruments have been revised annually since 1991.

Narrative:

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. Program managers and research 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 including the Department of Human Services, the Department of Education, the Governor's Commission on Juvenile Justice, the Commission on Children and Families and the Oregon Progress Board. The survey instruments have been revised annually since 1991 and this year consisted of one version for both 8th and 11th graders, containing 189 separate response items.

The OHT survey was surveys about four in ten of all 8th and 11th graders statewide. Surveyed schools were selected through five processes: As part of a statewide random sample, as part of the sample for Center for Disease Control and Prevention's Youth Risk Behavior Survey (YRBS), as a Coordinated School Health (CSH) school, as part of the Oregon Research Institute (ORI) Tobacco Prevention evaluation (there was some overlap between these first four groups) or as a volunteer school. The surveys were conducted by either Oregon Research Institute, for schools under their funding, or by a private contractor to DHS, who instructed classroom teachers in proctoring the survey.

In 2005, surveys were returned from 30,002 students, representing an overall response rate of 79.5% of those sampled. Of these, 3.2% were excluded because of extensive patterns of discrepant and/or dubious (extreme) answers, 4.8% were excluded because their grade level could not be determined or because of missing gender information. This left 27,622 valid surveys: 92.1% of the total received, with 14,708 from 8th grade, 11,028 from 11th grade, and 1,886 from 9th, 10th, and 12th grade as part of the YRBS sample, in 34 counties. There was no data collected at all from 2 counties, Lincoln and Josephine counties, and Tillamook County had no 11th grade data.

(source: <http://www.dhs.state.or.us/dhs/ph/chs/youthsurvey/index.shtml>)

//2009/ The 2006 Oregon Healthy Teens survey was conducted among over four in ten of all 8th and 11th graders statewide. Surveyed schools were selected through four processes: As part of a statewide random sample, as a Coordinated School Health (CSH) school, as part of the Oregon Research Institute (ORI) Prevention evaluation (there was some overlap between these three groups) or as a volunteer school. The surveys were conducted by a private contractor to DHS, who instructed classroom teachers in proctoring the survey. Surveys were returned from nearly 29,000 students, representing an overall response rate of 81.2% of those sampled. Of these, 3.0% were excluded because of extensive patterns of discrepant and/or dubious (extreme) answers, while 5.8% were excluded because their grade level could not be determined or because of missing gender information. This left 26,440 valid surveys (91.2% of the total received, with 15,291 from 8th grade and 10,676 from 11th grade in 32 counties. //2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The 2001-2006 Family and Child Health (Title V) Needs Assessment established priority needs in Oregon. The State Negotiated Measures represent indicators that meet OFH selection criteria: measures that relate to OFH and DHS priorities for which data are valid, currently available in Oregon, planned to be reliably tracked over five years, and related to evidence of favorable program outcomes. The State Negotiated Measures were also selected for their relevance to the Oregon Benchmarks and priorities, a statewide quality of life measure system coordinated through the Governor's office. A "MCH Monitoring System" created through the SSDI initiatives, maintains definitions of all performance measures, high level outcomes, and intermediate level outcomes, and the measure's relationship to agency or grant requirements such as the Oregon Benchmarks, Oregon Dept. of Human Services, Title V, and other federal, state or projects.

2001-2006 State Performance Measures

The ten state measures from the 2001-2006 were based on the priorities from the Family and Child Needs Assessment and on validity of data sources to measure progress over the five year time period. The state negotiated measures and their supporting activities reflect the focus of MCH programs in OFH and OCCYSHN to build infrastructure in public health systems for better service delivery and in improving population health through better program delivery. Measures related to pregnancy health, injury prevention, tobacco use, and water fluoridation are directly related to the reducing mortality rates, or the underlying morbidities, represented by the six Core Outcome measures. The other measures are related to building infrastructure to address MCH population needs. In Oregon, the focus of MCH infrastructure building is on access to care, enhancing of communication with and information for providers, and data capacity to better analyze indicators and outcomes in the future.

The 2005-06 Priorities Background and Overview:

The selection of health priority needs for the 2006 Needs Assessment began with a review and evaluation of work conducted by other offices and agencies during 2004-05. The Local Public Health Agency Plans, the CCF Plans, and other similar documents were reviewed and compiled to determine the highest priority issues felt by Oregon communities. The information from these documents was synthesized to develop the leading priorities most recently assessed by local agencies. A list of health topics was identified as leading problems or assets for Oregonians. These topics included: Insurance coverage and access to care; Perinatal care; Mental and emotional health; Substance abuse; Injury; Oral health; Obesity and nutrition; Health disparities; Prevention and screening; Reproductive health; Chronic disease prevention; Other: communicable disease, environmental health, geriatrics.

From these issues, overall priorities for Title V were discussed and prioritized among work groups formed around MCH populations and resulting in a selection of "aims". An aim is similar to a goal but it is measurable and active, and is intended to serve as an over-arching focus for performance or outcome measures. Criteria for the aims included:

- Importance: Based on health status indicator data, does the health topic significantly impact a large number or of a vulnerable sub-population of Oregonians (health disparity)?
- Ability to Impact: Can the health topic be improved upon in 5 years?
- Measurability: Can we measure the impact that we make?
- Leverage: Do current opportunities or resources (such as current efforts or initiative, funding, public awareness or political will) exist to leverage the impact of working on the topic?
- Alignment with State Agency Priorities: Does work on this topic promote and/or support the governor's and/or other state agencies goals and policy agendas?
- Alignment with Other Partners' Priorities: Does work on this topic address an issue of stated importance to our Local Health Departments or other partners?
- Impact on OFH programs: Will working on the topic build, expand, or shift the current work of OFH programs in a direction consistent with our values and mission?

The Aims selected are:

- Children's health needs are always met.
- Individuals and families exhibit healthy lifestyles.
- Children, adolescents and families experience optimal mental health and social emotional development.
- Parents and providers are confident in caring for children.
- Racial and ethnic disparities are eliminated (cross-cutting)
- Strong leadership is helping to reduce morbidity and mortality of the maternal and child health population (cross-cutting).

During the interim needs assessment years, the Oregon Title V Program will work to build the program and resource allocation necessary to address needs that will contribute towards the positive impact toward Oregon's National and State Negotiated Performance Measure objectives.

/2007/ The Office of Family Health is using the Capacity Assessment results to discuss and plan for better use of existing staff resources and needs for internal systems changes. Three areas being reviewed are: policy development and advocacy, program evaluation, and organizational structure. //2007//

/2007/OCCYSHN incorporates an evaluation process in each of its activities to assess the priorities and measure success toward the performance measure objectives and program outcomes. Mental health and dental health are identified as needs children and youth with special health needs, as well as the general child and youth population. Training and technical assistance to address the concern of mental health issues were pursued this past year and partnerships formed to develop effective strategies and system of care. //2007//

/2008/ OFH continues to work towards building competencies around program evaluation. Managers and program staff attended the CDC Program Evaluation Training in Fall, 2007 and Spring, 2008, and worked to improve integration of program evaluation practices in OFH programs and structure. //2008//

/2009/ A new Evaluation Manager is hired and will begin to develop an organizational structure for MCH programs, Office of Family Health, and Title V activities. //2009//

/2008/. During 2007, OCCYSHN community consultants found a need to increase emphasis on behavioral health, family involvement, access and adolescent transition. OCCYSHN is planning for community engagement processes to these priority issues for children/youth with special needs.

- OCCYSHN disseminated information and facts to educate legislators and the public about children/youth with special needs. In addition, OCCYSHN will seek involvement in rulemaking processes and provide information to providers and the public about the affect of legislative changes on children/youth with disabilities or chronic conditions and their families. //2008//

/2009/ During 2008, through conversations with county public health leaders, oral health has emerged as a critical need for children with special health needs. OCCYSHN will look to AMCHP for assistance in determining an effective method for gaining traction in Oregon around this issue. OCCYSHN will partner with the OFH in its oral health coalition on behalf of all children, and to develop opportunities to increase awareness of the need for oral health services for CYSHN and to increase the skills and knowledge of oral health professionals in serving CYSHN. Family involvement and cultural competency in care for CYSHN remain priority needs in addition behavioral health, adolescent transition and health care finance.

//2009//

B. State Priorities

Background on 2006-2011 State Priorities:

The 2005-06 Needs Assessment conducted an extensive capacity assessment for providing all levels of the Title V Pyramid of Services. The information from these capacity assessments will provide direction during the interim years to develop the programs, services and resource allocation that best contribute towards the state's performance measures. The greatest need from these capacity assessments was in the area of mobilizing partnerships, including with families, at the state and local levels, and in program evaluation and continuous improvement systems.

The overarching Aims selected in 2005 will provide guidance for Oregon's Title V programs through selection of additional program-level performance measures and evaluation. The state performance measures selected to represent these aims are intended to be the best indicators available for those aims. The Title V State Performance Measures are viewed as "intermediate" measures that are not ends in themselves, but rather the best indicators to monitor progress of efforts among state and local public health partners.

An exception to the list of State Performance Measures is the absence of a mental health performance measure. Mental health status for children, adolescents, pregnant women, and children with special health needs does not have reliable and valid data sources to acceptably measure progress toward improvement. An emotional health and mental health status measure would have been included in the state measures. However, mental health wellness and access to mental health services repeatedly arises as one of the top needs by families and by providers serving those families. Oregon Title V program therefore added mental health in its list of priorities, without a supported performance measure, with the commitment to actively work to develop appropriate measures during the interim years. The MCH Block Grant interim year updates will report progress in developing these measures.

The 10 state performance measures for 2006-2011 are listed below with their relationships with the 6 Aims selected through the needs assessment process.

Priority 1: Improve access to comprehensive and coordinated health care; facilitate screening, assessment and intervention services

SPM # 3: Percent of infants diagnosed with hearing loss that are enrolled in Early Intervention before 6 months of age

Population groups affected: Infants, Children, Children with Special Health Needs

SPM # 4: Percent of children that complete the 4th DTAP vaccine (12-18 mos)

Population groups affected: Infants, Children

SPM # 6: Percent of 11th graders who report having unmet health care needs

Population groups affected: Children and Adolescents

Priority 2: Support behaviors and environments that encourage wellness and reduce chronic disease.

SPM # 7: Percent of Oregonians living in a community where the water system is optimally fluoridated

Population groups affected: Infants, Children, Children with Special Health Needs, Pregnant Women

SPM # 2: Percent of smoking pregnant women who quit smoking during pregnancy and remained quit

Population groups affected: Women, Pregnant Women, Infants

SPM # 1: Percent of births that are intended

Population groups affected: Infants, Children, Adolescents, Women

SPM # 5: Percent of 8th graders who report being physically active for a total of at least 60 minutes a day for 5 or more days in the last 7 days.

Population groups affected: Children, Adolescents

Priority 3: Promote optimal mental health and social emotional development.

Population groups affected: Pregnant Women, Infants, Children, and Adolescents

For this priority, the Oregon Title V Program is committed to improving mental health status of mothers and children. The Program recognizes the current lack of reliable, valid population-based data to measure performance. In the next five years, the Title V Program will work to develop infrastructure, measures, and activities, integrated and linked with services reaching this population, in areas such as:

- Maternal depression
- Social-emotional health of young children
- Social-emotional health of adolescents

/2007/ With the completion of the Early Comprehensive Childhood Systems (ECCS) Plan, the Office of Family Health and Title V Programs are positioned to begin working on mental health issues. In addition, analysis of Oregon's data from the National Survey of Children's Health and the Oregon Healthy Teens Survey (YRBS) will provide baselines to help bring focus to the discussion. //2007//

/2008/ The Governor's Children's Wraparound Services Initiative committee work on mental health services is represented by the ECCS coordinator and Adolescent Health Manager from OFH. //2008//

/2009/ Substantial progress in finding a mental health indicator was made in 2007-9. As a result of the ABCD Learning Academy, a measure for screening Medicaid-covered children in well-child care has been developed, using the 96110 CPT code. This will allow the MCH program to track the use of standardized screening in well-child visits, as providers increasingly use this code for billing. Additional work in screening social/emotional development and perinatal mood disorder is underway in 2008, as shared planning with county public health nurses proceeds and the ABCD Screening Initiative and public-private partnership continues in 2008-09. //2009//

/2009/ The Adolescent Coordinated School Health program asks participating schools to report on Oregon Healthy Teens indicators related to mental health status. These indicators include questions about mood, suicidal ideation, and unmet mental health needs. /2009//

Priority 4: Parents and providers are confident in caring for their children

SPM# 8: Percent of health care providers who report confidence in caring for CYSHN and their families

Population groups affected: Children with Special Health Needs

/2008/ OCCYSHN is initiating development of a measure of provider confidence to better assess State Performance Measure #8: Providers are confident in the care of CYSHN. With assistance from OPER and CAHMI, OCCYSHN aims to develop and validate a measure of provider confidence by the middle of the 2008 program year. //2008// /2009/ The measure of provider confidence has been off set this past program year and is being

conducted by a simple self-report. OCCYSHN will review this performance measure and develop an alternative performance measure around providers' confidence and competence, their adequate preparation to care for CYSHN and their families.//2009//

SPM # 9: Percent of families of CYSHN who report costs not covered by insurance were usually or always reasonable.

Population groups affected: Children with Special Health Needs

SPM # 10 Percent of families of CYSHN who reside in rural areas report that needs are usually or always met.

Population groups affected: Children with Special Health Needs

Cross-cutting priorities - Performance and outcome measures, activities and resources, and on-going needs assessment will be developed to address the following priorities across all performance measures:

Priority 5: Promote equity in health by reducing disparities; promote equity means to create policies, systems and resources.

Priority 6: Advocate public health within existing systems; promote the role of public health and Office of Family Health as a partner in early childhood services and systems.

//2007/ The OFH Title V program in the Office of Family Health has been working on capacity priorities identified in the needs assessment, to develop structures that will better address the health priority issues. During 2006-07, the Title V Program, OCCYSHN, and local public health nurses and administrators will engage in joint priority setting and strategic planning to better align state and local MCH services and programs according to these priorities. OCCYSHN is collaborating with private groups and public agencies to explore the health access concerns for CYSHN as related to insurance coverage, training for providers and assessing capacity of nursing groups (school nursing, home health nurse and public health nurses) to address care coordination needs. *//2007//*

//2008/ OFH initiated an internal Policy Case Study Series for staff to provide information and training about policy development and leadership. The case study format is intended to provide a practical approach to increasing knowledge and competency in policy development and implementation, especially in the context of a government public health agency. *//2008//*

//2008/ Oregon's Early Comprehensive Childhood Systems Plan has entered its implementation phase. The Plan's shared objectives and strategies are being confirmed and incorporated into Title V program planning in OFH and OCCYSHN activities. A significant step in the ECCS Plan implementation is Oregon's award to participate in the ABCD Learning Academy sponsored by the National Academy of State Health Policy to improve and standardize early childhood developmental and psychosocial screening in Oregon. The Title V Program (OCCYSHN and OFH) is a co-leader with the State Medicaid Program and the Oregon Pediatric Society to participate in the Academy, and together they will lead development of a public-private stakeholder group, oversee a pilot to evaluate use of standardized screening tools and referrals, and develop strategies to spread the practice across Oregon's early childhood system of care. The strategies will include recommending policy changes to support the implementation of standardized developmental screening as a standard practice in well-child care. This opportunity became available at the right time in Oregon, as similar pilots upon which to build have already occurred in both pediatric and family practice settings, and it is a direct implementation of the ECCS recommendation to "promote the use of standardized developmental and psychosocial screening tools as routine components of well-child check-ups and community services." The ABCD initiative also addresses all the Title V priorities in multiple ways, from providing MCH leadership and facilitation to engage new partners (Pediatric Society and Medicaid) to improving screening, social/emotional development, and parent and provider confidence in caring for

children.

Other early childhood activities supporting the recommendations and goals of the ECCS Plan reflect the value of engaging a broad cross-section of stakeholders and leaders in development and ongoing refinement of the plan. The Title V Director, the ECCS Manager, and other Title V and public health staff are involved in these activities at multiple levels, including policy development, technical assistance for community planning, infrastructure enhancement, and service delivery system collaboration. State and local partners, as well as Oregon's emerging public-private partnership, have endorsed the ECCS Plan's framework and are working to align their early childhood activities with it.

Two efforts occurring at the Governor level are The National Governors Association (NGA) award for a Governor's Summit on Early Childhood and the Children's Statewide Wraparound Project. The Children's Wraparound Project was initiated by Executive Order 07-04 proclaiming the need for a statewide, integrated system of care for children and their families at risk for emotional, behavioral or substance abuse related needs. The EO established a Steering Committee and requires a report by December 2007 that lays out recommendations and a plan to finance and provide accountability for statewide emotional and behavioral health services for children, adolescents and their families that reflect values and wraparound principles. The Title V Director, ECCS Manager, and Child and Adolescent Health staff is involved in this initiative.

The NGA has awarded Oregon funds to hold a Governor's Summit on Early Childhood. The focus of this summit is to further the Governor's policy agenda and recent legislative action aimed to improve the health and well-being of young children at risk. The Summit will focus primarily on social/emotional -development and early childhood mental health, and is integrated with the Children's Wraparound Initiative. //2008//

/2009/ The Governor's Summit was held in March 2008 and resulted in a restructuring and development of a private-public leadership and work group to work on three different areas: health, parent education, and family support. The ECCS Project Manager is co-lead for the health work group. //2009//

/2008/ In 2006-2007, the Title V Program initiated a comprehensive, in-depth look at the health status of pregnant women and birth outcomes in Oregon to explore priorities and needs. This information is being captured in The Oregon Perinatal Data Book. The Data Book is comprised of leading perinatal health indicators that describe the overall picture of perinatal health in Oregon, with data obtained from Vital Statistics, PRAMS, and the National Immunization Survey. The information covers demographics of Oregon's child-bearing population, perinatal health, birth outcomes, and maternal and infant health. The data and graphic charts show comparisons with national data and the Healthy People 2010 goals to bring perspective to the data and how close Oregon is achieving those goals. Trends, include 10-year trends when available, give a picture of any significant changes over time.

The Perinatal Health Data Book will be disseminated widely among policy and program developers and decision makers. The data will be directly used in a state-local priority and planning initiative between the Title V program and the Association of Oregon Public Health Nurses. The data has shown worsening trends in low birthweight infants and access to early and adequate prenatal care, particularly among low-income women. The shared goal and priority setting by Title V-AOPHNS, to occur in Fall 2007, will result in consensus on the interventions and best practices targeted specifically to improve trends in perinatal health. //2008//

/2009/ The Perinatal Health Data Book was completed in late 2007. It has been disseminated among local and public policy makers and stakeholders, as well as being used for developing grant and legislative proposals. The analysis was instrumental in helping the public health nurse shared planning group determine areas of perinatal health to develop strategic plans. More on this in III.A. State Overview. //2009//

/2008/ The Adolescent Health Program is working in ongoing needs assessment and priority setting include the efforts by incorporating Youth Action Research methods to identify needs, priorities and goals based on the input of youth. The information from this research will be used to the development of strategies and policy recommendations for the new teen pregnancy prevention/adolescent sexual health State Plan.

The Adolescent Health Program added a mental health component to the Coordinated School Health program for the first time in the 2006-07 school year in 4 schools. A school mental health self-assessment and planning tool modeled after the CDC School Health Index was developed and pilot tested by 3 schools and 1 district behavioral program during the 2006-2007 academic year. This tool will be implemented widely in 2008 and the results will be used to help each school plan, strategize and further a coordinated school health approach to mental health services in their school. A School Based Health Center Mental Health Needs Assessment online survey was completed by each of the SBHCs to assess in detail their mental health staffing and capacity in order to understand where gaps exist. This information will be used to provide technical assistance and training to SBHCs in having better organization of existing mental health services, as well as serving as a capacity baseline when planning for future mental health services. //2008//

/2008/ To improve MCH Leadership capacity in Title V Programs, OFH and OCCYSHN staff and managers are attending both Public Health Leadership and MCH Leadership programs. During 2006-2007, three people attended the year-long Northwest Center for Public Health Practice, two attended the National MCH Leadership Academy, and three people participated in the --month Dept of Human Services Leadership training. //2008//

/2009/ The OCCYSHN Program Manger (now appointed as Director) attended the MCH Leadership Academy in Fall 2007 and is now making her application to the New Director's Mentor Program for the Fall/Winter of FY09. The new MCH Section Manager attended the MCH Leadership Academy of June 2008. //2009//

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	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	33	24	48	36	60
Denominator	33	24	48	36	60
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
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

Source: Newborn Screening

a. Last Year's Accomplishments

- Oregon continued to participate in the Northwest Regional Newborn Screening Program, administered by the Oregon State Public Health Laboratory (OSPHL).
- Systems continued to be in place to assure that all infants with a positive test result receive appropriate diagnostic testing, and that a health care provider accepts responsibility for treatment and/or monitoring of each infant diagnosed with a condition requiring treatment and/or monitoring. The primary care physicians of all children with metabolic conditions requiring treatment or monitoring are offered long-term follow-up through the OHSU/ CDRC metabolic clinic, the only comprehensive metabolic center in the state. Block Grant funds partially support the metabolic clinic. The primary care providers of infants with hemoglobinopathies and endocrinopathies detected by newborn screening are offered long term follow-up through the OHSU Doernbecher Children's Hospital's pediatric hematology and endocrinology programs.
- The Community Connections Network and CaCoon Public Nurse Home Visiting Program continued to provide community-based care coordination and follow-up for qualified children with conditions detected by newborn screening.
- State legislation continued to require public and private third party payers to cover medical food and formula for individuals born with errors in metabolism requiring medical food for optimal growth and development.
- The OSPHL newborn screening program website was maintained.
- The OSPHL continued offering WebRad, a secured web-based tool giving hospitals and physicians the ability to obtain newborn screening test results.
- OSPHL and CDRC staffs continued to participate in multiple national newborn screening-related committees and workgroups.
- Cystic Fibrosis was added to the Oregon newborn screening panel 11/1/06. Information on CF newborn screening was added to parent education materials, the OSPHL newborn screening website, and the Oregon Practitioners' Manual. Multiple talks on CF newborn screening were given and mailings were sent to health care providers. A contract was executed between the OSPHL and OHSU for Cystic Fibrosis Clinic staff to advise the program on policy and technical issues, consult on cases, and communicate directly with infants' health care providers when necessary. Cystic Fibrosis screening results and procedures were carefully monitored, and over the course of the year, protocols and procedures were updated.
- The Oregon WIC program and CDRC Metabolic clinic continue to provide medical formula for eligible infants/children under age five with errors in the metabolism. The CDRC Metabolic nutritionist promoted a national policy of third party reimbursement for medical foods.
- Telemedicine visits for infants, children, and adults with metabolic conditions continue through the Western States Genetic Services Collaborative.
- The OSPHL, OFH, and CDRC staff members continued participation in the Western States Genetic Services Collaborative, a HRSA-funded Cooperative Agreement. Piloting and evaluating a regional practice model for delivering genetics services, including diagnosis and treatment of children with conditions detected by newborn screening, is part of the project.

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 Lab and CDRC/OHSU	X			X
3. Practitioner manuals updated and distributed throughout the state; online resources available				X
4. Work with policy makers to address needs related to genetic condition follow up/management.				X
5. Collaboration between CDRC Metabolic clinic and WIC to assure medical formula provided for infants/children under the		X		

age of five with metabolic disorders of metabolism (e.g. PKU)				
6. Assure follow-up and treatment through CaCoon, Community Connections Network and CDRC Genetics and Metabolic Clinics.	X	X		
7.				
8.				
9.				
10.				

b. Current Activities

- Systems are in place to assure that all infants with a positive test result receive diagnostic testing, and that a health care provider accepts responsibility for treatment and/or monitoring of each infant diagnosed with a condition requiring treatment /monitoring. All children with metabolic conditions requiring treatment/monitoring are offered care through the OHSU/CDRC metabolic clinic, partially supported by Block Grant funds. Infants with hemoglobinopathies and endocrinopathies are offered care through OHSU Doernbecher Children's Hospital's pediatric hematology and endocrinology programs.
- Cystic Fibrosis was added to the Oregon newborn screening panel 11/1/06. CF screening results and procedures are being carefully monitored; protocols and procedures have been updated.
- State legislation is in place requiring public and private third party payers to cover medical food and formula for inborn errors of metabolism. The WIC program and CDRC Metabolic clinic continue to provide medical formula for eligible infants/children under age five.
- Community Connections Network and CaCoon Public Nurse Home Visiting Program provide community-based care coordination and follow-up for children with conditions detected by newborn screening.
- Telemedicine visits for infants, children, and adults with metabolic conditions continue through Western States Genetic Services Collaborative.
- Secure on-line access to newborn screening results is provided to hospitals and physicians.

c. Plan for the Coming Year

- The current newborn screening panel will continue next year. Quality assurance and education activities will continue.
- The primary care physicians of all children with metabolic conditions requiring treatment or monitoring will continue to be offered long-term care through the OHSU/ CDRC Metabolic clinic. The primary care providers of infants with hemoglobinopathies and endocrinopathies detected by newborn screening will continued to be offered long term care through the OHSU Doernbecher Children's Hospital's pediatric hematology and endocrinology programs.
- The Community Connections Network and CaCoon Public Nurse Home Visiting Program will continue to offer community-based care coordination and follow-up for children with conditions detected by newborn screening.
- The Oregon WIC program and CDRC Metabolic clinic will continue to provide medical formula for eligible infants/children under the age of five who have inborn errors of metabolism.
- The CDRC Metabolic nutritionist will monitor third party reimbursement for metabolic foods and formula, and to promote a national policy of third party reimbursement for medical foods.
- The OSPHL newborn screening program website, <http://www.oregon.gov/DHS/ph/ph/> will be maintained.
- Community Connections Network and the CaCoon Public Nurse Home Visiting Program staffs will continue to enter data for children with conditions detected by newborn screening that are served by these programs into the Oregon Community Health Integrated Data System (ORCHIDS). Results will be used for program planning and evaluation, and policy development.
- The OSPHL will continue to offer WebRad, a secured web-based tool giving hospitals and physicians the ability to obtain newborn screening test results for their patients.
- Newborn screening information in the Newborn Handbook, a resource book distributed to the

mothers of all Oregon newborns, will be updated as needed.

- OSPHL, OFH, and CDRC staff members will continue participation in the Western States Genetic Services Collaborative, a HRSA-funded Cooperative Agreement. Piloting and evaluating a regional practice model for delivering genetics services, including diagnosis and treatment of children with conditions detected by newborn screening, is part of the project.

- OSPHL and CDRC staffs will continue to participate in multiple national newborn screening-related committees and workgroups, including those on emergency preparedness, and long term newborn screening follow up.

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	2003	2004	2005	2006	2007
Annual Performance Objective	55	57	59	55	55
Annual Indicator	54.6	54.6	54.6	54.6	55.5
Numerator	62990	62990	62990	62990	
Denominator	115367	115367	115367	115367	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	56	57	57	57	57

Notes - 2007

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 - 2006

Data reported for 2004-2006 are from the 2003 National Survey for Children's Health - Children with Special Health Needs SLAITS data. The survey is conducted every 3-4 years. New data will be available in 2008-9.

a. Last Year's Accomplishments

- OCCYSHN's FIN core staff was comprised of 3 regular staff members to represent a parent perspective. Family staff participate in the OCCYSHN leadership team, internal committees, workgroups and planning meetings, and work to collaboratively to implement all OCCYSHN training activities. An additional family staff member was hired on a temporary basis to input resources to Disability Compass, an internet resource for families.

- FIN's state network included over 40 families participating in OCCYSHN activities and partnerships, representing a cross section of rural, urban and diverse socio-economic and ethnic families. Families in the network participate on a listserv, are engaged in a variety of activities and initiatives, provide educational presentations and attend OCCYSHN trainings, Family staff maintain regular contact with families in the network through phone calls, e-mails and in person whenever possible.

- Information to assist families with making decisions about the care of their child/youth was

disseminated in several ways:

- The local public health nurses and OCCYSHN nursing consultants provided information and decisional support to families in all counties of the state through the CaCoon program. Through consultation and home visiting families receive specific information about their child's condition, services and resources.
- Local CCN teams in 15 locations provided an interdisciplinary approach to address complex needs or unresolved issues related to CYSHCN. Through the CCN meetings, families received information and support within their community to assist in meeting the needs of their child or youth. During this year, teams met approximately monthly for the 9-10 month school year.
- FIN and community consultants presented educational sessions to a variety of parent and professional groups. During the past year, OCCYSHN staff and FIN network members presented at Oregon Parent Training and Information Center annual training, Northwest Down Syndrome Conference, Washington County Resource Fair, Celebrate Wellness Conference of the Oregon Office on Disability and Health, Oregon Association of Vocational Special Needs Programs, Northwest Early Childhood Institute.
- The OCCYSHN newsletter, the OCCYSHN Liner, included information for families as well as updates on OCCYSHN activities. The OCCYSHN Liner was disseminated to over 1,000 people, which includes families, providers, agencies, and the Oregon legislature.

-Local Family Liaisons (FL) received orientation and training from family staff and were serving on CCN multidisciplinary teams in five locations: Marion, Linn-Benton, Clackamas, Tillamook and Hood River Counties. At a sixth site in North Bend, a rural southern Oregon coastal town, FLs also participated on a rural pediatric practice team that was working on continuous quality improvement within the practice. On CCN teams, FLs represented a family perspective to the teams and supported local families served through the CCN meetings. Ongoing training opportunities and support for local FLs was facilitated through community consultants and family staff.

- Family staff were actively involved in more than 12 state and county/community level organizations.

-As a partnership of OCCYSHN and the LEND training program for allied health professionals, family staff coordinated the Family Mentorship Program, pairing LEND trainees with a Family Mentor, a family of a child or youth with special health care needs who mentored the trainee on practical realities of parenting a child with disabilities. Family staff served on the Training Coordinators Council and provided educational presentations about family centered care, systems of care, and adolescent transition to LEND trainees as part of the regular interdisciplinary forums.

-Through family staff and FIN, OCCYSHN partnered with the autism clinical program at CDRC to support and co-manage a parent consultant position. The parent consultant worked part time in the clinic to assist parents and do follow up phone calls. She was included in regular FIN meetings and activities.

- FIN collaborated to increase family perspectives on services and systems in the LEND Program, CDRC autism clinic, and the WSGSC.

-FIN staff has worked closely with the Western State Genetics Services Collaborative and is included in monthly meetings, the Data and Outcomes Committee and in planning for the annual meeting.

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 internal committees, activities and leadership.				X
2. Families are involved in community based activities.				X
3. OCCYSHN staff partner with state agencies, organizations and family groups to provide family perspectives, identify issues and share information.				X

4. OCCYSHN partners with other areas of CDRC 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

- FLs are added to CCN teams, bringing the total to 9 teams with FLs. A rural practice team is added in Klamath Co. with 2 FL's participating.
 - Family staff increases for a limited term to increase family participation on CCN teams and develop a training manual for FL's.
 - Family Professional Partnership initiatives are highlighted at OR Rural Practice Research Network annual convocation, in plenary and poster sessions at OCCYSHN's annual conference, at Child Advocacy Night at OHSU, and NW Down Syndrome Assoc's conference.
 - OCCYSHN participated in Region X Family Voices leadership development training in March 08.
 - Family staff participates in developing a Family Centered Care Survey for CDRC clinics. Survey is used for quality improvement and reporting to the legislature.
 - OCCYSHN continues disseminating information to families through CaCoon, CCN, its newsletter and website, WSGSC and through state and community based training events.
 - OCCYSHN staff works with the Family Action Coalition Team, the DD Council's Family Issues Committee, and Oregon Health Action Campaign to represent and support issues important to CYSHN and their families.
 - OCCYSHN partners with Disability Compass to enhance its online database of resources for families of CYSHN.
 - OCCYSHN invites families from its network to provide input to the Block grant application and report.
- OCCYSHN and OIDD provide financial support to Partners in Policymaking for leadership training and translation services.

c. Plan for the Coming Year

- OCCYSHN will continue to work on Family Professional Partnership and Medical Home activities that will include families on local teams and in activities. Evaluation of these activities will be completed to determine level of satisfaction for both families and professionals.
- Family Liaison Training Manual will be finalized and training sessions with Family Liaisons will begin in fall, 2008.
- OCCYSHN will work on plans for increasing family partnerships, the FIN network and involvement with CDRC and OCCYSHN. Efforts will include identifying additional activities and volunteer opportunities for families at the local and state level.
- OCCYSHN will support/partner with Family Voices and the Oregon Family Support Network in the Family to Family Health Information and Education Center activities. OCCYSHN and FV are investigating opportunities to combine or co-sponsor training and leadership development for families
- Partnership with the LEND program will be expanded to provide additional focus on services related to autism and training of providers. Family staff will assist with recruiting and supporting a "Family" trainee for the LEND program.
- FIN and the CDRC Office of Program Evaluation and Research will be working together to evaluate family satisfaction as well as program and policy improvements achieved through family involvement.
- Family staff will investigate opportunities to enhance role of FLs on community based teams to include more family to family connections and local resource identification.

- OCCYSHN will investigate alternative methods and additional partnership opportunities to connect with families across the state and to disseminate information in meaningful formats, especially given reductions in funding.
- OCCYSHN will promote families as partners and decision makers in its activities, partnerships, contracts and initiatives.
- Family staff will investigate opportunities to provide new employee orientation sessions at CDRC on Family Centered Care, Cultural Competency, and Family Professional Partnership.
- FIN and other OCCYSHN staff will work with the Office of Family Health to increase family involvement throughout Oregon Title V programs.

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	2003	2004	2005	2006	2007
Annual Performance Objective	53	55	60	53	53
Annual Indicator	52.3	52.3	52.3	52.3	47.4
Numerator	60337	60337	60337	60337	
Denominator	115367	115367	115367	115367	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	53	53	53	55	55

Notes - 2007

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 - 2006

Data reported for 2004-2006 are from the 2003 National Survey for Children's Health - Children with Special Health Needs SLAITS data. The survey is conducted every 3-4 years. New data will be available in 2008-9.

a. Last Year's Accomplishments

- A Medical Home video, developed to convey examples of implementing Medical Home concepts in 5 Oregon practices was placed on OCCYSHN's website.
- A partnership was developed with Disability Navigators to increase access to resources for families and providers; OCCYSHN resources and community based resources were collected and placed on Disability Compass, a searchable web database: <http://www.disabilitycompass.org>.
- Dr. James Ledbetter presented to the CDRC Grand Rounds on "Understanding the Alphabet Soup of Public Funding" which was web streamed and archived on the OCCYSHN website.
- Medical Home concepts, including care coordination, family professional partnership, and adolescent transition, were promoted through the CCN, CaCoon, and FIN program components

of OCCYSHN.

- CCN teams in 15 sites across the state met approximately monthly to provide interdisciplinary team care coordination/problem solving for CYSHN. An average of 5.4 community providers per child visit were included on CCN teams. Evaluations indicate that approximately 81.7% of children seen through CCN had a primary care provider.
- 21 CCN physicians participated in CCN inservice training on topics including Fetal Alcohol Syndrome, Failure to Thrive, Autism and Medication Management.
- The OCCYSHN website and newsletter provided information and links for families, communities, providers and policy makers.
- Family Professional Partnerships were implemented with 6 CCN teams and one rural pediatric practice by including one to two Family Liaisons on each team as team members. On CCN teams, Family Liaisons represent a family perspective on systems and services and support families who attend the CCN meeting. Within the rural practice, Family Liaisons participate in regular practice meetings and work on practice improvement strategies.
- Care Coordination and home visiting continued to be the primary goals for PHNs in the CaCoon program. OCCYSHN PHN consultants provided ongoing education and technical assistance to local PHN's around caring for CYSHN. At the local level PHNs link families with primary and specialty care, community services, and coach families on skills needed to care for CYSHN.
- Through an integrated services grant, OCCYSHN implemented a Screening Learning Collaborative in 5 rural communities. Communities developed individual action plans to increase the practice of developmental screening and linkage with appropriate follow up care. Participating teams met 3 times during the year to share strategies and learn about best practice and current research.
- OCCYSHN partnered with OFH, DMAP, and Oregon's AAP chapter, the Oregon Pediatric Society to enhance the practice of standardized developmental screening through the ABCD Learning Academy. This initiative built on work being done in the Screening Learning Collaborative and brought together state level agencies and organizations to address policy and practice. OCCYSHN staff participate in each of the committees and workgroups of the ABCD initiative and also facilitate the work of the Demonstration Task Force.
- OCCYSHN staff participated with OFH on development of a shared database, ORCHIDS-MDE, for public health programs to improve care coordination and assure children receive appropriate care, reduce duplicative efforts, and provide more accurate data.
- OCCYSHN staff tracked legislative and advocacy efforts to improve access to health care in the legislative session ending June, 2007. Although efforts to pass legislation to insure all kids did not pass, important messages related to children with special needs and medical home were provided by OCCYSHN through newsletters, fact sheets, testimony, participation in key discussions and on committees (Expanded Access Coalition, Health Services Coalition and others).
- OCCYSHN promotes Medical Home practice and concepts through its close partnership with the LEND program and presentations to the LEND trainees.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Community and statewide resources are available to families and providers		X	X	X
2. Educational programs focus on comprehensive care of chronic conditions/medical home		X	X	X
3. Promote effective communication between providers, families and programs		X		X
4. Public Health Nurses (CaCoon) and Community Connections Network (CCN) provide families of CYSHN with care coordination and related services.		X		X
5. Children are screened early and continuously and receive			X	X

appropriate follow up services				
6. OCCYSHN promotes timely and appropriate care for CYSHN in state program and policy arenas.				X
7.				
8.				
9.				
10.				

b. Current Activities

- OCCYSHN continues to promote Medical Home through CaCoon, CCN, and Family Involvement Network programs.
- Participate in AOPHNS to inform LHDs of CaCoon activities.
- A physician consult line is available to community providers linking them with Developmental Pediatricians and other specialty care providers at OHSU.
- Oregon's ABCD Screening Academy efforts continue and are resulting in billing/reimbursement improvements with DMAP.
- Promotion of developmental screening, linkage with primary care/early intervention/specialty care, and follow up services continue through activities of OCCYSHN's Screening Learning Collaborative. 3 additional learning sessions brought teams together to share results of their efforts and learn from each other.
- Screening Learning Collaborative Teams presented on their activities and findings at OCCYSHN's annual conference.
- Providers throughout the state attended OCCYSHN's annual conference, that included presentations on Medical Home from a rural pediatrician; Partners in Care by family members, Autism Screening by a developmental pediatrician, and many other sessions on improving care and medical/nursing practice.
- OCCYSHN facilitated a meeting of 8 Community Pediatricians and 4 Developmental Pediatricians at its annual conference to address issues related to CYSHN.
- OCCYSHN sponsored Grand Rounds and follow up discussions with the Oregon Primary Care Association and Office of Rural Health related to Medical Home/Primary Care Home for Oregonians.

c. Plan for the Coming Year

- OCCYSHN will prepare information for legislative session beginning January 2009, especially related to key issues affecting CYSHN: Primary Care/Medical Home, insurance and hearing aids for children
- Promotion of important concepts related to CYSHN and Medical Home will continue throughout OCCYSHN programs, initiatives, and efforts.
- Updates will be added to OCCYSHN website related to current research and best practices on Medical Home as well as resource links.
- OCCYSHN will explore using ORCHIDS generated data to assess whether CYSHN served in public health programs have a Medical/Primary Care Home.
- OCCYSHN will connect with key entities in the state who are working to improve access and quality of care for CYSHN, including OFH, OPCA, ONA, NWECI, OPS, Oregon Health Access Campaign and others.
- OCCYSHN will investigate opportunities and data sources that will identify disparities in care for CYSHN, including those related to geographic, racial/ethnic, and socio-economic differences.
- OCCYSHN will explore funding sources to expand activities, particularly related to Medical Home, care coordination, family professional partnership, and disparities in care.
- Partnership with the LEND program will continue and will specifically look to training and education about Autism Spectrum Disorders and appropriate care/Medical Home for children with ASDs.

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	2003	2004	2005	2006	2007
Annual Performance Objective	56	57	58	56	56
Annual Indicator	55.7	55.7	55.7	55.7	61.5
Numerator	64259	64259	64259	64259	
Denominator	115367	115367	115367	115367	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	62	62	65	65	65

Notes - 2007

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 - 2006

Data reported for 2004-2006 are from the 2003 National Survey for Children's Health - Children with Special Health Needs SLAITS data. The survey is conducted every 3-4 years. New data will be available in 2008-9.

a. Last Year's Accomplishments

- Oregon reported a rate of enrollment in private or public health insurance that is relatively high: NS-CSHCN data showed the percentage of families reporting they have health insurance was nearly 85% in 2001, and 89% in 2005/2006. However, a third or more of families reported that their insurance was not adequate to pay for the services they need. This is the basis from which OCCYSHN works to address the adequacy of coverage for families for the services they need to care for their children with special health care needs.

-The Family Support Program (FSP) processed 923 funding requests in FY07 and served 692 children. FSP staff managed special gift funds such as the Zetosch endowment, which provided financial support for educational products and services. These funds were frequently combined with FSP funds to pay for higher cost items. The increase in outreach combined with the 8.5% reduction in the FSP budget for this fiscal year resulted in full utilization of the annual budget allocation. The FSP Advisory Committee met monthly to review various program issues such as updating the application form, review of requests for exception and to track expenditures.

- Health care financing received increased focus from OCCYSHN through the analysis and tracking of health care legislative proposals impacting CYSHN. Staff partnered with advocacy groups, including Family Voices, to inform families of impact of proposed legislation and opportunities to provide testimony.

-A legislative fact sheet on challenges faced by families with inadequate insurance was shared with coalition partners, legislators and families of CYSHN.

-OCCYSHN worked to raise awareness of insurance and health care access issues within coalitions, with policy makers and with the public. Coalitions included the Oregon Health Action

Coalition, Expanded Access Coalition, Healthy Kids Learn Better, Human Services Coalition, Family Action Coalition Team, and Oregonians for Health Security.
 -OCCYSHN staff collaborated with the Oregon Health Services Commission and DMAP to staff the Commission's Genetic Advisory Committee. Resulting from this work was the 1/1/07 implementation of DMAP coverage guidelines about genetic services for children with developmental delay.-OCCYSHN partnered with CDRC, Medicaid and insurance partners to address issues related to reimbursement; OCCYSHN participated on the Oregon AAP Chapter Health Care Access Committee & AMCHP Health Care Finance Committee as well as the Autism Task Force regarding access to care and coverage.
 -CCN and CaCoon programs provided services and care coordination to children and youth who were uninsured or underinsured.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate Family Support Program to address families' out-of-pocket expenses.		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. Provide financial support to tertiary clinics at CDRC and community based programs.		X		X
5. Partner with DMAP to address genetics services coverage on OHP.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

-Applications for funding from the FSP increase in FY08. OCCYSHN continues to manage the Zetosch gift funds for educational equipment
 -Collaboration with DMAP continues related to Medicaid coverage of genetic services.
 -OCCYSHN will identify additional evaluation methods by which to assess families of CYSHN needs' at a community level. Assessment will be anchored to the NS-CSHCN.
 - OCCYSHN will analyze and track healthcare reform concepts/activities and proposed legislation and disseminates Health Care Financing information and recently passed or pending legislation.
 -Updated letters from OCCYSHN to newly approved SSI recipient families and to families who are denied SSI are provided to SSA for dissemination. Letters include references for services available to CYSHN.
 -Tom Wolff and Associates provide a two-day training on coalition building for OCCYSHN staff, families, and partners to assist OCCYSHN's efforts to increasing access to health care
 -OCCYSHN participates in OFH's Early Childhood Comprehensive Planning Initiatives to increase outreach efforts related to insurance enrollment and maximizing understanding/use of insurance programs and benefits. The OCCYSHN Director sits on the Early Childhood Council.
 -Continue financial supports at a reduced level to CDRC clinics. Continue to support public health nursing (CaCoon, and CCN teams to provide care and coordination to CYSHN.

c. Plan for the Coming Year

- OCCYSHN plans to continue the FSP at the same funding level in response to the ongoing need of families for financial help to pay out-of-pocket expenses. Program staff will continue to facilitate orders requiring multiple funding sources through coordination efforts with private foundations and other funding resources. A focused effort of the FSP Advisory Committee will center on an extensive review of the application and purchase order process with the goal to streamline activities. This action is necessary due to the increased number of funding requests and the complexity of program related functions. The FSP Advisory Committee will continue monthly meetings to review budget, trends in requested products and services, insurance issues, exceptions to policy and other related topics.
- Staff will participate in the tracking and analysis of proposed and new legislation impacting CYSHN and disseminate information to families, providers and partners.
- Continue to work with ENCCs to improve care coordination and access to services, introduce to concepts of family centered care and reduction of barriers to care.
- Participate in discussions with families, providers, policy makers and partners, including the Human Services Coalition of Oregon and the Expanded Access Coalition to identify, track and provide information pertaining to health care access and finance issues impacting CYSHN.
- OCCYSHN staff will collaborate with the Oregon Health Services Commission and DMAP to staff the commission's Genetic Advisory Committee. The committee will identify genetic services coverage issues requiring review, and if appropriate, make recommendations to the commission about changes in coverage.
- OCCYSHN will continue to provide financial support to the CDRC specialty clinics but at a rate of 15% less than in previous years due to the reduction in Block Grant funding for FY09.
- OCCYSHN will work with partners and evaluation staff to identify or track data that can be shared with program/policy makers to educate them about the financial impacts that insurance coverage and out of pocket costs have on families
- OCCYSHN will continue to work in partnership with the Office of Family Health Babies First! Program around response to changes in targeted case management.
- OCCYSHN will continue to explore alternatives/improvements that expand insurance coverage or other funding to provide care and care coordination not currently or adequately funded through public or private insurance. Demand for services identified through FSP, CaCoon and CCN program data will be used to educate and obtain additional funding or access to funding for unmet family needs.

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	2003	2004	2005	2006	2007
Annual Performance Objective	74	75	78	74	74
Annual Indicator	73.9	73.9	73.9	73.9	88.3
Numerator	85256	85256	85256	85256	
Denominator	115367	115367	115367	115367	
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

	2008	2009	2010	2011	2012
Annual Performance Objective	90	90	92	92	92

Notes - 2007

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 - 2006

Data reported for 2004-2006 are from the 2003 National Survey for Childrens Health - Children with Special Health Needs SLAITS data. The survey is conducted every 3-4 years. New data will be available in 2008-9.

a. Last Year's Accomplishments

- OCCYSHN funds the CaCoon program at the local county level to provide care coordination of CYSHN and to assist families in accessing services and coordinating the care of CYSHN. 6823 services were delivered to 1472 families FY07. The county ensures that specialized training and information on serving CYSHN is shared with the other county-based public health nurses also providing care coordination to CYSHN.
- 15 CCN teams continued with facilitation by Community Consultants. The CCN Teams provided assessments and care planning for 285 children FY07. Local providers participating on the CCN teams provided 1106 unique services addressing unresolved issues for CYSHN and to improve service capacity and awareness of issues related to serving children with special health needs in their own communities. OCCYSHN increased the number of local Family Liaisons on CCN teams to 7 during FY07 to continue to expand team expertise and identification of issues, needs, and barriers faced by families.
- OCCYSHN partnered with Disability Compass - a searchable web-based database of resources for families and people with disabilities. A unique and attractive aspect of Compass is its "continuous improvement" model for maintaining current information, including verification of contact information and content validity every six months while continuing to add resources. Partnership efforts were enhanced by hiring one of their staff to query program and community contacts regarding key resources that need to be available to families and providers. The staff input and verified over 250 unduplicated resources.
- CaCoon funding supported PHN participation on their county's LICC to enhance coordination across agencies serving young children. OCCYSHN participated on the SICC to represent the issues of CYSHN.
- The "OCCYSHN Liner" newsletter was published 3 times a year, "OCCYSHN Liner", with information and updates about services/supports for CYSHN, legislative actions, and state/national issues.
- OCCYSHN continued to support staff to serve as liaison between tertiary care centers and communities to improve the continuum of care for CYSHN when they leave the hospital. OCCYSHN maintained and updated its web-portal for discharge planners for CYSHN being released from hospitals. The portal provides resources to assist in planning transition to community. Staff provided information about community services for CYSHN to a variety of care management professionals, and provided information about tertiary care centers to a variety of local providers.
- Partnered with key state leaders on Early Childhood Team to address CYSHN and disseminate state's Comprehensive Systems Plan to communities, agencies and families.
- Through the MCHB funded Western States Collaborative Genetics Grant, staff are comparing time, cost and effort required to deliver genetic services using three methods of delivery: real-time telemedicine, outreach clinics, and centralized clinics in Portland which require family travel.
- OCCYSHN staff also partnered with the Oregon Health Services Commission which makes legislative recommendations about services to be covered under the Oregon Health Plan/Medicaid. Based on OCCYSHN suggestions, changes were made to policies that address what genetic services should be covered for children being evaluated for developmental delay.

- - OCCYSHN continued to explore feasibility of Oregon Clicks, a web based tool to assist families in identifying and applying for selected services. With consultation from Utah State University and state agency partners, OCCYSHN developed an initial model patterned after Utah Clicks and began efforts to test the model in three counties. Progress was challenged due to formal intra-agency administrative agreements and marketing.
- Staff developed a page to be included in the 2007 version of the Newborn Handbook which is published by the Office of Family Health each year. This was the first time that OCCYSHN was included in the Handbook which has wide distribution to first time mothers.
- OCCYSHN participated on Oregon Early Childhood Team chaired by the OCCF to identify and improve coordination of community-based services for children age 0 - 8 years at the local and state level.
- OCCYSHN partnership with OFH, OPS, and DMAP to participate in ABCD Learning Academy was finalized. OCCYSHN participated in core team, steering committee and evaluation workgroup and will facilitate the demonstration site group.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. OCCYSHN and family participation in state level program and policy planning groups to assure CYSHN priorities and cultural needs are addressed.				X
2. OCCYSHN/CaCoon provides care coordination, including hospital/clinic discharge to community.	X	X	X	X
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		X
4. Identify/enhance resources about services and systems of care for families and providers (Oregon Clicks, Disability Compass, OCCYSHN Liner newsletter, Newborn Handbook)			X	X
5. WSGSC/OCCYSHN explore and pilot alternative service delivery methods including telemedicine.		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- OCCYSHN funds the CaCoon program to all counties and 14 Community Connections Teams. CaCoon provides training, TA, care coordination and LICC participation. CCN funding facilitates local team activities, training and local capacity building.
- Pilot varied CCN models in selected communities to increase systems building, community engagement, and skills of local providers and to continue to improve local CCN team efforts around increasing family participation to enhance community based activities.
- Partner with state leaders on the ECC and development/implementation of a plan.
- Continue to expand connections with families and family organizations statewide, including Family Voices, to improve community-based services and access to care.
- Oregon Clicks was not pursued beyond its pilot stage ending in FY07. The interagency agreements between OHSU and the partnering agencies are being retired.
- To expand the array of health and cultural resources, OCCYSHN promotes Disability Compass to families and providers.
- Explore options to improve and sustain care coordination programs for CYSHN in light of reduced county funding. ORCHIDS data system provides evaluation data to help assess

needs/gaps in services for CYSHN.

-Work with ABCD and continuation of Screening Learning Collaborative to further increase statewide developmental screening practices; link community and education entities with pediatric providers; improve billing and reimbursement for screening.

c. Plan for the Coming Year

- OCCYSHN will begin a community engagement with selected CCN sites for needs assessment and asset mapping around the care of CYSHN; coalition building and sustainability of community initiatives. Expand connections with families and family organizations across the state.
- Continue to partner with/support Family-to-Family Health Information and Education Center/Family Voices.
- OCCYSHN will assess the feasibility of sponsoring a learning collaborative model within the state around one of three prevailing issues: oral health for CYSHN, screening and autism.
- Continue to explore options to improve and sustain home visiting programs for CYSHN in light of reduced funding at county levels. Analyze data collected through new ORCHIDS system to use in evaluating CaCoon program and needs/gaps in services for CYSHN.
- OCCYSHN will continue its partnership with key state leaders on the Early Childhood Council and its development of a comprehensive plan. OCCYSHN will incorporate this effort into its community-based activities to increase awareness at the community level.
- OCCYSHN will review its quality improvement procedures with each of its program components; performance standards and accountability will be increased to assure continued excellence in program performance.

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	2003	2004	2005	2006	2007
Annual Performance Objective	6	6	10	6	6
Annual Indicator	5.8	5.8	5.8	5.8	43.7
Numerator	6691	6691	6691	6691	
Denominator	115367	115367	115367	115367	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	45	45	48	48	48

Notes - 2007

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 - 2006

Data reported for 2004-2006 are from the 2003 National Survey for Children's Health - Children with Special Health Needs SLAITS data. The survey is conducted every 3-4 years. New data will be available in 2008-9.

a. Last Year's Accomplishments

- Developed brochures targeted to youth, families, and providers addressing adolescent transition. Brochures were disseminated to target population, in CDRC clinics and at presentations on adolescent transition (AT).
- Presented on AT and findings from Learning Collaborative at CDRC Grand Rounds, national annual meeting of AMCHP, and throughout Oregon at statewide conferences sponsored by OrPTI, the Oregon Pediatric Society and the Oregon Association for Vocational Special Needs Personnel. Presented a poster session at Multnomah County Transition Fair.
- Updated and expanded resources on OCCYSHN adolescent transition web page.
- Offered information and resources related to AT through the Family Involvement Network, CaCoon and CCN programs as well as in OCCYSHN newsletter.
- Sponsored attendance of CaCoon, CCN, Youth Advisory Group (YAG) and family partners at Building Futures training conference of Oregon Parent Training and Information Center (OrPTI)
- Continued sponsorship and facilitation of YAG; explored expanding scope of YAG advisory activities to encompass CDRC programs.
- Pursued and encouraged partnerships initiated through AT Learning Collaborative. Non-financial support through CaCoon, CCN and FIN has assisted in ongoing collaborative activities at multiple sites.
- Evaluated effectiveness of learning collaborative model as means of engaging communities and bringing together multiple stakeholders in local improvement activities.
- Built relationships with state level representatives through Healthy Kids Learn Better coalition. Shared AT information with school based health center nurses. Worked on AT initiatives through facilitation of COIT meetings. Distributed a paper on AT assets and gaps in Oregon to COIT members.
- Adolescent Transition Committee met monthly to develop a coordinated work plan for the spread of AT.
- Contributed AT resources to Disability Compass website.

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 Youth Advisory Group, 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 Adolescent Transition (AT) health care concerns.				X
4. Promote AT issues and Youth Involvement within program, agency and policy arenas.				X
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

- A lead OCCYSHN staff member will identify new opportunities to continue or enhance AT efforts and activities, including identifying additional sources for funding and partnership.
- Increase youth development training in youth advisory group (YAG) meetings and activities with the leadership of Youth Group Coordinator. YAG members will continue to take on leadership roles on advisory boards. YAG members share transition priorities with medical providers.
- Work with partner agencies to develop a consortium (Emerging Leaders Northwest) supporting youth leadership development in health care transition, secondary education and employment.
- Participate in CDRC/OIDD planning and initiatives and sponsored youth attendance at wellness conference.
- Strengthen partnerships with organizations addressing youth transition.
- Updated website including links with partner agencies, national resources on AT and web streamed training events at www.occyshn.org
- Disseminate AT information at OCCYSHN Annual Conference, LEND Interdisciplinary seminar, on Emerging Leaders Northwest website and with patient care teams at Shriners Children's Hospital.
- Contribute AT resources to Disability Compass website.

c. Plan for the Coming Year

- Continue partnerships with ODE (including COIT transition committee), Shriners Children's Hospital staff, CDRC clinics, Addictions and Mental Health Services, Oregon Parent Training and Information Centers, Family Voices, Family to Family Health Information and Education Center and others to address issues related to transition. OCCSYHN and the ODE will complete their assessment of re-convening the COIT-AT sub-committee.
- Partner with Engaging Leaders Northwest consortium members and youth to develop health care transition training curriculum and support youth in leadership and training roles.
- Increase youth leadership and advocacy skills training in YAG meetings and activities
- With new capability within OCCYSHN utilizing Adobe Connect technology, OCCYSHN will increase its connection with youth to engage around projects and provide training. Additional methods will be explored such as You Tube, Face Book, distance learning, etc. New partnerships will be explored with agencies such as Outside In, KASA, and the Independent Living Centers. Opportunities may include:
 1. Trainings for CCN and CaCoon on adolescent transition,
 2. Disseminating adolescent transition promising practices,
 3. Disseminating information on leadership and development by members of the YAG, and
 4. Training and education to family members about supporting youth transition.
- Identify opportunities to integrate and sustain Youth Involvement and Youth Leadership development with other CDRC initiatives including ELNW, "Dream It Do It", adolescent transition activities with CDRC and OHSU clinics, Healthy and Disabled, OIDD's Community Partnership Council, and others.ELN.
- Continue to participate in Healthy Kids Learn Better and connect with the Oregon Association of Vocational Special Needs Personnel (OAVSNP). -Coordinate with LEND on health transition to adult care with the UCP.
- Explore links within OHSU Internal Medicine around physician training efforts and with the RRTC on issues related to transition to adult care.
- Explore linkages with the OFH programs of School Based Health Centers and Adolescent Health to ensure integration of consideration of youth with special health needs.
- Assess the extent of AT health issues addressed at the community level through OCCYSHN supported community based services and in coordination with the ESDs and school districts.

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	2003	2004	2005	2006	2007
Annual Performance Objective	78	79	79	80	75
Annual Indicator	76.5	78.5	72	78.4	78.4
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	79	79	80	80	80

Notes - 2007

Target for 2007 should be changed to 79.0%
2007 data is not available from National Immunization Survey.

Notes - 2006

Source: National Immunization Survey
Target for 2006 should be changed to 79.0%

Notes - 2005

2004 rate should be changed to 78.9% (as of June, 2008)

a. Last Year's Accomplishments

- In 2007, 872,612 doses of vaccine valued at \$27,372,558 were shipped to public and private providers statewide.
- Several thousand health care and school professionals use Oregon's two 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 Immunization Registry sends monthly recall reports to over 350 Oregon clinics for two-year-old children who are overdue for shots. Oregon's Immunization Program uses ALERT data to create comprehensive reports about immunization practices for private and public clinics, and immunization quality improvement measures.
- Recall postcards are sent to children statewide who are not up-to-date on immunizations from both IIS. Recall notices are cited as an evidence-based best practice for immunizations.
- Ongoing data exchanges between Oregon's two immunization information systems (IRIS- the immunization electronic medical record for local health

departments and ALERT) and between the Oregon and Washington immunization registries allow records to be shared. Both of these efforts will improve data availability for clinical immunization decision-making as well as immunization rate tracking.

- The Oregon Immunization Program provided Immunization Practice Assessments (AFIX - Assessment, Feedback, Incentives, and eXchange) to every Medicaid-contracting health plan with a report detailing the immunization coverage rates of their two year-olds. A new project between DMAP and Medicaid began to implement quality improvement strategies focused on increasing immunization rates for two year olds. Interventions are focused on assessment of immunization rates by plan and recalls for past-due members.
- The Oregon Immunization Program and Washington State Immunization Program/CHILD Profile hosted the 2007 NW Immunization Conference: Partnering for Success. There were 550 attendees from 13 states and the Virgin Islands.
- Implementation of the new centralized vaccine ordering and shipping model promoted by CDC rolled out in August 2007.
- Vaccine-preventable disease flipbooks for providers' offices are now available in Spanish/English, Korean/English, Vietnamese/English and Chinese/English. They were also updated to include HPV and rotavirus vaccines.
- As of July 2007, hospitals statewide have access to state-supplied hepatitis B vaccine for all newborns. LHDs are partnering with the Immunization Program to enroll hospitals in this new program.
- OPIC and Immunization Program co-hosted 2 Fall 2007 Roundtable meetings focused on parent and provider vaccine hesitancy. These meetings were well attended and received high evaluation marks.

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-			X	

based strategies				
10.				

b. Current Activities

- A new Immunization Information System (IIS) was selected to replace the statewide registry and the public provider system.
- Population-based immunization rates, by county, for 2007, by census tract for 2006-07 and WIC/non-WIC rates for 2004-2006, are in production and will be shared with the local health departments (LHDs).
- A webinar training for LHDs in June 2008 will focus on population-based rates and AFIX clinic rates. Facilitated discussions with LHDs will generate ideas for using this data to target pockets of poorly immunized children.
- AFIX activities to improve immunization coverage rates across the state with healthcare providers and health systems continue.
- Annual funding through performance-based contracts to 34 LHDs supports their direct and population-based services to communities.
- 100% of WIC Agencies are screening 3-24 month olds for immunization status and referring as needed. In 2007, over 95% of WIC agencies reported using an electronic forecaster for clients.
- Public health nurses screen, educate, and administer immunizations through the Babies First and CaCoon home visitation program. They also advocate for adequate community immunization coverage in various multi-agency community meetings.
- The Immunization Policy Advisory Team (IPAT), OPIC, and DHS are working in partnership to learn about vaccine financing barriers faced by immunization providers and families, and to develop a strategic plan for 2008-2009.

c. Plan for the Coming Year

- Test and implement the new IIS. The new system will incorporate findings from the evaluation of 2007-08 reminder/recall pilot project.
- Provider education will continue to promote the free Vaccines for Children (VFC) program to eligible populations, the need for reasonable administration fees, and billing clients as appropriate.
- Public/private partnerships between LHDs and private providers, particularly for ALERT and VFC, will be supported through technical assistance and consultation.
- Population-based immunization rates by county and WIC status for 2008 will be produced and shared with local partners.
- Evaluate the AFIX model in Oregon and adjust program per evaluation findings.
- Launch a statewide social marketing campaign to reach vaccine-hesitant parents.
- Collaborate with Public Health nurses, through the Babies First and CaCoon home

visitation program, to identify best practices to improve immunizations for their populations. May include access to the ALERT registry data on immunizations for their clients to assure that appropriate recommendations are made.

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	2003	2004	2005	2006	2007
Annual Performance Objective	17.5	17	16	15.5	15
Annual Indicator	16.5	15.6	15.8	17.7	15.2
Numerator	1225	1117	1151	1303	1127
Denominator	74433	71614	72821	73444	73997
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
	2008	2009	2010	2011	2012
Annual Performance Objective	15	14.5	14.5	14	13.5

Notes - 2007

Source: Oregon Center for Health Statistics

Notes - 2006

Vital Statistics data for 2006 will be available later in 2007.

a. Last Year's Accomplishments

- The Oregon teen pregnancy prevention (TPP) program is a partnership between Title V and TANF, led by the Office of Family Health and Children, Adults, and Family Division (CAF) in the Dept of Human Services. This state team, Teen Pregnancy Prevention and Sexual Health Partnership (TPPSHP), was instituted in 2005. Membership includes: Oregon Department of Education, Oregon Commission for Children and Families, Family Planning Services, HIV/STD Prevention, three local health departments and the Oregon Teen Pregnancy Task Force (OTPTF), a non-profit group that has been in existence for 29 years. The Partnership meets monthly to assess and evaluate the statewide teen pregnancy prevention work, including creating a new statewide strategic plan, providing leadership for its implementation and develop ongoing policy recommendations.
- In 2006 and 2007, TPP/SHP began the planning process to create the Oregon Plan to Promote Youth Sexual Health for rollout in 2008. The plan process incorporates Positive Youth Development principles and a strong youth voice, and includes: literature reviews, new survey/data collection, analysis of state & local-level surveillance data, input from nine regional community forums, and Youth Action Research. Community Forums were completed in the following counties: Deschutes, Jackson, Lane, Multnomah (2 forums), Lincoln, Marion (2 forums) and Clatsop.
- The Teen Pregnancy Prevention (TPP) Coordinator continued intensive site visits around the state working with community groups and local health departments in implementing state strategies, developing resources/media for coalition use and

promotion of teen pregnancy awareness month (May).

- The state partnership continued discussions with Rights, Respect, Responsibility (RRR), a state coalition led by Planned Parenthood Health Services of Southwestern Oregon to improve collaboration and integrate recommendations contained in their report, We Can Do Better: Oregon Team Report on Western Europe's Successful Approaches to Adolescent Sexuality with the Oregon's Teen Pregnancy Action Agenda (2002).
- Oregon's abstinence education program, STARS (Students Today Aren't Ready for Sex), remains the primary abstinence education program in the state. STARS is based on the PSI (Postponing Sexual Involvement) curriculum and utilizes a peer leader model.
- A draft Oregon Plan to Promote Youth Sexual Health was completed and the intensive feedback and review process commenced. Plan development reflects intensive efforts of youth researchers, community members, organizations and government agencies. The development of a logic model, theory of change, data analysis/ synthesis were critical to the development of the new state plan.
- The TPP program published and distributed a new edition of the Rational Enquirer, a newsletter targeting teen pregnancy prevention activities to over 10,000 partners. Distribution includes adolescent pregnancy prevention agencies, lead staff, teen leaders and health educators (statewide).

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 and coordinate actions established by Oregon Teen Pregnancy Prevention Action Agenda			X	
4. Teen pregnancy prevention media campaign raises awareness of adolescents, parents and other adults.				X
5. Collaborations with schools and other programs, such as Coordinated School Health				X
6. Provide leadership in development and implementation of new statewide plan for Adolescent Sexual Health				X
7.				
8.				
9.				
10.				

b. Current Activities

- The OFH Teen Pregnancy Prevention (TPP) Coordinator works with the state partnership team and community groups, developing resources/media for local promotion of Teen Pregnancy Awareness Month.
- The TPP Coordinator provides on-site technical assistance to local health departments, community-based organizations, and coalitions to integrate adolescent sexual health services across the state.
- In April 2008 the Adolescent Sexuality Conference was held in Seaside, Oregon.
- A state budget proposal (policy option package-POP) was developed to give additional resources to the adolescent sexual health program to support the new

Oregon Plan to Promote Youth Sexual Health.

- A policy brief was developed and used for discussion with DHS about accepting federal Title V abstinence-only dollars.
- The 2008 edition of The Rational Enquirer was published and shared at the 2008 Adolescent Sexuality Conference. 8,000 copies were printed and distributed for May, National Teen Pregnancy Prevention Month.
- In June, with the retirement of the current TPP Coordinator, the position is being re-designed meet the upcoming public health demands, such as the dissemination and implementation of the new State Plan for Adolescent Sexual Health. The new duties for the Adolescent Sexual Health Coordinator will focus on data analysis and evaluation in order to develop sound public health policy.

c. Plan for the Coming Year

- The Adolescent Sexual Health program will continue all activities described for 2007 and 2008.
- The Adolescent Sexuality Conference will be held in April 2009 at Seaside, Oregon.
- A 2009 edition of the Rational Enquirer will be prepared and disseminated in May, Teen Pregnancy Prevention Awareness month. Also, a media campaign targeting adolescents and parents will continue supporting local campaigns with media resources, particularly during Teen Pregnancy Prevention Month.
- The Oregon Plan to Promote Youth Sexual Health will be rolled-out across the state in 2009. The majority of all activities in Adolescent Sexual Health will be devoted to implementing the plan, which focuses on 8 elements: policy, health inequities, services for youth and families, assurance, infrastructure, youth development, education of youth and families and data.
- Contingent on passage of additional funding, additional staff capacity will be added and the program will work on funding local entities around the state to implement specific pieces of the Oregon Plan to Promote Youth Sexual Health.

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	2003	2004	2005	2006	2007
Annual Performance Objective	55	55	55	55	52
Annual Indicator	50.0	50.0	50.0	50.0	42.7
Numerator	650	650	650	650	1261
Denominator	1301	1301	1301	1301	2953
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
	2008	2009	2010	2011	2012
Annual Performance Objective	52	52	52	52	55

Notes - 2007

Source: Oregon Smile Survey, 2007.

Notes - 2006

The next anticipated dateData source is the Oregon Smile Survey, last performed in 2000. Numerator and denominator is carried forward for each year. The next Smile Survey is scheduled for 2006/2007, and results will be available late 2007.

a. Last Year's Accomplishments

- The Oregon Smile Survey, completed in 2007, shows that every major measurement of dental health as worsened since 2002 (65% decay experience; 17% decay in permanent teeth; 20% rampant decay; and 36% untreated decay). Only 43% of third-graders had dental sealants. There was a decrease in overall sealant rates from 2002 to 2007. This can be attributed to two key points. First, increases in decay experience in permanent teeth and untreated decay indicate greater access to care challenges. And second, the 2002 Survey over-sampled Region 1 (Multnomah County), which has its own comprehensive dental sealant program. In 2007, the over-sampling was not utilized.

- The Oral Health Program continued to receive funding from the CDC. This funding began in the fall of 2002 and continues through June 2008. The funds support efforts to develop a statewide education campaign to increase awareness of dental sealants, to help communities sustain current activities, and to expand existing dental sealant programs. Additionally, the Oregon Health Program received state General Funds to purchase ten portable dental sealant units and support a full-time dental sealant coordinator position.

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				X
2. Smile Survey provides assessment data to monitor status of sealants			X	
3. Smile Survey provides assessment data to monitor status of sealants			X	
4. Statewide sealant program partnering with schools			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- As of June 2008, six portable dental sealant units have been purchased.

- The Oral Health Program began dental sealant programs in 32 new schools (43 total schools), targeting 1899 children. An estimated total of 5697 sealants will be placed.

- The Oral Health Program has applied for a CDC Cooperative Agreement to continue to build statewide oral health infrastructure and implement activities identified under our current cooperative agreement. The program will continue to implement a

school-based dental sealant program.

c. Plan for the Coming Year

- Schools participating in the dental sealant program in the previous year will continue to participate. A total of 112 schools are targeted for the 2008-09 school year, an estimated 5496 children will be screened and an estimated 16488 sealants will be placed. 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 next Smile Survey is conducted in 2012. However, we do expect to see some impact as our program targets first and second graders and we anticipate being able to provide more sealants before decay sets in. Previously, our program targeted second and third graders.

- The Oral Health Program will be piloting a demonstration project in coordination with the Exceptional Needs Dental Services (ENDS) program. This demonstration project will look at the barriers and possibilities to collecting Medicaid information through the school-based dental sealant program and receiving reimbursement from Medicaid and third party payers.

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	2003	2004	2005	2006	2007
Annual Performance Objective	3.7	3.6	3.4	3.2	2.8
Annual Indicator	4.4	3.6	3.0	3.0	3.0
Numerator	32	26	21	21	21
Denominator	722905	729110	699202	699202	699202
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
	2008	2009	2010	2011	2012
Annual Performance Objective	2.8	2.5	2.5	2.5	2.5

Notes - 2007

Source: Oregon Center for Health Statistics. Death data for 2006 and 2007 not available as of July 1, 2008.

2005 data is repeated for 2006 and 2007 for purposes of TVIS reporting.

Notes - 2006

Death statistic data for 2006 and 2007 not available as of July 1, 2008.

2005 data is repeated for 2006 and 2007 for purposes of TVIS reporting.

Notes - 2005

Death statistic data for 2006 and 2007 not available as of July 1, 2008.

2005 data is repeated for 2006 and 2007 for purposes of TVIS reporting.

a. Last Year's Accomplishments

- The Child Injury Prevention Program repeated the GIS mapping project for a second year to compare progress made in identifying counties in need of additional CPS Technicians and assistance in developing program infrastructure. Results were provided to the National Highway Transportation Safety Administration's Region X office for distribution in Alaska, and were presented at the Oregon Department of Transportation's annual Traffic Safety Conference. Trainings are scheduled or provided in 4 identified counties.
- Safe Kids chapters are completing self-assessments of a standardized Performance Assessment Tool to help identify areas for improvement. Additionally 2 of the 13 chapters will be assisted with capacity building in order to move into coalition status.
- Safe Kids Oregon's state office is also in the process of completing a state office performance assessment tool to identify areas for improvement. Results will be included into the 3-year strategic plan.
- Safe Kids Oregon is one of 7 states piloting a State Office Model for Safe Kids Worldwide. As part of this a statewide grant proposal was developed and submitted for motor vehicle safety efforts for all 15 chapters and coalitions.
- A Leadership training was held for Safe Kids coordinators and chairs of local chapters, followed by an annual conference. Training included building capacity for local child occupant safety programs.
- Oregon SAFE KIDS placed booster seat radio PSA's with 4 Spanish radio stations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Car seat safety promotion occurs through state and local media, local safety events			X	
2. Oregon Safe Kids provides support and technical assistance in the development of local coalitions				X
3. Home visiting programs provide anticipatory guidance and health education to parents about car seats		X		
4. Training for certified safety seat technicians occurs throughout the state				X
5. Safety seat inspections by local certified technicians assures correct use of seats			X	
6. Assessment of need for child safety seats provides information for programs				X
7.				
8.				
9.				
10.				

b. Current Activities

- Oregon Safe Kids will complete a statewide needs assessment to identify the most significant childhood injury incidences and risks statewide. Data will be used to create a 3-year strategic

plan to reduce childhood injuries statewide.

- OFH Nurse Consultants will partner with the child injury prevention program to assure that local MCH nurses continue to have education opportunities and up-to-date information regarding child car seat safety.

- CIPP will provide a county-by-county estimate of the number of child safety and booster seats needed to fully meet current and 5-year projected demands (based on current poverty rates among children). This number will assist county health departments and other agencies to understand countywide demand and need for child restraints, and the need for collaborative efforts to meet this need. CIPP and other statewide partners will assist counties in funding, training, and capacity building.

- Two statewide injury prevention trainings were held; one in conjunction with the Lifesavers Conference in April, 2008; and one in conjunction with the Oregon Transportation Safety Conference in October, 2008.

- CIPP, Oregon Safe Kids and partners attended the national Lifesavers Conference on motor vehicle safety in Portland in April. Additionally, the Oregon Safe Kids program director presented results of the child safety seat evaluation during one session at Lifesavers.

- Oregon Safe Kids assisted 3 chapters achieve coalition status as of July, 200

c. Plan for the Coming Year

- Oregon Safe Kids will assist one chapter in capacity building to move into coalition status, and develop one new chapter in Klamath County.

- The Child Injury Prevention Program/Safe Kids Oregon will continue to collaborate with the Child Safety Seat Resource Center to identify counties in need of nationally certified child safety seat technicians, based on a 2007 evaluation project.

- The Child Injury Prevention Program/Safe Kids Oregon will evaluate a single child passenger safety clinic tool implemented statewide, and report statewide child passenger safety data from checklists completed at the clinics.

- The CIPP/OSK program will provide one statewide training opportunity, and provide scholarships for Safe Kids coalition coordinators to attend the Oregon Transportation Safety annual conference.

- The CIPP/OSK program will produce an annual Safe Kids injury report to establish baseline indicators in each coalition throughout the state.

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	2003	2004	2005	2006	2007
Annual Performance Objective				55	58
Annual Indicator			53	56.4	56.4
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	60	62	62	64	64

Notes - 2007

Source: National Immunization Data, CDC. Table 2, Geographic-specific Breastfeeding Rates among Children. Correct trends are:

2006 data repeated for TVIS reporting.

Notes - 2006

Source: National Immunization Data, CDC. Table 2, Geographic-specific Breastfeeding Rates among Children. Correct trends are:

- 2000 = 54.3%
- 2001 = 57.5%
- 2002 = 47.9%
- 2003 = 62.3%
- 2004 56.4%

Data from 2004 also known as 2006 respondents - mothers of babies age 19-35 months old.

NIS does not provide a numerator and denominator.

Notes - 2005

- a) The number entered here represents 2004 data.
- b) 2005 NIS data is not yet available.
- c) The annual indicator, from NIS, for 2003 was 54.1%. Both are above the HP2010 goals.

a. Last Year's Accomplishments

- Oregon continues to have among the highest breastfeeding initiation rates in the country, and also meets the HP 2010 rates for 6 months of breastfeeding. However, breastfeeding exclusivity and duration continue to need improvement.
- The Office of Family Health (OFH) Breastfeeding Think Tank continued innovative activities such as promoting the Breastfeeding-Friendly Employer project and making it web-accessible, providing breast-feeding information in the Newborn Handbook (distributed to mothers in hospitals), tracking breastfeeding experiences through the statewide SafeNet hotline, and participating in World Breastfeeding Week. There has been continued dialogue with the Department of Medical Assistance Programs to assess lactation services and care offered through their programs.
- The law relating to expression of breast milk at work (House Bill 2372) was passed and went into effect January 1, 2008. This law is now the strongest in the country guaranteeing workplace accommodation for breastfeeding mothers. The law applies to pumping breast milk, addresses time and space needs and provides a remedy for non-compliance. It covers 70% of the Oregon workforce and applies to full and part time workers. -Partnership with the Bureau of Labor and Industries has occurred in order to implement the law.
- OFH continued to promote Senate Bill 744, which affirms a women's right to breastfeed in public. Cards explaining the law were printed in English and Spanish, and distributed to hospitals, employers and the public.
- WIC continued to promote and support a breastfeeding pump project. Pumps are provided to WIC participants through funding provided by the USDA. The Breastfeeding Training Module for WIC providers was promoted. WIC continued the research funded breastfeeding peer counselor program. Advanced breastfeeding training was provided for local WIC staff.
- TANF (Temporary Assistance for Needy Families) / WIC partnership continues to support working breastfeeding mothers, the only collaboration of its kind in the nation. TANF

implemented a new breastfeeding policy that assures mothers are encouraged to breastfeed and are referred for services especially WIC. All TANF staff statewide are trained on the importance of breastfeeding and the new policy. WIC developed a brochure specifically for TANF clients.

- The CDC Physical Activity and Nutrition grant continued to provide for the statewide breastfeeding coalition, The Breastfeeding Coalition of Oregon. The first annual meeting of the newly formed coalition occurred in the spring. The statewide Healthy Active Oregon conference included information about incorporating breastfeeding promotion into worksite wellness.
- Breastfeeding support language was added to the statewide emergency preparedness plans.
- Child care consultants received some training at their annual training conference about supporting breastfeeding in child care settings.
- Public health nurses practicing in statewide home visiting programs provide anticipatory guidance and health education parentally as well as assessment and support after birth in support of optimal nutrition through breastfeeding for clients enrolled in Maternity Case Management and Babies First.
- Efforts to improve data quality from breastfeeding surveillance continued.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assessment development activities include PRAMS questions and links with newborn screening data				X
2. Breastfeeding-Friendly Employer project assures mothers have opportunities to breastfeed at work			X	
3. Governor's Executive Order in 2001 requires all state agencies have location for breastfeeding				X
4. Education and technical assistance provided through the Newborn Handbook distribution to all pregnant women and new mothers				X
5. . WIC, Perinatal, and home visiting programs provide information & support to all pregnant women about benefits of breastfeeding	X	X	X	
6. WIC provides information and support for lactation, referrals to community organizations	X	X		
7. Coordinate with & support Breastfeeding Coalition of Oregon and key partners to update policy to promote breastfeeding support activities			X	X
8. Breast milk expression at work law (House Bill 2372, Statute?)				X
9. TANF/WIC collaboration supporting working mothers		X	X	X
10.				

b. Current Activities

- Continuing implementation of the breast milk expression and return to work law (HB 2372) in partnership with the Bureau of Labor and Industries.
- Continuing work on breastfeeding objectives with the OFH Nutrition and Physical Activity Work Group.
- OFH will proceed with implementation of the TANF project.
- WIC coordinated breastfeeding projects will continue

c. Plan for the Coming Year

- The Breastfeeding Think Tank in the Office of Family health will continue work on improving breastfeeding initiation and duration rates by implementing activities that raise awareness and provide breastfeeding education.
- To implement HB 2372, new breastfeeding support pieces will be developed, distributed and promoted using the Business Case for Breastfeeding and the Breastfeeding Friendly Employer Project.
- The WIC breastfeeding pump project, peer counselor demonstration/research project, Gold Ribbon Campaign Fathers Supporting Breastfeeding, sponsorship of the La Leche League conference, and advanced breastfeeding training will continue.
- Continue implementation of project recommendations of TANF population.
- Continue assessment, planning, and implementation of supporting breastfeeding in DMAP programs, perinatal regulations, and emergency preparedness.
- Oregon will participate in the World Breastfeeding Week by providing promotional materials to local health departments and WIC providers. An annual list of breastfeeding-friendly employers will be published during World Breastfeeding Week.
- OFH will continue to partner with the Nursing Mother's Counsel and the state breastfeeding coalition.
- Maternity Case Management and Babies First nurse home visiting programs will develop 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 (3 day Breastfeeding Basics course, 5-day Advanced Breastfeeding course and sponsorship of WIC staff to take the International Board of Lactation Consultants Exam will continue).

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	2003	2004	2005	2006	2007
Annual Performance Objective	98.5	98.8	99.1	99.4	99.7
Annual Indicator	95.0	93.4	95.4	95.4	96.7
Numerator	43565	43310	44594	45516	48205
Denominator	45844	46357	46763	47711	49843
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
	2008	2009	2010	2011	2012
Annual Performance Objective	99.5	99.5	99.5	99.5	99.5

Notes - 2007

Source: Numerator: EHDI Reporting System; Demoninator: Oregon Center for Health Statistics.

Notes - 2006

Denominator is provisional resident births for 2006, unadjusted for infant deaths.

a. Last Year's Accomplishments

- The Office of Family Health (OFH), Early Hearing Detection and Intervention (EHDI) Program, in collaboration with partners from the Newborn Hearing Advisory Committee and others, continued to provide technical assistance and support to hospital newborn screening programs, diagnostic centers and early intervention facilities to promote early identification and intervention for children with hearing loss.

- The Oregon EHDI Program completed its third year of mandated individual level reporting in 2006. Oregon Revised Statute 433.321 and 433.323 mandates the establishment of a Newborn Hearing Registry, Tracking and Recall system. This legislation provided the necessary authority for the EHDI Program to collect individual-level results and to follow-up with families, providers and local public health departments for those not completing the stages of the EHDI process (screening, diagnosis and intervention).

- On-going technical assistance was provided to hospital newborn hearing screening programs, diagnostic audiology centers, and early intervention programs regarding the reporting and follow-up protocols. In addition, the EHDI Program provided reports and feedback to these facilities assisting in ensuring infants receive necessary follow-up services. Increased contact and coordination was promoted with infants' medical homes regarding their hearing status.

- Progress continued on objectives related to EHDI program grants for the CDC (data system development) and HRSA (education and family support). The EHDI Program began expanding the use of the HiTrack electronic hospital reporting system to all screening hospitals in the Fall 2006. During 2006 this was a voluntary expansion. The use of an electronic reporting system will reduce the data quality issues of accuracy and timing observed with the use of reporting by metabolic cards. EHDI staff made a number of presentations to health care providers, including local public health departments, and early intervention staff about the EHDI program. Oregon EHDI staff also presented at national conferences (National EHDI Conference, 2006) regarding the development of educational materials for parents and health care providers.

- EHDI Program staff participated in a statewide work group of parents and professionals to establish improved services to families of infants with hearing loss, including improved referral processes to Early Intervention. The parents participating in this group established an Oregon Chapter of Hands & Voices.

- The EHDI Advisory Committee meets quarterly and includes four standing committees: EHDI Goals & Sustainability Issues, Quality Assurance, Family Issues, and a newly formed Early Intervention (EI) Committee. The Early Intervention Committee is comprised of a state Department of Education, Part C representative, EI county coordinators, as well as direct family service providers. An EI Committee work group revised the Oregon Administrative Rules eligibility criteria for children birth to three years to afford more consistent eligibility and enrollment practices throughout Oregon, especially for unilateral and mild hearing losses. The Family Issues committee is updating the Oregon EHDI Family Resource Guide.

- System enhancements are being developed to improve access to EHDI data for generating letters and to collect information from non-hospital newborn hearing screening facilities. New Screening Facility sites were trained in reporting results to EHDI. Data quality improvement activities are being conducted to ensure the accuracy of individual results.

- The EHDI Program and ODE have developed a Memorandum of Understanding with the Dept. of Education (ODE) to facilitate the referral and reporting procedures, to ensure that infants diagnosed with hearing loss receive timely referrals and enrollment in Early Intervention. The EHDI Program is now the single point of entry for referrals to Part C Early Intervention programs for infants with hearing loss. This change has reduced work for the diagnostic audiology centers and EI programs, and facilitates a seamless process.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement legislation requiring all hospitals with 200 or more births to conduct newborn hearing tests			X	X
2. Newborn data linking project includes diagnostic and early intervention data for children				X
3. Public education materials, such as the Newborn Handbook, provide information about hearing screening				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 centers and organizations				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- A statewide Pediatric Audiology Work group is developing best practice standards for behavioral testing of infants. The EHDI Diagnostic Audiology protocol is also being reviewed and revised, as necessary for changes in technologies.

- Twelve new hospitals were added to the list of existing HiTrack users, bringing the percentage of hospital hearing results reported electronically to 80%. Since the EHDI Program will be losing its ability to receive hearing screening results via the metabolic cards (the Public Health Lab is changing its own internal database system), the EHDI Program will be requiring all screening hospitals to use the HiTrack system.

- System enhancements are being developed to improve access to EHDI data for generating letters and to collect information from non-hospital newborn hearing screening facilities. New Screening Facility sites were trained in reporting results to EHDI. Data quality improvement activities are being conducted to ensure the accuracy of individual results.

- The EHDI Program began discussions with the Department of Education, Part C and the Oregon Children with Special Health Needs program regarding joint

long-term sustainability for the EHDI program.

- The EHDI Program sponsored a parent representative from the Oregon Chapter of Hands & Voices to attend to 2007 National Early Hearing Detection and Intervention Conference in Salt Lake City, Utah.

c. Plan for the Coming Year

- The Office of Family Health and EHDI Program will continue to provide technical assistance and support to screening and non-screening birth facilities/providers, diagnostic centers and early intervention sites.
- After implementation of the statewide electronic reporting system, follow-up protocols will be reviewed and adjusted. It is believed the new system will allow for earlier follow-up to help reduce loss to follow-up and ensure infants with hearing loss are enrolled in EI, before six months of age.
- Education and training is provided through presentations to groups, which include providers, local public health staff and other identified community partners regarding the EHDI program protocols and information about hearing loss issues and resources.
- The EHDI program coordinates the Early Childhood Hearing Outreach (ECHO) Team, which was developed out of the National Center for Hearing Assessment and Management's Hearing Head Start Project. The ECHO team provides on-going technical training and assistance to Early Head Start, Migrant Head Start and Indian Health programs using oto-acoustic emissions hearing screenings for their birth to three-year old populations. An NCHAM staff consultant participated in a multi-agency ECHO training, which included an existing program, a lay midwife, and a local public health nurse. The public health nurse was trained to do hearing screenings in her rural county, where infants are not screened at birth.
- EHDI follow-up staff will continue to contact families, medical home providers and local public health to assist families in navigating the system.
- The EHDI Sustainability Subcommittee will continue to meet and work on program sustainability beyond the time of current federal grants.
- Progress will continue on activities related in the CDC and HRSA early hearing detection and intervention grants, related to follow-up system development, provider and parent education and family support. The CDC-EHDI grant has been renewed until 2008 and the HRSA UNHSI Grant has been renewed until 2008.

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	2003	2004	2005	2006	2007
Annual Performance Objective	9.1	9	9	9	12
Annual Indicator	10.1	12.0	12.0	12.6	12.6

Numerator		101616	101616	119376	119376
Denominator		848001	848001	947427	947427
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
	2008	2009	2010	2011	2012
Annual Performance Objective	12	12	10	10	10

Notes - 2007

Source: Population Health Survey available every other year; numerator is calculated based on population of children 0-19 from Center for Population Research, Portland State University. Data repeated for 2007 for TVIS reporting.

Notes - 2006

Population Health Survey available every other year; numerator is calculated based on population of children 0-19 as of 2005.

Notes - 2005

Population Health Survey available every other year; numerator is calculated based on population of children 0-19 as of 2004.

a. Last Year's Accomplishments

- The Governor's Healthy Kids Plan, to provide health coverage for every Oregonian child using an 84.5 cent increase in Oregon's tobacco tax, was introduced to the 2007 Legislature. While the insurance coverage received bi-partisan support, the increased taxes did not. Therefore, the Plan and tobacco tax increase was referred to the voters for a constitutional amendment. However, the amendment failed to pass.

- OFH and OCCYSHN continued to work with partners to strengthen benefits counseling improved utilization of existing coverage and services for children with special healthcare needs, and enhanced outreach efforts to increase enrollment in public and private health insurance programs.

- DHS Office of Family Health staff continued to work with the Oregon Health Plan and Office of Medical Assistance Programs to enhance outreach efforts, coordination, and simplification of the Medicaid application process, including simplifying initial and re-application materials, simplifying the procedures for obtaining application forms, and simplifying application completion by identifying nontraditional community-based application sites throughout the state.

- The Office of Family Health merged the Child Health and Perinatal Health sections into a Maternal and Child Health section to create better consistency, communication and support for the programs serving pregnant women and young children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach and application assistance through local health		X	X	

department programs				
2. Information and referral through toll-free number, SafeNet.		X	X	
3. Coordination and collaboration in MCH programs and 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.				
8.				
9.				
10.				

b. Current Activities

- Title V Child Health programs continue to support universal comprehensive insurance and healthcare for expectant parents, young children and their families by: 1) strengthening early childhood system linkages with healthcare coverage initiatives; 2) enhancing outreach efforts to increase enrollment in public and private health insurance programs; 3) promoting health insurance portability to assure continuity of care; 4) maximizing third party reimbursement for developmental screening, assessment, promotion and prevention services, and care coordination; 5) maximizing understanding and use of current benefits and services; 6) increasing the number of healthcare providers participating in the Oregon Health Plan; and 7) promoting the Oregon Health Plan through various programs and services.

- The Oregon Child Care Health Consultation Program continues to educate childcare providers about the Oregon Health Plan and provide them with information and services for their client/families.

- Public health nurses at local health departments participate in the Babies First! program and CaCoon to provide families with children birth to age five with case management services that include assistance in accessing and utilizing Medicaid services.

- The state public health nurse regional team provides technical assistance to county health departments.

- The Oregon Mother's Care program assists pregnant women in completing OHP applications to facilitate access to services.

c. Plan for the Coming Year

- Governor Kulongoski is reviving the idea to utilize tobacco taxes to fund health insurance coverage for children, in his 2009-11 budget request.

- Three workgroups were established to implement the recommendations arising from the Governor's Summit on Early Childhood. Focus is on children, birth to 5 years of age, to support the overarching goal: Children are healthy, growing and learning. The three key components are: health, social/emotional development and mental health; safety, family support and parent education; and early care and education.

State and local, and private and public partnerships are driving this work. Title V staff participate in all three workgroups to ensure consistency between Title V and the action plan outcomes. A large component of this work will be to develop resource support through expanded insurance coverage.

- The Office of Family Health will continue to partner with the Division of Medical Assistance Programs (DMAP-Medicaid agency) to promote and clarify coverage of child health care and well-child visits for providers and parents, and to streamline application and renewal processes.
- The Oregon Pediatric Society is leading an effort to facilitate conversations with leading health insurance plans in Oregon to broaden coverage for preventive child and adolescent care, so that providers are encouraged to reach out to their insured patients for well-child care.
- Continue partnership among OFH, OCCYSHN, DMAP, Family Voices and the Oregon Health Action Campaign to educate legislators and other policy makers about the impacts of un- and under- insurance within our state.
- Partner with OCCYSHN and other Oregon groups to disseminate information about current trends on un- and underinsured youth.

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	2003	2004	2005	2006	2007
Annual Performance Objective				31	33
Annual Indicator			31.2	31.8	32.1
Numerator			33437	14255	14613
Denominator			107169	44826	45525
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
	2008	2009	2010	2011	2012
Annual Performance Objective	33	34	34	35	36

Notes - 2007

Source: Pediatric Nutrition Surveillance Survey.

Notes - 2006

The data entered here is cumulative data for 2003-05 from the Pediatric Nutrition Surveillance Survey.

Notes - 2005

The data entered here is cumulative data for 2001-2003 from the Pediatric Nutrition Surveillance Survey.

a. Last Year's Accomplishments

- The statewide WIC Nutrition Education Plan for FFY 2007 was devoted to utilizing the

information collected in the previous two years to strengthen community partnerships for promoting physical activity, fruit and vegetable consumption, and breastfeeding.

- WIC agencies conducted community assessments for resources for safe, developmentally appropriate physical activity opportunities for families and their young children, for fruit and vegetable promotion, and for breastfeeding.
- The State WIC program provided all local agencies with group education materials to promote physical activity for young children and their families in their client education programs, including materials to help families decrease the amount of time their children watch TV.
- All local agencies received tool kits for providing food demonstration to promote fruits and vegetables as part of nutrition education activities.
- State WIC staff participated in workgroups to revise the 2003 statewide Nutrition and Physical Activity Plans.

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; provide counseling to all parents on ways to promote healthy weight; clients at highest risk are referred to RDs, their medical provider and/or other resources in the comm	X	X		
2. Participate in and promote the following nationwide public health campaigns: National Breastfeeding Week, TV Turn-off, Fruits and Veggies More Matters promotion			X	X
3. Provide technical assistance and training for implementation of local WIC agency Nutrition Education Plans			X	X
4. Implement a participant-centered approach to identify WIC families' concerns and priorities around addressing and preventing overweight in children.	X	X		
5. Collaborate with state nutrition and physical activity programs and groups to identify best practices for promoting healthy weight in families across Oregon.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Tool kits for promoting physical activity with WIC participants was provided to local agencies, including lesson plans and activity cards that parents can use with their preschool children.
- One goal of the WIC Nutrition Education Plan is to improve the health outcomes of clients and staff in the local agency service delivery area. As part of the FFY 2007-2008 NE Plan, local agencies used data on prevalence of nutrition risk factors to assess their nutrition education activities and target them to the most prevalent risks in their service area.
- Local WIC staff were trained in the new Nutrition Risk Module which focuses on appropriate risk assessment and critical thinking, including assessing for overweight and risk of overweight.
- WIC staff, in collaboration with the Nutrition Council of Oregon, developed and

extensively field tested nutrition education materials aimed at increasing parental awareness of marketing of unhealthy foods to young children. The resulting poster has been distributed in both English and Spanish to all WIC agencies, Head Start programs, dental offices and other interested community partners.

- WIC staff began working on the implementation of the new WIC food package, which must be fully implemented by October 2009. Changes to the food package support the Dietary Guidelines and provides low-fat milk, less cheese, a cash benefit to purchase fresh fruits and vegetables, and more whole grain options.

c. Plan for the Coming Year

- The FFY 2008-2009 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, including nutrition assessment and education in preparation for the federally mandated implementation of the Value Enhanced Nutrition Assessment (VENA) project. The multi-year plan will continue to support the Oregon Statewide Nutrition and Physical Activity Plan, Breastfeeding Promotion, and MCH Title V National Performance Measures.
- As part of the FFY 2008-2009 NE Plan, local agencies will develop objectives and activities to facilitate healthy behavior change for WIC clients and WIC staff. Local agencies will select an appropriate strategy and objectives from the new statewide Physical Activity and Nutrition Plan for their population and setting to implement in the coming FFY.
- WIC will continue work to implement the new WIC food package changes, which will be fully implemented by August 2009.
- WIC will continue to work as a partner with other USDA FSN programs through the SNAP collaboration to develop and use common messages related to fruit and vegetable consumption.
- WIC will continue to play an active role in the Breastfeeding Coalition of Oregon and in other areas related to breastfeeding promotion and support.

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	2003	2004	2005	2006	2007
Annual Performance Objective				11.6	12
Annual Indicator			12.1	10.7	10.7
Numerator			201	4939	4939
Denominator			1661	46146	46136
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
	2008	2009	2010	2011	2012
Annual Performance Objective	10	10	9.5	9.5	9.5

Notes - 2007

Source: PRAMS, 2006; weighted data.

Notes - 2006

Source: PRAMS, 2006; weighted data.

The data for 2005 should be corrected; PRAMS 2005 data is the most recent available and the following shows trends over last few years. This is unweighted data:

2003: 12.1% (N=201, D= 1661 PRAMS respondents who reported they smoked during pregnancy.)

2004: 13.7% (N=235, D=1909 PRAMS respondents who reported they smoked during pregnancy)

2005: 13.7% (N=249; D=1866 PRAMS respondents who reported they smoked during pregnancy)

Notes - 2005

The data entered here is from the 2003 PRAMS, which is the most recent data available is from 2003.

The 2005 objective will be 11.8%.

a. Last Year's Accomplishments

- State Performance Measure 2 complements NPM 15, although the state measure is focused on continued cessation beyond pregnancy.
- Partnerships with the Division of Medical Assistance Programs (DMAP), local providers and agencies continued to provide training, information, and education on the 5 A's protocol and the DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services.
- Continued cessation screening and counseling in county services for family planning, prenatal care and MCM, nurse home visiting for high risk infants, and WIC.
- Completed Environmental Protection Agency (EPA) grant application for "Building Capacity to Address Environmental Exposures During Pregnancy" as collaborative effort between the Office of Family Health and the Environmental Health Section of the Public Health Division.

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. Implement EPA-funded Demonstration Project in two counties to build capacity to address environmental exposures during		X		X

pregnancy including second hand smoke.				
3. Strategic planning for sustaining outreach to private prenatal care and other services to screen clients and implement 5 A's cessation practice				X
4. Health education and social marketing about smoking during pregnancy through Family Planning and Babies First home visiting program services			X	
5. Screening and referral in Babies First, WIC and Family Planning client services		X		
6. Oregon's PRAMS-2 longitudinal survey will provide surveillance to assess prevalence of tobacco use during the postpartum period and up to two years after the infant's birth.				X
7.				
8.				
9.				
10.				

b. Current Activities

- Partnerships between DMAP, local providers and agencies will continue to provide training, information, and education on the 5 A's protocol and the revised 2008 DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services.
- Continued cessation screening and counseling for clients in family planning, prenatal care and MCM, nurse home visiting for high risk infants, and WIC.
- PRAMS-2 ("TOTS-the Oregon Toddler Survey") first year data (both weighted and unweighted) is currently being analyzed with reports out by late 2008.
- The Oregon Child Health Information Data System (ORCHIDS) Maternal Child Health Data Entry (MDE) system for local service providers and agencies are collecting statewide data on pregnant women who smoke including attempted smoking cessation in last 12 months, smoking frequency, other household smokers, household smoking rules, movement on the change spectrum regarding numbers of cigarettes per day and provider use of 5A's brief interventions for smoking cessation.
- Collaborative work between the Office of Family Health and the Tobacco Prevention and Education Program resulted in the publication of the "CD Summary: Maternal Smoking In Oregon: Helping Moms Quit, disseminated to licensed health care providers in Oregon and public health agencies.
- An action plan was created to concentrate on preconception health & will address prevention of smoking in younger girls by looking towards future pregnancies.

c. Plan for the Coming Year

- Partnerships will continue with DMAP, local providers and agencies in training, information, and education on the 5 A's protocol and the 2008 revised DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services.
- The "PRAMS-2" longitudinal survey will continue.
- Continued cessation screening and counseling in county services for family planning, prenatal care and MCM, nurse home visiting for high risk infants, and WIC.
- ORCHIDS/MDE is producing state and local level data reports on tobacco exposure during pregnancy and provider interventions. The information will be used to understand and plan for strategies and/or program changes.

- Implementation of the Preconception Health Action Plan in public health programs to address smoking prevention and cessation as it relates to client future pregnancies.
- Implementation of the Action Plan for the perinatal initiative addressing depression and the high correlation between depression and tobacco use.

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	2003	2004	2005	2006	2007
Annual Performance Objective	8	8	6	6	7
Annual Indicator	6.3	6.2	7.4	8.1	8.0
Numerator	16	16	18	20	20
Denominator	253202	256544	244360	246476	248780
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
	2008	2009	2010	2011	2012
Annual Performance Objective	7.5	7.5	7	7	6.5

Notes - 2007

Source: Oregon Center for Health Statistics

Notes - 2006

Source: Oregon Center for Health Statistics

Notes - 2005

Source: Oregon Center for Health Statistics

a. Last Year's Accomplishments

- The Youth Suicide Prevention Program (YSP) was awarded grant funding in June 2006 from the Garrett Lee Smith Memorial Act for State Suicide Prevention and Early Intervention Programs (GLSMA). In 2007, 3 funded regional/county sites (7 counties) and Warm Springs Reservation implemented grant objectives. The YSP Program worked with 3 project coordinators at these sites, which greatly increased capacity for prevention work. The prevention coordinators worked with local steering committees, became trainers, increased local awareness of the problems, and began work towards implementing RESPONSE programs in their local high schools. In addition, Warm Springs held a family retreat for suicide prevention in June.
- The prevention coordinators trained and began work with AMH and their Family Support Networks.
- The Youth Suicide Prevention Program gained 6 new QPR (Question, Persuade, Refer)

trainers in Oregon, with another 5 to become trainers by the end of 2007 including 2 who are bilingual in Spanish. These trainers, the youth suicide prevention coordinator, and another trainer in NE Oregon held 32 QPR trainings for a variety of audiences including crisis responders, clinicians, schools, juvenile justice, law enforcement, faith-based groups, community-based organizations, parents, and lay people in suicide prevention intervention skills,.

- The Connecting Youth Project entered its 3rd and final year. Without cooperation from the hospitals in two counties, planned interventions were not implemented with the youth and parents who received program services in the Northwest Health Foundation funded project. The YSP program stopped the project in the spring of 2007. One positive outcome of the project was the creation of a very strong youth suicide prevention coalition in Deschutes County.

- The Youth Suicide Prevention Program provided technical assistance to demonstration sites on Violence and Youth Suicide Prevention and continued to support the implementation of the Coordinated School Health "Blueprint for Action" state plan, a cooperative agreement between Adolescent Health (Oregon Public Health Division) and the Oregon Department of Education. The Youth Suicide Prevention Program participated as an advisory board member to the mental health component of Healthy Kids Learn Better.

- The YSP program collaborated with the 2005-funded GLSMA Oregon University Consortium and Blue Mountain Community College (BMCC) on their grant projects. The program worked with universities and a local psychiatrist to develop brochures for college youth and their parents. The YSP Coordinator sits on the Advisory Board for the BMCC grant to help determine and implement its grant objectives. The YSP Coordinator also attended meetings with the Native American Rehabilitation Assoc. (NARA, a 2005 GLSMA grant recipient) to increase understanding and collaboration.

- Increasing capacity in suicide intervention skills continued to be a priority. Applied Suicide Intervention Skills Training (ASIST) trainers held approximately 25 2-day trainings in Oregon in 2007. The GLSMA grant prevention coordinators held 6 ASIST trainings in their regions.

- The Confederated Tribes of Warm Springs held a week-long family retreat for youth and their families from Warm Springs and other tribes in Washington and Oregon in June 2007.

- The state and local Child Fatality Review teams reviewed all youth suicides that occurred in Oregon in 2007; the YSP program reviews 3 suicide deaths at each of the 2 state review team meetings. The YSP Coordinator represents the Youth Suicide Prevention Program on the State Child Fatality Review Team.

- In April 2007 the Injury Prevention & Epidemiology section (IPE) hired a new epidemiologist.

- The annual GLSMA grantees meeting was held in Portland in December 2007 and 10 people from Oregon were able to attend, including the GLSMA project director, the YSP Coordinator, 3 site coordinators and 2 of their supervisors, Warm Springs, and a representative from the Addictions and Mental Health Division who sits on the GLSMA grants management group.

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 plan.				X
2. Provide and facilitate training for providers, counselors, educators, and others on youth suicide prevention strategies.		X		X
3. Assess and monitor trends in youth suicides and suicide attempts through surveillance and participation on the State Child Fatality Review Team.				X
4. Train school teams to implement RESPOND in high schools as part of the Garrett Lee Smith Memorial Act (GLSMA) 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 GLSMA grant.		X		X
6. Assess the scope of screening for youth in school and health care settings that is taking place as part of the GLSMA award.				X
7. Support Family Health Networks as part of the GLSMA grant.				X
8. Maintain a statewide listserv to exchange and share research findings, trainings, collaboration, news, and local events			X	X
9. Educate the media on prevention and provide nationally-developed guidelines to increase safe reporting of high-profile suicides.			X	X
10.				

b. Current Activities

- Three regional GLSMA sites met with school districts in seven counties to introduce RESPONSE, a comprehensive, high school-based program named a Best Practice by SPRC and AFSP. Early evaluation showed an increase in knowledge, attitudes, and behaviors among participants, and more schools will implement in Fall 2008.
- The YSP program collaborated with PSU's Regional Research Institute to evaluate ASIST and QPR programs, and with Macro (national evaluators for GLSMA) to collect and analyze cross-site program evaluation data.
- The YSP Prevention Coordinator is conducting an assessment of state-level screening policies and protocols for youth in juvenile justice, mental health agencies, alcohol & drug treatment centers.
- The Adolescent Suicide Data System (ASADS) was revised to improve surveillance data by providing definitions for suicidal behavior and reporting intent, and moved from the Center for Health Statistics to the IPE section. A revised ASADS reporting form was implemented in hospital emergency departments.
- 12 new Oregon ASIST trainers completed the ASIST Training for Trainers and an ASIST training was held for the Oregon Army National Guard.
- The Yamhill County Suicide Prevention Coalition developed a community video and discussion guide on suicide prevention called "Breaking the Silence."
- The YSP Coordinator presented QPR trainings to NARA, the Coquille, and Burns-Paiute Indian tribes.

c. Plan for the Coming Year

- GLSMA regional sites will assess the feasibility of implementing the Air Force Model as a strategy for worksite suicide prevention for youth 18-24.
- The YSP program will continue to work with the National Guard to increase intervention skills training and to prevent suicides. ASIST training will be provided to 1 in 50 national Guard staff and troops scheduled for deployment in 2009.
- Grant sites will conduct suicide prevention conferences in NE Oregon and Southern Oregon to disseminate findings and lessons learned. The conferences will be open to statewide participation and will incorporate findings from NARA, the University Consortium, and BMCC GLSMA grants. Activities will expand reach to professionals, families, and youth who are not officially part of the projects but have interest in learning about suicide prevention, intervention, and postvention.
- The YSP program will apply for funding from SAMHSA for a second round of GLSMA grants in the spring of 2009, if eligible.
- Grant sites in Lane County, Jackson County, and Union County will each hold a training targeting mental health professionals in order to expand their clinical training in counseling suicidal patients.

The YSP program will continue activities:

- Support regional sites and support broader efforts to implement RESPONSE..
- Facilitate increasing the number QPR trainers available throughout Oregon.
- Support and provide technical assistance to local coalitions and youth suicide prevention efforts throughout Oregon.
- Work with Regional Research Institute, Macro, and GLSMA sites to evaluate youth suicide prevention programs, including enhanced follow-up evaluation of selected trainings.
- Provide staff support for statewide coalition on suicide prevention.
- Provide technical assistance and program support to the Coordinated School Health Program and participate on the advisory board for the mental health grant sites.
- Support ASIST (Applied Suicide Intervention Skills Training) trainings throughout the state.
- Deliver presentations and provide data about veterans and suicide; make powerpoint presentation available to others.
- Keep updated statistics and data and make them available through fact sheets, the YSP website, the YSPNetwork listserv and powerpoint presentations.
- Disseminate Yamhill County Coalition's video and discussion guide, "Breaking the Silence," through the YSPNetwork listserv and the YSP website.
- Work to increase responsible reporting of suicide deaths in news media throughout the state.
- Work with faith-based organizations to provide education about appropriate memorial services.
- The Injury Prevention and Epidemiology section Epidemiologist will begin to analyze data from ASADS, using findings to increase prevention awareness and to instruct prevention activities.

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	2003	2004	2005	2006	2007
Annual Performance Objective	85	85	85	85	81
Annual Indicator	76.8	81.9	79.1	75.7	99.2
Numerator	358	397	375	368	475

Denominator	466	485	474	486	479
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
	2008	2009	2010	2011	2012
Annual Performance Objective	99	99	99	99	99

Notes - 2007

Source: Hospital Discharge Data, 2007.

Previous year reported from 6 hospitals with NICUs. 2007 data is reporting from all hospitals and birthing centers.

Oregon does not have designated high risk delivery facilities, so numerator is based on very low birthweight infants born in hospitals.

Notes - 2006

Oregon does not have designated high risk delivery facilities, so numerator is based on very low birthweight infants born in hospitals.

Notes - 2005

Oregon does not have designated high risk delivery facilities, so numerator is based on very low birthweight infants born in hospitals.

a. Last Year's Accomplishments

- There are 56 hospitals in the state that provide obstetric care. Seven have NICUs. There is no regulated designation of NICU as Level III in Oregon. The 7 NICUs are staffed with Neonatologists and are Level III according to standards of the AAP Perinatal Levels of Care. The Oregon NICUs are:
 - o Portland metro area: St. Vincent's, Legacy Emanuel, Doernbecher Hospital NICU (OHSU)
 - o Willamette Valley semi-urban: Salem Hospital in Salem, Sacred Heart in Eugene
 - o Southern Oregon semi-urban: Rogue Valley in Medford
 - o Central Oregon rural: St. Charles in Bend
- Coverage in Oregon's rural and frontier areas is non-existent, requiring families to fly or drive to one of the urban or metro area hospitals
- OHSU provided consultation to providers caring for high risk deliveries & neonates, funded in part by OFH, including those in rural and frontier areas

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Advocacy for assuring systems and services are available to appropriately care for VLBW infants				X
2. Assessment and surveillance of status of VLBW infants among all population groups			X	
3. Monitor and promote access to NICU care and consultation for		X		X

families and prenatal care providers living in rural and frontier areas				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- The OCCYSHN program has been providing a 0.5 FTE CaCoon nurse consultant to serve as liaison between OCCYSHN, local health departments and tertiary care centers. The nurse attends NICU rounds at OHSU and has periodic contact with other hospitals.

- OHSU provides consultation to providers caring for high risk deliveries & neonates, funded in part by OFH.

- The OCCYSHN program developed a web portal that has resources available to discharge case managers at hospitals and local public health nurses. A proposal is currently being developed to revamp the web portal to provide information to a broader range of professionals

- The DHS, Office of Family Health continued to examine various methods to determine levels of care and staffing, insurance, geographic, and policy factors affecting admissions and transfers.

- Oregon, a primarily rural state, believes 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).

c. Plan for the Coming Year

- The DHS, Office of Family Health will continue to work toward the assessment, evaluation, and recommendations of regional and statewide data for the appropriateness of hospital care for high risk mothers and newborns.

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	2003	2004	2005	2006	2007
Annual Performance Objective	84	85	85	85	82
Annual Indicator	81.0	81.5	81.0	79.2	78.4
Numerator	37207	38532	36610	38475	38484
Denominator	45935	47290	45195	48559	49078
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
	2008	2009	2010	2011	2012
Annual Performance Objective	82	83	84	85	85

Notes - 2007

Source: Oregon Center for Health Statistics

Notes - 2006

Source: Oregon Center for Health Statistics

a. Last Year's Accomplishments

- Oregon MothersCare (OMC), a statewide initiative to improve access to early prenatal care, provides services at 29 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.
- This program has developed partnerships among public and private agencies to streamline, coordinate, and promoted access to prenatal services. Project components include a toll-free hotline (SafeNet), a referral and support system, to assist women in finding and using prenatal services, including dental services, in their community, and an ongoing public awareness, outreach, and education campaign. During 2007, the program assisted 5,337 women in gaining access to prenatal services.
- The Office of Family Health (Title V Program) continued to provide funding and technical assistance to local health departments to support Maternity Case Management (MCM) and home visiting services in an effort to increase access and effective utilization of prenatal care and other services. All county health departments had the option of allocating Title V and state funding to a local Oregon MothersCare (OMC) site; a first trimester pregnancy access program. In addition, a dedicated portion of Title V funds was distributed to existing OMC sites.
- OFH provided funding and technical support to local health departments to provide maternity case management to women without public or private insurance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach and linking of 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. FamilyNet 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. Advocacy for early prenatal care system and quality improvements				X

7. WIC and Family Planning programs refers women screening positive for pregnancy		X	X	
8.				
9.				
10.				

b. Current Activities

- Oregon Health Plan eligibility for pregnant women remains at 185% of Federal Poverty Level.
- The Perinatal Health Data Book was published and distributed. It provides a comprehensive overview of the health status of pregnant women across various indicators, population groups, and geographic locations. It is helping to identify priorities, plan policies and programs, and identify specific indicators to track perinatal health status improvement efforts.
- The state-local shared strategic planning meeting between Title V programs and the Association of Oregon Public Health Nursing Supervisors resulted in a commitment to focus on two perinatal initiatives: 1) "Preconception Health" which cover issues prior to the first pregnancy and continue through subsequent pregnancies, and 2) "Perinatal Depression" which impacts adequacy and timeliness of prenatal care. Action plans have been created for both of these initiatives.

c. Plan for the Coming Year

- Oregon MothersCare (OMC), a program to improve access to early prenatal care, including dental care, assists local health departments and other OMC access sites to: formalize partnerships with prenatal care providers and other providers offering pregnancy related services, promote SafeNet, the toll-free hotline for referrals to local prenatal services; streamline systems for accessing care; and assist women to obtain a pregnancy test, OHP, a prenatal care provider, and WIC, maternity case management or other pregnancy services. OMC also supports a social marketing campaign for promoting early prenatal care.
- In an effort to serve a larger population, all county health departments have the option of applying Title V and state funding to assist in the development and operations of a local Oregon MothersCare (OMC) site. Some Title V funds are being allocated specifically to support Oregon MothersCare. The DHS Office of Family Health will continue to provide technical support and assistance to these local projects.
- Collaboration and support will continue with community-based efforts to increase access to prenatal care and improve birth outcomes.
- The state-local shared planning process will continue in 2009, with identification of priorities and evidence-based interventions, and seek out opportunities for developing grant resources or program activities to implement a new perinatal health plan with a focus on the two initiatives addressing preconception health and depression.

D. State Performance Measures

State Performance Measure 1: *Percent of births where mothers report that the pregnancy was intended*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				62.7	63
Annual Indicator	61.6	62.9	62.0	62.1	62.1
Numerator	28212	28720	28456	30025	30025
Denominator	45799	45660	45905	48336	48336
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	63.4	63.8	64	64	65

Notes - 2007

Source: PRAMS, 2006. Weighted numerator and denominator

Notes - 2006

Source: PRAMS, 2005. Weighted numerator and denominator

Notes - 2005

Source: PRAMS, 2004. Weighted numerator and denominator

a. Last Year's Accomplishments

- The Oregon Family Planning Program served 77,499 clients in clinics supported by Title X and Title V funds preventing an estimated 13,729 unintended pregnancies. An additional 42,106 Oregonians received family planning services through clinics participating in the Medicaid waiver Family Planning Expansion Project (FPEP).
- A total of 115,765 female clients were served, representing approximately 60% of the estimated Women in Need (WIN) supplying publicly-funded contraceptive services and supplies in Oregon.
- In addition to contraceptive services provided and pregnancies averted, these clinical programs provided basic preventive health care services and exams for 119,605 women and men. Over 42,000 Pap smears and 47,000 clinical breast exams were done in Family Planning clinics.
- Family Planning clinics were particularly challenged by level Title X funding, as well as the barriers presented by FPEP citizenship verification required by the federal Deficit Reduction Act. Other challenges included dramatic increases in the cost of contraceptive supplies.
- Research on the impact of citizenship requirements on client numbers continued.
- Continued ongoing quality assurance activities, including on-site evaluations of local Family Planning clinics, reviews of grant program annual plan and FPEP chart audits to determine appropriateness of services billed.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family planning and reproductive health programs provide preventive clinical services for all women		X		
2. Training and education for clinic staff to ensure that providers are up-to-date on clinical information and techniques, best practices in client counseling and education, and program requirements				X
3. Outreach and referral in communities to increase access and utilization of family planning services			X	

4. Technical assistance and consultation for Comprehensive Clinic Program Efficiency (COPE) quality improvement				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- It is estimated that nearly 14,000 unintended pregnancies were averted in 2007 because of services provided in Title X and Title V MCH-supported clinics. Our goal is to maintain current resource levels so as to continue providing family planning services to low-income Oregonians.
- We continue to focus on the impact of requiring citizenship verification for FPEP eligibility. Data indicates a decline in services provided through FPEP of 38% in the first five months of citizenship verification.
- Priority requirements continue to be implemented by the Title X program, including increasing involvement of male partners in family planning services, encouraging family participation in the decisions of minors seeking family planning services, and providing counseling to minors on how to resist coercion into sexual activities.
- An in-depth cost analysis training was offered to all Title X delegates to ensure appropriate fiscal guidelines are followed.
- Vasectomies have been added to FPEP as a covered service.

c. Plan for the Coming Year

- Continue to work, on a national level, to ensure contraceptive supplies remain at the lowest cost possible.
- Continue to work with agencies to support clinics despite lack of revenue. Many agencies have had to limit clinic hours, close clinic sites, lay off staff and eliminate walk-in appointments.
- In order to address the decline in client numbers due to static Title X funding and restrictive citizenship requirements for FPEP, we plan to focus on outreach, particularly in underserved communities (rural locations, communities of color, etc).
- Explore the addition of female sterilization (including Essure(r)) to menu of services at family planning clinics.
- Offer trainings and resources on clinic efficiencies to family planning clinics.
- Focus on promoting, through training, technical assistance, and material development, the Culturally and Linguistically Appropriate Services (CLAS) standards to all family planning clinics.

State Performance Measure 2: *Percent of smoking women who quit smoking during their pregnancy and did not begin smoking postpartum.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				57.9	64
Annual Indicator	57.3	60.8	63.6	52.0	52.0

Numerator	2121	2633	2232	2501	2501
Denominator	3703	4328	3508	4807	4807
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	64.5	64.5	65	65	65

Notes - 2007

Source: Oregon PRAMS; 2006 data repeated for 2007 for TVIS reporting.

Notes - 2006

Source: Oregon PRAMS

Notes - 2005

Source: Oregon PRAMS; data for annual indicator and objectives are based on PRAMS weighted PRAMS data for "smoking" respondents who reported quitting smoking during pregnancy and did not begin postpartum.

a. Last Year's Accomplishments

State Performance Measure 2 complements National Performance Measure 15, though NPM 15 focuses on cessation during the last 3 months of pregnancy. For purposes of research and comparisons of individual measures with other states or nationally, strategies and activities for both measures are replicated in the narratives for both measures in the Title V Information System.

- Partnerships continued with the Division of Medical Assistance Programs (DMAP), local providers and agencies in training, information, and education on the 5 A's protocol and the DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services.
- Continued cessation screening and counseling in county services for family planning, prenatal care and MCM, nurse home visiting for high risk infants, and WIC.
- The results of the first year of the PRAMS-2 ("TOTS-the Oregon Toddler Survey") were collected.
- The Oregon Child Health Information Data System (ORCHIDS) Maternal Child Health Data Entry (MDE) system for local service providers and agencies was rolled out.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide training and technical assistance to local MCM providers on the Five A's Intervention and motivational interviewing for pregnant women		X		X
2. Surveillance using the longitudinal PRAMS-2 data to assess prevalence of tobacco use during the postpartum period and up to two years after the infant's birth.			X	X
3. Strategic planning for sustaining outreach to private prenatal care and other services to screen clients and implement 5 A's cessation practice				X
4. Health education and social marketing about smoking during pregnancy through Family Planning and Babies First home visiting program services			X	
5. Screening and referral in Babies First, WIC and Family		X		

Planning client services				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Partnerships between DMAP, local providers and agencies continue.
- First year data (both weighted and unweighted) from the PRAMS-2 ("TOTS-the Oregon Toddler Survey" - a longitudinal survey of PRAMS participants, addressing the health of mothers and their two year old which includes questions about tobacco use by the mother and in the household) is being analyzed. Survey data continues to be collected.
- Continued cessation screening and counseling in county services for family planning, prenatal care and MCM, nurse home visiting for high risk infants, and WIC.
- Collaborative work between the Office of Family Health and the Tobacco Prevention and Education Program resulted in the publication of the "CD Summary: Maternal Smoking In Oregon: Helping Moms Quit" with distribution to licensed health care providers in Oregon and public health agencies.
- The Oregon Child Health Information Data System (ORCHIDS) Maternal Child Health Data Entry (MDE) system for local service providers and agencies is collecting data on pregnant women who smoke; including attempted smoking cessation in last 12 months, smoking frequency, other household smokers, household smoking rules, movement on the change spectrum regarding numbers of cigarettes per day and provider use of 5A's brief interventions for smoking cessation.
- An action plan was created to concentrate on preconception health & will address prevention of smoking in younger girls by looking towards future pregnancies.

c. Plan for the Coming Year

- Continue partnerships between DMAP, local providers and agencies in order to provide training, information, and education on the 5 A's protocol and the revised 2008 DHHS Clinical Practice Guidelines on smoking cessation in local MCM and prenatal care services.
- Continue the PRAMS-2 survey.
- Continue cessation screening and counseling in county services for family planning, prenatal care and MCM, nurse home visiting for high risk infants, and WIC.
- ORCHIDS/MDE will produce state and local level data reports on tobacco exposure during pregnancy and provider interventions to use in evaluating program effectiveness and/or modifying program interventions.
- Implement statewide action plan for preconception health initiative.

State Performance Measure 3: *Percent of infants diagnosed with hearing loss that are enrolled or in Early Intervention before 6 months of age.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				53.4	54
Annual Indicator			40.7	34.7	49.2
Numerator			24	25	29
Denominator			59	72	59
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	54	55	56	57	58

Notes - 2007

Source: Oregon EHDI Program

Notes - 2006

EHDI referred a total of 81 infants to EI. Of those, 38 enrolled in EI by six months of age, six enrolled between six and 12 months of age, 17 did not enroll, and 20 had an unknown enrollment status. Of the 17 infants who did not enroll in EI, five were not eligible for the program due to normal hearing (4) or due to unilateral/mild loss (1), two moved out of Oregon, seven families refused the services, and three were lost to follow-up. Excluding the seven infants who were not eligible for the program or moved out of the state, the rate of enrollment by six months of age was 51% (38/74).

a. Last Year's Accomplishments

- The Early Intervention Subcommittee of the Newborn Hearing Screening Advisory Committee, convened to ensure consistent eligibility criteria across the State, such as interagency exchange of information issues currently obscured by FERPA and HIPAA, worked with the Oregon Department of Education to review and change the Part C Eligibility Criteria for infants with hearing loss ages birth to three years of age. The new criteria are more inclusive of all types and degrees of hearing loss including mild and unilateral hearing loss. Although the Department of Education, Part C, has approved the new criteria, another process is needed before implementation begins.
- A statewide pediatric audiology workgroup developed Best Practice Standards for behavioral testing of infants. The EHDI Diagnostic Audiology protocol was also reviewed and revised and will be disseminated within the year.
- EHDI Program staff worked with parents and professionals on the Newborn Hearing Screening Advisory Committee to establish improved services to families of infants with hearing loss, including improved referral processes to Early Intervention, resources and access to information and services.
- The EHDI Program sent reports to the EI programs regarding the status of infants referred to their program and requested updated information regarding enrollment status.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue working with Department of Education/EI programs to improve referral and eligibility process				X
2. Educate primary health care providers about the importance of timely early intervention services				X
3. Maintain an update list of Early Intervention programs and				X

provide to diagnostic centers and health care providers				
4. Increase referrals to Children with Special Health Care Needs Nursing Program to assist families in receiving timely intervention services		X		X
5. EHDI Program will continue to be single point of referral for birth to three year olds with hearing loss to Early Intervention programs		X		X
6. Improve Parent-to-Parent Support for parents with children with hearing loss.		X		X
7.				
8.				
9.				
10.				

b. Current Activities

- The EHDI Program is in the final phase of upgrading to the 4.0 HiTrack reporting system. This new system has extensive capabilities to collect, manage and follow-up on newborns and infants. A new evaluation plan is currently being developed to address these changes.
- The EHDI Program continues to: ensure that infants with hearing loss are enrolled and receiving EI services before 6 months of age; make EI referrals directly to Part C for infants diagnosed with hearing loss; send reports to EI programs regarding the status of infants referred to their program. EI Referral and Enrollment Status forms are being revised to help facilitate the reporting of enrollment status outcome for each infant.
- The Family Issues committee is creating a parent brochure for parents with children who have been newly diagnosed with hearing loss. It will be given to parents at the time of hearing loss diagnosis. The brochure is being developed in English and Spanish.
- The EHDI Program continues to operate its loaner hearing aid bank, providing easy access to loaners for all infants birth to three years of age who are enrolled in EI Programs.

c. Plan for the Coming Year

- Work with Hands & Voices to begin a parent mentoring program for parents of infants with hearing loss. EDHI will hire a parent coordinator to establish the program as well as follow up with families who have not passed initial testing.
- Send "scorecards" to hospitals ranking their compliance with the mandatory screening requirement in an effort to improve the quality of data that is reported.
- Continue to work closely with diagnostic audiology centers and early intervention programs to ensure timely diagnosis and enrollment in early intervention for infants with hearing loss. The EI subcommittee of the Advisory Committee will meet at least quarterly to address concerns regarding EI services. The EHDI Program will continue to send status reports to each county Part C program to monitor the status of infants referred to EI for hearing loss.
- EHDI staff will continue to contact families, medical home providers and local public health to assist families in navigating the system. Referrals to Oregon's Children with Special Health Care Care Coordination (CaCoon) nursing program will continue for

all infants identified with hearing loss.

State Performance Measure 4: *Percent of children that complete the 4th DTaP vaccine by two years of age.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				68.5	69
Annual Indicator	64.1	66.4	65.1	65.5	65.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	69.5	70	70.5	70.5	71

Notes - 2007

2006 data is repeated for 2007 for TVIS reporting.

Notes - 2006

Source: 2006 National Immunization Survey

Notes - 2005

The performance objective for 2005 is 68%. Numerators and denominators are not available from the National Immunization Survey.

a. Last Year's Accomplishments

Continued to disseminate print materials (posters, rack cards) at OPIC coalition meetings and statewide conferences and partner meetings

- Maintained information on the OPIC website for the "Focus on the 4th DTaP Campaign", a joint Oregon-Washington childhood pertussis immunization campaign. The campaign included parent materials, provider materials, radio and TV PSAs and billboards.
- Local health departments were encouraged to focus some of their annual planning efforts on improving 4th DTaP rates in their communities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Communication Network established between Oregon and Washington state coalitions to share immunization information			X	X
2. Educational materials distributed through Communication Network and posted to websites			X	X
3. 4th DTaP Multimedia Campaign in Oregon and Washington – Radio, TV, Billboards			X	
4. Local health departments using state funding to build on 4th DTaP in their communities – billboards, special outreach, special recalls	X		X	

5. Educational materials provided to Oregon SafeNet (211info) on 4th DTaP campaign.		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Promote 4th DTaP as one strategy to improve pertussis prevention across the lifespan. Promotion efforts include: radio PSAs and on-air interviews targeting African American parents and grandparents (25-54); television PSAs in English and Spanish through targeted programming on Comcast; and written information for parents and providers posted to our website.
- Providing free adult/adolescent pertussis vaccine (tdap) to new mothers and fathers to protect their newborns and promote an early understanding and appreciation of vaccines.
- Continue working with local health departments and private providers to focus quality improvement efforts on increasing the timely administration of 4th DTaP. The Immunization Program leads this process by completing immunization assessments that measure up-to-date rates and clinic practices that affect those rates.
- Pilot test earlier and targeted reminder/recall strategies with parents to identify which methods and timing might increase uptake of timely 4th DTaP.

c. Plan for the Coming Year

- Continue statewide promotion of pertussis prevention across the lifespan; may include media messaging, parent and provider education, etc.
- Implement new parent reminder/recall strategies statewide to address 4th DTaP uptake, based on pilot project evaluation and recommendations.
 - Continue to provide assessment data, technical assistance, and financial resources to local health departments for outreach activities to promote the 4th DTaP.
 - Continue to provide assessment data and technical assistance, and financial resources to private providers to increase 4th DTaP rates.
 - Evaluate the 4th DTaP education campaign and determine next steps to increase educational messaging to providers and parents.

State Performance Measure 5: *Percent of 8th graders who report being physically active for a total of at least 60 minutes a day for 5 or more days in the last 7 days.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				75	75
Annual Indicator			59.0	59.0	56.2
Numerator			9063	2094	5016

Denominator			15363	3550	8928
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	70	73	75	75	75

Notes - 2007

Source: Healthy Teens Survey, 2007.

Notes - 2006

Source: Healthy Teens Survey (YRBS), 2005

Notes - 2005

The performance objective for 2005 is 72.5%.

This data is unweighted. The HTS question for this indicator began in 2005.

a. Last Year's Accomplishments

- Representatives from each section in the Office of Family Health (OFH) met to coordinate the integration and promotion of increased fruit and vegetable consumption and physical activity into OFH programs. They also worked to identify the strategies which are now listed in the recently released Oregon Physical Activity and Nutrition Plan 2007-2012 (and can be incorporated into OFH programs' activities).

- 82 Oregon schools and over 15,689 children and parents participated in Walk and Bike to School Day.

- Promoted RFP applications for State Safe Routes to School federal grants, and planned 2007 Walk and Bike to School Week in October.

- HKLB teams assessed and implemented physical activity in participating schools, providing Walk and Bike to School Day activities and information.

- Developed a coalition in partnership with Physical Activity Network, Kaiser Permanente, Oregon PTA, Multnomah County Libraries and the NW Media Literacy Center, Community Health Partnerships, OSU Extension and YMCA to sponsor Oregon's TV-Turnoff Week. The coalition staged and publicized a variety of events during the week, attracting participants throughout Oregon and SW Washington. In preparation for the event, the coalition published a wide variety of print media regarding TV-Turnoff Week and the potential effects of excessive screen time. Representatives from OFH contributed to the creation, promotion and distribution of more than 20,000 copies of TV-Turnoff and Screen Time Awareness materials, including a flyer created by several OFH members titled, "You Have the Power: 5 Steps to Guide Your Child's TV Time".

- Worked in collaboration with the Oregon Physical Activity and Nutrition (PAN) Program which is housed within the Office of Disease Prevention and Epidemiology. Members of OFH assisted PAN partners in writing Oregon's current statewide physical activity and nutrition plan. The plan takes a population-based approach to obesity prevention, nutrition and physical activity promotion through policy and environmental change. The OFH Physical Activity and Nutrition group worked with the Office of Disease Prevention and Epidemiology (ODPE) Physical Activity Network (PAN) program to adopt 60 minutes/day of physical activity as the most appropriate state MCH measure for physical activity.

- HKLB traveling teams assessed and implemented physical activity in HKLB schools. HKLB also provided information about Walk and Bike to School Day roundtables at HKLB Institutes and through the HKLB list-serve. Healthy Kids Learn Better (HKLB) and other OFH representatives worked to promote and support the new School Wellness Policies adopted for the 2006-2007 school year.

- Physical activity messages are a routine part of SBHC visits. The School-based Health Center program (SBHC) continued to develop goals on obesity prevention, physical activity and nutrition and BMI measurements.
- The State WIC Program recommended a physical activity objective for WIC locals in local nutrition education plans. WIC worked to incorporate messages around physical activity into their one-on-one nutrition counseling.
- OFH worked to provide resources on physical activity and nutrition to child care. For parents of young children, home visiting public health nurses promoted physical activity messages to promote growth and development, such as infant tummy time and appropriate screen time.
- Family Planning and Women's Health programs made physical activity and nutrition materials available on their website. The Immunization program participated in TV-Turnoff Week by handing out promotional stickers through local immunization clinics.
- Worked with the group Oregon Active Community Environments (ACE) which includes diverse partners who work toward creating policies to shape an environment that fosters physical activity in daily lives of all Oregon residents.
- Local public health nurses taught parents activities to promote growth and development in their children.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate Nutrition and Physical Activity across the Office of Family Health Programs, and Worksite Wellness Activities			X	X
2. Provide leadership and coordination of Walk and Bike to School Day for communities			X	X
3. Collaborate with Safe Routes to School programs			X	X
4. Assist WIC and Child Health with promoting TV-Turn Off Week and distributing materials			X	X
5. Assist WIC and Child Health programs provide education on limiting screen time			X	X
6. Compile and analyze state-level physical activity data from a variety of sources				X
7. Promote family-centered physical activity promotion activities when possible in state and local programs and policy efforts			X	X
8. Support population-based planning and policy efforts to include adequate daily physical activity.				X
9. Support school staff in adopting and implementing school wellness policies that focus on physical activity within the school day			X	X
10.				

b. Current Activities

- The OFH Nutrition and Physical Activity Workgroup continues to meet monthly to work on consistent messaging around physical activity and nutrition and integrating these messages into all OFH programs.
- OFH is working in collaboration with our PAN partners to promote legislative policies based on

the physical activity strategies listed in the statewide physical activity and nutrition plan to help combat obesity and diabetes in Oregon.

- Walk and Bike to School Day: OFH programs are planning the 2008 Walk and Bike to School Day as well as summer training on sustaining walking and biking activities throughout the year.

- Healthy Kids Watch Less TV: OFH continues to participate with the state-wide coalition and is currently in the process of evaluating the 2008 TV-Turnoff Week.

- We are working with Oregon Childcare Resources and Referral Network to get information about physical activity and decreased sedentary activity out to the public. We are working through Wellness in School Environments to ensure that school wellness policies are in place, assessed and evaluated.

- School-based Health Centers continue to give messages about physical activity. Home visiting public health nurses promote physical activity messages. The Immunization program participated in 2008 TV-Turnoff Week by handing out promotional stickers through local immunization clinics. WIC developed activity cards to give to participants

c. Plan for the Coming Year

- OFH Nutrition and Physical Activity Workgroup: Representatives from each section in the Office of Family Health (OFH) will continue to meet and work on coordinating consistent messaging around physical activity and nutrition and integrating these messages into all OFH programs. This group will continue to work to identify strategies listed in the recently released Oregon Physical Activity and Nutrition Plan 2007-2012 that can be incorporated into OFH programs' activities.

- Safe Routes and Walk and Bike to School Day: OFH programs will assist with planning the 2009 Walk and Bike to School Week and continue to promote the need for sustainability within this program.

- OFH will continue to collaborate with the Safe Routes to School programs.

- Healthy Kids Watch Less TV: Continue to participate in state-wide coalition, promote the importance of limited screen time for children and families, disseminate our "You Have the Power" handouts, and plan for 2009 TV-Turnoff Week with partners.

- OFH Programs: Continue to integrate physical activity messages and activities into OFH programs. Continue to utilize physical activity data, including the new Elementary School Survey and exploring new avenues of collecting needed data.

- Continue to develop our working relationship with the Oregon Childcare Resources and Referral Network (CCRRN) and get information about physical activity and decreased sedentary activity out to the public. Look for opportunities, like the United Girls' Summit, to promote and educate on the importance of physical activity. Continue to work with groups like WISE to ensure that School Wellness policies and evaluative monitoring systems are in place.

- Continue to participate in worksite wellness activities in PSOB and work on bringing more activities and policy decisions to OFH. Continue working with partners and promoting activities that promote physical activity and an active, healthy life for Oregonians.

- Statewide Nutrition and Physical Activity Plan: Continue our partnership with the Oregon PAN program to promote strategies listed in the state plan that address the environments in which Oregonians spend their time and support physical activity in each socio-ecological level.

State Performance Measure 6: *Percent of 11th graders who report having unmet health care needs.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				30	29
Annual Indicator			33.5	28.1	29.2
Numerator			3527	724	1646
Denominator			10529	2576	5637
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	29	28	28	27	26

Notes - 2007

Source: Healthy Teens Survey, 2007.

Notes - 2006

Source: Healthy Teens Survey (YRBS), 2005.

Notes - 2005

The objective target for 2005 is 31% and for 2006 is 30%.

This data is unweighted. The HTS question for this indicator began in 2005.

a. Last Year's Accomplishments

- The CSH case study methodology was updated and a new set of case studies were initiated, analysis was completed and the final report is pending. Weighted data from the CDC portion of the 2006 OSHP survey was obtained and reported on. Planning for a revision process for the 2008 survey cycle is anticipated.

CSH sites were expanded in FY 2007 and included five new sites that will focus on physical activity & nutrition, four on asthma, and four mental health demonstration sites funded by a HRSA grant leveraging an additional \$40K of private partner funding and will focus on mental health.

Major activities in the state Coordinated School Health (CSH) program included the distribution of approximately \$40K to fund the training and travel of school teams participating in the FFY 2006 cohort of schools to focus on mental health in schools and to support team development, provision of a series of planning/TA activities, forums and follow-up activities to assist the school teams in assessing school health needs using CDCs School Health Index and to pilot a Mental Health School Health Index and to develop and implement a local school plan to address their selected health issues, facilitation of data collection and evaluation activities including creating a school profile, documenting assessment and planning outputs, facilitating participation in school health policy surveys (Oregon School Health Policy Survey) and student behavioral risk (Oregon Healthy Teens Survey), designing, conducting and analyzing formative data and interview information to develop a case study methodology for identifying factors that support a successful CSH program or identify barriers to the process.

- Major activities in the state School Based Health Centers (SBHC) program included the distribution of \$1.3M in state general fund infrastructure funding to local public health authorities to support the development and operation of certified SBHCs and funding of state program office/staff, provision of 3 Phase I planning grants in counties currently without certified SBHCs and targeted technical assistance to

help plan, develop and certify at least 2 new school sites, providing leadership and staffing to sustainability workgroups composed of private and public partners, insurers and payors working on the long-term financing of SBHCs and other safety net providers, planning and maintaining a SBHC state 'certification' review process to assure minimum standards are met and to promote best practices of care, and collecting and maintaining a statewide medical encounter and operations database to monitor, evaluate and report on SBHC services and utilization.

- The 2007 Legislature approved the Governor's recommended budget that will expand the SBHC program by an additional \$1 million per year, open up to 13 new centers, implement a new quality improvement program, and expand state program office staff in the areas of clinical nursing and health care economic analysis and modeling. This is the largest expansion our program has attempted in the last 20 years. Eighteen sites across twelve counties were awarded one-year planning grants. Thirteen of the planning sites were in seven counties with certified SBHCs, and the additional five planning sites were in five counties without any certified SBHCs.

-In spring 2007, two newly certified SBHCs were added to the SBHC system, bringing the state total to 45 certified SBHCs in 19 counties.

- The SBHC program completed a cost-revenue study of SBHCs across the state and submitted the results for publication.

- We facilitated the design and development of a new health communications booklet targeted toward parents of young adolescents (ages 11-15) and promotes adolescent well-visits as a means to increase preventive health guidance, increase risk screening, and promote early intervention as a means to reduce unmet physical health and emotional health needs. The booklet also contains tear-off cards for parents and teens that can be used to communicate doctors about areas of health concern.

- Adolescent Health staff participated in the governance group for the Oregon Healthy Teens (OHT) survey and on content, financing and general governance committees to ensure appropriate measures are included in the survey related to unmet physical and emotional health needs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Technical assistance, training and funding for local School-Based Health Center planning in communities				X
2. Support and technical assistance to build infrastructure and sustainability for local School-Based Health Centers				X
3. Consultation and technical assistance for certification of School-Based Health Centers				X
4. Data collection and evaluation of School-Based Health Center clients and visits				X
5. Infrastructure funding, technical assistance and planning with HKLB school sites				X
6. Data collection and evaluation of Coordinated School Health				X

programs				
7. Collect data for the Oregon School Health Policy & Programs Survey to assess ??				X
8. Participate on the Oregon Health Teens Survey (YRBS) Governance Group				X
9.				
10.				

b. Current Activities

- The Coordinated School Health program finished up the last year of a five-year CDC cooperative agreement with the Department of Education. The program was not refunded by CDC. The Public Health Division is planning for a new public health-led effort to maintain the HKLB program and continue Coordinated School Health in Oregon.

- Healthy Kids Learn Better released an RFA for a school district grant opportunity for the Healthy Kids Learn Better Mental Health Demonstration Project. The goals of the program include: 1) Discovering strategies schools can use to create and maintain coordinated school health programs with limited state involvement; 2) Greater refinement of the School Mental Health Inventory; and, 3) Discovering ways to meaningfully involve youth in the CSH process.

-The SBHC program is providing all new planning sites with targeted technical assistance to help plan, develop and prepare for 2009 certification.

-The SBHC program is working with sites to fill gaps and strengthen the system in identified areas of need within the SBHC mental health system.

- The SBHC program conducted a workgroup to re-evaluate and revise current certification standards.

- The Adolescent Health program piloted an evaluation of the adolescent well-visit booklets with a local independent physician's association. We collected data on parental opinions of the booklet, as well as whether parents were more likely to schedule a well visit for their youth.

c. Plan for the Coming Year

- Healthy Kids Learn Better will continue partnering with the Health Promotion and Chronic Disease Prevention Program on the Tobacco Related and Other Chronic Disease Initiative. This initiative is designed to increase local public health capacity to address chronic disease prevention, early detection, and self-management across schools, communities, health systems, and work sites. HKLB will provide training support related to working with schools utilizing a coordinated school health approach.

- HKLB will also work to create online tools that schools can use to engage in a Coordinated School Health planning and assessment process with limited State involvement.

-The SBHC program will continue to support existing and second-year planning sites, with the expectation that all SBHCs will be certified by the spring of 2009. The SBHC state 'certification' review process ensures that all sites meet minimum standards and promote best practices of care. The SBHC program continues to collect

and maintain a statewide medical encounter and operations database to monitor, evaluate and report on SBHC services and utilization.

- Recommendations for changes to the SBHC certification standards will be presented to the Conference of Local Health Officials (CLHO) for approval

- The SBHC program will continue to use information from the Mental Health Needs Assessment Project and work with partners to provide technical assistance, training and system development in the area of emotional health.

- The SBHC program will fully implement compliance with a set percentage of key performance measures in all certified SBHCs. Progress will be demonstrated yearly to meet the Statewide goals.

- The SBHC program will continue to work with the State Immunization Program to provide a second round of planning grants to promote increased adolescent immunizations in SBHCs.

- The SBHC program requested additional monies to focus on expansion and sustainability of the SBHC model. The proposed expansion of the SBHC system into new and existing counties would increase access to 3,000-7,000 additional students. The sustainability component of this request focuses on an increase in the funding base to improve SBHC capacity and provide mental health services and/or improve surveillance of mental health services through implementation of quality assurance measures, such as data reporting and referral monitoring.

- Adolescent Health will analyze the results of the well-visit booklet evaluation, looking at the CPT codes of participating patients to see if there was any impact on well-visit rates. Targeted distribution of the booklets through SBHCs, county health departments and immunization clinics will also occur.

- Adolescent Health will work on advancing a policy proposal to extend health insurance coverage to older adolescents (age 18-25) by extending the age at which they are considered dependents, for insurance purposes, and allowing them to remain on parental coverage

State Performance Measure 7: *Percent of Oregonians living in a community where the water system is optimally fluoridated.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	27	27	27	28	21
Annual Indicator	19.2	20.3	20.3	19.7	19.7
Numerator	678853	728469	737549	737549	737549
Denominator	3541500	3582600	3631440	3743904	3743904
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	21	21	21	21	21

Notes - 2006

The projection is based on an increase in population, not a decrease in the number of communities with fluoridated water.

The objective target is adjusted to 21% for 2006.

a. Last Year's Accomplishments

- The Oral Health Section continued to receive funds from the CDC to enhance the infrastructure and capacity for optimal water fluoridation, provide technical assistance in Oregon on community water fluoridation; and establish and support existing community coalitions that will advocate for optimally fluoridated water.
- The Oral Health Program worked with the Drinking Water Program to connect Oregon into the Water Fluoridation Reporting System (WFRS).
- The Statewide Oral Health Coalition began strategic planning with the Healthy Smiles Coalition in support of community water fluoridation. The coalition is a diverse group that includes providers, social services, public health, education, non-profits, managed care, and many others.
- The Oregon Legislature again heard testimony in support of HB 3099, but the bill did not move out of the House.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Advocate for community water fluoridation through public education and policy development				X
2. Establish and provide technical assistance in the development of community coalitions				X
3. Collaborate with Oregon Drinking Water Systems to provide technical assistance to water districts			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- The Oral Health Program continues to maintain the WFRS data.
- The Oregon Oral Health Coalition is continuing to coordinate with the Healthy Smiles Coalition regarding water fluoridation. The Northwest Health Foundation provided a small grant to support continued strategic planning.
- The Oral Health Program began recruitment for a water fluoridation coordinator.
- The Oral Health Program submitted an application for a new CDC Cooperative Agreement. This cooperative agreement includes key performance measures for community water fluoridation.

c. Plan for the Coming Year

- In collaboration with the DHS Drinking Water Program (DWP), the Oral Health Program will continue to maintain Oregon data in the CDC Water Fluoridation Reporting System (WFRS).
- The Oral Health Program will continue to provide technical assistance to local

communities.

- The Oregon Oral Health Coalition will continue to collaborate with the Healthy Smiles coalition in support of community water fluoridation.

State Performance Measure 8: *Percent of health care providers who report confidence in caring for CYSHN and their families*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	93	94	95	95	95
Annual Indicator	93.2	97.7	91.7	95.1	95.1
Numerator	124	130	166	137	137
Denominator	133	133	181	144	144
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	96	96	98	98	98

Notes - 2007

This represents a proxy measure of confidence. This is the number of providers trained of those "available" in the program year to train, including CaCoon Coordinators (45), Promotoras (4), community members of the Community Connections Network (42), CDRC clinicians (35), LEND Trainees (12) and our Family Liaison (6). Of the 144 providers who were available to receive training by OCCYSHN, 135 participated in training activities.

OCCYSHN is working to develop a measure of confidence of providing care to CYSHN.

The numbers reported for 2006 and 2007 are identical due to the fact that we inadvertently reported 2007 data in 2006. In 2008 we have begun to implement a survey item asking trained providers to indicate the extent to which they are confident in the care of CYSHN and their families.

Notes - 2006

This represents a proxy measure of confidence. This is the number of providers trained of those "available" in the program year to train, including CaCoon Coordinators (45), Promotoras (4), community members of the Community Connections Network (42), CDRC clinicians (35), LEND Trainees (12) and our Family Liaison (6). Of the 144 providers who were available to receive training by OCCYSHN, 135 participated in training activities.

OCCYSHN is working to develop a measure of confidence of providing care to CYSHN.

Notes - 2005

This year the number of potential providers to train relative to caring for CYSHN increased to 181. This includes:

- 75 Community based providers via our Community Connections Network
- 45 Public Health Nurses via our CaCoon Program
- 5 promotoras via our CaCoon Program
- 35 CDRC Clinicians
- 16 LEND Trainees (these numbers may change slightly from year to year)
- 5 providers via the Oregon Rural Providers Research Network (ORPRN)

a. Last Year's Accomplishments

OCCYSHN is committed to ensuring a skilled and competent workforce and providers of children and youth with special health needs. One avenue by which OCCYSHN addresses this commitment is through its training program. OCCYSHN seeks to respond to the needs of Oregon providers throughout the state.

- OCCYSHN staff oriented 5 new CaCoon PHNs and conducted 31 CaCoon site visits to monitor services, provide consultation.
- PHN staff significantly revised the CaCoon Manual. The manual includes enhanced formatting and supports the CaCoon program through a presentation of the program standards and needed resources to support the CaCoon Coordinators.
- OCCYSHN's family staff trained 7 new family liaisons to participate on Community Connections Network (CCN) and rural practice teams. 5 CCN teams were oriented to working in partnership with families by introducing the concept of family liaisons as part of their team.
- -OCCYSHN staff oriented CCN local coordinators, physicians and professional adjuncts on team roles, responsibilities and team processes through their regular monthly site visits.
- Community Consultants to CCN teams facilitated a total of 5 local medical training consults, 1 community hospital Grand Rounds session, and 7 in-service trainings. 384 people participated in the trainings. In-service/consultation topics included assessment and treatment of children with a variety of chronic health conditions and developmental, learning or behavioral disorders.
- OCCYSHN staff arranged a web cast by CDRC Psychologist Kurt Freeman on "Common Child Rearing Challenges in Young Children: How to Help Parents and Caregivers Manage." This presentation was delivered to 48 allied health professionals at 5 community sites. Training was requested by participating communities. 88.9% of respondents to a Follow-up Evaluation Survey agreed or strongly agreed that training increased their confidence in caring for CYSHN.
- OCCYSHN sponsored community partners to attend the OrPTI Transition Conference 2007 titled "Building Futures" and Motivational Interviewing Workshop.
- OCCYSHN and Oregon Addictions and Mental Health Division partnered to deliver a statewide Cross Systems Forum on young children with behavioral health issues. 142 professionals attended; 77.8% responded to a Follow-up Evaluation Survey indicating satisfaction with the quality of the training.
- The OCCYSHN Screening Learning Collaborative teams in 5 communities continued efforts to increase developmental, behavioral & social/emotional screening. Teams representing Deschutes, Klamath, Umatilla, Wallowa, and Lane counties identified and implemented activities to increase the number of children screened and referred to Early Intervention services.
- Findings from OCCYSHN's Adolescent Transition Learning Collaborative were shared in multiple venues, including LEND ID Forum, AMCHP, OrPTI, Oregon Association of Vocational Special Needs, and with CCN/CaCoon providers.
- OCCYSHN staff provided training to Public Health and Preventive Medicine Residents on the purpose and goals of OCCYSHN programs; CDRC Grand Rounds and LEND Interdisciplinary forum trainings on EPSDT and Medicaid.
- Telemedicine was piloted in 5 sites with 24 visits, giving local providers a better understanding of genetic services.
- Director of Early Childhood Services/Oregon Department of Education (ODE), Office of Family Health & OCCYSHN collaborated to develop a universal referral form for use by primary & tertiary care referral sources.
- OCCYSHN Director provided medical consultation to Director of EI/ECSE (ODE) and State Interagency Coordinating Council on categorical eligibility for Early Intervention services based on diagnosed physical or mental conditions associated with significant delays.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide training and technical assistance for providers of CYSHN through a variety of venues and formats.				X
2. Develop and provide training to Family Involvement Network;				X

support leadership training for families.				
3. Partner with agencies/associations to include topics of chronic conditions/special health needs on training agendas				X
4. Disseminate information on evidence-based best practice/promising practices.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Ongoing training/supports continue for PHNs, CCN teams, and Family Liaisons. Specific training to PHN's includes ORCHIDS-MDE, Targeted Case Management, and updates to the CaCoon Manual.
- OCCYSHN partners with OFH for the Spring 2008 Training Conference "Celebrating Oregon's Communities"; 215 attended including MDs, PHNs and families.
- OPS, OCCYSHN and partners provide regional trainings on ASD and autism screening tools for primary care providers.
- OCCYSHN sponsors up to 2 local in-service or consultation trainings for each CCN community.
- OCCYSHN staff presents at "Partnerships Between Education & Medicine" Event in Central Oregon to increase understanding of MCH and OCCYSHN health systems and programs.
- OCCSYHN staff benefits from Tom Wolff presentations on building coalitions for healthy communities.
- OCCYSHN staff provide 6 training sessions to LEND trainees.
- Screening Learning Collaborative continues in 5 communities to increase screening of young children.
- OCCYSHN participates in Oregon ABCD Screening Academy to increase identification, and follow up for young children at risk for developmental delays, behavior, social or emotional challenges.
- Alternative delivery of training, including videoconferences (SLC), web portals, web casting, telemedicine (Genetics) and/or regional trainings (CaCoon Manual) are being piloted and evaluated.
- OCCYSHN web page is updated to include web casting, videoconferences, PowerPoint presentations, and current literature on best practice.

c. Plan for the Coming Year

- OCCYSHN will continue work with state and community partners to streamline services, avoid duplication of effort, work toward better coordination across systems. To improve services and systems of care, OCCYSHN partners with families and family groups to assure health and related services meet the needs of Oregon families.
- OCCYSHN will evaluate and explore improved ways to assess needs, satisfaction, and impact on practice, policy, and decision-making.
- Continue and enhance orientation of new CaCoon PHN's and CCN Team Members. Continue ongoing community consultation and supports.
- Provide orientation training and ongoing support Family Liaisons.
- Provide at least one local In-service training or Consultation for each CCN community on issues related to care for CYSHN.
- Provide annual CCN/CaCoon coordinator training and annual conference; or consider more cost effective training strategies including regional trainings or webinars and other distance training technologies.
- Enhance the use of alternative delivery of training/educational sessions, including

- videoconferences, web portals, web casting, telemedicine and/or regional trainings.
- Update and maintain current information on OCCYSHN web page, including web casting, videoconferences, PowerPoint presentations, and current literature on best practice.
 - Partner with LEND program and CDRC providers on distance trainings to increase rural and frontier provider confidence and competence in caring for CYSHN.
 - Provide CDRC Grand Rounds & LEND Interdisciplinary Forums on MCH and OCCYSHN topics or programs.
 - Participate in Oregon ABCD (Assuring Better Child Development) Screening Academy efforts increase identification, treatment, and follow up for young children with developmental delays behavior, social or emotional challenges.
 - Conclude TA to Screening Learning Collaboratives in 5 communities and disseminate findings on effective practices for increasing early childhood developmental, behavioral & social/emotional screening.
 - Continue collaboration with Early Childhood Services at ODE to train primary care and tertiary care providers on use of universal referral form to Early Intervention/Early Childhood Special Education.
 - Continue/enhance partnerships with state agency partners to streamline services, avoid duplication of effort, work toward better coordination across systems, including OFH, ODE, SPD, Child Welfare, and others.
 - Continue partnership with Disability Compass, Family Voices, Family to Family, OrPTI and other family groups to promote family professional partnerships, medical home and family centered care.
 - OCCYSHN will pursue improvements in evaluation methods and tools to measure impact on change in practice, policy, and decision making. - OCCYSHN will investigate methods and tools to improve evaluation and assessment of parents' and providers' confidence in caring for CYSHN.

State Performance Measure 9: *Percent of families of CYSHN who report costs not covered by insurance were usually or always reasonable.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				65	65
Annual Indicator			62.3	62.3	85.5
Numerator			70694	70694	99990
Denominator			113418	113418	116988
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	86	86	90	90	90

Notes - 2007

This year's report of State Performance #9 is derived from item C8Q01_B of the NS-CSHCN for 2005/2006. There is a slight variation in the item from the 2001 survey in that the response option "No out of pocket costs" was added which 7.9% of Oregon respondents selected.

Notes - 2006

2006 data not available; data from 2005 is carried forward.

Notes - 2005

The indicator of this measure is the National Survey of CSHCN (SLAITS) Item C8q01_b which reads, "Are the costs not covered by (child's name) health insurance reasonable?" The response options are Never, Sometimes, Usually, or Always.

Weighted estimates for the Oregon respondents to Item C8q01_b are reported:

Numerator is calculated as Always = 36,196 + Usually = 34.498 Denominator weighted estimate for Oregon of 113,418, yielding a calculated Annual Indicator for 2005 of 62.3%.

a. Last Year's Accomplishments

- The OCCYSHN (SOCS grant) Advisory Committee provided suggestions related to future activities for addressing costs not covered by insurance at the October 2, 2006 meeting. They included linking with several action groups in rural communities in which the SOCS grant was carrying out activities.
- The Health Care Access Survey data was analyzed and the findings included in a Fact Sheet to inform legislators and the public about the needs of families and providers related to caring for CYSHN.
- OCCYSHN continued the Family Support Program to provide financial assistance to families for their out-of-pocket costs for services and products not covered by insurance or inadequately covered; fully utilized all budgeted funds this year after expanded outreach to families and providers. 692 families received a total of 923 services from FSP.
- OCCYSHN continued to support care coordination for families through local public health nurses in the CaCoon program in every county. Through care coordination, families have increased access to the health care they need for their children.
- OCCYSHN facilitated local CCN Team to address issues related to CYSHN. Local providers and agencies participated in regular meetings, documented needs and worked to facilitate services needed by CYSHN, whether or not covered by insurance. There is no charge for families whose children are seen in the CCN Teams. 164 unique children children were seen in the CCN teams around the state over 203 visits.
- OCCYSHN dedicated staff fte to the work of enhancing partnerships with family organizations, agencies, OHSU Government Relations, key legislators and Oregon state legislative staff to assure awareness and understanding of issues related to CYSHN as they are addressed and included in the planning and evaluation of services at the state level. Additionally, OCCYSHN staff analyzed and tracked healthcare legislation; informed partners, families and policy makers on the impact of healthcare legislation on CYSHN.-OCCYSHN collaborated with the Oregon Health Services Commission and DMAP to staff the OHSC's Genetic Advisory Committee; resulting in 1/1/07 implementation of DMAP coverage guidelines about genetic services for children with developmental delay and an algorithm for deciding about coverage for genetic tests.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue Family Support Program to assist families with costs not reimbursed/paid by insurance or other funding		X		
2. Collect/analyze data related to out of pocket costs incurred by families				X
3. Educate/inform decision makers of the impact on families of out-of-pocket costs and needs for comprehensive coverage or additional funding for services, e.g. respite care				X
4. Provide information and education to families about maximizing healthcare and related benefits (CaCoon, CCN, partnerships with Family to Family Health Information & Education Ctr)		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- Review and disseminate data from the 2006 NS-CSHCN related to out of pocket costs for families.
- Analyze and track proposed healthcare and telemedicine legislation. Analyze and track health care reform concepts and activities; use analyses to develop educational print materials and presentations for families, providers, and partners.
- The Spring 2008 OCCYSHN Annual Conference addressed health care finance topics Address Medicaid reimbursement for developmental and behavioral screenings in pediatric primary care through ABCD Screening Academy. -Engaged in discussions with DMAP around Oregon Health Plan consumer protections for families of CYSHN.
- Assist DMAP to implement genetic services policies and monitor utilization of genetic services; continue partnership with Oregon Health Services Commission related to coverage of services under the OHP and staffing its Genetics Advisory Committee.
- Continued community-based services to families through CaCoon and CCN; continued Family Support Program and efforts to identify additional supports and foundation funding to help in meeting family needs not covered by insurance.
- Identified sources on family costs for care, insurance denials, and successful appeals.
- Partnered with Oregon's Family to Family Health Information and Education Center to look at opportunities for cross training Family Liaisons to provide additional information and navigational supports to families within CCN catchment areas.

c. Plan for the Coming Year

- OCCYSHN will track and analyze proposed and new legislation impacting CYSHN; use the analysis to inform development of educational materials and/or presentations for families, providers and partners.
- OCCYSHN will join discussions with families, providers, policy makers and partners, including Human Services Coalition of Oregon and the Expanded Access Coalition to identify, track and provide information pertaining to health care access and finance issues impacting CYSHN.
- OCCYSHN will engage with selected communities to conduct needs assessments and planning related to CYSHN and local systems of care; provide summary of survey data of Oregon's CYSHN families and provide community forum for discussion on unique needs facing the communities.
- Continue to provide financial assistance to families through FSP and other gift funds at the same level of funding.
- Continue collaboration with the Oregon Health Services Commission and DMAP to staff the commission's genetic advisory committee with the aim of identifying genetic services coverage issues requiring review, and if appropriate, make recommendations about changes in coverage.

State Performance Measure 10: *Percent of families of CYSHN who reside in rural areas report that needs are usually or always met.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				80	80
Annual Indicator			80.3	80.3	72.4
Numerator			6988	6988	7200
Denominator			8706	8706	9945
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	82	82	85	85	85

Notes - 2007

Source: National Survey of Children with Special Health Needs, 2005-06.

There are an estimated 116,988 CSHCN in Oregon. 8.5% of CSHCN population in Oregon live in small town/rural areas. $116,988 \times .085 = 9945$ CSHCN living in small town/rural areas of OR. 27.6% of CSHCN in OR had 1 or more unmet needs for health care services. ($9945 \times .276 =$ about 2745 CSHCN with unmet needs living in small town/rural areas of OR.) $9945 - 2745 = 7200$ CSHCN with no unmet needs living in small town/rural areas of OR or 72.4%. This number is very similar to OCCYSHN reported in 2006 BUT it may not represent an improvement since there were more CSHCN living in small town/rural areas of OR (9945 vs. 8706) AND the level of unmet needs increased as well (27.6% vs. 19.7%). These shifts appear to result in a net increase in the number of CSHCN with unmet needs living in small town/rural areas of OR, but this may be in within the range of sampling error, something we will aim to examine this next program year.

Notes - 2006

2006 data is not available; 2005 data from the SLAITS NS-CSHN is carried forward.

Notes - 2005

Based on a sample population of children with special needs (responding to the NSCH-CSHN survey) an estimated 8706 were living within zip codes identified as being "small town or rural" as the weighted denominator. 80.27% had no unmet needs, yielding a derived estimate of 6988 children (numerator) with special health needs living in rural areas with no unmet needs.

a. Last Year's Accomplishments

- 16 Oregon families received genetic services by telemedicine through the WSGSC at 3 sites: Medford (Jackson County), Bend (Deschutes County), and Eugene (Lane County). OCCSYHN supported CaCoon nurses that provide support to the sites. Preliminary evaluation results from FY2007 services indicated families are generally comfortable with telemedicine and that it saves them money and travel time; physicians and genetic counselors are comfortable with the visits when a physical examination is not required; metabolic and clinical genetics physicians' and genetic counselors' preparation and follow-up time are about the same as for in-person or outreach visits; and preparation time for the metabolic nutritionists is longer than for in-person or outreach clinic visits due to the time spent preparing educational materials. The number of families seen in FY2007 was considerably lower than hoped. The primary barrier to seeing more families was coordinating the conflicting schedules of originating and remote site facilities and staffs. All rooms and equipment are used for multiple purposes, and project staff members devote only a small portion of their FTE to this project.
- OCCYSHN provided support to Jackson County in its development of a plan to provide child psychiatry services via telemedicine. Several key variables inhibited implementation.
- OCCYSHN collaborated with the Addiction and Mental Health Division to sponsor a May 2007 "Child Mental Health Cross Systems Forum." Families and professionals from public health, mental health and other selected community agencies and providers had an opportunity to speak to the needs of families in their communities and discuss ways to form stronger collaborative relationships.
- OCCSYHN community-based programs, CaCoon and Community Connections Network, continued in all 36 counties and 15 communities, respectively with consultant and training support from OCCYSHN.
- Family Liaisons were added to Community Connections teams, bringing the total to 5 community teams with Family Liaisons. The Family Liaisons provided supports and follow up with families who visit the teams and assist with teams in identifying local resources.
- With OCCYSHN support the Klamath Falls CCN team held a community forum on fetal alcohol syndrome open to professionals and interested community members.
- OCCYSHN facilitated a live telecast of the roll out presentation of the Early Childhood Plan (<http://222.oregon.gov/DHS/ph/ofhs/mch/docs/eccsplanexcsummary.pdf>children) that was made

available to counties so allow participation of CaCoon Coordinators, CCN Partners and physicians. The goal was to support greater awareness and knowledge of the planning process around state level early childhood initiatives.

- OCCYSHN provided TA to the Marion County Health Department (Salem, Oregon) in a discussion with two pediatric practices about integrating developmental screening into their practices.

- Through the Screening Learning Collaborative, 5 communities continued to work on expanding developmental screening. Teams from these mostly rural areas participated in 3 learning sessions. Topics addressed were Behavioral/Emotional Screening Tools and their use, Cultural Competency in screening, and the third learning session addressed implementing the ASQ in a pediatric practice, developing the critical pathways (referral) for children and families subsequent to administering the ASQ, and then a case study on one pediatric practice that was had established a successful screening practice.

- The Developmental Pediatrician Consult line was developed as a resource for community based providers to tap for information on low incidence and chronic conditions of children. The CDRC Developmental Pediatricians participated in an on-call rotation schedule for receiving the phone consult queries.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue and enhance OCCYSHN's community based activities, including CaCoon and CCN programs	X	X	X	X
2. Improve developmental screening policies, practices, and follow-up services (ABCD Learning Academy & OCCYSHN's Screening Learning Collaborative)				X
3. Provide focused training to providers throughout the state to increase capacity to provide care to CYSHN				X
4. Collaborate with CDRC providers to link services and information with providers in rural communities				X
5. Partner with other state agencies and organizations to advocate for policy changes that will benefit CYSHN and increase provider capacity to serve CYSHN				X
6. Pilot and promote alternative methods of training, information sharing, and service delivery (telemedicine)				X
7.				
8.				
9.				
10.				

b. Current Activities

- WSGSC telemedicine services continue in select rural areas. Staff are working to improve scheduling logistics to increase potential for telemedicine as an economic solution for access to genetics services.

- Analysis of cost, satisfaction, and other data is underway to evaluate viability of telemedicine as a method of offering genetics services and to inform decisions about using telemedicine for other specialty services.

- OCCYSHN continues to partner with LEND to provide community experiences for trainees, including Cornelius Latino community work and Tillamook Multi-modular screening. LEND faculty provides training to CCN teams on Cultural Responsiveness in Health Care.

- CDRC clinicians provide consults and in-service training to CCN teams and CaCoon Nurses to increase capacity in rural communities, including developmental pediatrician consults through a toll free line for community providers.

- Screening Learning Collaborative continues in 5 communities with 3 additional learning sessions. Lessons learned were shared at OCCYSHN's statewide conference in April 2008.
- Partnership with ODE and OFH focuses on developmental screening and follow-up, improving EI processes, and joint training on Targeted Case Management.
- Family Liaisons in four rural counties are working to increase the number of local resources available on Disability Compass to assist families in their communities.
- Family Liaisons are added to CCN Teams bringing total to 9 CCN sites and 2 rural practice sites.

c. Plan for the Coming Year

- Through WSGSC, OCCYSHN will continue telemedicine services and efforts to evaluate the use of telemedicine for providing access to specialty care in rural parts of the state.
- OCCYSHN community consultants will work with local teams to identify needs and opportunities to improve services in rural communities utilizing community engagement and public health needs assessment methods.
- OCCYSHN will continue partnership with Disability Compass and will encourage use of the online database by families and providers. Educational sessions will be jointly sponsored to increase usage and number of additional resources available to families across the state.
- Staff and consultants will partner with other groups and agencies to educate policy makers about needs of families, including special needs considerations in increasing access to medical/primary care homes and the need for comprehensive insurance coverage.
- Focus on developmental screening and access to follow up services will continue through OCCYSHN's participation in the ABCD Learning Academy. Connection with Screening Learning Collaborative Teams after the Learning Collaborative officially ends will be maintained through policy updates, information dissemination, and ongoing needs assessment activities.
- OCCYSHN will collaborate with Oregon Family Voices, Oregon Family Support Network, and the Oregon Family to Family Health Education and Information Center to increase family leadership and family to family connections across the state.
- Based on initial contacts with OHSU psychiatrists and ongoing partnership with the state's Addictions and Mental Health Services group, OCCYSHN will continue efforts to enhance mental health services across the state.
- OCCYSHN will be exploring alternative methods to connect and maintain connections with rural families and providers given increased travel costs and reductions in overall funding.
- OCCYSHN will assess the viability and use of the Developmental Pediatricians Consult Line. Maintaining an accurate count of calls has been challenging and the process and "marketing" of this resource will be evaluated.
- OCCYSHN will also assess the extent to which a dedicated PHN consult line would be helpful to PHNs who are providing care coordination around Oregon.
- Turnover in key OCCYSHN staff have interrupted progress toward assuring underprovided services are addressed within the state for children with special health needs including dental services and mental health. OCCYSHN will explore the extent to which dental services are available to CYSHN and formulate an approach to address unmet needs in this key area of health along with further work in the area of mental health.

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.

Health Status Indicators # 01A-02B, Low Birthweight

Low birthweight and premature birth are partially a reflection of the prepregnancy health of mothers. They may also be a reflection of a complex web of genetic factors. Recent changes in perinatal health care have influenced the proportion of infants born with low birthweight. (1) the most important of these is the routine use of electronic fetal monitoring, which has become routine since the 1970s. This may have led to a decrease in infant morbidity and mortality (since some infants may have been spared prolonged periods of hypoxia during birthing) but it has also led to increased preterm delivery (when abnormal efm readings led obstetricians to perform emergency cesarean deliveries). (2) a second important cause of increased low birthweight and preterm delivery is the increased use of assisted reproductive technologies, which has led to an increase in multiple births. Multiples are more likely to be born prematurely and have low birthweight. (3) a third cause of increased low birthweight is the increased rate of cesarean deliveries, regardless of efm. Legal liability issues have dramatically curtailed vbac (vaginal birth after cesarean) and led to a decrease in other vaginal deliveries. Elective cesarean deliveries are more common and more widely accepted.

Oregon's health status indicators that focus on low and very low birthweight (#01a-02b) have changed very little since 2003. The total percent of low birthweight infants has remained at 6.1%. The percent of singleton infants born with low birthweight has increased from 4.5% to 4.7%. (there were no significant changes in the very low birthweight numbers for 2003-2007.) Since the changes are more apparent among singleton births than in the general population, these changes have led us to conclude that oregon's overall increases in low birthweight are probably resulting from increased elective cesarean deliveries, especially for infants whose gestational age has been incorrectly inferred from ultrasound dating of the pregnancy.

Changes in the rate of infants born pre-term and/or with low or very low birthweight are also factors in service delivery planning or coverage. Oregon has fewer health providers, especially OB/GYN practitioners, and most significantly, many practitioners do not accept clients covered by Medicaid. In addition, there are few specialists for children with special health needs, except in the Portland metropolitan areas. An additional factor that contributes to timely delivery of services or referrals to specialists is complicated by reliable transportation, remote and rural communities, and weather conditions in those rural areas. Low birthweight rates are increasing nationally for a variety of reasons, such as shortened gestational age, medical management of pregnancy, and multiple births. These are issues that are generally found in the population at large, not solely in the low income and uninsured population. While the disparity between Medicaid and non-Medicaid remains constant, further analysis will be conducted to determine the particular characteristics of the disparity to better understand areas to focus capacity building.

/2009/ Oregon continues to have lower low birthweight rates than the rest of the U.S. However, rate among African Americans, Native Americans and Asian/Pacific Islanders are higher than Oregon overall. (Oregon Perinatal Data Book, 2007. <http://www.oregon.gov/DHS/ph/pnh/databook.shtml>) //2009//

Health Status Indicators #03A-03C -- Child Deaths; and #04A-04C; Child Non-Fatal Injuries

Childhood injury rates have not changed significantly over the past few years. These data are used in Oregon to determine the effectiveness of current interventions and programs leveraged by Title V. Systems are in place to support education and awareness among parents, schools, health providers, and other service providers to prevent injuries including injuries sustained in motor vehicle crashes.

/2009/ A news release in April, 2008, reports that Oregon has reduced unintentional injury deaths to children by 54% since 1995, higher rate of decline than the 45% nationally. The leading injuries causing death during that time are motor vehicle deaths -- 44%; suffocation -- 18%; drowning -- 13%; fire -- 5%; and other land transport (primarily all-terrain vehicles) -- 4%. The reduction in deaths is credited to a multitude of efforts by individuals, community organizations, and governmental agencies. //2009//

Health Status Indicators # 05A-05B, Chlamydia rates

Chlamydia rates among teen and adult women for the past several years are unchanged. These rates reflect the extent of safe sex practices and awareness among women and their partners of sexually transmitted diseases. Oregon has a system in place through a variety of programs to provide outreach to women who may be at risk, such as family planning clinics, universities and school-based health centers, social service programs, and community venues.

/2009/ The Public Health Division is working with the Oregon Public Health Lab to support a new kind of Chlamydia test that does not require a pelvic exam. The availability of Nucleic Acid Amplification Tests (NAAT urine tests) is expected to increase both primary screening and re-screening rates by eliminating the need for women to undergo a pelvic exam. The Dept. of Human Services is submitting a Legislative Concept to amend Oregon law to allow for the practice of Expedited Partner Therapy (EPT) for treating the sexually transmitted infections (STIs) Gonorrhea and Chlamydia in Oregon. Permitting EPT gives medical providers one more tool to effectively treat STIs and reduce re-infection rates by allowing them to prescribe or dispense antibiotic therapy for the sex partners of individuals infected with Chlamydia and Gonorrhea, even if they have not been able to perform an exam of the patient's partner(s). //2009//

F. Other Program Activities

- MCH Toll-free Telephone Number: SafeNet was established in April 1991, and is funded jointly by the Title V and Title XIX Agencies. The service is provided through an interagency agreement with 211Info and the Office of Family Health. SafeNet, is designed to 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; and provide follow-up and advocacy to insure that clients statewide are able to access available services. Outreach for SafeNet occurs through Medicaid card messages and inserts (WIC, prenatal, flu, and dental), televised PSA's (both national and local), websites, DHS offices, OHP staff, 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. /2007/ Women's health resources are now included in the SafeNet database. SafeNet worked with an OFH data analyst to create a system to identify service gaps for women in the state by examining "unmet need" calls. //2007//

/2008/ SafeNet and OFH recognized that the number of Spanish speaking callers did not come close to representing the Spanish speaking population in Oregon. SafeNet collaborated with Migrant Head Start staff to conduct interviews and focus groups to define the problem. The result is a very successful design for an outreach campaign to promote SafeNet to low income Spanish speaking families in Oregon. //2008//

- The Immunization Program received a grant to study the immunization practices and beliefs of those parents who claim religious exemptions to school immunization requirements and a CDC Registry Sentinel Site Capacity Building Grant to improve immunization registry data quality and to provide support for routine analysis of immunization registry data. /2007/ The Immunization Program is shifting to CDC's vaccine distribution process to reduce the number of times vaccines change hands. Local health departments will receive vaccines directly from distributors, rather than through the state Immunization Program. Oregon and Washington immunization registries completed a Data Exchange to provide more complete shot histories for both states and avoid the cost of duplicating a child's shots. //2007//

/2008/ The Immunization Program is expanding access to free vaccines for underinsured children through the Vaccines for Children (VFC), in collaboration with county health departments and FQHCs. A study in early 2008 for a registry-based Reminder/Recall study will guide planning for expanding the ages and types of contacts made with parents to encourage timely immunizations. New school immunization requirements for hepatitis A, 2nd dose, Varicella, and pertussis will take effect in school year 2008-09. //2008//

The Oregon WIC Program was awarded a 3 year research grant to implement and evaluate the impact of peer counseling on breastfeeding duration among Oregon WIC clients. This study will use sound scientific methodology to answer important questions about effectiveness of peer counseling and support. /2007/ WIC entered its second year of a 3-year USDA funded study Breastfeeding Peer Counseling. This randomized control trial underway at three local WIC agencies seeks to determine the effect of telephone based peer support on the breastfeeding duration of Oregon WIC clients. //2007//

/2008/ WIC entered its third and a final year of a randomized control trial to determine whether telephone based peer counseling can increase breastfeeding duration and exclusivity among WIC clients in three study sites. Close to 2,000 women have been enrolled in the study, and preliminary results should become available before the end of the year. //2008//

- The Oregon WIC Program was also awarded a one year research grant to do an initial investigation of the development of a series of health messages to encourage fruit and vegetable consumption among families with young children. This study will address the questions around the best ways, messages, and message delivery to encourage low income families to eat more fruits and vegetables. /2007/ In September 2005, WIC was awarded funding by USDA to conduct a three-year research study titled "Using Motivational Interviewing and Boosters to Increase the Offering of Fruits and Vegetables by WIC Parents of Preschoolers." The goal is to integrate these practices into WIC nutrition education programming. The first local agency piece is beginning in late summer of 2006. //2007//

/2008/ The three local agencies participating in this study received initial training in motivational interviewing, followed by monthly continuing education pieces created by state staff. Although study results will not be available until 2008, early feedback from local agency staff show the technique to be highly popular and is perceived by local staff as being a more effective way of counseling clients. //2008//

/2009/ The Womens' and Reproductive Health Section was awarded a 5 year grant from the Centers for Disease Control and Prevention (CDC) to implement a WISEWOMAN program here in Oregon to decrease the risk of heart disease and strokes among low-income women by promoting early detection and prevention. The work under this grant will provide cardiovascular risk factor screening, risk reduction, and access to treatment to low-income, uninsured/under insured women 40 - 64 years of age currently receiving services through the Oregon Breast and Cervical Cancer Program. //2009//

/2009/ OCCYSHN's CaCoon program has begun to establish an active relationship with the Exceptional Needs Care Coordinators on behalf of Title V CSHCN's population. ENCCs were invited and attended the annual OCCYSHN conference in which they were introduced

to the CaCoon program and its support materials around care coordination for CYSHN and their families. This effort will be continued as a partnership in assuring effective care coordination for this population. //2009//

G. Technical Assistance

Oregon's Title V technical assistance requests are to support agency and program efforts to address priorities, conduct ongoing assessment, planning, improve services design and delivery, and develop evaluation and leadership competence.

Perinatal Depression Symposium

A state and local public health nurse work group has developed recommendations and action plan on improving abilities to address perinatal depression. The desired outcomes of the symposium are to improve capacity to deliver perinatal depression information, increase understanding of perinatal depression among Oregon health providers and professionals, increase investment at state and local levels to address perinatal depression, and develop ongoing partnerships and networks for addressing perinatal depression.

Purpose: One of the activities is to develop and co-sponsor an Oregon Perinatal Depression Symposium targeted at a broad range of providers.

Supports: General system capacity issue

Proposed Consultants: A nationally recognized expert in perinatal depression to be the keynote speaker at the symposium

Intimate Partner Violence/Child Abuse Training

Public Health Nurses (PHN) who conduct home visiting with at-risk families often encounter a variety of home life situations that can have an emotional impact on the Nurse. While professional, some PHNs may be inexperienced in how to handle the emotional impact they experience and/or provide appropriate plans of actions for clients, especially for those living in rural communities.

Purpose: Training for county PHNs is needed to help them deal with IPV, CA and strategies for helping clients get the services they need, especially small and rural communities.

Supports: General system capacity issue

Proposed Consultants: Expert in risk communication for health professionals or related field

Program Evaluation Capacity Assessment

OCCYSHN is improving its program evaluation capacity to better assess effectiveness of program activities and identify key variables that require its ongoing surveillance and assessment.

Purpose: An assessment of the OCCYSHN evaluation capacity is needed to strengthen the ability to accurately profile the health needs of the CYSHN population. Consultation and technical assistance is needed to develop the Center's program evaluation, data analysis, and surveillance capacity and leadership.

Supports: Data-Related Issues

Proposed consultant: External consultant in surveillance, program evaluation, and assessment capacity building

Surveillance and Evaluation Capacity Improvement

The Title V Program in the Office of Family Health is continuing to build its capacity in surveillance, assessment and program evaluation. A new Evaluation Unit is in its formative stage and one of its needs is to build a team of surveillance and evaluation experts that are cross-trained in skills.

Purpose: External consultation is needed to train program evaluator professionals in population data analysis methodologies and to train population data professionals in program evaluation methodologies.

Supports: Data-Related Issues

Proposed consultant: External consultant in evaluation assessment and capacity building

Strategic Plan for 2010 MCH Needs Assessment

Oregon's Title V Program would like to create a strategic plan for the next five-year needs assessment, including identifying data analyses that need to occur and opportunities for qualitative input on the priorities of stakeholders and the public. This will allow for a more in-depth assessment directed at policy and program planning and implementation. The plan should include methodologies, process, timelines and resource/staffing needs for data collection and analysis, shared local/state MCH priority setting, system of care capacity assessment, evidence-based intervention and program analysis, and expected assessment outcomes.

Purpose: To prepare an assessment plan relevant to current and emerging priorities and issues

Supports: Needs Assessment

Proposed consultant: Evaluator and/or planner to work with Title V Leadership and staff in a retreat to develop a strategic plan for the five-year needs assessment

Family Professional Partnerships

OCCYSHN, in coordination with the OFH, is working to enhance Family Professional Partnerships (FPP) and the inclusion of families as necessary and critical partners in decision making all levels. OCCYSHN's Family Involvement Network provides coordination and expert consultation on efforts addressing FPP and the inclusion of families in the care and decision making of their children. OCCYSHN is requesting technical assistance to address the importance and benefits of FPP within clinical and public health arenas, as well as strategies for economic sustainability. OCCYSHN also seeks assistance in strengthening its ability to effectively engage and disseminate this model to practices and programs throughout Oregon.

Purpose: Increase involvement of families across all Title V programs

Supports: National Performance Measures 2, Families will be involved in decision making and are satisfied with services and NPM 5, Families report that community-based service systems are organized so they can use them easily.

Proposed Consultant: This request would be most beneficial if it included a team that included a Pediatric and or Family Practice Physician Champion and a Family Leader. Dr. Rich Antonelli is recommended as a Physician Champion and Christie Blakely or Eileen Forlenza from Colorado as Family Leaders.

V. Budget Narrative

A. Expenditures

The expenditures for the Federal/State Partnership 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 match also includes expenditures in local health departments not reimbursed by federal funds, including those matching funds received by the county for Targeted Case Management and Medicaid Administrative Match. The State MCH Funds are a combination of state general funds, other non-federal grant funds to the state, and county expenditure and revenue reports submitted to the Public Health Division for Perinatal, Babies First, and School Based Health Centers programs. County reports do not separate these revenue sources when reporting expenditures, therefore the revenue reports are used in both budget and expenditures as part of the MCH state match.

The expenditures and the budget for the Federal/State Partnership are prorated among populations:

- Pregnant Women: Perinatal Program (Block Grant and General Funds)
- Children <1 year: Babies First! Clients < 1 year (General Funds); Public Health Lab Newborn Screening (Other Funds - Fees)
- Children 1-22 years: Babies First! Clients > 1 year (General Funds); Child and Adolescent Health, Injury Prevention, Oral Health, Teen Pregnancy Prevention, Suicide Prevention (General Funds); School Based Health Centers (General Funds); Immunization (Block Grant portion);
- CSHCN: CaCoon, Community Connections (Title V Block Grant, Clinical Fees, mandated state general fund 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 to the type of activities occurring in the state-level programs. OCCYSHN programs are allocated approximately 10-15% 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). This report should be considered preliminary since the expenditures for the most recent Federal Fiscal Year were not closed at the time of reporting. The expenditures for FY 2004 are based on expenditures to date (May, 2005) for the period October 1, 2003 to September 30, 2004. /2007/ Expenditures for FY 2005 are for the period October 1, 2004 through September 30, 2005. /2008/ Expenditures for FY 2006 are for the period October 1, 2005 through September 30, 2006. //2008// **/2009/ Expenditures for FY 2007 are for the period October 1, 2006 through September 30, 2007. //2009//**

B. Budget

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 in local health departments using revenue from matching funds received by the county for Targeted Case Management and Medicaid Administrative Match.

The expenditures and the budget for the Federal/State Partnership are prorated among

populations:

- Pregnant Women: Perinatal Program (Block Grant and General Funds)
- Children <1 year: Babies First! Clients < 1 year (General Funds); Public Health Lab Newborn Screening (Other Funds - Fees)
- Children 1-22 years: Babies First! Clients > 1 year (General Funds); Child and Adolescent Health, Injury Prevention, Oral Health, Teen Pregnancy Prevention, Suicide Prevention (General Funds); School Based Health Centers (General Funds); Immunization (Block Grant portion);
- CSHCN: CaCoon, Community Connections (Title V Block Grant, Clinical Fees, mandated state general fund 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 to the type of activities occurring in the state-level programs. OCCYSHN programs are allocated approximately 10-15% in Enabling services and the remainder in Infrastructure services.

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 OCYSHN for serving the children with special health care needs. No administrative or indirect is retained prior to transfer. The required Maintenance of Effort for Oregon is \$3,950,427 and the DHS, Office of Family Health assures this minimum through funds generated at the state and local levels that benefit the maternal and child health population. The state meets the required three-for-four dollar match. Source of funds for match are state general funds and county local funds, including patient fees, local general funds, and non-Medicaid 3rd-party payments. The Oregon Legislature appropriates the state funds on a biennial basis and the state appropriates funds for local grants on an annual basis.

The proposed MCH budget is estimated using the Legislative Approved Budget for the 2003-05 biennium for the Office of Family Health. At the time of preparation, the 2005-07 Governor's Recommended Budget was not approved by the Legislature. The budgeted amounts are calculated to be half of the legislative approved spending limitation. /2007/ The FY 2007 budget is based on the LAB for the 2005-07 Biennium. //2007//
/2008/ The Budget for FY 2008 is based on the Governor's Recommended for state biennium 2007-2009. The Legislative Approved Budget, approved June 29, 2007, does not differentiate substantially from the Governor's recommended. //2008//
/2009/ The budget for FY 2009 reported in Forms 2-5 are based on 50% of the Legislative Approved Biennial Budget adopted in July 2008. The level of the Block Grant is based in the current FY 2008 award as the FY 2009 budget for Title V is not approved at the time of this writing. //2009//

/2007/ The Title V Program in the Office of Family Health has not yet determined extent of cuts to the Block Grant in FY 2006. Oregon will be analyzing state level programs and activities early next federal fiscal year. Because of concurrent cuts in the state general fund and the phasing out of other grants, funds from other sources will not be available to backfill losses in Title V. //2007//

/2008/ OFH has managed Block Grant reductions through cost savings across the office, which include those savings resulting from staff vacancies and delays in purchasing supplies and equipment. OFH has also targeted other state level funding sources to backfill Block Grant reductions. For FY 2008, OFH will continue to shift costs where possible, but retains the strategy to not reduce contracted levels with county health departments. //2008//

/2009/ The OFH Budget was increased by the Legislature for the 2007-09 biennium, with an increase to expand School-Based Health Centers to \$5.6 million a year. The CDC Physical Activity and Nutrition grant was not renewed for the Public Health Division,

accounting for about \$150,000 per year support in the Office of Family Health for child and adolescent nutrition activities and for breastfeeding promotion activities. Title V is backfilling these activities for now. The CDC Coordinated School Health grant was not renewed for Oregon creating a shortfall for the Healthy Kids Learn Better program. This program is being supported with Tobacco Prevention funds and state General Funds. On the other hand, new funds have been received for chronic disease management in a CDC Wisewoman grant. Pending grants are the CDC Genomics grant, CDC Oral Health Grant, HRSA First Time Mothers grant, and the ACYF Evidence-Based Home Visitation Grant.
//2009//

/2009/ Affecting 2009 and the future are the cuts to county health department revenues due to the lack of federal renewal of timber tax revenue payments. This revenue will drastically reduce about a third of Oregon's counties' revenues that support public health, thus reducing their expenditures and ability to provide a share of the financial match for Title V, but also for other federal grants and Medicaid Administrative Match dollars. The actual impact is unknown at this time, and federal legislation is pending to cover one-more-year of the revenue, though it was not passed in time to meet the July 1, 2008 budget deadline for most county budgets. The timber tax revenue payments were established in the 1990's to help counties where the timber industry was severely cut. These counties subsequently utilized these federal revenues for local services rather than levy local taxes.
//2009//

/2007/ For OCCYSHN, reduction in Title V block grant funds to Oregon resulted in a decrease in the CDRC outpatient clinic support. The 2004-05 quality improvement exercise will be a starting point to evaluate how clinic dollars are spent by disciplines providing clinic services that are not reimbursed. It is anticipated that the revenue generated from an increase clinical services and better provider documentation will increase reimbursement and benefits counseling/advocacy will offset the reduction.

The annual Family Support Program funds were decreased. This program has been in operation for three years, and was under spent in the past. However, with the increase in the uninsured and increase in out-of-pocket expenses by families, combined with more word of mouth advertising of Family Support Program (FSP), it is anticipated that the funds will be fully utilized this year. Improved data collection and analysis is being pursued this year to provide a better understanding of expenditures from FSP funds. Reports and comments from families who have received these limited support dollars are very positive and indicate that services and products result in improved for quality of life.

Both the CaCoon program and Community Connections Network will be funded with a small cost-of-living increase. These two programs have been flat funded for the past two years despite increase in caseloads and services delivered. The formula used to determine the CaCoon Care Coordinator funding for each county will be reassessed and updated to reflect current population shifts and demographics including poverty and anticipated number of children with special health needs. The planned expansion of the Promatora program to additional counties (currently there are 4 counties that participate in this program) has been delayed to provide evaluation of funds available.

The OCCYSHN strategic plan will evaluate training needs over the next five years that will optimize skill building in a cost efficient manner. Face-to-face meetings are preferred by most partners, but travel expenses and time away from work site have created challenges in scheduling meetings. OCCYSHN will explore other options and evaluate the best venue for the proposed material/training. A partnership with Office of Family Health, Oregon Department of Education, Oregon Mental Health and Addictive Services and Oregon Family Voices will be able to reduce overhead cost of meetings. In previous years, Community Connections Network teams have been offered two Continuing Medical Education events per community per year. However, with the reduction in the Block Grant funds, combined with an increase cost of CME credits, each

community will be offered only one program of their choice, with a certificate of attendance offered rather than CME credits. OCCYSHN staff will partner with hospital and Medical groups to offer CME for physicians to encourage engagement in the training opportunities offered through the Center. Additional training opportunities may be available to CCN teams through the integrated services grant, SOCs. //2007//

/2008/ Financial support to the CDRC clinics will remain the same with no further reduction. Both the CaCoon and Community Connections Clinics will be funded without a cost of living increase due to budget constraints.

//2008//

/2009/

The 1.7% reduction in MCH funding to the Title V Block Grant along with the corresponding state match, resulted in an overall reduction in OCCYSHN's budget for FY09 of \$64,250. As a result of these reductions, further reductions were made to the financial support to the CDRC Clinics. CaCoon, Community Connections Network Teams and the Family Support Program dollars will remain constant. To the extent it is considered effective and feasible given the many rural areas into which OCCYSHN seeks to take its training programs, distance learning methods will be employed to the fullest extent possible. Community Connections Network teams will be offered one educational or consultation program of their choice, and one staffed by an OHSU- CDRC clinician. This will be the first year in nearly 10 years in which the OCCYSHN will not have additional MCH dollars from integrated services grants or other sources of funding which have supported targeted curriculum and training development activities with which to extend its activities beyond a small no-cost extension to complete activities during FY09. The timber revenue cuts will significantly impact communities in their abilities to sustain their activities on behalf of CYSHN. Airline travel to rural communities will be eliminated or reduced significantly to make on-site work more difficult to achieve within budget realities. The ongoing in-kind support provided by community partners becomes ever more significant in OCCYSHN's ability to affect services through collaborative efforts at the community level. OCCYSHN will continue to apply for supplementary funding to supplement its activities. OCCYSHN will look toward continued partnerships, such as with Family Voices centered on family trainings, to continue its efforts.

//2009//

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.