Oregon State Action Plan Table 2026 Application/2024 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 person-centered preconception, prenatal, interconception and postpartum services	A) By October 1, 2030 increase the percentage of women who attended a postpartum checkup within 2 weeks after giving birth from 90.9% to 91.8%. B) By October 1, 2030 increase the percentage of women who attended a postpartum checkup and received recommended care components from 76.2% to 81%.	1. Build infrastructure for the Postpartum Care priority area that addresses staff capacity, roles, and the goals that will be developed to address Postpartum Care needs of the MCAH population. 2. Develop both state and local level strategies and measures for the Postpartum Care priority area through community and partner engagement. 3. Provide support to Title V grantees as they prepare for and begin implementation of local level work within the Postpartum Care priority area.	ESM PPV.1 - Percent of individuals engaged in strategy development who are external partners.	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Perinatal/Infant Health					
Enhanced environmental and social drivers of health.	By October 1, 2030, decrease the percentage of women with a recent live birth who experienced housing instability in the 12 months before a recent live birth from 8.8% to 8.3%.	1. Build infrastructure for the Housing Instability priority area that addresses staff capacity, roles, and the goals that will be developed to address Housing Instability for the MCAH population. 2. Develop both state and local level strategies and measures for the Housing Instability priority area through community and partner engagement. 3. Provide support to Title V grantees as they prepare for and begin implementation of local level work within the Housing Instability priority area. 4. Build on existing state level work by strengthening policies and systems that enhance access to safe, stable, and affordable housing for the MCAH population.	ESM HI-Pregnancy.1 - Percent of individuals engaged in strategy development who are external partners.	NPM - Housing Instability - Pregnancy	**Linked NOMs:** Severe Maternal Morbidity Maternal Mortality Low Birth Weight Preterm Birth Stillbirth Perinatal Mortality Infant Mortality SUID Mortality Neonatal Abstinence Syndrome Postpartum Depression Postpartum Anxiety
Child Health					
Improved	By October 1, 2030, increase the	1. Build infrastructure for the Food Insufficiency priority area that	ESM FS.1 - Percent	NPM - Food Sufficiency	**Linked NOMs:**

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lifelong nutrition.	percentage of children, ages 0 through 11, whose households were food sufficient in the past year from 72.4% to 77%.	addresses staff capacity, roles, and the goals that will be developed to address Food Insufficiency for the MCAH population. 2. Develop both state and local level strategies and measures for the Food Insufficiency priority area through community and partner engagement. 3. Provide support to Title V grantees as they prepare for and begin implementation of local level work within the Food Insufficiency priority area. 4. Build on existing state level work by continuing to strengthen partnerships developed while working on the previous state priority of Foundations – nutrition and food insecurity. 5 Build on existing state level work by facilitating networking calls among local grantees working on the state priority of Foundations – food insecurity to help inform new strategy development.	of individuals engaged in strategy development who are external partners.		School Readiness Children's Health Status Behavioral/Conduct Disorders Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All Adverse Childhood Experiences
High quality, family-centered, coordinated systems of care for children, youth and families.	A) By October 1, 2030, increase the percentage of children with special health care needs, ages 0 through 17, who have a medical home, from 41.8% to 42%. B) By October 1, 2030, increase the percentage of all children, ages 0 through 17, who have a medical home, from 47.9% to 52%.	1. Build infrastructure for the Medical Home (ages 0-17) priority area that addresses staff capacity, roles, and the goals that will be developed to address Medical Home (ages 0-17) for the MCAH population. 2. Develop both state and local level strategies and measures for the Medical Home (ages 0-17) priority area through community and partner engagement. 3. Provide support to Title V grantees as they prepare for and begin implementation of local level work within the Medical Home (ages 0-17) priority area. 4. Build on existing state level work by identifying ongoing medical home efforts and opportunities for expansion to children with or without special health needs, supporting programming efforts, and aligning with partner programs for collaboration on shared projects.	***Inactive -*** *ESM MH.1 - Primary care involvement in shared care planning*	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Adolescent Health					
Resilient and connected youth	By October 1, 2030, increase the percentage of adolescents who receive needed mental health treatment or counselling from	1. Build infrastructure for the Adolescent Mental Health priority area that addresses staff capacity, roles, and the goals that will be developed to address Adolescent Mental Health for the MCAH population.	ESM MHT.1 - Percent of individuals engaged in strategy development who are	NPM - Mental Health Treatment	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death

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	74.8% to 79%.	2. Develop both state and local level strategies and measures for the Adolescent Mental Health priority area through community and partner engagement. 3. Provide support to Title V grantees as they prepare for and begin implementation of local level work within the Adolescent Mental Health priority area.	external partners.		Adolescent Injury Hospitalization Children's Health Status Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Children with Special Health Care Needs					
High quality, family-centered, coordinated systems of care for children, youth and families.	By October 1, 2030, 52% of children with special health care needs, ages 0 through 17, received needed care coordination.	Strategy 11.1.1. OCCYSHN will improve access to family-centered, team-based, cross-systems care coordination for CYSHCN and their families through workforce development and financing activities. Strategy 11.1.2. OCCYSHN will support a continuum of cross-systems care coordination efforts using evidence-informed approaches (at the local, regional and state level). Strategy 11.1.3. Workforce Development Strategy 11.2. Health in Education Strategy 11.3. Family Involvement and Leveraging Family-to-Family Health Information Center Grant Strategy 11.4. Community Engagement and Partnership Strategy 11.5. Systems and Policy Change Strategy 11.6. Assessment and Evaluation Strategy 11.7 Autism Assessment Strategy 11.8. Health Emergency Ready Oregon (HERO) Kids Registry	***Inactive -*** *ESM MH.1 - Primary care involvement in shared care planning* ESM MH_CC.1 - Children assessed for autism spectrum disorder by ACCESS teams.	NPM - Medical Home; Medical Home_Care Coordination	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
High quality, family-centered, coordinated	By October 1, 2030, 26% of adolescents with special health care needs, ages 12 through 17, received services to prepare for	Strategy 12.1. OCCYSHN will increase the capacity of the workforce serving youth with special health care needs to address the move from pediatric to adult health care.	***Inactive -*** *ESM TAHC.1 - Young adult with medical complexity/family*	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care

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systems of care for children, youth and families.	the transition to adult health care.	Strategy 12.2. Health in Education Strategy 12.3 Family Involvement and Leveraging Family-to Family Health Information Center Grant Strategy 12.4. Community Engagement and Partnership Strategy 12.5. Systems and Policy Change Strategy 12.6. Assessment and Evaluation Strategy 12.7. Randall Children's Hospital Every Step Clinic Strategy 12.8. PATH Project	*participation in transfer to adult health care preparation appointments* ESM TAHC.2 - Training participant knowledge about key moving to adult health care concepts.		
High quality, family-centered, coordinated systems of care for children, youth and families.	By October 1 2030, OCCYSHN will seat a total of fourteen CYSHCN Family Leaders on state, regional, agency, or organization workgroups or committees.	Strategy 1.1. Workforce Development Strategy 1.2. Health in Education Strategy 1.3. Family Involvement and Leveraging Family-to-Family Health Information Center Grant Strategy 1.4. Community Engagement and Partnership Strategy 1.5. Assessment and Evaluation Strategy 1.6. CaCoon Strategy 1.7. Medical Legal Partnerships Strategy 1.8. ACCESS Strategy 1.9. Optimal Health for All Workgroup	No ESMs were created by the State. ESMs are optional for this measure.	SPM 4: Number of state, regional, agency, or organization workgroups or committees that OCCYSHN works with to seat a CYSHCN Family Leader on	
High quality, family-centered, coordinated systems of care for	By October 1, 2030, increase the number of caregivers of CYSHCN served through CaCoon public health nurse home visiting from 67 to 77.	Strategy 2.1. Family Involvement and Leveraging Family-to-Family Health Information Center Grant Strategy 2.2. Community Engagement and Partnership Strategy 2.3. Systems and Policy Change	No ESMs were created by the State. ESMs are optional for this measure.	SPM 5: Number of caregivers of CYSHCN served through CaCoon public health nurse home visiting	

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children, youth and families.		Strategy 2.4. Assessment and Evaluation Strategy 2.5. Unmet Needs			
Cross-Cutting/Systems Building					
High quality, family-centered, coordinated systems of care for children, youth and families.	By October 1, 2030, increase the percentage of children who have a healthcare provider who is sensitive to their family's values and customs from 94.6% to 95.6%.	1. Build infrastructure for the Person and Family Centered Services and Care priority area that addresses staff capacity, roles, and the goals that will be developed to address Person and Family Centered Services and Care for the MCAH population. 2. Develop both state and local level strategies and measures for the Person and Family Centered Services and Care priority area through community and partner engagement. 3. Provide support to Title V grantees as they prepare for and begin implementation of local level work within the Person and Family Centered Services and Care priority area.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Percentage of children who have a healthcare provider who is sensitive to their family's values and customs.	
Stable and responsive relationships.	By October 1, 2030, increase the percentage of parents and caregivers who have someone they can turn to for emotional support with raising children from 79.8% to 84%.	1. Build infrastructure for the Parent and Caregiver Support priority area that addresses staff capacity, roles, and the goals that will be developed to address Parent and Caregiver Support for the MCAH population. 2. Develop both state and local level strategies and measures for this the Parent and Caregiver Support priority area through community and partner engagement. 3. Provide support to Title V grantees as they prepare for and begin implementation of local level work within the Parent and Caregiver Support priority area. 4. Build on existing state level work by identifying successful 2021-2025 Foundations of MCAH work spanning individual, family, community, and policy levels to carry forward. 5. Build on existing state level work by identifying Title V supported programs that support parents and caregivers, such as home visiting systems.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: Percentage of parents and caregivers who have someone they can turn to for emotional support with raising children.	
Resilient and	By October 1, 2030, increase the	1. Build infrastructure for the Safe and Healthy Environments priority area	No ESMs were	SPM 3: Percentage of	

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connected communities.	percentage of children that live in safe neighborhoods from 60.4% to 65%.	that addresses staff capacity, roles, and the goals that will be developed to address Safe and Healthy Environments for the MCAH population. 2. Develop both state and local level strategies and measures for this the Safe and Healthy Environments priority area through community and partner engagement. 3. Provide support to Title V grantees as they prepare for and begin implementation of local level work within the Safe and Healthy Environments priority area. 4. Build on existing state level child injury prevention work by providing technical assistance and data to local grantees, review and monitor ongoing legislation and policy changes, and participate in collaboration efforts with statewide partners.	created by the State. ESMs are optional for this measure.	children that live in safe neighborhoods.	