Oregon State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
High quality, culturally responsive preconception, prenatal and inter-conception services	By October 1, 2025 increase the percent of women with a past year preventive medical visit from 70.8% to 77.0%, through improved accessibility, quality, and utilization.	1. Strengthen early identification of and supports for women's behavioral health needs 2. Support advanced training, coaching and quality improvement activities for home visitors related to well woman care. 3. Ensure access to culturally responsive preventive clinical care for low income and undocumented women. 4. Establish community based perinatal, women's and infant health advisory groups to share best practices, strategize and impact policy change. Engage affected communities including people of color in leadership. 5. Partner with Maternal Mortality Review Committee to understand contributing factors to maternal morbidity and mortality (state only).	ESM WWV.1 - Percent of new mothers who have had a postpartum checkup. ESM WWV.2 - Among local grantees who select well woman care, percent who report improved knowledge, skills, or policies based on provided technical assistance. ***Inactive -*** *ESM WWV.3 - Completion of environmental scan of organizations and partners to facilitate determination of Title V's role in increasing diversity in the perinatal workforce.* ESM WWV.4 - Number of OHA Office of Equity and Inclusion certified community health workers and doulas.	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

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			Inactive - *ESM WWV.5 - Completion of environmental scan to determine role of Title V in perinatal behavioral health.*		NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression,

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					Formerly NOM 24) - PPD
High quality, culturally responsive preconception, prenatal and inter-conception services	A) By October 1, 2029 increase the percent of women who attended a postpartum checkup within 12 weeks of giving birth from 90.8% to 92.8%. B) By October 1, 2029 increase the percent of women who attended a postpartum checkup and received recommended care components from 86.0% to 88.5%.	Gather information to inform future strategies and activities to improve postpartum care access and quality. Support advanced training, coaching and quality improvement activities for home visitors related to postpartum care.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Improved lifelong nutrition	By October 1, 2025 increase the percent of infants who are ever breastfed from 93.5% to 94.4%; and increase the percent of infants breastfed exclusively through 6 months from 31.6% to 37.0%.	1. Promote & support laws and policies for pregnant & lactating people in the workplace. Focus on populations with additional barriers. 2. Support advanced training, coaching and quality improvement activities for home visitors related to chest/breastfeeding. 3. Ensure that providers who serve tribal members have training in culturally specific approaches to promotion and support of lactation. 4. Ensure access to culturally responsive preventive clinical care for low income and undocumented individuals. 5. Establish community based perinatal, women's and infant health advisory groups to share best practices, strategize and impact policy change. Engage affected communities including people of color in leadership.	ESM BF.1 - Breastfeeding initiation among Non-Hispanic Black mothers. ESM BF.2 - Breastfeeding initiation among Non-Hispanic American Indian/Alaska Native mothers. ESM BF.3 - Exclusive breastfeeding at 6 months among Non-Hispanic Black mothers. ESM BF.4 - Exclusive breastfeeding at 6 months among Non-Hispanic American Indian/Alaska Native	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

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			mothers. ESM BF.5 - Among local grantees who select breastfeeding, percent who report improved knowledge, skills, or policies based on provided technical assistance. ***Inactive -*** *ESM BF.6 - Completion of environmental scan of organizations and partners to facilitate determination of Title V's role in increasing diversity in the perinatal workforce.* ESM BF.7 - Number of OHA Office of Equity and Inclusion certified community health workers and doulas. ***Inactive -*** *ESM BF.8 - Number of providers engaged in anti-racism or cultural humility training.*		
Child Health					
Safe and supportive environments	By October 1, 2025, decrease the rate of hospitalization of 0 to 9 year old children for non-fatal injuries	1. Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.	ESM IH-Child.1 - Injury death rate among children 0 - 9	NPM - Rate of hospitalization for non-fatal injury per 100,000 children,	NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM

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	from 127.1 to 121.0, by addressing upstream drivers of child injury.	2. Strengthen workforce capacity to address child injury prevention at the state and local level. 3. Strengthen partnerships to support child injury prevention. 4. Develop, implement and/or promote education and communication strategies for child injury prevention. 5. Improve data collection, analysis, interpretation, and dissemination ot child injury data to focus prevention efforts.	years of age ESM IH-Child.2 - Transportation injury death rate among children 0 - 9 years of age ESM IH-Child.3 - Drowning death rate among children 0 - 9 years of age ESM IH-Child.4 - Poisoning injury rate among children 0 - 9 years of age ESM IH-Child.5 - Among local grantees who select child injury prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance ***Inactive -*** *ESM IH-Child.6 - Percent of engaged partner groups including other state agencies, local grantees, and marginalized community representatives, that report satisfaction*	ages 0 through 9 (Injury Hospitalization - Child, Formerly NPM 7.1) - IH-Child	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

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			with level of engagement in the development of a collaborative child injury report. ***Inactive -*** *ESM IH-Child.7 - Completed assessment of injury prevention risk assessment, education, and remediation in Oregon's public health home visiting programs.*		
	By October 1, 2029 increase the percent of all children, ages 0 through 17, who have a medical home, from 50.4% to 55.4%.	Expand the medical home work currently being done in CYSHCN domain to include children and adolescents ages 0-17. Complete Oregon's 2025 Title V Needs Assessment, identifying need and strategies for this priority area.	ESM MH.1 - Primary care involvement in shared care planning	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the

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					past year (Forgone Health Care, Formerly NOM 25) - FHC
Adolescent Health					
Stable and responsive relationships; resilient and connected children, youth, families and communities.	By October 1, 2025, decrease the percentage of adolescents age 12-17 who bully others from 16.3% to 12.4%, and decrease the percentage of those who are bullied from 47.9% to 30.0%.	1. Support the workforce to understand the impact of bullying on adolescent health. 2. Support bullying prevention education in schools. 3. Determine gaps and opportunities for bullying prevention partnerships and initiatives with internal and external partners. 4. Support youth participatory action research on bullying prevention.	ESM BLY.1 - Percent of 8th and 11th graders who have experienced bullying. ESM BLY.2 - Percent of 8th and 11th graders who have experienced bullying due to their race or ethnicity. ESM BLY.3 - Percent of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity. ESM BLY.4 - Percent of 8th and 11th graders who have experienced bullying due to a disability. ESM BLY.5 - Among local grantees who select bullying prevention, percent who report improved knowledge, skills, or policies based on provided technical	NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

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			assistance. ESM BLY.6 - Completion of environmental scan of youth serving agencies. ESM BLY.7 - Number of activities completed that increase local access to bullying prevention resources.		
Children with Special Health Care Needs					
High quality, family-centered, coordinated systems of care for children and youth with special health care needs	By September 2025, 40% of shared care plans will have a representative of primary care help LPHAs prepare for or participate in shared care planning meetings	Strategy 11.1: We will improve access to family-centered, team-based, cross-systems care coordination* for CYSHCN and their families through workforce development and financing activities.	ESM MH.1 - Primary care involvement in shared care planning	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care,

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					Formerly NOM 25) - FHC
High quality, family-centered, coordinated systems of care for children and youth with special health care needs	By 2025, 60% of young adults with medical complexity (YAMC) or their families enrolled in transfer of care intervention will participate in their scheduled preparation appointments.	Strategy 12.1. We will increase the number of YSHCN and their families who receive information about transition to adult health care from their providers through family-informed workforce development, quality improvement, systems incentives, and family awareness activities.	ESM TR.1 - Young adult with medical complexity/family participation in transition preparation appointments	NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
Cross-Cutting/Systems Building					
Stable and responsive relationships; resilient and connected children, youth, families and communities.	By October 1, 2025 decrease the percentage of new mothers who experienced stressful life events before and during pregnancy from 44.8% to 38.0%.	OCCYSHN will promote trauma-informed care for CYSHCN and their families by incorporating a family-informed, trauma-informed lens to workforce development activities. MCAH Foundations - community, individual and family capacity: Support/fund programs - such as home visiting - that engage families and build parent capabilities, resilience, supportive/nurturing relationships, and children's social-emotional competence. MCAH Foundations - community, individual and family capacity: Build community capacity for improved health, resilience, social/cultural connection and equity. MCAH Foundations - assessment & evaluation: Engage families and communities in all phases of MCAH assessment, surveillance, and epidemiology, including interpretation and dissemination of findings.		SPM 1: Percentage of new mothers who experienced stressful life events before or during pregnancy	
Enhanced equity and reduced MCAH health disparities.	By October 1, 2025 increase the percentage of children age 0-17 who have a healthcare provider sensitive to their family's values and customs from 94.0% to 95.2%.	OCCYSHN will improve CYSHCN and their families' access to culturally sensitive and responsive care through workforce development. MCAH Foundations - policy & systems: Strengthen economic supports for families through policy development, implementation, and promotion. MCAH Foundations - policy & systems: Develop and/or strengthen systems and partnerships to promote food sovereignty, and to address food security and systemic barriers to accessing food resources.		SPM 2: Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs	

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		MCAH Foundations - policy & systems: Foster cross-system coordination and integration to ensure screening and referral for SDOH, and equitable access to needed services for the MCAH population. MCAH Foundations - policy & systems: Develop and implement systems that actively promote equitable, anti-racist, and trauma-informed workplaces, institutions, and services. MCAH Foundations - policy & systems: Strengthen policies and systems that provide equitable access to safe, stable and affordable housing for the MCAH population. MCAH Foundations - workforce capacity & effectiveness: Advance the skills and abilities of the workforce to deliver equitable, trauma informed, and culturally and linguistically responsive services. MCAH Foundations - workforce capacity & effectiveness: Implement standards for workforce development that address bias and improve delivery of equitable, trauma-informed, and culturally and linguistically responsive services. MCAH Foundations - workforce capacity & effectiveness: Support efforts to expand capacity and improve diversity in the workforce. MCAH Foundations - assessment & evaluation: Ensure all Title V performance measurement and evaluation includes a health equity focus which leads with race and ethnicity to identify and address disparities.			
Enhanced social determinants of health	By October 1, 2025, decrease the percentage of households with children that receive food or cash assistance from 42.3% to 41.3%.	OCCYSHN will increase access to needed care and supports through investigation of barriers that inhibit CYSHCN and their families' timely access, and develop family-informed activities to reduce or eliminate the barriers. Foundations - policy & systems: Strengthen economic supports for families through policy development, implementation, and promotion. Foundations - policy & systems: Develop and/or strengthen systems and partnerships to promote food sovereignty, and to address food security and		SPM 3: Percent of children living in a household that received food or cash assistance	

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		systemic barriers to accessing food resources. Foundations - policy & systems: Foster cross-system coordination and integration to ensure screening and referral for SDOH, and equitable access to needed services for the MCAH population. Foundations - policy & systems: Develop and implement systems that actively promote equitable, anti-racist, and trauma-informed workplaces, institutions, and services. Foundations - policy & systems: Strengthen policies and systems that provide equitable access to safe, stable and affordable housing for the MCAH population. Foundations - assessment & evaluation: Conduct continuous needs assessment and/or analysis to add to the Foundations of MCAH (SDOH, Equity, CLAS, and Trauma/ACES) knowledge base and improve effectiveness of Title V interventions and innovations.			