Oregon State Action Plan Table 2027 Application/2025 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 91.9%. 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 health education materials (e.g. brochures, videos, digital content) about perinatal mental health. 3. Expand access to community-based perinatal care including mental health care. 4. Support Traditional Health Workers (e.g. Community Health Workers, Doulas) to provide postpartum mental health screenings and support clients in accessing behavioral health services.	***Inactive -*** *ESM PPV.1 - Percent of individuals engaged in strategy development who are external partners.* ESM PPV.2 - Number of home visiting resources that have been improved or added to, to support home visitors in connecting their clients with postpartum care and postpartum mental health care.	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. Promote policies that increase access to safe, stable and affordable housing for families and individuals during pregnancy and early childhood. 2. Develop cross-sector systems, programs, and initiatives to meet the integrated housing and other service needs of the MCH population. 3. Develop or advocate for medical-legal partnerships to provide legal services to MCH clients with unsafe/unstable housing or at risk for eviction. 4. Work with housing advocates and shelter systems to address child/family	***Inactive -*** *ESM HI-Pregnancy.1 - Percent of individuals engaged in strategy development who are external partners.* ESM HI-Pregnancy.2 - Percent of partnerships in which opportunities for collaboration to	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

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		safety and other needs in the shelter system. 5. Enhance access to programs that address home safety and housing remediation concerns for the MCH community. 6. Provide screening, education, counseling, and referral to housing support services in MCH and other health care settings for those experiencing unstable housing.	support housing needs among women, families, and children in Oregon have been explored.		Postpartum Anxiety
Child Health					
Improved lifelong nutrition.	By October 1, 2030, increase the percentage of children, ages 0 through 11, whose households were food sufficient in the past year from 72.4% to 74%.	1. Increase the availability of fresh fruits and vegetables in low-income areas. 2. Promote local food production initiatives, particularly in low-income areas. 3. Support increased access and use of nutrition assistance programs. 4. Improve access and use of school, after school, and summer meal programs. 5. Increase Tribal food sovereignty through increasing access to traditional foods. 6. Collaborate with healthcare providers to screen for and address food sufficiency.	***Inactive -*** *ESM FS.1 - Percent of individuals engaged in strategy development who are external partners.* ESM FS.2 - Percent of pre-existing or new partnerships actively engaged or leveraged to promote food sufficiency resources, policies, or programming.	NPM - Food Sufficiency	**Linked NOMs:** 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 53%.	1. Advance policies and systems that promote continuous access to health insurance and medical homes. 2. Collaborate with partners to ensure children stay insured and have continuous access to a medical home. 3. Strengthen home visiting programs to support and ensure families have continuous access to a medical home.	***Inactive -*** *ESM MH.1 - Primary care involvement in shared care planning* ESM MH.2 - Percent of system level partners working on health care insurance access with whom the Title V team has advocated for medical home for children,	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			with and without special healthcare needs, 0 through 17.		
Adolescent Health					
Resilient and connected youth	By October 1, 2030, increase the percentage of adolescents who receive needed mental health treatment or counselling from 74.8% to 81%.	1. Strengthen the workforce to deliver youth-centered, responsive mental health services. 2. Support schools and communities to implement programs that build youth protective factors and resilience. 3. Elevate youth and family voice to shape and guide mental health initiatives 4. Promote awareness and reduce stigma around adolescent mental health. 5. Build and strengthen cross-system partnerships to address gaps in adolescent mental health services.	***Inactive -*** *ESM MHT.1 - Percent of individuals engaged in strategy development who are external partners.* ESM MHT.2 - Percent of Youth Advisory Council (YAC) members who agree the YAC has improved policy or practice regarding adolescent mental health and resources in Oregon.	NPM - Mental Health Treatment	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death 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	***Inactive -*** *ESM MH.1 - Primary care involvement in shared care planning* ESM MH.2 - Percent of system level partners working on health care insurance access with whom the Title V team has advocated for medical home for children, with and without special healthcare	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

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		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	needs, 0 through 17. ESM MH_CC.1 - Children assessed for autism spectrum disorder by ACCESS teams.		
High quality, family-centered, coordinated systems of care for children, youth and families.	By October 1, 2030, 26% of adolescents with special health care needs, ages 12 through 17, received services to prepare for the transition to adult health care.	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. 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	***Inactive -*** *ESM TAHC.1 - Young adult with medical complexity/family participation in transfer to adult health care preparation appointments* ESM TAHC.2 - Training participant knowledge about key moving to adult health care concepts.	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care
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	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	

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		Strategy 1.6. CaCoon Strategy 1.7. Medical Legal Partnerships Strategy 1.8. ACCESS Strategy 1.9. Optimal Health for All Workgroup			
High quality, family-centered, coordinated systems of care for children, youth and families.	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 Strategy 2.4. Assessment and Evaluation Strategy 2.5. Unmet Needs	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	
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 95.8%.	1. Build community capacity for health, resilience, social/cultural connection and optimal health for all. 2. Support policies to ensure systems are trauma-informed and promote optimal health for all. 3. Develop or promote initiatives that build individual, family and community resilience, and prevent health impacts of stressful life events. 4. Support and improve competencies of the MCAH and early childhood workforce to promote optimal health for all.	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. Develop or enhance cross-sector systems to support parents and caregivers in the community. 2. Build community capacity for programs or initiatives that support parents and caregivers. 3. Provide services that engage families and build parent capabilities,	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.	

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		resilience, supportive and nurturing relationships, and children's social-emotional competence (e.g. home visiting or parenting education). 4. Develop systems and policies to increase access to safe and affordable child care, and after school activities			
Resilient and connected communities.	By October 1, 2030, increase the percentage of children that live in safe neighborhoods from 60.4% to 66%.	1. Develop and implement policies to improve community safety and/or child health outcomes. 2. Coordinate systems to enhance access to resources for community violence and/or child injury prevention. 3. Implement or promote programs and initiatives that create safe and healthy environments and promote the prevention of child injury and community violence. 4. Create safe community spaces or events to promote recreation, physical activity, violence prevention and/or community connection. 5. Conduct assessment of local child injury safety and community violence needs and/or disseminate data to increase understanding and mobilize partnerships around safe and healthy environments.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 3: Percentage of children that live in safe neighborhoods.	