Maternal and Child Health Services Title V Block Grant

Oregon

FY 2023 Application/ FY 2021 Annual Report

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Table of Contents

I. General Requirements

I.A. Letter of Transmittal

PUBLIC HEALTH DIVISION
Center for Prevention and Health Promotion
Maternal and Child Health Section
Kate Brown, Governor

Oregon Health Authority

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July 13, 2022

Christopher Dykton, Interim Director, Division of State and Community Health
Maternal and Child Health Bureau, HRSA
5600 Fishers Lane, Room 18-31
Rockville, MD 20857

Dear Mr. Dykton:

Enclosed are the FY 2023 Maternal & Child Health (MCH) Title V Block Grant Application and FY 2021 Annual Report for the State of Oregon.

Title V funds provide critically needed funding to assure that health care gaps from changing demographics are addressed, along with building and supporting policy and program infrastructure changes that support communities and improved health outcomes. The Oregon Title V Agency continues to develop its processes and evaluation in the context of the priorities and performance measures.

Thank you for your consideration of this application.

Sincerely,

Cate Wilcox, MPH
Title V Director and MCH Section Manager
Center for Prevention and Health Promotion

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

III.A.1. Program Overview

Oregon's Title V framework and leadership role

Oregon's Title V program relies on shared leadership between the Oregon Health Authority (OHA) Public Health Division (PHD) Maternal and Child Section (MCH), its Adolescent and School Health program (ASHP), and the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) at Oregon Health and Science University's Institute on Development & Disability. A leadership team makes Title V program and policy decisions and ensures alignment across the programs and agencies. Designated state priority leads oversee state level program and policy work and provide technical assistance and oversight to local public health and tribal Title V grantees. Title V Maternal, Child and Adolescent Health (MCAH) also has a tribal liaison who supports the work of the tribal Title V MCAH grantees. The state priority leads, Title V coordinator, Title V MCAH and OCCYSHN Title V staff, and Title V MCAH tribal liaison coordinate work across populations/domains. MCAH work is also integrated and coordinated across priorities through perinatal and women's health, injury prevention, and foundations of MCAH teams.

Findings from the Title V five-year needs assessment guide the identification of Oregon's Title V needs and priorities. These in turn inform development of the structure and work of the program, guided by Title V staff and leadership, as well as grantees, families, and community partners. Ongoing needs assessment and surveillance activities are conducted in the interim years to support development of evidence based/informed activities, monitor progress, identify emerging issues, and modify approaches as needed.

Title V MCAH and OCCYSHN strategies, activities and measures are developed by Oregon's Title V subject matter experts, in consultation with researchers, MCHB, and state and local partners, and family and youth leaders. Thirty percent of Title V funding is allocated to OCCYSHN to address the Title V CYSHCN national and state-specific cross-cutting priorities at both the state and local levels. The remaining funds are administered through the OHA PHD to implement and monitor state and local level MCAH work in the maternal/women, perinatal/infant, child, adolescent, and cross-cutting domains.

Population needs, Title V priorities, strategies, and plans

Oregon's 2020 Title V Needs Assessment identified six national and three state-specific priorities for 2021-2025. These are: well woman care, breastfeeding, prevention of child injury and bullying, medical home and transition to adult health care for CYSHCN, toxic stress/trauma/ACEs, social determinants of health and equity, and culturally and linguistically responsive MCAH services (CLAS). An overview of Oregon's Title V MCAH priority needs, strategies, progress and plans for each domain is outlined below.

Maternal/Women's Health Domain

Oregon's Title V program provides leadership for policy and system development efforts in maternal/women's health including support for universally offered home visiting, maternal mortality review (MMRC), and ensuring that health system transformation addresses the need for comprehensive, culturally responsive women's and maternal health services.

Needs/priorities

Based on the 2020 MCAH needs assessment, high quality, culturally responsive preconception, prenatal and inter-conception services are a priority need for this maternal/women's health. This need is addressed through work on well-woman care (NPM 1). Social determinants of health; health equity; safe and supportive environments; stable and responsive relationships; and resilient, connected families and communities are cross-cutting needs that also impact this population and are being addressed through both NPM 1 and Oregon's cross-cutting systems domain work.

Strategies

Well woman care strategies focus on support for behavioral health needs; home visiting workforce development; access to culturally responsive preventive care for low income and undocumented women; and development/engagement of community based advisory groups.

Perinatal/Infant Health Domain

Title V provides leadership and technical assistance for linkages to prenatal care, oral health, maternal mental health, and other perinatal/infant services; infant mortality reduction; PRAMS and ECHO surveillance systems; early hearing detection and intervention (EHDI); breastfeeding support; Universally Offered Home Visiting, and integration of perinatal/infant health into programs and policies across state and local agencies.

Needs/priorities

Based on the 2020 needs assessment, improved nutrition is a priority need for perinatal/infant health, which is being addressed through work on breastfeeding (NPM 4). Social determinants of health; health equity; safe and supportive environments; stable and responsive relationships; and resilient, connected families and communities are cross-cutting needs that also impact this population and are being addressed through both NPM 1 and Oregon's cross-cutting/systems building work.

Strategies

Breastfeeding strategies focus on support/implementation of workplace laws and policies; workforce development including training and enhanced diversity; culturally appropriate approaches for work with tribal communities; access to culturally responsive preventive care for low income and undocumented women; and development/engagement of community based advisory groups. Additional food security strategies impacting this population are included in the Foundations of MCAH work within the cross-cutting domain.

Child Health Domain

Title V's work in child health focuses on increasing community and caregiver capacity to promote the foundations of health: stable responsive relationships, safe supportive environments, and nutrition and healthy behaviors. A major focus is integration of child health into programs and policies across state and local agencies, including the early learning and education systems.

Needs/priorities

Based on the 2020 needs assessment, enhancing safe and supportive environments; stable and responsive relationships; and resilient/connected families and communities are needs for Oregon's children. The need to address social determinants of health and health and equity also impact this population. These needs will be addressed through work on child injury (NPM 7), as well as through Oregon's cross-cutting/systems building work on the Foundations of MCAH.

Strategies

Child injury strategies focus on improved data capacity; use of child injury data to inform policy; enhanced workforce

capacity; partnerships and coalition-building including around shared risk and protective factors.

Adolescent Health Domain

Title V strengthens policies and systems that support adolescent health in school-based health centers, schools, health systems, and communities. The program engages youth to inform policies and programs that reflect their needs through youth advisory councils, focus groups, surveillance tools and youth action research.

Needs/priorities

Based on the 2020 needs assessment, enhancing safe and supportive environments; stable and responsive relationships; and resilient/connected families and communities are needs for Oregon's adolescents. The need to address social determinants of health and health equity also impacts this population. These needs will be addressed through work on bullying (NPM 9), as well as through Oregon's cross-cutting/systems building work on the Foundations of MCAH.

Strategies

Bullying prevention strategies focus on workforce development; bullying prevention education in schools; development of partnerships and shared initiatives; and Positive Youth Development strategies, including authentic youth engagement strategies and youth participatory action research.

Children and Youth with Special Health Needs (CYSHN) Domain

Title V CYSHCN provides leadership and support for the development of comprehensive, coordinated, family-centered systems of care that are culturally responsive for CYSHCN and their families. It leads efforts that support equitable access to care for CYSHCN, and partners with families and communities in policy and strategy development.

Needs/priorities

Based on the 2020 needs assessment, assuring high quality, family-centered, coordinated systems of care for CYSHCN, increasing health care equity and culturally and linguistically responsive services (CLAS), and reducing disparities are needs for Oregon's CYSHCN. These priorities will be addressed through work on NPMs 11 and 12 and all three state priorities.

Strategies

Medical Home (MH) strategies focus on increasing cross-systems care coordination (CSCC) for CYSHCN and their families through public health nurse home visiting; supporting local public health in convening cross-sector child health teams to implement family-centered shared care planning; supporting regional and state learning collaboratives and an online Community Health Worker curriculum to prepare the workforce to respond to the needs of the CYSHCN population; promoting regional and state level infrastructure development to support CSCC, including coordination of emergency care between families and providers; and leveraging the Oregon Family to Family Health Information Center to both support families of CYSHCN and incorporate their wisdom into the work.

Health Care Transition (HCT) strategies focus on developing the health care and public health workforces' ability to prepare youth with special health care needs (YSHCN) and their families for transferring from pediatric to adult health care. Strategies are integrated with those of MH, given their interrelationship. Quality improvement projects, begun as part of the Children with Medical Complexity CoIIN work focused on transition, will continue. ORF2FHIC is leveraged to continue to educate families and YSHCN about HCT and its importance.

Cross-cutting/Systems Building Domain

Oregon's Title V program uses a life course focus and equity lens to maximize investment in policies, systems and programs that support lifelong health. Work in this domain crosses all priorities and is the primary focus of the state-specific priorities.

Needs/priorities

Based on the 2020 needs assessment, Oregon's MCAH needs in the cross-cutting/systems domain include: enhancing safe and supportive environments; assuring stable, responsive relationships and resilient, connected families and communities; improving lifelong nutrition; increasing health equity; addressing social determinants of health and equity; and assuring high quality, culturally responsive preventive systems and services. These needs span the lifecourse and all MCAH populations. The Title V program addresses these needs through work in each of the domains and national priority areas, as well as through the work on Foundations of MCAH, which addresses state-identified priorities of toxic stress, trauma, ACEs and resilience; culturally and linguistically responsive MCAH services (CLAS), and social determinants of health and equity (SDOH-E).

Strategies

The OHA MCAH Title V program addresses cross-cutting domain priorities through a set of upstream "Foundations of MCAH" strategies. This approach reflects the integrated nature of work on social determinants of health and equity, trauma/ACEs, and equity/CLAS. Strategies are grouped as follows.

- Policy and systems strategies focus on equitable, anti-racist and trauma informed workplaces, institutions, and services; systems to integrate screening and referral for SDOH-E; housing, food systems, and economic supports for families.
- Workforce strategies focus on skills and abilities of the workforce to deliver equitable, trauma informed and culturally appropriate services, and standards to address these.
- Community, individual and family capacity strategies focus on programs (e.g., home visiting) and community strategies that promote family health, safety, protective factors, resilience, and equity.
- Assessment and evaluation strategies focus on development and use of data on social determinants of health, trauma, and equity to drive MCAH policy and programs.

OCCYSHN strategies to address SDOH-E, trauma/ACEs, and CLAS similarly focus on integration of strategies and systems across Title V work to support CYSHCN and their families.

Progress on State and National Performance measures

Title V MCAH and OCCYSHN staff monitor progress on state and national performance measures (SPMs and NPMs). Oregon's NPMs have shown mixed results during the past year. NPMS that have shown improvement include 1: well woman care, 4A: breastfeeding initiation, 4B: exclusive breastfeeding at 6 months, and 9: bullying. One NPM has worsened slightly; 7.1: child injury hospitalizations. The changes in NPMs are small and should be interpreted with caution.

Thirty-nine percent of CYSHCN had a medical home (NPM 11) in 2016-17 compared to 38% in 2019-2029 (National Survey of Children's Health). Meaningful improvement occurred between 2016-2017 and 2019-2020 on health care transition (NPM 12). During the former timeframe, only 17% of youth with special health care need received services necessary to make transitions to adult health care compared to 27% during the latter timeframe.

Among SPMs, two showed improvements. These were 2: children with a healthcare provider who is sensitive to their family's values and customs, and 3: children living in a household that received food or cash assistance. These improvements were both moderate and the small changes should be interpreted with caution. One SPM worsened;

1: prenatal stress. This increase may have been partially due to the stress brought on by the COVID-19 pandemic.

Title V partnerships and community engagement

Partnerships and community engagement are core to Oregon's MCAH Title V work. Our extensive array of partners, spanning family and community, local governments, tribes, and state and national agencies, is described in detail in Section III.A.2. of the grant narrative.

III.A.2. How Title V Funds Support State MCH Efforts

Title V funds complement and support overall state MCAH efforts. The 30% of funding that goes to OCCYSHN provides capacity for work with partners and local grantees on medical home and transition initiatives impacting CYSHCN; and expertise, advocacy, and partnership both within OHSU, and externally to strengthen systems and services, and improve and the health of children and youth with special health needs and their families.

The remaining 70% of Title V funding, administered through the OHA PHD, is used to support maternal, child, and adolescent health specialists, nurses, epidemiologists, and policy analysts working in: local health departments, tribes, and at the state level. The MCAH capacity provided through Title V supports work on the identified Title V priorities; ongoing MCAH assessment and surveillance, policy and partnership work; and multiple planning and system development efforts to which Title V staff contribute at the state and local level. The flexibility of the Title V program and funds have been critical to supporting Oregon's response to the COVID-19 pandemic at both the state and local levels. It has allowed for quick and nimble shifting of capacity to where it was most needed for both COVID-19 and wildfire emergency response, which was not always allowed with other federal grant funds.

Stakeholder engagement and partnerships are central to all phases of Oregon's Title V work, enabling Title V to leverage work across the state on behalf of the MCAH and CYSHCN populations. They enhance the scope and ability of Title V funding to impact the health of Oregon's women, children, youth, and families, including children and youth with special health needs. The Title V Director, CYSHCN Director, Adolescent Health Director, and Title V staff all work with external and internal stakeholders to provide MCAH leadership and ensure that Title V work is represented and integrated statewide. These partnerships – including with the Governor's Children's Cabinet, Coordinated Care Organizations, the Early Learning Division, local health authorities, and tribes - provide critical opportunities to leverage Title V's work and develop collaborations which benefit the MCAH population and maximize use of funds. This work - especially with families and communities - also informs ongoing needs assessment, strategy implementation, evaluation, and modification of strategies/activities throughout the 5-year cycle.

III.A.3. MCH Success Story

OCCYSHN is especially proud of two achievements since the last submission. First, an EMSC Innovation and Improvement Center (EIIC) grant was awarded by HRSA to further development of the HERO Kids Registry. This registry allows family members of CYSHCN to record critical information about their child's health, which is then available to emergency medical services and emergency departments. This grant and support from Title V enabled OCCYSHN to contract with a software developer, form advisory committees, and secure partnerships key to operating a statewide registry. Second, OCCYSHN developed and launched an online training for Community Health Workers (CHW) to prepare them to work with CYSHCN and their families. The CHW workforce helps local public health authorities by increasing local workforce capacity to serve a greater number of CYSHCN, often in a more culturally responsive manner. In addition to CHWs, OCCYSHN piloted the course with professionals and paraprofessionals in CCOs, primary care, community-based organizations, and education. It was learned that the course is relevant and useful to those in navigation roles across sectors. The curriculum will help build broad workforce capacity to coordinate care for CYSHCN across systems.

Oregon Title V's partnership with Medicaid has yielded several policy and system changes this year that will have long-term positive impacts on MCAH health and equity. Partners hold regular MOU meetings focused on identifying opportunities and strategies to support our shared populations. Over the past year Title V collaborated closely with Medicaid on Oregon's new 1115 waiver request, which includes continuous eligibility for children birth to 6, expanded age range and services for transition age CYSHCN (up to age 26), and other key strategies to address social determinants of health. Equally important, Oregon's Medicaid program decided not to include the EPSDT program in the waiver request – opening a door to strengthen EPSDT as a key prevention, diagnosis, and treatment program for children/families in Oregon. This is a significant change for Oregon, as implementation of EPSDT under the waiver had created equity barriers for families and confusion for providers. The MOU group will work with Medicaid over the coming year to support implementation of a comprehensive, visible, and equitable EPSDT program. Another achievement of this partnership was the appointment of Oregon's Title V's CYSHCN Director to the Medicaid Health Evidence Review Committee. This committee makes decisions about the prioritized list for Medicaid-covered services, and Dr. Hoffman, a practicing pediatrician, will provide a strong voice for both equity and CYSHCN at that critical table. Finally, Title V is working with Medicaid and Health Policy and Analytics to develop a Child Health Policy Option Package. If approved, the package will fund a Child Health team that works across OHA to promote policy, systems, data, and programs supporting child health.

OHA Adolescent and School Health created a statewide youth advisory council which will make decisions on how to invest $1 million to increase capacity in schools and communities to better serve youth and schools as they recover from the pandemic. In May 2022, OHA appointed 20 youth leaders representing identities and perspectives of communities across Oregon disproportionately impacted by COVID-19. The council will help define what recovery looks like, identify needs and health inequities that are priorities for youth, and improve state level community and youth engagement. All youth are paid for their time serving on the council and youth-driven community-based organizations will provide mentoring and support.

III.B. Overview of the State

Oregon's Demographics, Geography, Economy, and Urbanization

Demographics and Urbanization

Oregon's population of 4.2 million makes it 27th in population among US states. Oregon has large rural and frontier areas, resulting in an overall population density of 40 people per square mile. Oregon's population has increased faster than the national average and grown over 10% in the last decade. Growth has increased not only in urban, metropolitan areas but also in some rural areas. Approximately 65% of Oregonians live in urban areas, 33% live in rural areas and 2% live in frontier areas (Oregon Office of Rural Health). Population density ranges from about 4,228 persons per square mile in Portland to 7 persons per square mile in frontier areas and 23 persons per square mile in areas with 50,000 or less population (US Department of Agriculture). Portland is the largest metropolitan area, with about 2.5 million people. Other urban centers include Salem, the state capital, Eugene, in the mid-Willamette Valley, Bend, in Central Oregon, and Medford, in Southern Oregon. There are 9 Federally recognized Native American tribes in Oregon and Indian people from over 100 tribes make up the approximately 76,000 Native Americans and Alaska Natives living in Oregon. The Portland area has the 9th largest urban Native American population in the US, and 43-member tribes from Idaho, Oregon and Washington participate in the Northwest Portland Area Indian Health Board.

Oregon's population has been increasing at a faster pace than the U.S. population as a whole over previous decades. Higher population growth is associated with a healthy economy characterized by higher employment and overall economic prosperity. Additionally, faster population growth also exerts long-term effects on traffic congestion, expanding urban areas at the cost of diminishing agricultural land, greater demand for affordable housing, childcare services, and increased demand for public services, among others. Oregon's population change is greatly influenced by net migration. Currently, nearly 87 percent of population growth in Oregon is attributed to net in-migration. The contribution of migration in Oregon's population growth will play an enormous role once the natural increase (births minus deaths) is expected to turn negative in 2027. When that happens, then the entire increase in population will have to come from the migration component (Oregon Demographic Trends, 2019).

With increasing population mainly due to in-migration, Oregon's population is getting increasingly diverse in terms of race and ethnicity. Still, it remains one of the least diverse states in the country. In the 2020 Census, 75.1% reported as non-Hispanic White only, which has continued to decrease over time. Hispanics make up the largest minority population at 13.4%, more than doubling since the 2000 Census. Other races have slightly increased, with Asians at 4.9%, Native Hawaiian or Other Pacific Islander 0.5%, African Americans at 2.2%, American Indian/Alaska Natives at 1.8% and 2 or more races at 4%. Approximately 15% of Oregonians speak a language other than English at home and about 10% of the population is foreign-born. About 10% of the population under 65 years has a disability (US Census).

Oregon's birth rate is declining, following national patterns, with 47.8 live births per 1,000 women ages 15-44 compared to the national average of 55.8 for 2020 (Oregon Vital Statistics Annual Trends ; CDC provisional data ;). In 2020, Oregon had 39,817 resident births, of which 66.2% were non-Hispanic White, followed by 19.9% Hispanic, 5.3% Asian, 4.0% mixed race, 2.5% African American, 1% American Indian/Alaskan Native and 0.7% Native Hawaiian/Pacific Islander (Oregon Vital Statistics Annual Report). In 2020, 5.5% of the population was under 5 years of age, and 20.5% was under the age of 18 (US Census). Overall, the median age of Oregonians is 39.7 years, and as of 2017 the median age of mothers is 29 for all births (OVS, 2017).

Geography

At 96,981 square miles, Oregon is the ninth largest state in the U.S. Oregon's landscape varies from rainforest in the Coast Range to barren desert in the southeast. Oregon's large size and geographic diversity create challenges for the Maternal, Child, and Adolescent Health system, including the concentration of services in urban areas, geographic and weather barriers (including recent climate disasters like wildfires, extreme heat, and ice storms), to delivering and accessing health services, and issues related to workforce capacity and training needs varying vastly

in different regions of the state. Rural and frontier service areas have greater unmet need than urban areas (as determined by low score of 46.4 vs. 62.1 for urban service area). In rural and frontier services areas, ten have zero primary care provider FTE, 24 have zero dentist FTE and 21 have zero mental health provider FTE. While Oregon's five-year (2014-2018) average inadequate prenatal care rate is 59.6 per 1,000 births per year, the average rate in frontier service areas is 97.1. Of note the Warm Springs service area which serves tribal members has a rate of 196.5, which is triple the state rate (Oregon Areas of Unmet Health Care Need Report, 2020). Although the COVID-19 pandemic has resulted in a significant increase in telehealth services, broadband internet services may not be available in rural and frontier areas. Overall, about 86% Oregonians have broadband internet subscriptions (US Census).

Geography presents a considerable barrier to accessing care for CYSHCN. Families living in rural and frontier Oregon counties experience challenges getting the services they need, particularly specialty care. Specialty care services for children are concentrated in urban areas along the Interstate 5 corridor, especially in Portland, where the only teaching hospital, Oregon Health & Science University (OHSU), is located. Mental and behavioral health services are especially difficult for CYSHCN and their families to access, due to a lack of providers throughout the state. The COVID-19 pandemic resulted in a sudden and substantial increase in telehealth services. It may be possible to leverage telehealth to improve or increase health care and services for rural Oregon CYSHCN with insufficient access to local providers. However, in order for telehealth services to be equitable, families need access to broadband internet, digital literacy education, and skilled translation services. Additionally, providers need payment parity between in-person and virtual visits—available during COVID—to continue to offer telehealth as a care option. Steps to codify that parity were taken with HB2508 in the 2021 Oregon Legislative session.

Economy

Oregon's economy impacts maternal and child health, as well as population growth and state revenues. The top employers are in food services, administrative and support services, trade contractors and construction, health care and hospitals, computer and electronic manufacturing, and retail (Oregon Blue Book). 62.3% of the population aged 16 years and older is in the civilian workforce, and females comprise 57.9%; these are both similar to the national averages (US Census).

Prior to the COVID-19 outbreak, Oregon's seasonally adjusted unemployment rate had peaked in May 2009 at 11.6%, and unemployment rates steadily improved over the decade. In March 2022, Oregon's unemployment rate was 3.8%, placing it 30th among states and is well below the 6.1% it reached in March 2021(Bureau of Labor Statistics). However, the recovery prior to the pandemic was unevenly experienced around the state with southern and central Oregon counties experiencing greater unemployment (Oregon Employment Division). Oregon, like other states, has experienced unprecedented unemployment during the COVID-19 outbreak. In April 2020 every major industry in Oregon lost jobs as the economy suffered the largest one-month contraction in history, losing roughly 13% of jobs. Payroll employment in the leisure and hospitality industry fell an astounding 54.6% in April 2020. While private education and health care are large sectors that have historically added jobs during recessions and expansions, these sectors shed the second-largest number of jobs in April 2020 when COVID-19 measures directly prohibited elective and non-urgent medical procedures and closed schools. Private-sector employers cut 30,300 jobs in April 2020 () (Oregon Employment Division).

Oregon's median household income was $62,818 in 2020 which is similar to the national average. The overall poverty rate is 11.4%, which is slightly higher than the national average (US Census). Oregon has a new three-tier minimum wage rate that vary by geography As of July 1, 2022 the highest rate of $14.75 per hour is within the Portland urban growth boundary, a standard rate of $13.50 per hour in other areas of the state, and a rate of $12.50 per hour in designated nonurban counties. Although Oregon's minimum wage is higher than most other states, private-sector workers in Oregon tend to work fewer hours per week and their average wage earnings are below the national level. One-third of Oregon's jobs paid an average wage of less than $15 per hour in 2019 (Oregon Blue Book). Wealth inequality across racial/ethnic groups persists with the median income of Black ($48,000), Hispanic ($56,900) and American Indian ($60,500) families with children being significantly less than the median income of white families with children ($89,100) (The State of America's Children 2021).

Almost all racial/ethnic minority populations have higher poverty rates than non-Hispanic Whites. In 2018, the unemployment rate for Latino Oregonians was 5.6%, compared to the 4.1% unemployment rate for White Oregonians. In 2014, the last year data was available for Black Oregonians, they faced an unemployment rate twice as high as Whites (Oregon Center for Public Policy, 2019). The 2019 poverty rate for children under 18 years is 13.1% and 12.7% for children under 6 years, the 10th highest in the US. Additionally, 5.6 percent of children under

18 (6.4% of children under 6) are very poor. Children of color have significantly higher rates of poverty than white children (10.2%) in Oregon: 20.2% for Hispanic children, 33.8% for Black children and 25.2% for Alaskan Native/American Indian children (The State of America's Children 2021). Nineteen percent of CYSHCN ≤17 years live in households with incomes below 100% of the Federal poverty level (NSCH, 2019-20).

Oregon's strengths and challenges that impact MCH populations

Key state issues impacting Maternal, Child, and Adolescent Health include: health systems transformation, Oregon's Early Learning System transformation, medical home for CYSHCN including cross-systems care coordination and shared care planning, and the modernization of Oregon's Public Health system. Upstream factors, including the state of Oregon's economy, employment, equity, education, and the environment are also key drivers of Maternal, Child, and Adolescent Health across the lifespan. The impacts – both direct and indirect – of the COVID-19 pandemic on Oregon's MCAH population will doubtless be unfolding for many years. This year's report was written to account for those impacts that are known at this time.

Oregon health systems transformation

Oregon's health systems transformation efforts have been ongoing since before the Federal Affordable Care Act (ACA) implementation, and alignment of public health, including Maternal, Child, and Adolescent Health work with health system transformation is a key priority for the State. Oregon's health system transformation, and the unique role Coordinated Care Organizations (CCOs) in serving the MCAH population is described in detail in section III.E.2.b.iv.

CYSHCN needs and health systems transformation

Children make up 47.6% of Medicaid and CHIP populations as of November 2020 (Centers for Medicare and Medicaid Services). Oregon's CCOs are responsible for ensuring care for people covered by Medicaid. Despite the state's commitment to the Triple Aim, families and providers still report considerable challenges for the CYSHCN population. Families experience confusion about who is responsible for coordinating care for CYSHCN across multiple systems. While CCOs are required to provide specific care coordination activities for CYSHCN, implementation has been both complex, and uneven. Lack of CCO care coordination capacity and a lack of clarity around what is required of CCOs have contributed to uneven care. Primary care practices with PCPCH status attest to making progress toward standards that may or may not include CYSHCN. The inconsistency in types and amounts of coverage confuses families and exacerbates disparity and inadequate care for CYSHCN. While coverage for Applied Behavioral Analysis (ABA) for children with Autism Spectrum Disorder is mandated, access remains uneven.

Education

Over their lifespan, children in Oregon have access to private and public preschools, Head Start, public schools, community colleges, universities, and graduate education. About 90% of persons in Oregon older than 25 years have graduated from high school (US Census).

Oregon's Early Learning Division (ELD) supports all of Oregon's young children and families to help them learn and thrive. The Division is focused on: childcare, early learning programs and cross systems integration, policy and research, and equity. Programs provided through the ELD include Early Head Start, Head Start and Oregon Pre-K, Healthy Families Oregon, Preschool Promise, and Relief Nurseries.

Oregon has 197 public school districts, 1,246 public schools, and 560,917 students enrolled from kindergarten through grade 12. Pandemic conditions led to a drop in enrollment with a total decrease of 18,030 students (-3.1%) over five years. Among K-12 public school students in Oregon, 39.6% are students of color which has increased from previous years; 17,693 students experienced houselessness; 14.2% receive special education services, and almost 10% are English Language Learners. Oregon's 4-year high school graduation rate for all students is 82.6%, a significant increase over the past several years. The opportunity gap between students of historically underserved races/ethnicities and other students (White, Asian, Multi-racial) has continued to decrease by 3.1% in five years (Oregon Department of Education, 2021).). Data also indicate gaps in providing school health-related services. In 2020-2021, "30% (n=60) school districts did not report any school nurse FTE [full-time equivalent hours]. Out of the 137 districts who did report school nurse FTE, 44 were hired for less than half time, meaning that a nurse was available less than 20 hours a week for the entire district…[and] only 15 school districts (7.6%) meet the recommended ratio of 1 nurse to every 750 students." [source ODE Annual Report.

Every child in Oregon identified as needing special education has at least one of the disabilities defined in the Individuals with Disabilities Education Act. In Oregon, children must have a diagnosed physical or mental condition that is likely to result in a developmental delay to receive Early Intervention/Early Childhood Special Education (EI/ECSE) services. In 2021, 79,782 Oregon children (age 3 – 21 years) were in special education, 3,330 children (age 0 – 3 years), received EI services, and 8,273 children (age 3-5 years) received Early Childhood Special Education services (Oregon Department of Education). The educational impacts of the pandemic on CYSHCN remain to be seen. Anecdotal reports indicate that many children in special education experienced particular difficulty with online education.

National Association of School Psychologists' analysis of 2020 data from the U.S. Department of Education showed that Oregon had 1,659 students per school psychologist, highlighting the shortage of mental health services in schools in the same timeframe when the American Academy of Pediatrics declared a "national emergency in child and adolescent mental health." Oregon's higher education includes seven public universities and the Oregon Health & Science University, 17 public community colleges, over 50 private colleges and universities, and hundreds of private career and trade schools. About 33% of Oregonian's have a Bachelor's degree or higher (US Census).

Early learning system transformation

Oregon's early learning system transformation, guided by the Early Learning Council (ELC), is a key partnership for Title V, and another effort that is shaping the changing context for maternal and child health in our state. The vision for early learning system transformation is to: 1) Ensure all Oregonian children arrive at kindergarten ready to learn and having received the early learning experiences they need to thrive; 2) Children are living in families that are healthy, stable and attached and 3) Oregon's early learning system is aligned, coordinated and family-centered. The ELC directs the Early Learning Division of the Oregon Department of Education, which is responsible for numerous activities and initiatives including but not limited to:

- 16 regional Early Learning Hubs which coordinate services for children 0 to kindergarten entry across five sectors: early learning, human services, health, K-12 and business.
- The Office of Child Care, which manages childcare licensing and monitoring throughout the state.
- Implementation of a tiered quality rating improvement system for childcare known as Spark.
- Coordination with Early Intervention/Early Childhood Special Education services.

In 2018, The Early Learning Council (ELC) completed a strategic planning and engagement process, which resulted in the Raise up Oregon Plan (RUO). Title V was a key partner in its development, and now in its implementation. The ELC established the Raise up Oregon Agency Implementation Coordinating Team (RUOAICT) to drive cross-sector implementation of the RUO plan. The Title V Director sits on this team.

Early Learning Hubs ensure that systems are aligned so that children 0-5 and their families can access the services and resources they need to be ready for kindergarten. The Hubs are particularly relevant to CYSHCN because they create referral pathways for screening and assessment. They guide the programming for children with special health care needs. They ensure that systems are addressing the needs of families, as well. Some Early Learning Hubs have expanded their workforce to include Family Navigators or Family Resource Specialists, positions designed to help families identify and access community resources.

Patient-Centered Primary Care Home (PCPCH) Program

The PCPCH Program is Oregon's realization of the patient-centered medical home concept. The program's goal is to accomplish the Triple Aim of health care. OHA established a set of recognition criteria, a technical assistance guide, and a self-assessment tool to aid practices in achieving PCPCH recognition. Initially the program consisted of three tiers of recognition, with the 3rd tier being the most advanced level of recognition. In 2017, the program revised the recognition criteria and expanded to five tier levels, with the 5th tier being the highest.

Modernization of Public Health

Governmental public health in Oregon is currently undergoing a major restructuring and modernization based on the recommendations of a legislative task force and the core functions of public health. HB 3100, the Modernization of Public Health Bill is based on the Task Force Report and uses a framework of foundational capabilities and programs that are needed throughout the state and local public health systems. The changes focus on the need to achieve sustainable and measurable improvements in population health; continue to protect individuals from injury and disease; and be fully prepared to respond to public health threats. A Public Health Modernization manual has been developed, along with a Modernization Plan based on assessment of the capacity and gaps in the

governmental public health structure across Oregon. Phase one funding of $5 million was spent to enhance communicable disease capacity in select communities; phase two funding, approved by the 2019 Legislature provides an additional $10 million to modernize the public health approach to communicable disease, emergency preparedness and impacts of climate change on health. In 2021, the Oregon Legislature allocated an additional $45 million in funding, an important and notable investment in Oregon's public health system. The additional investment brought the total investment in public health modernization to $60.6 million. State Title V and local grantees are integrally involved in ensuring that maternal, child, and adolescent health programs are aligned with and central to public health modernization.

Housing

Oregon has nearly 1.8 million housing units with 62.4% being owner-occupied (Census Bureau). Of households that spend 30% or more of income on housing, 51.6% rent, 31.4% had mortgages, and 14.9% own without mortgages. The median monthly housing cost for each group was $1,110 for renters, $1,699 for mortgaged owners, and $538 for owners without a mortgage. 2.2% of households did not have a telephone service and 7.5% were without a car or vehicle for transportation. According to the Portland Housing Bureau 2018 report on housing costs and income, the rent growth has slowed in the past two years to just over 2%, and the average rental unit now costs $1,430 per month. Rising rental and home sale prices in recent years have displaced many Portlanders, disproportionately affecting people of color and lower incomes.

Oregon has experienced an increased number of unhoused people, a crisis worsened by the pandemic. As of January 2020, an estimated 14,655 Oregonians experienced homelessness on any given day. Of that total, 825 were family households, 1,329 were Veterans, 1,314 were unaccompanied young adults (aged 18-24), and 4,339 were individuals experiencing chronic homelessness. The total number of homeless students for the 2018-2019 school year was 23,141, as reported to the Department of Education (United States Interagency Council on Homelessness, January 2020).

Oregon Health Authority's roles, responsibilities and interests impacting Title V service delivery

Oregon's Title V work is interwoven with the priorities and initiatives of Oregon Health Authority (OHA) and the Public Health Division, the OHSU Institute on Development & Disability (IDD), and those of the local health departments and tribes. At the state level, Title V aligns with the OHA Triple Aim, IDD's priorities, the Oregon State Public Health Improvement Plan, and the Public Health Division Strategic Plan, as well as with the priorities of the Coordinated Care Organizations (CCOs).

The Oregon Health Authority (OHA) is responsible for most state-level health-related programs in Oregon, including Public Health, Medicaid, Addictions and Mental Health, the Public Employees, and Oregon Education Benefit Boards, and the Oregon State Hospital. The Oregon Health Policy Board oversees the OHA and is a nine-member, citizen-led board appointed by the Governor and confirmed by the Senate

Oregon's public health statutes and programs are administered by the Public Health Division within OHA, and most of Oregon's 36 county jurisdictions is the designated local public health authority (LPHA). Currently, there are 33 LPHAs and one health district serving three small rural county populations. Two counties have given back their local public health authority to the state, and in those counties OHA is responsible for the mandated public health services. LPHAs are legislatively mandated to provide ten core public services. The Conference of Local Health Officials represents and advocates for local health departments in negotiations with the state and works to assure that they have the skills and resources necessary to carry out their work.

Oregon Health Authority (OHA) Triple Aim and Strategic Goal

OHA is the central agency that oversees health transformation in Oregon, guided by the Triple Aim of improving the lifelong health of Oregonians; increasing the quality, reliability, and availability of care for all Oregonians; and lowering or containing the cost of care so it's affordable to everyone. OHA also has a strategic goal of eliminating health inequities in Oregon by 2030. Title V's prevention and health promotion work supports the Triple Aim and the strategic goal through interventions with vulnerable populations at critical stages of the life course. Section III.E.2.b.iv describes Title V's work in support of health system transformation and the partnership with CCOs in more detail.

Institute on Development & Disability

The Institute on Development and Disability (IDD) is part of the Department of Pediatrics at OHSU. The IDD works

with patients, families, clinicians, researchers, and other professionals to improve the lives of people with disabilities. They perform research, advocacy, and education. IDD provides health care to people of all ages who experience disabling conditions. They embrace the right of people with disabilities to determine the course of their lives, and to live as fully integrated, contributing members of their communities.

State Public Health Improvement Plan

As part of Public Health Accreditation, Oregon created a state health profile and developed a State Health Improvement Plan (SHIP),which was updated in 2020 for the 2020-24 priorities. The SHIP priorities include: Institutional bias; Adversity, trauma and toxic stress; Economic drivers of health (including issues related to housing, living wage, food security and transportation); Access to equitable preventive health care; and Behavioral health (including mental health and substance use). Title V is a critical partner whose work is threaded across all the SHIP priorities.

CCO Community Health Improvement Plans and Outcome Metrics

Title V work also aligns with, and supports, the community health improvement plans of the CCO's, as well as their performance metrics. Each of the 16 CCOs has developed a community health improvement plan (CHIP) which details their commitment to improving population health through a long-term, systemic effort, and is required to report on those plans annually. The CCOs are also being measured and receive enhanced payment based upon, their health indicators in key MCAH areas such as pre-K well child visits, child and adolescent immunizations, preventive oral health, depression screening, and postpartum care. OHA chose to drop the longstanding adolescent well care visit metric in the 2020 round of CCO incentive metrics. This change impacted the selection of Oregon's MCHB priority areas for the new block grant cycle. In 2018 and 2019 a legislative requirement was enacted for CCOs to invest some of their profits back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on services to address health inequities and the social determinants of health and equity (SDOH-E), named the SHARE Initiative. CCOs may also use their global budgets to address members' social needs and community SDOH-E through health-related services (HRS). Title V works with the CCOs, providing technical assistance, data, and contracted public health and prevention services.

Oregon's system of care for meeting the needs of underserved and vulnerable populations, including CYSHCN

Populations served

About 6% of Oregon's population is under five years of age, and 21% is under age 18 (USCB, 2019). Overall, 18.7 percent of Oregonians under age 18 live below the federal poverty level (The State of America's Children 2021).

The 2019-2020 National Survey for Children's Health (NSCH) estimated that 21% of Oregon children 0 to 18 years have special health care needs. These CYSHCN were mostly White, non-Hispanic, with 19.6% having Hispanic ethnicity, and 8.4% identifying as other, non-Hispanic.
Nearly 81.5% of Oregon CYSHCN have a condition that affects their daily activities, and 35.5% experience two or more functional difficulties (NSCH, 2019-2020).

According to the most recent state prevalence rates, 3.1% of Oregon children, ages 3 through 17 years, have autism spectrum disorder (ASD), compared to 2.9% nationally (NSCH, 2019-2020). In 2020-21, about 10,570 Oregon youth (age 5–21) receiving special education had ASD (Oregon Department of Education, 2021).

Of children and youth under age 21 insured, wholly or partially, through Oregon Medicaid in 2018-2020, 9.7% met the criteria for having complex chronic disease (OPIP, OHA & DHS 2021). These children are disproportionately from communities of color, with 6.7% Black/African American, 4.9% Native American, and 5.6% identifying as multiracial (OPIP, OHA, DHS, 2018). Eighteen percent of Medicaid enrollees were categorized as having non-complex chronic disease (OPIP, OHA & DHS, 2021). With 19.2% Black/African American, 17.8% multiracial, and 17.6% American Indian/Alaska Native (OPIP, OHA, & DHS, 2021).

Oregon's Birth Anomalies (birth defects) Surveillance System (BASS) tracks the prevalence of select birth anomalies using birth certificate, hospital discharge, and Medicaid data. Data are collected on children who receive public health nurse home visiting services through the CaCoon program. The most prevalent conditions reported for CaCoon recipients in FY2021 were developmental delay, autism spectrum disorder, and other chronic conditions. In FY2021, 39% of children served in the CaCoon program had multiple conditions. The BASS program within PHD's

MCH Section is Title V supported, and works closely with the MCH Title V Women, Perinatal and Infants Team as well as OCCYSHN.

NSCH (2019-2020) estimates suggest that only 39.6% of YSHCN had worked in the previous 12 months, likely due to challenges in managing their own health, difficulty accessing available resources to support their health and disability related needs, and other social factors.

Health services infrastructure

Primary care and safety net health services are available through independent medical providers and through the following facilities.

- Hospitals: 62 hospitals
- Federally Qualified Health Centers: 34 FQHCs operating more than 270sites
- Rural Health Clinics: 107 clinics in 30 counties
- Tribal and Indian Health Service: 9 federally recognized tribes and the Urban Indian program have multi-county service areas and associated clinics
- School-Based Health Centers: 78 clinics in 25 counties

Oregon's Primary Care Office (PCO) works closely with the non-profit Oregon Primary Care Association (OPCA) and the Office of Rural Health to support Oregon's safety net services. Oregon has 149 designated primary care Health Professional Shortage Areas (HPSA), 124 mental health HPSAs and 134 dental HPSAs. More than 300 sites have been approved as part of the National Health Service Corps (NHSC) to provide medical, dental, and mental and behavioral health services to all Oregonians, regardless of their ability to pay. In 2020, Oregon's Community Health Centers provided 1,617,104 visits for 355,353 clients, including 82,697children. Of these patients, 18% were uninsured and 57% were covered by Medicaid (NAHC, 2020).

Oregon's safety net includes a robust network of school-based health centers (SBHCs) which are statutorily defined, certified and funded. During the 2020-21school year, there were 78 SBHCs in 47 high schools, 6 middle schools, 11 elementary schools and 14 combined-grade campuses. During the 2020-21 service year, SBHCs provided 91,058visits for 28,610clients. Oregon Health Plan (OHP), Oregon's Medicaid program (medical, dental, and mental health care services), is provided primarily through Coordinated Care Organizations (CCOs) - Oregon's version of Accountable Care Organizations. There are currently 15 CCOs serving Oregon's 36 counties. CCOs currently serve nearly 90% of OHP clients. The innovative structure and function of CCOs is a central component of health reform in Oregon, as described in previous reports.

Integration of services

Integration of primary care, behavioral health and social services continues to be an area of opportunity in Oregon. Several cross-agency workgroups have been formed in the past several years to identify solutions to these issues. Most recently, in 2019 a Governor's Behavioral Health Advisory Council was created with the task of developing recommendations aimed at improving access to effective behavioral health services and supports for all Oregon adults and transitional-aged youth with serious mental illness or co-occurring mental illness and substance use disorders. This work will be closely aligned with similar state level efforts, including the State Health Improvement Plan, the Oregon Alcohol and Drug Policy Commission Strategic Plan, and the Oregon Tribal Behavioral Health Strategic Plan. Membership in these groups reflects the diversity of sectors that support Oregon's children and families in various settings, including schools, early learning, transportation, housing, criminal justice, and health.

Financing of services

Insurance coverage

According to the most recent Oregon data, about 4 million Oregonians - 95% - are covered by health insurance. Insurance coverage increased by 1.4% from 2019 to 2021, over the Covid-19 pandemic. Despite significant gains in health insurance coverage, disparities remain for some groups in Oregon. The percentage of the population that is below 400% of the Federal Poverty Level (FPL) has lower insurance coverage than those above 400%. People living in frontier areas have lower insurance coverage than rural or urban areas. While insurance coverage is high in Oregon, low-income people are less likely to be covered. Young adults, between ages 19 – 34 were less likely to be covered than any other population. Among children 18 and under, 97% were covered by insurance. Disparities in un-insurance by race and ethnicity are evident, with Asian Oregonians having the lowest un-insurance rates, and Native Hawaiian/Pacific Islander having the highest followed by Hispanic Oregonians (19%; 15.4% respectively) at any time over the past year.

Despite Oregon's high rate of health coverage, more people could be covered. Most people who were uninsured when the study was conducted were eligible for the Oregon Health Plan or a subsidy to reduce the cost of commercial health coverage.

- Children: 9 out of 10 children who lack health coverage are eligible under OHP or a premium-reduction subsidy through the health insurance marketplace.
- Adults: Similarly, nearly 9 in 10 young adults and 8 in 10 older adults (ages 35-64) qualify for OHP or a subsidy for commercial health coverage.
- Reasons for lack of OHP coverage: The top three reasons Oregonians cited for not being covered by OHP were: concern about high costs of coverage (44 percent); not eligible, make too much money (36 percent); and concerned about quality of care (21 percent).

Oregon has expanded Medicaid coverage (Oregon Health Plan – or OHP), to cover adults whose income is 133% of the Federal Poverty Level (FPL). Pregnant women are covered to 185% FPL, and children to 300% with Medicaid and CHIP. OHP pays for medical, dental and mental health services for low-income Oregonians. Since ACA implementation, OHP enrollment has grown by 718,520 people, and OHP now covers over 1.3 million Oregonians . OHP pays for 43% of Oregon births, including prenatal and delivery coverage for approximately 3100 undocumented women covered through the state-funded prenatal expansion program and Citizen Alien Waived Emergent Medical (CAWEM) program. About 20% of all Medicaid enrollees are Hispanic, 3% African American, 1.5% American Indian/Alaskan Native, 3% Asian or Pacific Islander, 58.5% Caucasian, and 14% "Other" or "Unknown". More than one-third (36.8%) of Oregon CYSHCN < 18 years were insured through Medicaid (NSCH 2019-2020).

In July 2017, the Oregon Legislature passed Senate Bill 558, known as the Cover All Kids Act, expanded the Oregon Health Plan to include all children and teens under 19, regardless of immigration status, up to a household income of 300% of poverty. The estimated impact is that 17,000 undocumented children and teens were newly eligible for healthcare as of January 1, 2018.

Also passed into law in July 2017, was House Bill 3391, known as the Reproductive Health Equity Act (RHEA). This bill expanded coverage for Oregonians to access reproductive health services, especially those who, in the past, may have not been eligible. It also provides protections for the continuation of reproductive health services with no cost sharing and prohibits discrimination in the provision of reproductive health services. The Reproductive Health Equity Act ensures that Oregonians with private health insurance coverage, including employee-sponsored coverage, have access to reproductive health and related preventive services with no cost sharing regardless of what happens with the Affordable Care Act. Medical care for undocumented women up to 60-day postpartum will also be covered.

State revenues and budgets

Over 90% of the state's general fund supports core functions in three areas: education, health and human services, and public safety. Oregon does not have a sales tax, and recent attempts to increase corporate taxes through ballot measures have failed to pass. Furthermore, state law mandates a "kicker" refund to taxpayers in any year in which state revenues exceed projected by more than 2%. Consequently, even with robust employment and income tax collections, the state continues to face budget shortfalls.

Oregon statutes and regulations with relevance for Title V Block Grant authority and state programs

The following are key state statutes for Oregon's Title V program:

- ORS 413 defines to the Oregon Health Authority (OHA) and the Oregon Health Policy Board, which were created by the Oregon Legislature in 2009. Most health-related programs in the state are under the OHA, including Public Health, Medicaid, Addictions and Mental Health, the Public Employees and Oregon Education Benefit Boards. OHA is overseen by the Oregon Health Policy Board.

- ORS 431.375 governs the policy on local public health services; local public health authority, and the provision of maternal and child public health services by tribal governing council.

- HB 3650, passed in 2011, sets the framework for health system transformation and the CCOs which are a cornerstone of Oregon health system transformation and provide care to Oregon's Medicaid (OHP).

- HB 3100, passed In July 2015, implements the recommendations made by the Task Force on the Future of Public Health Services and sets forth a path to modernize Oregon's public health system so that it can more proactively meet the needs of Oregonians. Legislation to expand support for Public Health modernization is considered each current session.

- ORS 326.425 establishes the Early Learning Council, which oversees the Oregon Early Learning System.

- ORS 444.010, 444.020 and 444.030, the Oregon Health and Science University (OHSU) is designated to administer a program to extend and improve services for CYSHCN, including the administration of federal funds made available to Oregon for services for children with disabilities and CYSHCN.

- Oregon is one of 39 states that passed ASD mandates that require health insurers to provide the behavioral therapy Applied Behavior Analysis (ABA) to children with ASD and other developmental disorders under 18 years old who have health insurance.

- HB 4133, passed in 2018, created Oregon's Maternal Mortality and Morbidity Review Committee (MMRC).

- SB 526 (2019), passed universally offered home visiting for Oregon newborns.

- HB 3391, the Reproductive Health Equity Act, provides expanded coverage for reproductive health services including preventive services with no cost sharing, and services for Oregonian who had previously been ineligible due to immigration status.

- HB 4035 makes a $120 million investment to maintain health care coverage gains achieved during the pandemic, even as many Oregonians will face a challenge in keeping their coverage when the federal Public Health Emergency related to COVID-19 ends. Through this legislation Oregon has an opportunity to reduce unnecessary coverage transitions while preserving existing coverage options for people who are best served through marketplace or employer-sponsored plans.

- HB 4052: Mobile Health Units - aims to improve access, starting with communities most affected by health inequities. The bill requires OHA to provide grants, funded with $1.6 million General Funds to operate two culturally and linguistically specific mobile health units as pilot programs to improve health outcomes of Oregonians impacted by racism.

- State Budget (biennium): Expanded Citizenship Waived Medical (CWM) program, formerly known as Citizen-Alien Waived Emergent Medical (CAWEM), covers emergency care for adults who would qualify for Medicaid if they met the U.S. citizenship or
residency requirements. Previously, emergency coverage was based on the final diagnosis. Unfortunately, this could result in considerable expense for individuals if they go to an emergency room in good faith, but the diagnosis determines there was no serious cause for alarm. The policy could also discourage people with an actual emergency from seeking care, for fear of unexpected charges. The budget includes $5.4 million General Funds ($14.2 million Total Funds) to cover admission to an emergency room when a person presents symptoms a prudent layperson would consider an emergency, even if the final diagnosis turns out to be not serious. https://www.oregon.gov/oha/ERD/SiteAssets/Pages/Government-Relations/OHA%20End%20of%20Legislative%20Session%20Report%202022.pdf

- State Budget (biennium): Extended Postpartum Eligibility. There are severe racial disparities in maternal mortality among Oregonians, with studies showing American Indian/Alaska Native and Black people at a significantly higher risk of dying from a pregnancy related cause. The state Maternal Mortality and Morbidity Review Committee identified "inadequate access and missed opportunities to health care and medical services" and "inadequate access to wrap-around services" as contributing factors to maternal mortality. The budget includes $2.4 million General Funds ($8.8 million Total Funds) to provide additional months of postpartum health care. This will help ensure the potentially complex health needs following pregnancy can be attended to, resulting in improved health outcomes for all Oregonians.
https://www.oregon.gov/oha/ERD/SiteAssets/Pages/Government-Relations/OHA%20End%20of%20Legislative%20Session%20Report%202022.pdf

- HB 4150: Community Information Exchanges. Systemic inequities and regional variations in the availability and delivery of social and medical services have long plagued many people and communities in Oregon. A Community Information Exchange (CIE) helps address this by enabling community-based organizations, state agencies, health systems, county health departments, social service agencies, and technology partners to coordinate efforts to assess and address the social determinants of health. HB 4150 instructs OHA's Health information Technology Council to convene the Community Information Exchange Workgroup to accelerate, support, and improve a secure and confidential statewide Community Information Exchange.

III.C. Needs Assessment Update

III.C.1. Ongoing Needs Assessment activities

OHA MCAH ongoing NA activities

Ongoing needs assessment for the MCAH population in Oregon was conducted throughout the year through various assessment and surveillance projects. Some of the ongoing activities have been described in previous needs assessment updates. For a description of the 2020 Five Year Title V Needs Assessment, please see link provided.

- Review of disparities and data trends in National Performance Measures, National Outcome Measures, and State Performance Measures.

- As a part of the increased focus on addressing social determinants of health, assessment and evaluation strategies, activities, and measures were developed for use at both the state and local level, to monitor and improve efforts to address upstream risk and protective factors for maternal and child health, with a specific focus on equity. These strategies and activities can be seen in the Cross Cutting Plan: Foundations: Assessment & Evaluation, section III.E.2.c.

- In partnership with SSDI, ongoing quality assurance of the reporting functionality for local grantees was conducted, to ensure reliable data for evaluation and reporting purposes.

- Annual assessment of local grantee measurement and evaluation, with the provision of technical assistance as necessary.

- Dissemination of the report on the Title V Five Year Needs Assessment among partners, providers, and grantees.

- Ongoing collaboration with Oregon Office of Health Analytics to ensure the representation of maternal and child health outcomes, including Title V priorities, in Coordinated Care Organization metrics.

- Ongoing partnership with the Oregon Early Learning Division to develop performance measurement metrics which are inclusive of maternal and child health indicators, including those relevant to Title V priority areas. This partnership included the provision of reliable performance measurement data to the ELD, for use in their data dashboard.

- Analyzed racial and ethnic disparities in preterm birth, infant mortality, and SIDS/SUIDs related infant mortality, in partnership with the MCH Policy Team, for use in the production of a Safe Sleep Fact Sheet.

- In partnership with CSTE/CDC Applied Epidemiology Fellow and MCH Epidemiologist (CDC Assignee), conducted analysis on the association between adverse childhood events and cognitive disability using data from a four-year race/ethnicity oversample from the Behavioral Risk Factor Surveillance System (BRFSS). A manuscript on this analysis has been composed and is currently undergoing approval processes with the Maternal and Child Health Section and CDC, for submission to a peer-reviewed journal.

- Title V Research Analyst served as consultant for Babies First/CaCoon during transition to the use of new data collection forms, and a new data collection system, THEO. Part of the process of developing the new forms was soliciting feedback and information from service providers, community partners, and expert consultants. A data equity workgroup was formed with these multidisciplinary partners, including community members, in order to improve Title V funded home visiting data collection; by increasing the cultural and linguistic responsiveness of the questions and collection methods, and by framing the data collection using a trauma informed lens.

- Babies First evaluation: In partnership with the MCH Nurse Team, the CDC/CSTE Applied Epidemiology Fellow, and the CDC Assignee MCH Epidemiologist, the Title V Research Analyst has begun work on and evaluation of the partially Title V funded Babies First home visiting program. The first stage of the evaluation is a qualitative analysis of program processes across the state. The program was developed in Oregon based on best practices, as a safety net to serve families who are not eligible for home visiting programs with strict eligibility requirements such as Nurse Family Partnership. Since the program was designed to be flexible, each county administers the program slightly differently, so an evaluation of the processes at each site is crucial to examine the effectiveness of different components of the program. The first stage of data collection is individual qualitative interviews with staff at Babies First sites, including Nurse Supervisors, Nurse Home Visitors, and Community Health Workers. The interviews have been completed and are currently being analyzed using qualitative data analysis software. Next stages of the evaluation will be conducted in following grant period years.

OCCYSHN ongoing NA activities

OCCYSHN's ongoing needs assessment activities included (a) review of the most recent NSCH data (2019-2020), (b) planning a third participatory needs assessment study, (c) review of end of year programmatic reports required of LPHAs who contract with OCCYSHN, (d) one-on-one or group conversations with LPHA grantees when providing technical assistance, and (e) monitoring of reports from partner agencies

III.C.2. Changes in health status and MCAH needs

OHA MCAH changes in health status and MCAH needs

Changes in health status in Title V areas of identified need are noted below.

- Well woman care: The percent of women age 18 to 44 with a past year preventive visit in Oregon increased from 70.8% in 2018, to 72.0% in 2019, to 73.0% in 2020. Sample size obtained by the BRFSS survey is not sufficient to disaggregate single years of data by race/ethnicity in order to examine racial/ethnic disparities.

- Breastfeeding: The rate of breastfeeding initiation in Oregon increased slightly from 93.2% in 2017 to 93.7% in 2018 and remains higher than the national level. Exclusive breastfeeding at six months increased in Oregon from 35.6% in 2017 to 36.3% in 2018. Disaggregation by race/ethnicity is not available from the National Immunization Survey for either of these performance measures.

- Child injury prevention: The rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9, increased from 122.1 in 2018, to 125 in 2019, though this increase is not statistically significant. In 2019, rates were highest among non-Hispanic White children (136), followed by non-Hispanic Black children (129.7), and non-Hispanic Asian/Pacific Islander children (82.7). Rates were lowest among Hispanic children (77.3). There was insufficient sample size to reliably report the rate among non-Hispanic American Indian/Alaska Native children.

- Bullying prevention: The rates of parent reported bullying perpetration and bullying victimization both decreased from 2018/2019, to 2019/2020, from 16.1% to 15.4%, and 44.1% to 38.3%, respectively. In 2019/2020, rates of perpetration were highest among non-Hispanic White adolescents (19.1%), followed by Hispanic adolescents (9.2%), non-Hispanic multiple race adolescents (8.4%), with the lowest rates of perpetration among non-Hispanic Asian adolescents. Rates of victimization were also highest among non-Hispanic White adolescents (44%), followed by non-Hispanic multiple race adolescents (37.9%), then Hispanic adolescents (26.6%), with non-Hispanic Asians having the lowest rate of victimization (23.3%). Sample size of the National Survey of Children's Health in Oregon was not sufficient to examine rates for either of these performance measures among non-Hispanic Black, non-Hispanic American Indian/Alaska Native, or non-Hispanic Native Hawaiian/Other Pacific Islander adolescents.

- Toxic stress, trauma, ACEs, and resilience: From 2019 to 2020, the percent of new mothers who experienced at least 2 types of prenatal stress increased from 42.8% to 46.6%. This increase may have been partially due to the stress brought on by the covid-19 pandemic. The highest rates of new mothers who experienced at least 2 types of prenatal stress were among non-Hispanic American Indian/Alaska Native mothers (67.6%), followed by non-Hispanic multiple race mothers (61.6%), then non-Hispanic Pacific Islander mothers (58.1%),

then Hispanic mothers (47%), then non-Hispanic White mothers (46.9%), then non-Hispanic Black mothers (44.9%), with the lowest rates among non-Hispanic Asian mothers (26.6%).

- Culturally and linguistically appropriate services: From 2018/2019 to 2019/2020, the percent of children with a healthcare provider who is sensitive to their family's values and customs increased slightly from 94% to 94.3%. Sample size of the National Survey of Children's Health in Oregon was not sufficient to disaggregate data by race/ethnicity.

- Social determinants of health and equity: The percentage of children living in a household that received food or cash assistance decreased slightly from 42.8% in 2018/2019 to 41.4% in 2019/2020. Sample size of the National Survey of Children's Health in Oregon was not sufficient to disaggregate data by race/ethnicity.

OCCYSHN changes in health status and MCAH needs

Less than a quarter of CYSHCN (22%) in Oregon received care in a well-functioning system in 2019-2020. Numerous disparities were observed for CYSHCN with more complex health needs as compared to CYSHCN with less complex health needs. For example, fewer CYSHCN with more complex health needs had adequate and continuous insurance (61% vs 74%), received care that met the standards of a medical home (33% vs 55%), received family-centered care (78% vs 97%), effective care coordination (45% vs 71%) and transition services (21% vs 47%) and both preventive medical and dental care (70% vs 84%). These CYSHCN also had greater difficulty getting needed referrals (40% vs 11%) and a majority of them had difficulty accessing needed mental health treatment or counseling.

A greater proportion of transition-aged CYSHCN (12-17 years) had a plan of care to meet their health goals and needs as compared to non-CYSHCN in the same age group (41% vs 24%). However, only about a quarter of CYSHCN (24%) had plans of care that addressed transition. Furthermore, only 14% of transition-aged CYSHCN saw adult healthcare providers as compared to 20% of non-CYSHCN. About half of CYSHCN (49%) did not know how to obtain or keep insurance as they became an adult and did not have anyone discuss this with them. The results suggest that there are opportunities for improvement in transition preparation for CYSHCN.

III.C.3. Changes in Title V program capacity and impact of those changes on service delivery

OHA MCAH changes in Title V program capacity and impact on service delivery

Over the past year, Oregon's Title V program has continued to be impacted by the COVID-19 pandemic, although to a lesser extent than the previous year. As OHA stood up its COVID Response and Recovery Unit (CRRU) during 2021, some Title V staff accepted 18-24 month positions in the new Unit, while others who had served on the Emergency Response Team returned to their regular positions. Limited duration positions were created to backfill staff serving on the CRUU and ongoing staff stepped up to fill gaps as they were able, allowing most MCH capacity to be retained. Additional staff deployments during the Omicron surge created more temporary vacancies, with some work consequently delayed or deferred. HR capacity to post and fill positions has been severely strained this year resulting in delays in filling positions, including one key MCH OPA 3 position which was vacant for more than 6 months. Title V staff have continued to work primarily remotely for the year, with the opening of the Portland State Office Building taking place on May 1, 2022. Increases in state level capacity are anticipated in the coming year as 3 new MCH management positions have been approved by the legislature and will be filled in the coming months.

At the local level, MCAH Title V capacity continues to be strained to varying degrees throughout the state. All local public health authorities continue to be engaged in responding to the COVID-19 pandemic, and its multiple impacts on the MCH population. In some LPHAs MCH staff are playing key roles in their local COVID-19 response and have had to shift local staffing to support COVID-related activities for the MCH population – including health education, support for quarantine and isolation, contact tracing, assistance with access to vaccination, etc. For many grantees, staffing is limited, staff have resigned, and there are challenges to filling positions (especially in rural areas and where there are culturally/linguistically specific needs). As the pandemic stretches on the strain on local public health is growing, with staff suffering directly from the public's lack of support for their COVID-related work. MCH services which are not pandemic-related are also impacted as bad feelings about the Public Health Department's role in

pandemic response often spills over into negative feelings and treatment of staff and program offerings in MCH. These shifts, as well as increased needs of the MCH population resulting from the pandemic have resulted in some grantees needing to modify their Title V plans and change the Title V priorities on which they are focused.

OCCYSHN changes in Title V program capacity and impact on service delivery

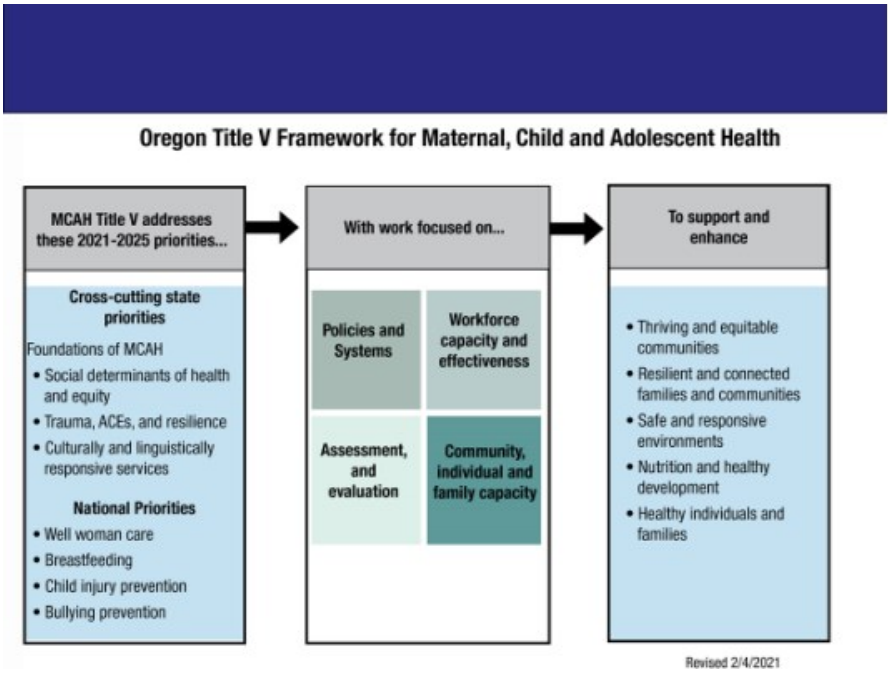
At the state level, our program capacity has remained relatively stable. During FY21, we hired a Bilingual Outreach and Training Specialist into our Family Involvement Program, which expanded our capacity to conduct Table Talks and training sessions completely in Spanish. In spring 2022, one of our longest serving ORF2FHIC Parent Partners left her position to focus on her career. During FY21, we filled an Implementation Specialist vacancy in our Systems and Workforce Development Unit. We recently hired a Systems Innovation Project Manager to join the S&W team. The additional capacity will help us expand our cross-systems care coordination efforts. As described in Section BG2023_III.E.2.b.iii, we hired a part-time Senior Program Evaluation Research Analyst in October 2021, which strengthened the capacity of our Assessment and Evaluation Unit.

At the local level, public health authorities and their partners, including clinical providers, have been generally negatively impacted by COVID-19 response as described by OHA MCAH. Their diminished capacity has further limited their ability to provide services to CYSHCN and their families. LPHA capacity to conduct home visits has diminished, and referrals to the CaCoon nurse visiting program have dropped sharply. LPHAs are gradually rebuilding and recovering relationships with area providers and families, after losing significant momentum during the pandemic.

III.C.4. Efforts to operationalize NA findings

OHA MCAH efforts to operationalize NA findings

MCAH Title V has continued this year to implement the re-structured program framework which aligns our MCAH Title V work with our 2020 Needs Assessment findings. The new framework, shown below, demonstrates our commitment to align Title V policies and programmatic work to respond to the upstream needs of social determinants of health and equity, trauma/toxic stress/ACEs and resilience; and culturally/linguistically responsive services. These 3 state priority areas are being approached in an integrated manner as “Foundations of Maternal, Child, and Adolescent health. Work across the Foundations areas is focused on policy & systems; workforce capacity and effectiveness; community, individual and family capacity; and assessment and evaluation. Domain-specific work on national priorities (well woman care, breastfeeding, child injury, and bullying prevention) is also being conducted in sync with and using the lens of our Foundations work. All plans for the coming year in the state action plan reflect these efforts to operationalize our state’s needs assessment findings.



OCCYSHN efforts to operationalize NA findings

OCCYSHN continues to use 2020 needs assessment findings to inform our annual block grant planning and activity implementation. For example, key findings showing that CYSHCN who are members of Black and Latinx communities experience institutional and personally mediated racism serve as an impetus for us to incorporate health equity and antiracism into our work as described in our state action plan. Additionally, OHA MCAH and OCCYSHN will collectively explore ways to advance LPHA capacity to provide culturally responsive, antiracist care. Given the continued need for CYSHCN, particularly those with more complex needs, to receive support preparing for transition to adulthood, we also continue our Children with Medical Complexity CollN work (Block Grant plan Section 12.2).

III.C.5. Changes in organizational structure and leadership

OHA MCAH changes in organizational structure and leadership

Changes in OHA, PHD, and MCAH Title V leadership and staffing over the past year have been minimal:

- Jordan Kennedy moved to a new position in OHA in August 2021. Recruitment for his replacement is currently underway.
- Two new management positions will be added to MCH this year. Catalina Aragon will be the new MCH Program and Policy Manager; the other position is in recruitment. Both managers will support and coordinate with Title V work across the MCH section.
- Several State level Title V staff either took limited duration positions or moved to other OHA positions this year. Both Title V lead positions – the bullying prevention and the MCH Title V programs position - have been filled.

Changes in local level public health leadership have been extensive over the past two years – both among administrators and staff leading MCH programs. The stress of the ongoing COVID-19 response is resulting in continuing resignations and strains on local public health capacity.

- Half of local public health administrator positions (16 of 32) have turned over between March 2020 and April 2022.
- One LHPA has ceased operating entirely and ceded their local public health authority to the state, which is conducting only state mandated public health functions in that county.
- There has also been extensive turn-over in local public health MCH staffing due in part to retirements and resignations brought on by the stress of the COVID-19 response.

State Title V program has adjusted program and reporting structures to accommodate strained local public health capacity and help to ensure maximal support for the MCH population during the pandemic.

Changes in OHA organizational structure have continued over the past year in response to the ongoing COVID-19 pandemic. The pandemic response was initially managed through an emergency management/incident management team structure. During the summer of 2020, Oregon established the COVID-19 Response and Recovery Unit (CRRU), to coordinate statewide efforts to prevent and mitigate the spread and effects of the pandemic. The CRUU is a shared unit of the Oregon Health Authority (OHA) and the Department of Human Services (DHS), which is now being integrated into the Public Health Division. One of the key changes associated with the CRUU that impacts the MCAH population is the development of community engagement specialists and contracts with multiple community agencies across Oregon to provide outreach and COVID-related support to their populations. Although this is not a change in MCAH Title V capacity, the impact of this structural and capacity change on MHAC population in marginalized communities around the state cannot be over-stated. There are currently 179 community agencies receiving funding to support the COVID-related needs of individuals and families in their communities. The work is being actively supported by a diverse team of community engagement specialists, whose focus is on reducing barriers and ensuring that local communities and agencies have the support they need from the state.

An additional OHA structural change this year has been the development of shared equity and public health modernization funding for Community Based Organizations (CBOs) across Oregon. This is a key component of OHA's commitment to community engagement and equity and builds upon CBO funding and engagement initiated during the COVID-19 pandemic. The CBO funding opportunity braided funding from multiple state and federal sources and programs, with the goal of simplifying the process for CBOs to engage with OHA by blending funding for

8 program areas into one shared application, with a commitment to shared workplan, reporting, and budget tracking requirements. A total of $31 million was awarded to 147 CBOs for work spanning Adolescent and School Health; Commercial Tobacco Prevention; Communicable Disease Prevention; Emergency Preparedness; Environmental Public Health and Climate Change; HIV/STI Prevention and Treatment; ScreenWise: Breast and Cervical Cancer Prevention; and Overdose Prevention. Although MCH Title V funding is not included in the grants, the Title V Program is working in partnership with the newly funded grantees and programs to support the equity work as it impacts MCAH populations.

OCCYSHN MCAH changes in organizational structure and leadership

Fortunately, OCCYSHN has not experienced organizational structure or leadership changes within our center, the Institute on Development and Disability, or within the OHSU Department of Pediatrics.

III.C.6. Emerging public health issues and capacity to address them

OHA MCAH Emerging public health issues and capacity to address them

Key emerging MCAH public health issues in Oregon this year include the direct as well as indirect impacts of COVID-19 on the MCAH population, as well as the related issues of racial justice and equity, and mental and behavioral health.

- COVID-19 continues to be a significant public health issue impacting the MCAH population in Oregon. The impacts of the pandemic include both the direct impact of the disease – particularly the disproportionate impact on communities of color, as well as the economic and social impacts related to the ongoing closures, job losses (particularly for low-income families and women of color), women being forced to leave the workforce to care for children who are without childcare or school, etc., and inequitable access to vaccines. increased significantly. Targeted Federal funding, as well as flexibility in use of Title V funding to address these issues are helpful. However, limitations in available qualified staff in many areas of the state (especially rural areas), as well as staff turn-over with the ongoing high stress nature of the response present ongoing capacity challenges.

- The need to focus on racial justice and equity as core public health work has also been an emerging focus this past year. This is on ongoing issue, but the disparities and injustice of the past two years – both due to the pandemic and to police and other racial violence - have elevated the issues and our need to focus public health capacity and resources directly on anti-racism work.

- Mental and behavioral health needs of children, youth and families have also escalated during the past year – in relation to both the above issues. Children, youth, and families are experiencing unprecedented isolation and have been cut off from many of their usual forms of social and community support. The need for culturally responsive services for children, youth and families has never been greater. The state is working to respond in a variety of capacities, but at this juncture needs far outweigh capacity.

- A shortage in infant formula due to supply chain issues and the recall of several products has impacted the safety and wellbeing of infants across Oregon, particularly among low income and marginalized communities. Programs such as home visiting and WIC, in partnership with community-based agencies, have been key in connecting families to resources during this shortage.

OCCYSHN emerging public health issues and capacity to address them

As our staff becomes aware of reports or news stories that describe issues affecting CYSHCN, and populations of CYSHCN (e.g., those with disabilities) and their families, we share them with applicable partners, particularly when we lack capacity to act. For example, the State Interagency Coordinating Council's (SICC) 2021-2022 Governor's Report showed shortfalls in the percent of Oregon 3-5 year olds receiving adequate levels of Early Childhood Special Education services; the shortfalls are particularly pronounced for children with moderate and high needs. OHSU's University Center for Excellence in Development and Disability (UCEDD) has a number of connections within the Oregon Department of Education, and faculty and staff with particular interest in the early childhood population. The Family Involvement Program Manager, Care Coordination Specialist, and an ORF2FHIC Parent Partner (latter two staff are SICC members) presented these findings during a UCEDD staff meeting, which facilitated a connection between their personnel and the SICC.

Click on the links below to view the previous years' needs assessment narrative content:

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,129,512	$6,172,689	$6,178,818	$6,091,610
State Funds	$10,116,862	$11,960,373	$10,720,618	$21,856,666
Local Funds	$7,003,170	$9,707,490	$5,594,165	$6,377,931
Other Funds	$7,684,389	$9,783,913	$8,527,525	$10,176,807
Program Funds	$0	$0	$0	$0
SubTotal	$30,933,933	$37,624,465	$31,021,126	$44,503,014
Other Federal Funds	$37,139,702	$44,501,432	$39,882,886	$33,784,920
Total	$68,073,635	$82,125,897	$70,904,012	$78,287,934

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,172,689	$6,040,858	$6,091,610	
State Funds	$13,276,271	$16,632,981	$22,291,675	
Local Funds	$9,707,490	$3,816,493	$6,377,931	
Other Funds	$11,838,611	$9,392,842	$10,108,921	
Program Funds	$0	$0	$0	
SubTotal	$40,995,061	$35,883,174	$44,870,137	
Other Federal Funds	$43,526,340	$34,526,065	$36,324,636	
Total	$84,521,401	$70,409,239	$81,194,773	

	2023	
	Budgeted	Expended
Federal Allocation	$6,946,987	
State Funds	$19,925,824	
Local Funds	$3,816,493	
Other Funds	$9,598,510	
Program Funds	$0	
SubTotal	$40,287,814	
Other Federal Funds	$37,034,624	
Total	$77,322,438	

III.D.1. Financial Expenditures

Oregon's expenditure report represents the totals from both Title V agencies -- Oregon Health Authority-Public Health Division-Center for Protection and Health Promotion (CP&HP) and the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) in the Department of Pediatrics at Oregon Health and Sciences University (OHSU). The total state funds and other funds expenditures include those identified as benefitting the health of the maternal, child and adolescent populations. These expenditures are funded by the state general fund and other non-federal organizations. The expenditures are within CP&HP, though, not specifically under the organizational authority of the Title V director. Other funds also include the Newborn Metabolic Screening Program conducted in the Public Health Lab of the Public Health Division. Though this program is not within CP&HP, it provides a critical public health service to the MCH population. The local funds expenditures include expenditures at the county level that are funded by patient fees, third party insurance, and county general funds. Funding from Medicaid is excluded because of potential matching at the local level. Notes about the sources for the expenditures and budget are included in the forms section of this grant application.

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 are considered to be enabling services. Funds that are used at the state level, in CP&HP, are considered to be public health services and systems. There are no direct services expenditures.

The Oregon Center for Children and Youth with Special Health Needs reports its expenditures and includes the 30% Federal funds transferred from CP&HP to OCCYSHN along with matching OHSU state general funds. OCCYSHN's community-based programs are allocated approximately 30% in enabling services and public health services and systems for the federal MCAH block grant and 100% in enabling services for the non-federal MCAH block grant.

The Oregon Title V expenditures represent actual expenditures at the time of the report preparation.

To ensure compliance with BG 3.0 reporting, we thoroughly reviewed all expenditures in CP&HP to determine Oregon's total investment in the health of the maternal, child and adolescent populations. There are some variances from last year's reported expenditures. County expenditures continue to be included as local funds. The tobacco cessation program funding includes a percentage of that program's funding based on the portion of program services provided to the Title V population.

III.D.2 Financial Narrative Budget

Oregon's budget report represents the projected totals from both Title V agencies -- Oregon Health Authority-Public Health Division-Center for Protection and Health Promotion (CP&HP) and the OHSU Oregon Center for Children and Youth with Special Health Needs (OCCYSHN). The total state funds and other funds budgets include projected expenditures identified as benefitting the health of the maternal, child and adolescent populations. These expenditures are funded by the state general fund and other non-federal sources. The expenditures are within CP&HP, though, not specifically under the organizational authority of the Title V director. The majority of other funds is from the Newborn Metabolic Screening program conducted in the Public Health Lab of the Public Health Division. Though this program is not in CP&HP, it provides a critical public health service to the MCAH population and is included to align with the National Performance Measures and Form 4. The local funds budget includes expenditures at the county level that are funded by patient fees, third party insurance, and county general fund. Funding from Medicaid is excluded because of potential matching at the local level. Other federal funds include federal grants awarded to CP&HP that benefit the Title V population. The primary sources of these funds include the USDA Nutrition Program for Women, Infants, and Children (WIC), the HRSA Maternal, Infant and Childhood Home Visiting program, and the Medicaid Title XIX match.

Oregon’s Title V Program meets its 30%-30% minimum requirement by transferring 30% of the Oregon MCAH Block Grant appropriation to OCCYSHN for serving the children and youth with special health care needs. No administrative or indirect is retained by CP&HP prior to transfer. The required Maintenance of Effort for Oregon is $3,950,427, which is achieved through funds generated at the state and local levels that benefit the maternal and child health population. Also, the OCCYSHN budget includes the required 3:4 Title V match from state general funds through a state budget line item for the OHSU Child Development and Rehabilitation Center. CP&HP considers the cost allocation of central support services to represent administrative costs. The 10% of the total budget limit is maintained by transferring excess expenses to the State General Fund. The 3:4 Title V match is achieved in the budget with projections of revenue from state general funds, county local funds including patient fees, local general funds, and non-Medicaid 3rd-party payments and other funds, mainly the newborn screening fees. To ensure compliance with BG 3.0 reporting, we thoroughly reviewed all expenditures in CP&HP to determine Oregon’s total investment in the health of the maternal, child and adolescent populations and make budget projections accordingly. There are some variances from last year’s reported expenditures. County expenditures continue to be included as local funds. The tobacco cessation program funding includes a percentage of that program’s funding based on the portion of program services provided to the Title V population.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Oregon

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E Five-year State Action Plan

III.E.2. a. State Title V Program Purpose and Design

Overview of Oregon's Title V Program Purpose and Design

Oregon's Title V program relies on shared leadership between the Oregon Health Authority (OHA) Public Health Division's Maternal and Child Section, its Adolescent and School Health program, and the Oregon Center for Children and Youth with Special Health Needs at Oregon Health and Science University. A leadership team consisting of the Title V MCH Director (Cate Wilcox), Title V CYSHCN Director (Ben Hoffman), Title V Adolescent Health Director (Rosalyn Liu), Title V CYSHCN Assessment and Evaluation Manager (Alison Martin), Title V Coordinator (Nurit Fischler) and the MCH Assessment and Evaluation Manager (John Putz) meet twice monthly to address Title V program and policy issues and ensure alignment across the agencies.

OHA MCAH Program Purpose and Design

Partnership and leadership roles

Within the MCAH Title V program, each Title V priority has a designated state lead who oversees state level program and policy work and provides technical assistance and oversight to the local level Title V grantees (public health and tribal) working on that priority (see Supporting Document #5). MCAH Title V also has a designated tribal liaison who supports/oversees the work of the tribal Title V grantees. The state priority leads from MCH, Adolescent Health, and OCCYSHN, Title V coordinator, Title V research analyst and Title V tribal liaison meet monthly to coordinate work across populations and domains. The Title V coordinator also serves as the MCH Policy Lead, ensuring that system and policy work for Title V and other MCH programs (MIECHV, Early Hearing Detection and Intervention, Oral Health, etc.) are coordinated and integrated.

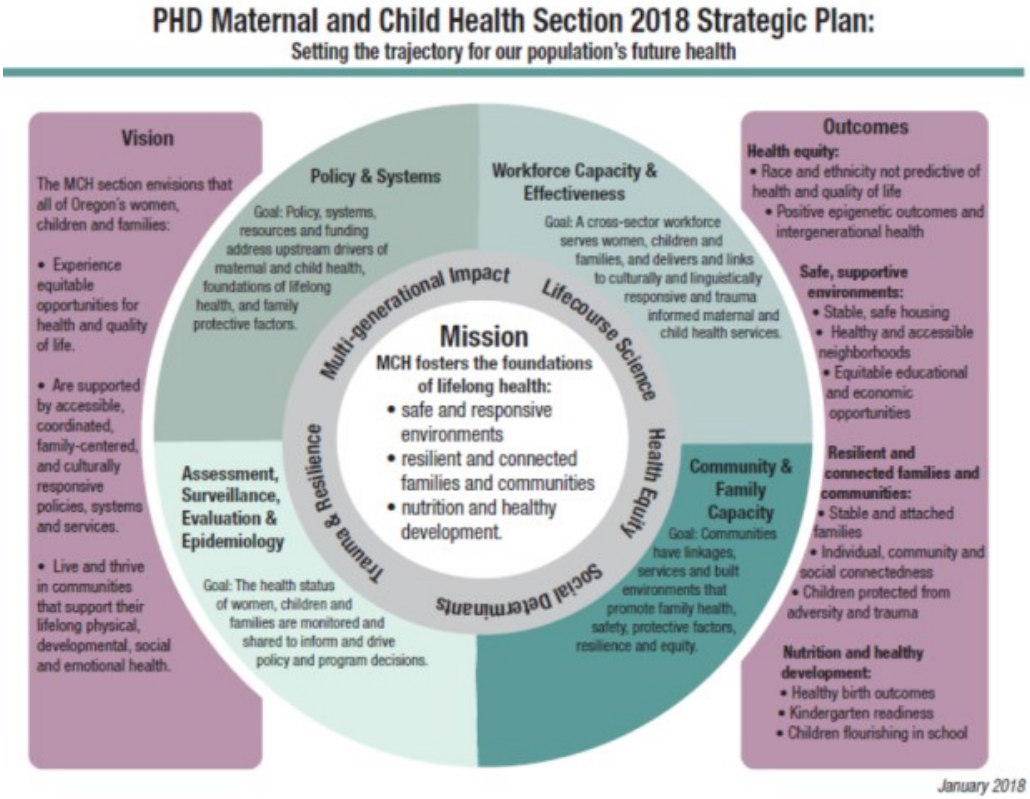
The Title V leadership team and priority leads participate in external and internal work teams and committees to provide MCAH leadership and ensure that Title V work is represented by appropriate subject matter experts and integrated into related work within the agency, across state agencies, and with external partners. Key policy and system development initiatives which Title V MCAH staff either convene or contribute to include the: Governor's Children's Cabinet, Health Aspects of Kindergarten Readiness metrics work group, Reach Out & Read Advisory Committee, Act Early Advisory Committee, Childhood Obesity CoIIN, Raise UP Oregon Agency Implementation Coordination Team, Braided CCO Equity funding team, OHA Health Disparities Advisory Committee, CCO Metrics and Scoring Committee, Oregon Pediatric Improvement Project, March of Dimes Perinatal Collaborative, State Health Improvement Plan committees (adversity and trauma, institutional bias, economic drivers of health and behavioral health), Trauma Informed Oregon Advisory Board, OHA Trauma Informed Policy Committee, Regional Kindergarten Readiness Network, Preschool Development Grant Needs Assessment Coordinating Committee, Oregon Safe Kids, Shared Risk and Protective Factors Work Group, Child Maltreatment Prevention Interagency Agreement group; Maternal Mortality Review Committee, State Child Fatality Review Team, and Domestic Violence Fatality Review Team. Adolescent Health staff provide expertise and leadership to: Confederation of Oregon School Administrators Workgroup on Social Determinants of Health, Oregon Department of Education Safe and Effective Schools Working Group, Student Health Systems Division and Oregon School Activities Association workgroup on student athletes, Oregon Pediatric Improvement Project, and the Healthy Kids Learn Better Coalition.

Program Framework and Strategic Approach

The MCH Section strategic plan, and the Adolescent & School Health strategic plan (Supporting Document #4), as well as the OHA Performance Management System, PHD strategic plan and PH Modernization provide a framework for how the Title V program addresses MCAH priorities in Oregon.

The Mission of the MCH Section is to foster the foundations of lifelong health: safe and responsive environments; resilient and connected families and communities; and nutrition and healthy development. The lenses that the section uses in all its work include life course science, health equity, social determinants, trauma and resilience, and multi-generational impact. The work is focused in four key areas: policy and systems; workforce capacity and effectiveness; assessment, surveillance and epidemiology; and community & family capacity. Each area has a goal and several strategic priorities (see graphic below and Supporting Document #4 for complete plan), and Title V's

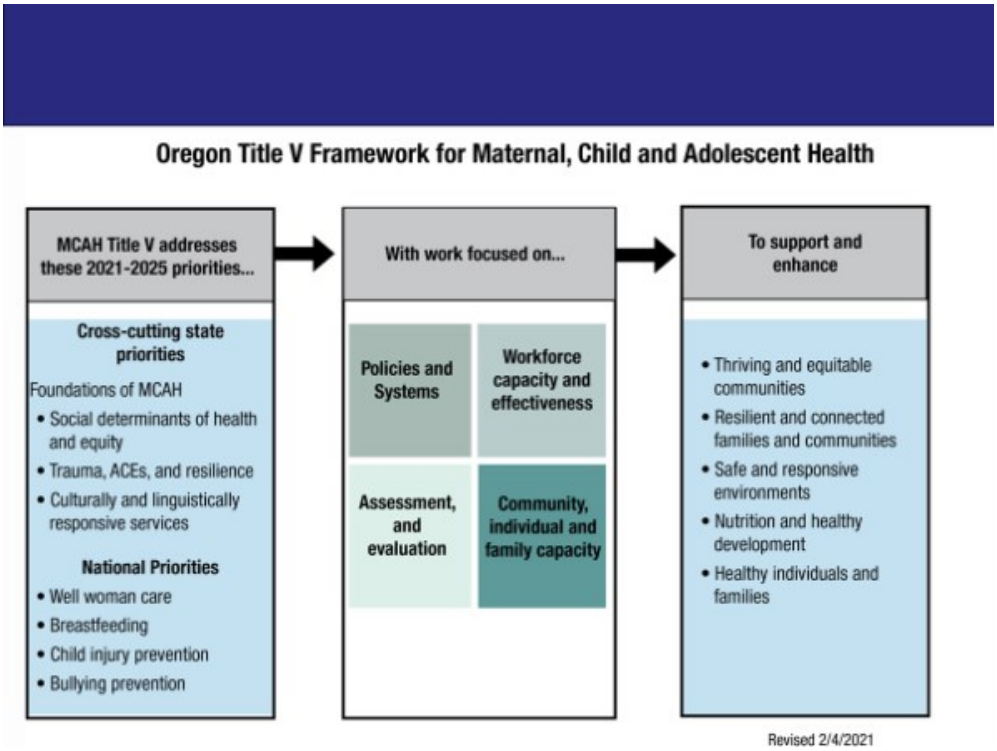
work is integrated across all of these. The graphic below illustrates this framework.



The MCAH Title V program has adopted a new framework for the 2021-2025 grant cycle, illustrated in the graphic below. This framework reflects the findings of our 2020 Needs Assessment, and the Title V program's commitment to ensure that MCAH Title V work is focused upstream, using the lenses of racial equity, social determinants, and trauma/toxic stress – as well as the multi-generation and life course approaches outlined in the graphic above. The framework below illustrates how the MCAH Title V program is addressing our three state level Title priorities - social determinants of health and equity; trauma, toxic stress, ACEs and resilience; and culturally and linguistically responsive services (CLAS) – jointly as the foundations of maternal, child and adolescent health. This framework recognizes that work on all 3 of these topics is integrally inter-connected. It also reflects the understanding that work on our 4 national priorities (well-woman care, breastfeeding, child injury prevention, and bullying prevention) must also integrate a focus on Foundations of MCAH work. The framework (see below), and the related set of strategies and activities (see supporting document 5) organize the Title V priority work into four core public health functional areas: policy and systems; workforce capacity and effectiveness; individual, family and community capacity; and assessment and evaluation. The goals of each of these areas are as follows:

- Policy and Systems: Policy, systems, resources and funding address upstream drivers of maternal, child and adolescent health, foundations of lifelong health, and family protective factors.
- Workforce Capacity & Effectiveness: Support a cross-sector workforce that serves women, children, youth and families, and delivers and links to culturally and linguistically responsive and trauma informed maternal and child health services.
- Community, Individual & Family Capacity: Communities, individuals and families have access to resources, services and built environments that promote family health, safety, protective factors, resilience, and equity.
- Assessment & Evaluation: Data on social determinants of health, trauma, and equity are monitored and shared to inform and drive policy and program decisions.

Note: Recognizing the inter-connected nature of the upstream cross-cutting/systems work, MCAH strategies and activities for our 3 state priorities will be merged under “Foundations of MCAH” and organized into the 4 key Foundations areas outlined above in the State Action Plan Narrative (Sections III.E.2.c).



Organizationally, Title V’s Adolescent Health work sits within the Adolescent & School Health Unit, with a mission of supporting the health of all youth in Oregon through evidence-based and data driven policies, practices, and programs. The Unit’s work is comprised of four program areas: policy and assessment; school-based health centers, school nursing, and youth sexual health.

Oregon’s state and local public health structure has been going through re-structuring and transformation for several years as part of Public Health Modernization. The goal of public health modernization is to ensure equitable capacity and focus on core public health functions across the state. The Title V program is working closely with Public Health Modernization, providing leadership for the MCAH community’s participation in this effort. Given the situation with the Title V pandemic over the past year, and the resulting stresses on local public health capacity, the need for equitable and consistent public health core functions is more apparent than ever. Public Health Modernization legislation passed in June 2019 allocating $25 million to enhance state and local public health modernization efforts. Legislation to allocate an additional $45 million in public health modernization funding was approved in the 2021 Legislative Session. Title V strategies and activities are built around the foundational public health capabilities and support this transformation in practice.

OCCYSHN Program Purpose and Design

OCCYSHN’s mission is to improve the health and well-being of Oregon’s children and youth with special health care needs (CYSHCN). Our vision is that all Oregon CYSHCN are supported by a system of care that is family centered, community-based, coordinated, accessible, comprehensive, continuous, and culturally sensitive and responsive. We pursue this vision within the context of Oregon’s health care transformation, and the Title V Block Grant purpose and requirements. We are located within the Institute for Development and Disability at Oregon Health & Science University (Oregon’s only academic medical center), which allows for fruitful collaboration with influential health care providers, researchers, and change-makers.

We strive to ensure that Oregon CYSHCN receives well-coordinated care in patient-centered medical homes, and that CYSCHN have an effective transition from pediatric to adult health care. Our cross-cutting state priority areas

focus on health equity for CYSHCN by improving access to culturally and linguistically appropriate services, addressing the impacts of social determinants of health and equity on CYSHCN, and promoting trauma-informed care.

OCCYSHN staff are Oregon's subject matter experts on issues affecting CYSHCN. We inform health care policy, administration, and practice with our data and evaluation expertise, our long-term experience with community-based care coordination, our relationships with health care providers and families of CYSCHN statewide, and our knowledge about Oregon's health care systems.

OCCYSHN brings a systems-based perspective to pursuing our priorities. We view health care systems, and the context in which they operate, as the primary locus of intervention to influence the infrastructure serving CYSCHN and their families. Our leadership role in improving systems of care for CYSHCN requires effective partnerships with the people, programs and institutions that make up those systems. (See Critical Partnerships lists for NPMs 11 and 12.) OCCYSHN convenes and participates in cross-systems, interagency collaborations on behalf of CYSCHN to strengthen systems of care. We are committed to integrating family members of CYSHCN into all efforts to improve the systems that serve them.

OCCYSHN's work is organized into three primary units: Family Involvement; Systems and Workforce Development; and Assessment and Evaluation. The Family Involvement Program ensures that family members of CYSHCN are supported, that their voices are heard, and that they have an active role in designing and implementing policies and programs that affect them. The Systems and Workforce Development unit partners with local public health authorities around the state on programs and projects aimed at coordinating care for CYSHCN and improving local systems of care. The Assessment and Evaluation unit conducts surveillance, needs assessment, and program evaluation research for OCCYSHN. Our programs and projects (see list below, with links for more information) combine the expertise of our work units to address our priorities and advance policy goals.

OCCYSHN's strategies to address national and state priorities were developed using 2015 and 2020 needs assessment results, reported experience of stakeholders about systems serving CYSHCN, and evidence-based/informed resources such as the *Standards for Systems of Care for CYSHCN* (AMCHP & NASHP, 2017; NASHP, 2020). We integrate learnings from technical assistance into our work, and we bring over thirty years of experience working with community and state partners to improve systems of care for Oregon CYSHCN.

OCCYSHN embraces innovative approaches to advancing our priorities. We use on-line platforms to build learning communities, engage family members of CYSHCN in care coordination, and share information between families, first responders, and emergency departments in emergency situations. We are exploring the intersection of legal issues and health care systems as they impact CYSHCN. We conducted some of the first studies in the nation on the health care experiences of CYSHCN from families of color. As we implement our block grant strategies, we will continue to fine-tune our efforts and explore new approaches to improving Oregon's health systems infrastructure to improve the health and well-being of CYSHCN and their families.

OCCYSHN Programs and Projects

- Advocacy: OCCSYHN participates on committees, workgroups, and collaborations that impact CYSHCN. We also provide data and expertise to inform administrators and policymakers.
- Assessment and Evaluation collects, analyzes, and disseminates data about issues and interventions for Oregon's CYSHCN.
- CaCoon is a home-visiting public health nursing program. Nurses across the state work with families to coordinate care for CYSHCN.
- Community-Based Autism ID Teams use local medical-educational teams to establish a single, valid, and timely evaluation for autism spectrum disorders. Teams determine both educational eligibility for autism services and a medical diagnosis for children up to age five, and refer families to appropriate services.
- Community Health Worker Project: OCCYSHN developed an online course for community health workers. The training addresses the particular needs of CYSHCN and their families. Community health workers often provide culturally and linguistically congruent services, thereby advancing health equity.
- Family Involvement is a partnership between families and professionals. The Family Involvement Program empowers families of CYSHCN, and increases opportunities for those families to inform health care practice and policy.
- HERO Kids Registry (launching 2022) will be a voluntary, no-cost registry where families can provide vital information about their child, which will be made available to emergency responders and emergency departments.
- Learning Communities use video conferencing technology to discuss practice situations involving caring for CYSHCN. Participants teach and learn from each other about coordinating care for CYSHCN, and strengthen local systems of care.
- Policy Project: This collaboration between OCCYSHN and the Oregon Law Center improves systems of care by addressing legal challenges faced by families of CYSHCN.
- Medical Complexity Project: The MCHB-funded Children with Medical Complexity Collaborative Improvement and Innovation Network (CMC CoIIN) improves the quality of life for children with medical complexity, the wellbeing of their families, and the cost-effectiveness of their care, through innovative care and payment models.
- Shared Care Planning is a process for coordinating care across health, education, and community service systems. OCCYSHN contracts with partners around Oregon to implement shared care planning for CYSHCN in their communities.
- Zetosch Funds come to OCCYSHN from the Oregon Community Foundation. Funds are designated for purchasing educational equipment for Oregon CYSCHN in low-income families. Implementation requires that OCCYSHN collaborate with health, education, and service providers statewide.

III.E.2.b.i MCH Workforce Development

OHA MCAH Workforce Development

Workforce Strengths and Capacity

The state-level Title V program funds 16 FTEs spread across 20 positions in the Public Health Division's Maternal and Child Health, and Adolescent and School Health units, as well as 2 FTEs at the 211info to provide the MCH Warmline capacity for Oregon. Currently, none of these positions are vacant.

Oregon's MCAH workforce strengths include an experienced and dedicated workforce that continually demonstrates creativity and flexibility in the face of changing systems and funding. At the local level, MCAH staff and programs are deeply connected to community needs and integrated into local systems of health care social services, and education, making them a vital voice for MCAH population health in many policy and planning arenas.

Title V workforce capacity is always a concern, as MCAH needs on both the state and local level always exceed our Title V capacity. Additionally, the COVID-19 pandemic has stressed Oregon's state and local MCH workforce, as it has across the country. Over the past year staff have continued to fill multiple roles – supporting COVID-19 emergency response, doing their regular work, and filling in for absent or re-deployed co-workers. At the same time, they have re-structured their jobs to continue to work and provide services remotely while navigating the ongoing stresses of the pandemic on their families and communities. In many communities, local public health staff have been targeted and harassed as a result of their work in responding to the COVID-19 pandemic. While everyone is exhausted, the flexibility, dedication, creativity, and perseverance they have continued to demonstrate as the pandemic stretches beyond the second year is truly impressive.

Recruitment and Retention

The state level Title V Program's recruitment and retention plan is firmly grounded in our commitment to racial equity and our racial equity policy and hiring guidelines.

- The MCH Section and Title V program is focused on implementing our racial equity policy to ensure recruitment and retention of a diverse and trauma informed workforce. The policy is included in Supporting Document #4.

- The MCH Section has implemented recruitment and hiring practices targeted at increasing equity in hiring and retention. The guidelines originally developed by the MCH Section have been integrated into a Public Health Division wide equity hiring guideline that is now used agency wide.

- Recruitment and retention of diverse staff has been a particular focus of the past year. This is in alignment with our section's racial equity goals, and also in response to the fact that an increased focus on community engagement and racial equity at the Division level resulted in several of our key staff members being promoted to other positions in the agency.

- Retention efforts in the past year have largely focused on supporting staff to work remotely, equipment, flexible work schedules, shared workloads, and other mechanisms to enable staff to balance work and home responsibilities through the COVID-19 pandemic. Ongoing efforts to create a trauma informed and anti-racist workplace are also key to staff retention.

- We have continued to experience vacancies and transitions as staff find opportunities for career advancement through new positions created with COVID and ARPA funding. This has created gaps, but also prompted creativity and opened opportunities for MCH staff to move up within our Title V program. The Title V Director's flexibility and support has been a key factor in retaining Title V staff through this challenging period.

Staff training and workforce development

MCAH workforce development needs are addressed through a variety of mechanisms on both the state and local

levels. Workforce capacity-building efforts, which reflect the changing MCAH landscape in Oregon, are a central focus of workforce development efforts including: public health modernization, health equity and cultural/linguistic responsiveness, and early childhood/home visiting. Due to the COVID-19 pandemic, support for remote work and service delivery has been a big focus of the past year.

- The MCH Section has an ongoing focus on racial equity work – including a contract with Engage to Change to support the MCH section to enhance staff capacity and integrate anti-racist policy and practices. This work is intended to create an inclusive and supportive workplace that promotes retention of a diverse staff. It is carried out through monthly trainings with all MCH Section staff and guided by a core planning team which includes the MCH Title V Director and MCH Title V equity lead.

- State MCAH staff have individual employee development plans and attend conferences, trainings, university courses, or other development opportunities to meet the goals of those plans. State staff participate in a state government leadership training opportunity, as well as the Northwest Center for Public Health Practice's training and leadership development opportunities. All of these activities have shifted to being conducted virtually during the pandemic.

- Title V sponsors or supports a variety of workforce development activities throughout the year, which are available to both state and local MCAH staff. Current areas of focus include:
    - Training to enhance capacity for trauma-informed and equitable workforce and workplace are a major focus of MCAH workforce development. All MCH staff received support from "Engage to Change" contractors to assess equity-related concerns and needs. All staff now have health equity as part of their workforce development plans, as well as dedicated time in their job descriptions to pursue this professional development. This work with state and local MCAH workforce aligns with Oregon's MCAH Title V Foundations priorities and strategies, as well as with Public Health Division and OHA priorities.
    - The state MCAH program is active in mentoring MCAH students and new professionals. Even with remote learning, Title V was able to support an internship for a student from a local high school throughout the school year.

- Over the past year, Title V staff have also participated in equity and community engagement training as a part of the Division level Public Health Modernization program and the community engagement work supporting funding for community-based organizations serving marginalized communities across the state. A 6-part training series was provided by the PHD Community Engagement Team in partnership with trainers from Washington State.

- Local MCAH programs receive ongoing technical assistance and training through state MCAH nurse consultants, Title V program, policy, and research staff, and nutrition consultants. In alignment with our Foundations of MCAH work, Title V has been working to build grantee capacity to conduct work in policy and systems; workforce development; community, individual and family capacity; and assessment and evaluation. State Title V staff also work with local grantees to build their capacity in relation to priority selection, plan development, measurement and tracking of Title V activities, and reporting.

- A critical and ongoing consultation/workforce development activity is the training of new LPHA Administrators, MCH supervisors and staff in local health departments around the state. Orientation for new LPHA staff is conducted regularly by the State Public Health Division and is supplemented by MCH program-specific training conducted by the MCH Nurse team. MCAH Title V staff supplement this training with orientation to the MCAH Title V program for new LPHA and tribal staff and administrators on an ongoing basis.

- The Oregon MothersCare (OMC) program provides quarterly training and ongoing technical assistance to local OMC coordinators and supervisors across the state to facilitate enrollment in Oregon Health Plan (OHP) and other forms of health insurance, and access to prenatal services.

- Local MCAH programs serve as field placement sites for nursing students as well as high school, undergraduate and graduate students – providing critical exposure to public health career opportunities.

Training needs and MCH workforce development with partners

The Title V program anticipates that training needs of MCH partners in the coming year will include support for implementation of the Title V Foundations of MCH focus, as well as support for our new priorities of child injury prevention and bullying prevention, and ongoing priorities of breastfeeding and well woman care. However, given the ongoing pandemic and high level of stress on local public health partners, we are taking a conservative approach to MCAH workforce training and leaning heavily on the support aspect of that equation. One way to minimize burden and maximize responsiveness to partner needs is to align our training and workforce development activities with others'. MCAH Title V plans to do this in the coming year through multiple partnerships including with the PHD Collaborative funding for CBO modernization and equity project; the Early Learning Division, MIECHV, and our OCCYSHN Title V partners. We plan to do listening sessions in Fall 2022 and continue to assess and respond to partners' needs as capacity at the local level (hopefully) stabilizes in the coming year and they are able to return to a more pro-active, rather than crisis response position in regard to their workforce needs.

Innovations in staffing structure and workforce financing

- Oregon's modernization of public health initiative provides a framework for ensuring capacity to deliver foundational public health programs and ensure foundational public health capabilities across both state and local level public health. Title V programming and staffing at both the state and local level are aligned with modernization efforts. Significant progress has been made this year in developing a strong equity and community engagement focus for the modernization work, which is reflected in the development and staffing of a Community Engagement Team at the PHD level, as well as funding of 147 community-based organizations, along with LPHAs and tribes to advance PH modernization and equity work across the state.

- The COVID-19 pandemic has created multiple opportunities for innovations in staffing structure and workforce financing. One example of this innovation is the transition to remote delivery of services such as home visiting. Another innovation relates to the engagement of diverse community partners in the delivery of public health services. The Public Health Division has traditionally funded local public health authorities and tribes for the vast majority of public health work in Oregon. Given the need to partner more closely with communities to address COVID-19 inequities, the Public Health Division expanded funding to nearly 180 community-based organizations (CBOs) across Oregon. The modernization and equity funding described above is a direct outgrowth of the work begun with COVID funds.

- The MCAH Title V program is working with both the CRRU and the newly formed Public Health modernization/equity teams to integrate an MCH lens and provide matrixed staff support to both of these critical equity workforce programs.

OCCYSHN Workforce Development

OCCYSHN staff expertise includes assessment and evaluation, child health, community engagement and development, cultural competency, family engagement, family-professional partnerships, health literacy, health policy, public health nursing, and special education. OCCYSHN has made strides towards diversifying its staff (e.g., age, ethnicity/race, sexual orientation). Continuing our internal work to dismantle racism and white supremacy may help us continue to recruit and retain a diverse staff. OCCYSHN's staffing has been stable for the last few years, which has lent consistency to our work and enabled us to pursue new projects.

We are recruiting a full-time Systems Innovation Manager, a new position in the Systems and Workforce Development unit. The position will expand our capacity to influence systems of care for Oregon CYSHCN.

OCCYSHN supports professional development for all staff. Annual goals for professional development and annual performance reviews are part of all staff positions. Staff professional development opportunities range from internal support for professional publications to participating in state, national, and OHSU-sponsored conferences and trainings. We are focused on educating ourselves about racism and other forms of oppression, so that we can better understand and address the needs of CYSCHN from families of color and other minoritized communities. Our internal Equity Workgroup engages in quarterly training and discussion on equity-related topics, and presents quarterly to OCCYSHN staff.

OCCYSHN provides professional development to public health nurses and other health and service providers, including Community Health Workers (CHWs), through Systems and Workforce Development efforts. These block grant activities include support, training, and technical assistance on cross-systems collaboration and care coordination (Strategies 11.1 and 12.1 of the block grant plan). Topics covered in virtual meetings of care

coordination teams include engaging professionals and families in shared care planning, using an online care coordination platform, and family-friendly meeting facilitation. OCCYSHN developed an online training curriculum for CHWs and partnered with Oregon State University to disseminate it as part of their CHW course offerings. We have not formally assessed the CYSHCN workforce training needs. The workforce development opportunities we have offered responded to requests from local public health authorities (LPHAs), and to our own observations of training needs. LPHA partners provide feedback in TA sessions, and at listening sessions during OCCYSHN's annual meetings. We also identify training needs by working with LPHAs on cross-systems care coordination activities. The LPHA workforce has been further strained by the demands of COVID. LPHAs faced high turnover before the pandemic, as it is hard for them to compete with other nursing opportunities. Workforce challenges affect their capacity to implement community-based care coordination.

OCCYSHN's community-based autism identification teams (Strategy S2.2, ACCESS Program) build the capacity of physicians and educators around the state to evaluate children 0-5 for autism spectrum disorders (ASDs) and other developmental issues. Medical providers on ACCESS teams are trained to use a specific screening tool, and to collaborate with educators to evaluate for both medical diagnoses and educational eligibility. OCCYSHN employs an ASD subject matter expert to provide technical support and consultation to ACCESS medical providers and team members. We also provide monthly case-based learning sessions using the ECHO model. These ECHO sessions are open to other interested educators and physicians (outside the ACCESS program), to increase knowledge about education-medical ASD evaluations.

OCCYSHN's Children with Medical Complexity (CMC) Collaborative Improvement and Innovation Network (CoIIN) team is implementing a health care transition-focused quality improvement (QI) project with two OHSU pediatric and one adult clinic. We identified provider and clinic professional development needs through a root cause analysis, QI learning, and our five-year needs assessment results. To meet these needs, we have developed a 50-minute seminar about supporting the transition from pediatric to adult health care for children with medical complexity. We have piloted it with general pediatrics providers and family medicine medical students. We also adapted it to present to CCO care coordinators during a FY22 Care Coordination Learning Collaborative. Ultimately, our goal is to develop an educational seminar for use in a range of health system and partner venues. (Strategy 12.2 of the block grant plan.) Our needs assessment findings confirmed that Oregon families of CYSHCN of color experience racism in health care settings. Given the deleterious effects of racism on health outcomes and well-being, OCCYSHN has worked with our needs assessment partners to disseminate our findings to health, education, and community service providers (Section III.C.1.a.), with the goal of informing the CYSHCN workforce and improving health care and services for CYSCHN from families of color. We will use the findings as one source of information to identify and promote culturally sensitive health care practices (State Action Plan Section S2.1.2) among health care providers and staff.

OCCYSHN partners with OHSU's Institute for Development and Disability's Child Development and Rehabilitation Center (CDRC) to improve health care for CYSHCN. This partnership prioritizes care coordination, behavioral health, medical consultation, feeding and nutrition, genetics, and high-risk infant care and follow-up. CDRC provides direct services to Oregon CYSHCN and their families in Portland, Eugene, and at outreach clinics. CDRC offers a family-centered, team-based, interdisciplinary care model. Multiple specialists evaluate a child on the same day, and develop holistic, integrated diagnostic summary and family recommendations. CDRC's approach helps families "pull the pieces together" for their children through direct care efforts. CDRC maintains the care model due in large part due to the support of Title V.

OCCYSHN's co-location, and coordination with, the University Center for Excellence in Developmental Disabilities Education, Research, and Service (UCEDD), Leadership Education in Neurodevelopmental & Related Disabilities (LEND), and Oregon Office on Disability and Health (OODH) programs strengthens our capacity to address workforce needs related to CYSHCN and their families. OCCYSHN partners with UCEDD and LEND to educate pre-service students and community service providers. OCCYSHN also collaborates with UCEDD and OODH on shared priorities, such as health care transition for YSHCN.

III.E.2.b.ii. Family Partnership

OHA MCAH Family Partnership

Oregon's MCAH program is committed to building the capacity of women, children, youth, and families, including those with special health care needs to partner in decision making for the Title V program. Special efforts are made in assessment, planning, policy development, and program implementation to include family members and representatives of communities experiencing disparities – and to engage families and consumers in ways that are culturally and linguistically accessible.

State and local efforts to build and strengthen family/consumer partnerships include:

- Oregon's 2020 MCAH Title V Needs Assessment had a strong family/community partnership component, including eight contracts with organizations that work with under-represented communities to ensure that the voices of those families and communities are heard in the upcoming needs assessment. Plans to engage additional families/communities in ongoing assessment have been delayed due to the COVID-19 pandemic but will resume as capacity at both the state and local levels allow.

- Oregon engaged family/community members through our work on the AMCHP-led SDOH CoIIN initiative. Since the end of that project, parent storytellers have continued to partner with the Title V program to advocate for improvements in childcare. Most recently, one of the participants convened several of her fellow storytellers, along with MCH Title V staff, organized an evening film showing with a panel presentation and discussion about the importance of accessible childcare to maternal and child health.

- Local Title V programs are administered through local health departments and tribes in each county in Oregon, and all have unique approaches to engage families/consumers to meet the specific needs of their communities. Consumers are engaged in needs assessment, program development and quality assurance in local Title V programs through community meetings, advisory boards, surveys, etc.

- State level Title V staff partner with a wide range of community agencies, as well as local public health agencies and tribes to ensure family and consumer voice informs program and policy decisions, and community programs such as the Healthy Birth Initiative Community Action Network that help ensure consumer voice in our program planning and implementation.

- The MCH Maternal Mortality Review Committee engages family/community members on its Advisory Board. The Board reviews maternal deaths, analyzes and recommends related system and policy changes.

- The Oregon Birth Anomalies Surveillance Team works with the Oregon Family to Family Health Information Center to coordinate efforts to meet the needs of families who have children and youth with special healthcare needs (CYSHN). Efforts include providing relevant data about birth rates and trends, collaboration on tips sheets for families, promotion of events on social media, and applying family input into our program design. We plan to continue to build upon this partnership next year to support and better understand the needs CYSHN families and communities.

- Title V is partnering with Oregon's Early Learning Division to provide funding to community-based organizations, local health departments or tribes to support the implementation of culturally responsive community awareness campaigns to promote safe sleep for infants in Oregon. Community campaigns will use health messages developed by the Oregon Safe Sleep Coalition and be based on best practices in promoting safe sleep. Title V and the Oregon Safe Sleep Coalition will use the lessons learned from these community campaigns to inform future efforts to promote safe sleep.

- Family Connects, Oregon's universally offered home visiting program, is engaging families by working with Community Leads in 4 early adopter sites on community alignment plans for implementation of Family Connects. They are also recruiting community members for Family Connects RAC work planned for this summer.

- The MCH Section has begun a practice of involving paid family representatives on hiring panels. The family representatives serve on all phases of the candidate screening and interview process.

- The MCH nurse team is working with staff and program participants from Oregon's African American Infant Mortality Reduction program, Healthy Birth Initiative (HBI) to assess nurse home visiting forms and other required home visiting tools and ensure that they are culturally relevant, and trauma informed.

- The Oregon Early Hearing Detection and Intervention program (EHDI) engages families of infants who are deaf or hard of hearing (D/HH) and D/HH adult community members in various aspects of the program, including:
    - 13 years of funding investment in the Oregon Chapter of Hands & Voices to provide informational support and peer to peer connections for families of newly identified infants.
    - Representatives of Hands & Voices have guaranteed time on every agenda of the EHDI Advisory Committee to provide updates and engage the membership around family needs and support.
    - Caregivers and D/HH adults participate as members of the EHDI Advisory Committee.
    - Funding support for caregivers to participate in the annual National EHDI Conference.
    - Caregivers of infants newly identified as D/HH are invited to provide feedback about their experiences with the EHDI system to identify opportunities for improvement.
    - Caregivers and D/HH adults are invited to review and provide feedback for family letters, the EHDI website and other communications.
    - EHDI staff convene and facilitate system partners and members of the D/HH community to address gaps in support for children and families.

- MIECHV is working to engage parents as partners in CQI work "Joy in Work and Joy in Parenting" and intend to use American Rescue Plan Act funding to launch a parent/family-based workgroup to develop a plan for the equitable distribution of concrete supports for families like prepaid grocery cards and gas cards.

- The Adolescent and School Health (A&SH) Unit has a focus on engaging youth in the development and implementation of their policies and programs. This is achieved through youth participatory action research curriculum implemented through SBHC youth advisory councils across the state. ASH is in the process of standing up a statewide Youth Advisory Council (YAC) to make recommendations on spending of COVID-19 recovery funds. Out of 300 applications, a team of reviewers will identify 20 youth for the YAC. Youth engagement is also a key focus of work on the new Title V priority of bullying prevention.

- The MCH Section's Rape Prevention Education Program funds local prevention educators that work with communities and youth to build skills to prevent violence before it happens. This is done by the educators teaching youth to promote positive social norms, skills building around bystander intervention in risky situations, and promoting consent, and creating and nurturing healthy and safe environments and relationships

- The Title V program has partnered closely over the past year with the Public Health Division's new initiative to fund community-based organizations for public health modernization and equity work in under-represented communities across the state. Although Title V funding is not directly invested, the increased investment in equity and public health modernization work including in emergency preparedness, climate health, tobacco prevention, opioid overdose prevention, and adolescent health will have a significant impact on health of the MCH population. Title V's investment in this partnership will include ongoing support and TA to both the state level programs and the community-based organizations as the funding is disseminated and programming implemented over the coming year.

- The Public Health Division also has multiple advisory groups which rely on community and consumer representatives to develop policies and programs. These include the WIC Advisory Committee, Oregon Partners to Immunize Children, Immunization Advisory Committee, Genetics Advisory Committee, Teen Pregnancy Task Force, the Youth Sexual Health Partnership, and the Marijuana Communications Committee.

- During the COVID-19 pandemic, the Public Health Division has greatly expanded the opportunities for under-

represented families and communities to have input into all aspects of state Public Health work. A new Community Engagement team within the COVID Response and Recovery Unit (CRRU) supports contracts with 179 community-based agencies to provide COVID-related services to their communities. These contracts have greatly improved the relationships with under-represented communities across the state, and the PHD's understanding and ability to support their needs well beyond COVID-19.

OCCYSHN Family Partnership

OCCYSHN ensures family partnership in all Title V CYSHCN activities through a robust Family Involvement Program (FIP). Tamara Bakewell, MA, who is the parent of an adult CYSHCN, manages the FIP. She is an integral member of OCCYSHN's leadership team, helping to guide OCCYSHN's strategic planning and implementation. Ms. Bakewell serves on state-level committees and workgroups (Strategies 11.1 and 12.1 of block grant report). She is also Oregon's Family Delegate to AMCHP.

The FIP Manager regularly invites families of CYSHCN to share their lived experience to inform OCCYSHN efforts. The FIP collaborates with Systems and Workforce Development staff to convene family listening sessions on topics specific to their work. Family quotes and examples are included in workforce training materials, and the FIP Manager represents the family voice at regional meetings, ECHO sessions, and other OCCYSHN activities. She also recruits and trains family members of CYSHCN to review OCCYSHN's block grant application. FIP staff help track policy related to CYSCHN. They inform OCCYSHN's CoIIN quality improvement efforts, and they help develop and implement the ACCESS program and the HERO Kids project. (See NPM strategies 11.1 and 12.1, and SPM strategy 2.2.)

The FIP Manager coaches external stakeholders on integrating family input into their work, using the "Planning for Meaningful Family Involvement" tool she developed. This tool, deemed a "cutting edge" practice by AMCHP's Innovation Station in 2019, was revised in 2020 to make it even clearer and easier to use. The FIP Manager recruits family members of CYSHCN to offer legislative testimony on measures with the potential to impact them. She also recruits family members of CYSHCN to serve on external committees and workgroups, and to provide technical assistance to professional stakeholders. She coaches and supports family members on public speaking, to better equip them to share their message and influence systems change. Upon request, FIP Parent Partners provide external organizations with family-focused feedback on programs, policies, and written products.

OCCYSHN's FIP houses Oregon's Family to Family Health Information Center (ORF2FHIC). Staff include the FIP Manager, the Bilingual Outreach and Training Specialist, the Parent Partner/Resource Specialist, and two community-based Parent Partners (PPs). PPs help Oregon families navigate health care financing, partner with providers in health care decision-making, access medical homes, prepare for health care transition, find and use community-based services, and access health screening.

Since its inception in 2011, the ORF2FHIC has served families through one-to-one peer support, group trainings, web-based information and resources, and family-friendly tip sheets, toolkits, and resource guides. PPs model advocacy skills, and help families find the information they need. PPs create content for the ORF2FHIC web and print communications. The FIP collaborates with community partners to help them create accurate, up-to-date, plain-language materials for families. Non-English-speaking families of CYSHCN who contact the ORF2FHIC get interpretation services from culturally specific, community-based agencies. The Bilingual Outreach/Training Specialist translates materials into Spanish and disseminates them through Latino community organizations.

Each year ORF2FHIC hosts 12 to 15 informal family listening sessions around the state (or virtually). The gatherings are structured around topics of interest to families. Recent topics include school nursing services, using telehealth, and safety/emergency planning. In these listening sessions, families of CYSHCN share valuable insight into the challenges they face finding and using health care and services. ORF2FHIC presents information gleaned from the listening sessions to OCCYSHN staff and applies it to both internal and external quality improvement.

The FIP and ORF2FHIC serve Oregon families of CYSHCN. In the process, they provide OCCYSHN with critical first-hand information we apply to improving systems of care for CYSHCN. OCCYSHN's efforts are informed and enriched by hearing directly from families of CYSCHN about the challenges they face.

II.E.2.b.ii.a MCH Epidemiology Workforce

OHA MCAH Epidemiology Workforce

The Maternal and Child Health Section is supported by an Assessment, Evaluation, and Informatics (AE&I) Unit. The AE&I Unit consists of an Assessment, Evaluation, and Informatics Manager, the state MCH Epidemiologist, 8 research analysts, including the Lead Research Analyst who also serves as the Title V Research Analyst, 5 informaticists, and other program staff. The Public Health Division has strong connections with local academic institutions including the public health faculties of Oregon Health & Science University (OHSU), Portland State University and Oregon State University. Many doctoral level staff members at the Public Health Division have appointments at these universities. The Maternal and Child Health Section is currently hosting a first year CDC/CSTE Applied Epidemiology Fellow and plans to apply to serve as a host billet site for future fellows.

Currently, Dr. John Putz serves as the Assessment, Evaluation, and Informatics Manager. In this capacity he provides management-level oversight of epidemiological and scientific work. Dr. Putz serves on the Science and Epidemiology Council of the Oregon Health Authority's Public Health Division. He served as the State of Oregon's COVID-19 Operations Chief, Deputy Operations Chief, and Health Intelligence Chief, and Active Surveillance Director during the first six months of the pandemic response. Dr. Putz earned his B.S. (Honors and Cum Laude) in Psychology and Ecology & Evolutionary Biology from The University of Arizona, M.A. in Clinical Psychology from Indiana University, and Ph.D. in Public Health (Health Behavior) from Indiana University. Dr. Putz has significant experience in epidemiological work in non-profit, academic, local government, and state government sectors. He led the Indiana Research and Evaluation Office of Centerstone, the nation's largest provider of non-profit community-based mental healthcare services from 2010-2016. In that capacity Dr. Putz directed the evaluation, research, analytic, and surveillance components of federally funded mental health and infectious disease programs. This work included the establishment of a HCV screening, referral, and education program amongst persons living with serious mental illness (e.g., schizophrenia, bipolar mood disorder) and co-morbid addiction issues. Dr. Putz served as the national chair of Centerstone's clinical research advisory board and led the agency's national clinical research program (serving as Principal Investigator on government and industry funded clinical trials). Following his work at Centerstone, Dr. Putz served as Clinical Research Manager (2016-2018) at the Indianapolis city-county public hospital/primary care system (Eskenazi Health). In this role Dr. Putz chaired the agency's research committee and served as Research Integrity Officer for the agency.

Dr. Suzanne Zane currently serves as Oregon's State MCH Epidemiologist. Dr. Zane has been an epidemiologist with the Centers for Disease Control and Prevention since 1997, beginning with training in CDC's Epidemic Intelligence Service from 1997-1999 with the Division of Global Migration and Quarantine. She has been a scientist in the Division of Reproductive Health since that time, first as a maternal health epidemiologist, and for the past decade as a senior MCH epidemiologist assigned to non-CDC agencies to build epidemiologic capacity (2 years at the Northwest Tribal Epidemiology Center, serving the Federally-recognized Tribes of Oregon, Washington and Idaho, and 8 years at the Oregon Health Authority). She provides epidemiologic and scientific planning and oversight for Oregon Public Health Division's Maternal and Child Health Section surveillance and research analyses, which also include all oral health activities, and has a key scientific role in the Oregon PRAMS and Early Childhood Health in Oregon (ECHO) surveys and the Birth Anomalies Surveillance System, provides epidemiologic consultation to other state public health programs, and is the clinical epidemiologic interface between the MCH Section and external partners such as the pediatric cardiology department at Oregon Health and Science University and Oregon Child Protective Services/Child Welfare. Dr. Zane earned her MPH from the University of South Florida and her Doctorate in Veterinary Medicine from Cornell University.

The Lead Research Analyst for the Oregon Maternal and Child Health Section also fulfills the role of Title V Research Analyst for the state. This position is currently filled by Maria Ness. Prior to this position, she served as the Program Evaluation and Surveillance Manager at the Philadelphia Department of Public Health, Division of Maternal, Child and Family Health. Ms. Ness is a graduate of the two-year CDC/CSTE Applied Epidemiology Fellowship, which she completed at the Oregon Health Authority's Maternal and Child Health Section. Ms. Ness holds a Master of Public Health in Epidemiology and Biostatistics from the University of Sydney. Ms. Ness is a prior recipient of the Robert Wood Johnson Foundation National Award for Outstanding Epidemiology Practice in Addressing Racial and Ethnic Disparities. In her role as Lead Research Analyst, Ms. Ness sits on multiple state level advisory boards, such as the Behavioral Risk Factor Surveillance System Advisory Committee, and the Student Health Survey Advisory Committee. Ms. Ness also provides epidemiologic consultation for the Policy Team and the Nurse Team within the Maternal and Child Health Section.

OCCYSHN Epidemiology Workforce

OCCYSHN's Assessment & Evaluation (A&E) team is responsible for designing and executing studies that track the needs of Oregon CYSHCN and their families and meet the data and analysis needs of OCCYSHN staff. Currently five staff compose the A&E team:

- Alison Martin, PhD, MA, Manager. Dr. Martin began working with OCCYSHN in April 2014. Title V CYSHCN and CMC CoIIN funding support her at 0.90 FTE. (The University Center for Excellence in Development Disabilities, the Oregon Health & Science University – Portland State University School of Public Health, and HERO Kids Innovation grant support her remaining 0.10 FTE.)
- Sheryl Gallarde-Kim, MSc, Program Evaluation Research Associate. Ms. Gallarde-Kim began working with OCCYSHN in December 2012. Title V CYSHCN and HERO Kids Innovation grant funding support her at 1.0 FTE.
- Lindsey Patterson, PhD, MS, Senior Program Evaluation Research Associate. Dr. Patterson began working with OCCYSHN in October 2021. Title V CYSHCN funding supports her at .50 FTE.
- Shreya Roy, PhD, Program Evaluation Research Associate. Dr. Roy began working with OCCYSHN in May 2019. Title V CYSHCN and CMC CoIIN funding support her at 1.0 FTE.
- Raúl Vega-Juárez, Program Evaluation Research Assistant 2 (1.0 FTE). Mr. Vega began working with OCCYSHN in January 2020. Title V CYSHCN and CMC CoIIN funding support him at 1.0 FTE.

Dr. Martin developed Drs. Patterson and Roy and Mr. Vega's positions to expand OCCYSHN's assessment and evaluation capacity. Dr. Patterson, our most recent addition, brings additional senior-level program evaluation design, implementation, and management experience, in addition to advanced statistical and qualitative analysis expertise. We have capitalized on the experience and skill sets of each staff member, while also creating additional space to develop new and existing skills and knowledge. A&E's additional capacity benefited OCCYSHN in FY2022. We had enough staff to continue to develop briefs that summarize key needs assessment findings, contribute to the development of the CHW curriculum and begin its evaluation design, add to our annual NSCH analysis plan and computation, further advance shared care planning program evaluation efforts, and begin planning for another participatory needs assessment study while also working on journal manuscripts.

Limited data exist to describe Oregon CYSHCN and their families. OCCYSHN routinely uses the Child and Adolescent Health Measurement Initiative's Data Resource Center-prepared data tables. When our research questions demand more complex analyses, we conduct them. We also use state-specific secondary data to describe subpopulations of CYSHCN. For example, we had financial resources to support a collaboration with Neal Wallace, PhD, to apply the Pediatric Medical Complexity Algorithm (Simon et al., 2014) to All Payers All Claims

2010-2014 data. These analyses allowed us to describe the percentage of Oregon children ages 21 years and younger with complex chronic disease, with their health care costs and utilization. We compared costs and utilization for those served in Oregon's patient-centered medical homes (PCMH) with those not served in a PCMH. Our needs assessment report also uses results from Oregon National Core Indicators and Oregon Healthy Teens surveys. (See OCCYSHN's 2020 Needs Assessment Report, Chapter 2.)

OCCYSHN conducts quantitative and qualitative primary data collections when additional data are needed. Examples of the former are the family and youth surveys for our 2015 needs assessment. Examples of the latter are the participatory needs assessment studies we conducted with the Latino Community Association and the Sickle Cell Anemia Foundation of Oregon. (See 2020 needs assessment chapters 3 and 4.) Our assessment and evaluation team is building expertise in conducting participatory research.

A&E also evaluates block grant activities. The staff has the expertise, knowledge, and skillsets needed to determine appropriate evaluation approaches; develop program evaluation plans and logic models; develop and implement data collection methods and procedures; develop and implement quantitative and qualitative analytic plans; and disseminate findings. Additionally, the A&E unit monitors program implementation. For example, every month they compute descriptive statistics on data describing the implementation of OCCYSHN's shared care planning strategy. These results allow the Systems & Workforce Development unit to monitor LPHA progress on shared care planning requirements. In all of its work, OCCYSHN's A&E unit collaborates with OCCYSHN Systems & Workforce Development unit and Family Involvement Program. The A&E unit responds to program needs for data and analysis that advance OCCYSHN's ability to serve CYSCHN.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The Oregon State Systems Development Initiative (SSDI) program develops, enhances, and expands Oregon's Title V Maternal and Child Health (MCH) data capacity for the Title V Needs Assessment and performance measure reporting in the Title V MCH Block Grant program. The program facilitates informed decision-making and resource allocation that support effective, efficient and quality programming for women, infants, children and youth, including children and youth with special health care needs. The Oregon SSDI program has three central goals: (1) Build and expand Oregon MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation and evaluation. (2) Advance the development and utilization of linked information systems between key MCH datasets in the state. (3) Support program evaluation activities around the National Performance Measures (NPM) that contribute to building the evidence base for the Title V MCH Block Grant program.

Oregon's SSDI program has historically supported efforts to obtain access, and make available, the minimum and core data sets. As a result of these efforts, all of the 24 Minimum/National Dataset (M/NDS) indicators, all of the eight Core/National Dataset (C/NDS) indicators, and all of the 13 Core/State Dataset (C/SDS) indicators were found to be obtainable through various sources. Efforts have been made to promote the availability of the minimum and core datasets within MCH through meetings and discussions with assessment and evaluation teams. Many of these indicators are utilized, as needed, for the Title V Needs Assessment and various reporting activities; in many cases, this has led to data sharing activities between programs when working with internal partners' datasets such as Immunizations, Vital Statistics, Hospital Discharge, and Medicaid datasets.

Over the course of 2020, the SSDI program faced many challenges with staffing and partner capacity due to the COVID-19 response effort. Many project tasks had to either be put on pause during the year or work was shifted to focus more primarily on supportive efforts and pre-work that could be done without significant partner engagement. However, in late 2020 and the first quarter of 2021, the SSDI team was able to pivot back as some program teams began to see a return in capacity. One key project was further enhancements to Oregon's Title V local plan and reporting database. This system, created and managed by the SSDI team, has been continuously enhanced to improve local reporting efforts to the state Title V program team. These reports are a critical component for the Title V program assessment, monitoring, and reporting efforts for the State Action Plan and assist the Title V program team members supporting local program implementation of Title V work. In early 2021, the Title V team introduced the revisions to the state and national priority areas and related strategies needed for FY2022 local plans. Additionally, the team received feedback from local programs that suggested activities related to each strategy would be very helpful for local programming. These program revisions combined into a series of adjustments to the Title V local plan and reporting database. This effort involved restructuring components of the data collection, tightening up relationships between the data, and redesigning user interface components, thereby enhancing end-user ease of use for current and historic data, further improving the quality of reported data, and improving the Title V program's ability to analyze and leverage the data in local county and tribal support and Title V grant reporting.

Building off those efforts and planning early in the year, SSDI team focused the rest of 2021 and early 2022 on the two key tasks of continued support for the Title V local grant reporting database enhancements and furthering database migration work for local public health home visiting programs engaging in MCH programming and reporting. The Title V reporting database required annual updates for the local FY2021 reports as well as establishing the baseline system content for the upcoming FY2022 plans for each local county and tribal partner. The content adjustments from early 2021 worked well for end users, but corrections were needed within the system design for the FY2022 plans to be successfully set up. Future work to streamline these processes have been added

to the work plan for later 2022 and early 2023. Along with those fixes in preparation for the FY2022 plans, adjustments were made to the interface to account for additional content allowing users to sign up for one-on-one walkthroughs with state Title V staff, a new process in how users worked on and reviewed their plans with state staff. Revised on-screen instructions and user guide updates were included as well as links to external resources for local users. In addition to the data system revisions, a technical hurdle was cleared by SSDI staff during a required server migration and software version update for the Title V database in early 2022. This work entailed coordinating and conducting the migration as well as supporting the Title V team with all aspects that impacted end-users.

Lastly, 2021 and early 2022 saw significant movement towards the database migration for local public health home visiting programs who engage in Title V programming and reporting. With respect to SSDI and Title V goals and objectives, the database migration efforts include tracking and supporting any state and local needs for the data, establishing plans for assuring continuity of reporting capabilities, and establishing workaround processes, should they be necessary. The SSDI team has worked in tandem with the data migration team, and thanks to these coordinated efforts, planning and initial migration efforts have met those needs. This work will continue to be conducted throughout 2022 while the full rollout and system migration occurs over the course of the year.

III.E.2.b.iii.c Other MCH Data Capacity Efforts

OHA MCAH Other data capacity efforts

- Data enhancement activities:
  In 2020, the Oregon legislature passed a law that requires health care providers, including state programs, to collect race, ethnicity, language, and disability at a specific level of specificity, to allow for disaggregation of marginalized, underserved, or at-risk communities. The guidelines for how to collect this data are known as REAL-D guidelines. The Maternal and Child Section has been implementing REAL-D guidelines into its programs and data collection in a stepwise fashion, with high priority surveys being transitioned first. The Pregnancy Risk Assessment Surveillance System and oral health programming and surveys were considered high priority and are now utilizing the REAL-D protocol. Other MCH programs such as Babies First are in the process of transitioning to the use of the REAL-D guidelines.

- National and state surveys and monitoring systems:
  The Maternal and Child Health Section has direct or indirect access to many surveys and surveillance systems. Systems that are coordinated directly by the section include the Pregnancy Risk Assessment Monitoring System (PRAMS), and its three-year follow back survey, ECHO, the SMILE survey and Healthy Growth Survey, and the Birth Anomalies Surveillance System. The section also produces an annual Oral Health Surveillance System report. Staff from the Maternal and Child Health Section are involved in other state and national surveillance as members of advisory boards for the Behavioral Risk Factor Surveillance System and the Student Health Survey. Oregon is also contributing to a statewide race/ethnicity oversample for the National Survey of Children's Health.

- Availability/accessibility of state and local MCH data information systems:
  The Maternal and Child Health Section works in partnership with other departments to access state and local MCH data such as vital statistics, hospitalization data, Medicaid data, and WIC data. The Section also has its own programmatic home visiting data collection systems and collects data on Early Hearing Detection and Intervention.

- Collection and tracking of real time data:
  The Maternal and Child Health Section collects real time data on its home visiting and other programs, and is able to access this data through centralized databases hosted by the section. Home visiting programs include Babies First, CaCoon, Nurse Family Partnership, and MIECHV home visiting.

- Creation of data review boards:
  In the 2018 legislative session, Oregon passed House Bill 4133 which gave direction to the Oregon Health Authority to form the Maternal Mortality and Morbidity Review Committee. The committee conducts studies and reviews of incidents of maternal mortality and severe maternal morbidity in Oregon, examines whether social determinants of health are contributing factors to the incidence of maternal mortality and severe maternal morbidity, and shares findings and information with health care providers and facilities, social service providers, law enforcement, and many others. Members are appointed by the Governor and include a family medicine physician, an OB/GYN physician, a maternal fetal medicine physician, licensed registered labor and delivery nurses, licensed direct entry midwives, doulas, traditional health workers, community-based organization representatives, a medical examiner, and a maternal and child health subject matter expert from the Oregon Health Authority.

- Provision and sharing of data with other state and local partners:
  The Maternal and Child Health Section produces an annual report which summarizes the Adverse Childhood Experiences data from the Behavioral Risk Factor Surveillance System. The section produced a Needs Assessment report summarizing the findings of the five-year Title V needs assessment which was shared with partners. There is a formal process in place which is used by the section for sharing data reports with academic and community agency partners. The Maternal and Child Health section often delivers presentations of data to partners such as early childhood division partners, other sections within the Public Health Division, and legislators. The section is currently engaged in a partnership with the Injury and Violence Prevention Program to develop a shared risk and protective factor framework for prevention of injury, including child injury and adverse childhood experiences, which are both currently selected Title V priorities.

- Advances in information technology that facilitate automated data analyses and reporting:
  The data collection for home visiting services is currently being revised and a new system is being developed, which will facilitate automated data analyses and reporting. The new data platform is known as THEO and will be used for home visiting programs including Babies First and CaCoon, which are both partially funded by Title V, in addition to MIECHV home visiting programs. The rollout of the THEO has begun, with early adopter sites currently utilizing the system, in order to provide feedback before the eventual complete rollout of the system across the state.

- Key challenges faced in Oregon's efforts to improve the use of MCH data:
  The main challenge that the Maternal and Child Health Section has faced in improving the use of MCH data is limited staff capacity. This is due in combination to Title V staff capacity being dedicated to covid efforts, as well as vacancies in Title V positions due to staff turnover.

OCCYSHN Other data capacity efforts

OCCYSHN provides block grant funding annually to OHA PHD to support collecting and cleaning home visiting data entered by LPHA public health nurses. We collaborate with MCH to obtain CaCoon data extracts on a triannual basis. The Assessment and Evaluation (A&E) unit computes descriptive statistics that include the number of CaCoon clients served, number of visits, race/ethnicity of the clients, and their insurance type. The A&E unit shares these results with the Systems and Workforce Development (S&W) unit to support program monitoring and improvement. OCCYSHN has contributed expertise to the design and development of a new data system (THEO) that will eventually replace the current data system (ORCHIDS).

As described in Strategy 11.6 of the block grant report, OCCYSHN's A&E Manager is collaborating with OHA's MCH epidemiologist, Dr. Suzanne Zane, on work with state partners to purchase an oversample of non-dominant ethnic/racial households for the National Survey of Children's Health (NSCH). OCCYSHN A&E continues to maintain data systems for monitoring and evaluating LPHA implementation of shared care planning activities (report sections 11.4 and 12.2). We also support the Oregon Family-to-Family Health Information Center by collecting and analyzing data and helping them document the results to meet their annual reporting requirements.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

OHA MCAH Emergency Planning and Preparedness

Consistent with the goals and aims of the Title V block grant program, Oregon MCH is proactive in its emergency preparedness and response planning. Oregon MCH has been and continues to be involved in the ongoing State of Oregon COVID-19 pandemic response, is prepared to assist in the governmental response to the ongoing infant formula shortage, was a critical component of the State's public health response to the 2015-2016 Zika virus epidemic and is planning for involvement in the upcoming Pacific Northwest wildfire season as needed. As Oregon's emergency management capacity has evolved and strengthened because of the COVID-19 pandemic response, OHA has re-focused on the multitude of natural (e.g., wildfires, cyanotoxins, extreme heat, drought, earthquakes) and person-created hazards (including upcoming large open access events like the upcoming World Athletic Championships in Eugene, Oregon) that exist in our state. MCH has been involved in these new hazards planning meetings through providing technical guidance and staff support.

Oregon MCH contributes to the State of Oregon's emergency preparedness and response function through 1) training of staff in Federal Emergency Management Agency (FEMA) Incident Command System courses, 2) encouraging MCH staff to serve on the Oregon Health Authority Incident Management Team, 3) incorporating preparedness training and topics into staff professional development activities, 4) providing staff to serve on longer-term professional development opportunities ("job rotations") with the State of Oregon's COVID-19 Response and Recovery Unit, 5) maintaining critical state data systems for the surveillance and response to public health emergencies, 6) sharing appropriate guidance from MCHB to local grantees around allowable use of Title V funds to support emergency preparedness and response activities, and 7) encouraging MCH staff to serve on the State of Oregon Portland State Office Building Incident Response Team (to assist in the personnel and logistical evacuation, safety, and continuity of operations that team serves).

The State of Oregon has a written EOP which is realized at the agency level through the Oregon Health Authority's Health Security, Preparedness, and Response (HSPR) program and related Public Health Continuity of Operations plans. The HSPR program is funded by the U.S. Department of Health and Human Services through the U.S. Centers for Disease Control and Prevention (CDC) Cooperative Agreement and the Hospital Preparedness Program (HPP). HSPR ensures that Oregon's communities and hospitals have an improving level of preparedness for health and medical emergencies by supporting the development and testing of plans, providing training, managing volunteers (e.g., through Oregon's federally-supported Medical Reserve Corps and the State Emergency Registry of Volunteers in Oregon [SERV-OR]), and encouraging collaboration. These plans are reviewed on an ongoing basis and are adapted and improved upon following major Incident Management Team activation events.

The State of Oregon's EOP specifically considers the needs of the MCH population, which includes at-risk and medically vulnerable women, parents, infants, and children. Inclusion of MCH staff on Incident Management Team activations, assignment of physician/epidemiologist resources specific to MCH populations for response activities, and partnership with local health authorities and community-based organizations that serve the MCH population helps the State to realize this goal.

Title V program staff are involved and consulted in the planning and development of the State's EOP through their ongoing participation in HSPR-led emergency preparedness and response activities. This occurs before, during, and after an Incident Management Team activation, disaster, or other emergency.

Title V leadership is part of the Incident Management Structure (IMS). Within the framework of the COVID-19

response Title V leadership and staff served in positions including Operations Chief, Deputy Operations Chief, Health Intelligence Chief, Branch Director, Unit Leader, Group Supervisor, and technical staff assignments (e.g., epidemiologist, nurse consultant, informatics specialist, contact tracer, case investigator, community liaison).

Based on ongoing Title V program needs assessment efforts and lessons learned from previous emergency responses, several critical gaps in emergency preparedness and/or surveillance data were identified that could impact the state's ability to adequately assess and respond to MCH population and program needs in a future disaster or public health emergency. These include 1) a need for MCH staff with dedicated FTE for emergency preparedness and response activities, 2) improved Continuity of Operations planning for MCH surveillance and survey programs (e.g., CDC-funded Pregnancy Risk Assessment Monitoring System), 3) readily deployable guidance to staff at the local level for their MCH related work in an emergency, and 4) planning for backfilling staff deployed for emergency response duties.

The Title V program has participated in the development of emergency preparedness and response training, communication plans and tools/strategies to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population. MCH staff are involved in all levels of these activities and continue to participate in them via the ongoing State of Oregon COVID-19 response.
The Title V program has participated in the development of coordination plans with public health programs (e.g., newborn metabolic screening, newborn hearing screening, immunization, home visiting, WIC, shelters and other MCH programs), to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population. Each program funded by Title V has adapted to the operational challenges posed by the ongoing COVID-19 response, including revisions to operational guidance at the local level and support for ongoing data collection and surveillance activities at the state level.

OCCYSHN Emergency Planning and Preparedness

OCCYSHN is aware of gaps in emergency preparedness for families of Oregon CSYCHN, and we are working with local public health authorities to improve their capacity to address disasters (Strategy S2.3). The health, education, and financial well-being of CYSHCN and their families continue to be impacted by the COVID-19 pandemic. A shortage of primary care was exacerbated by the pandemic, and schools continued to face disruptions and inadequate special education and therapy workforce. In the summer of 2021, western Oregon experienced a three-day record-breaking heatwave. As temperatures rose to 116 degrees, OHA kept in close contact with OCCYSHN and ORF2FHIC, and with social service agencies and community-based organizations. They provided information about cooling center locations, and advice for helping people without access to air conditioning. ORF2FHIC disseminated information to families of CYSHCN about accessing flexible CCO funds for fans or window air conditioning units. Western Oregonians also experienced an extreme cold weather event in 2021. Two snowstorms followed by a major ice storm felled trees and caused long-lasting power outages. Some families were without power for more than ten days. Some relocated to hotels or stayed with friends.

In addition to extreme weather events, wildfires and smoke are ongoing issues for Oregon CYSHCN, as is the risk of a major earthquake. In light of these natural disaster-related health and safety risks, Oregon families require support and resources to keep their CYSHCN as safe as possible.

Family members of CYSHCN contribute valuable expertise to emergency planning. OCCYSHN gathered a group of eight parents of medically involved children for a listening session to hear about what they need in an emergency. Families of medically involved CYSHCN said they did not need more checklists of tasks, or suggestions for what to put in go-kits. What they need is concrete instructions, and evacuation plans. They need to know what facility capacity has to care for their medically fragile child in an emergency, and what routes they can use to get there. They would like Oregon's Individual Service Plans to include emergency planning steps for caregivers. OCCYSHN helped

the group develop recommendations and comments and submitted those to Oregon's Medical Surge Planner.

OCCYSHN's Director and Family Involvement Program manager were invited to serve as subject matter experts for the US Department of Health and Human Services' *Child and Adolescent Health Emergency Planning Tool Kit*. The Toolkit is a companion to HHS' *Maternal Child Health Emergency Planning Toolkit*.

OCCYSHN is nearing the launch of HERO Kids, a statewide electronic registry for CYSHCN (Action Plan Section 11.10). HERO Kids helps parents provide emergency medical services and hospital emergency departments with critical health information about CYSHCN, to inform care in an emergency. HERO Kids Registry may eventually include reunification information, for use in a major disaster that separates CYSHCN from their caregivers.

OCCYSHN will continue strengthening systems of care by gathering and disseminating insights from family members of CYSHCN. We will hold at least one family listening session to discuss disaster preparedness, and we will collaborate on Oregon's Emergency Operations Plan.

OCCYSHN looks for opportunities to inform statewide emergency planning efforts. At present, two parents of CYSCHN serve on Oregon's Occupational Health, Safety and Emergency Services' Disability Advisory Council, offering insight on emergency preparation challenges for families of CYSHCN. OCCYSHN's Family Involvement Program Manager serves as the Family Representative on Oregon's Emergency Medical Systems for Children (EMSC) Advisory Committee, where she keeps abreast of issues like pediatric hospital surge capacity.

III.E.2.b.v.a. Health Care Delivery System – Public and Private Partnerships

OHA MCAH public and private partnerships

Oregon's Title V program is strongly committed to collaborating with a wide range of partner agencies to expand the capacity and reach of the state Title V MCAH and CYSHCN programs. These partnerships and collaborations span public and private sector entities across the state, as well as MCHB and other Federal programs which serve the MCAH population.

The "Public and Private Partnerships Table" in Supporting Document 3 provides a detailed description of the key the collaborations and partnerships which are listed below.

- Other MCHB investments: State Systems Development Initiative (SSDI), Maternal, Infant and Early Childhood Home Visiting (MIECHV); Intimate Partner Violence CoIIN, Children's Healthy Weight CoIIN, Healthy Start Grants

- Other Federal Investments: Nutrition Program for Women, infants and Children (WIC), Early Hearing Detection and Intervention Program (EHDI),), Rape Prevention Education, PREP Teen sexual health grant, Pregnancy Risk Assessment Monitoring System (PRAMS), CDC Immunizations, Preschool Development Grant

- Other HRSA Programs: FQHCs

- State and local MCH programs: Universally Offered Home Visiting, Maternal Mortality and Morbidity Review Committee (MMMR), Local Public Health MCH Programs, Conference of Local Health Officials (CLHO)

- Other Oregon Health Authority programs: Adolescent and School Health Programs, Injury and Violence Prevention Program, Tobacco Prevention and Education Program, Chronic Disease Prevention, HIV/STD, Newborn Metabolic Screening Program, Medicaid and CHIP, HealthPolicy & Analytics Division, Health Systems Division, State Public Health Director's Office, Office of Equity and Inclusion

- Other governmental agencies: OR Department of Human Services, OR Department of Education, OR Department of Justice, Early Learning Division, OR Housing and Community Services

- Tribes, Tribal Organizations and Urban Indian Organizations: Oregon Tribes, Northwest Portland Area Indian Health Board, Native American Youth and Family Center

- Public health and professional educational programs and Universities: see table in supporting document 3 for details

- Health systems: see table in supporting document 3 for details

- Community and non-profit organizations see table in supporting document 3 for details

- Advisory boards and inter-agency work groups: see table in supporting document 3 for details

Among the many partnership initiatives with which Title V MCAH is engaged, a few highlights from the past year are outlined below:

- MCAH Title V's transition to a more upstream focus on the "Foundations of MCAH" (social determinants of health and equity, trauma, toxic stress, ACEs and resilience; and culturally and linguistically responsive services), has aligned with opportunities to develop shared initiatives with both the State Health Improvement Plan (Healthier Together Oregon), and a cross-Center initiative focused on shared risk and protective factors (SRPF). The SRPF work is bringing together the state offices of Injury and Violence Prevention, Maternal and Child Health, Adolescent and School Health, and Chronic Disease Prevention to develop a shared strategic approach to violence prevention as well as improved lifelong health. This work has progressed over the

course of the past year on a variety of levels, including through a contract to conduct a literature review and develop a synthesis graphic showing the interwoven nature of upstream MCAH, injury and violence prevention, and chronic disease prevention efforts.

- Oregon's Title V staff continued to partner with and support a major Public Health Division expansion in partnerships with community-based agencies. In response to the COVID-19 pandemic, partnerships and contracts have been developed with over 170 community-based agencies to fund outreach, education, and support related to COVID-19. These agencies serve diverse and often marginalized communities throughout Oregon and bring culturally relevant services and funding to families and communities most in need. This past year the partnerships initiated through COVID were expanded to fund CBOs to engage in upstream Public Health work on equity, community engagement, and policy, systems and environment initiatives.

OCCYSHN public and private partnerships

OCCYSHN collaborates with state and community-based agencies and organizations, health care and service providers, and family members of CYSHCN to improve systems of care serving Oregon CYSHCN and their families:

- OCCYSHN's Family Involvement Program identifies and mentors family members of CYSHCN to provide their perspective to program and policy efforts, both within OCCYSHN and at regional and statewide levels. For example, we recruited family members to provide feedback on Oregon Health Plan denial letters and input to Oregon's Medical Surge Planner on the needs of families of medically complex children in emergencies.

- OCCYSHN partners with local public health authorities, education service districts, and health and service providers statewide to implement community-based programs. OCCYSHN's ECHO-based virtual learning communities provide a platform for health and service providers across the state to collaborate on improving care coordination for CYSHCN.

- OCCYSHN collaborates with OHA to strengthen the public health nursing home visiting workforce, increase alignment of CaCoon with OHA's Babies First! program, and develop the THEO home visiting data system.

- OCCYSHN partners with OHA and Oregon Pediatric Improvement Partnership as opportunities arise. We provide input based on our long-term and wide-ranging experience implementing cross-systems care coordination for CYSHCN.

- OCCYSHN leads Oregon's participation in an MCHB-funded Collaborative Improvement and Innovation Network (2017-2021). Oregon's project addresses the transition from pediatric to adult health care for young adults with medical complexity. We collaborate with OHSU's Doernbecher Children's Hospital General Pediatrics and Adolescent Health and OHSU's Beaverton Primary Care Clinics to develop and implement quality improvement projects. We also collaborate with OHSU's Department of Pediatrics Transition Workgroup to inform the development of clinic infrastructure that supports transition.

- In an effort to better serve CYSCHN from diverse cultural and ethnic backgrounds, OCCYSHN collaborates with the Sickle Cell Anemia Foundation of Oregon, the Latino Community Association of Central Oregon, and the Portland-based African Youth Community Organization. We also partner with Oregon State University to host OCCYSHN's online course for community health workers, Supporting Families: Navigating Care and Services for Children with Special Health Needs.

- OCCYSHN leads a collaboration between Oregon Health Authority's Emergency Medical Services for Children program, Oregon Portable Orders for Life-Sustaining Treatment Registry, and Beyond Lucid Technologies LLC to develop a ground-breaking emergency information registry for CYSHCN. This innovative on-line platform allows families to record critical details about their child's health that can be available to medical providers responding to CYSHCN in emergencies. The registry launches Fall 2022.

III.E.2.b.v.b. Health Care Delivery System – Title V MCH-Title XIX Medicaid IAA

The Title V MCH - Title XIX Medicaid Inter-Agency Agreement provides a framework for coordination between the two programs on issues related to the MCH population. Oregon's current Title V-Medicaid IAA was developed in 2017, and a five-year agreement was signed in April 2018. As part of the IAA, quarterly meetings were established as the mechanism by which the designated agency liaisons will monitor implementation of the MOU and update its provisions as needed. The MOU states that the agencies will "meet on a quarterly basis to share information, discuss and resolve current issues, and promote coordinated long-range planning" (p 12). Membership in the MOU quarterly meetings initially included designated liaisons from the 3 signing agencies: Title V MCAH, OCCYSHN, and Medicaid. Since implementation that group has expanded to include representatives from OHA Health Policy and Analytics, OHA Health Systems Transformation Center, and OHA Health Systems Behavioral Health, and OHA COVID-19 Response and Recovery Unit.

The Purpose of Oregon's IAA is to enable Oregon's Medicaid, Title V MCAH, and Title V CYSHCN programs to carry out the mandate of cooperation contained in the related provisions of the federal statutes and regulations and achieve their shared goal of improving the health of women, children, adolescents, children and youth with special health care needs, and families in Oregon. Specific purposes are to:

- Develop and implement initiatives that address the underlying causes of preventable diseases;
- Increase coordination/collaboration between the Title V Program and Medicaid;
- Support a system of care across various agencies providing services for the maternal, child, adolescent, and children/youth with special health care needs populations;
- Formalize the responsibilities of each agency;
- Hold agencies accountable for their roles and responsibilities;
- Ensure policy continuity over time;
- Provide methods for communication and information exchange; and
- Meet the requirements of both Title V and Title XIX.

Objectives span 4 broad areas as follows:

- Programmatic, policy and relationship-building
- Assessment, evaluation and data sharing
- Identification, outreach, and referral of population
- Reimbursement and finance

Outcomes of the Title V – Medicaid IAA partnership include:

- Coordination on shared legislative agendas, policy option packages, and bill analyses.
- Quarterly coordination meetings at which policy and systems issues impacting our shared populations are discussed and addressed. Our Title V – Medicaid IAA partnership has been very active during FY2022 – expanding in membership and the frequency of meetings, as well as the scope of our work. In addition to regular discussion of policy and systems issues affecting our shared populations, and coordination on shared legislative agendas and bill analyses, our partnership has achieved the following outcomes during FY2022:
    - Advocating for adoption of the 1-year postpartum Medicaid eligibility through state plan amendment that was made possible through President Biden's American Rescue Plan (ARPA). Oregon's State Plan Amendment for 12 months postpartum coverage was approved and implemented April 1, 2022. Additionally, Oregon's state legislation known as the Reproductive Health Equity Act ensures 2 months postpartum coverage for the CAWEM population, and our Healthier Oregon legislation will extend the 12-month postpartum coverage for undocumented postpartum members of the CAWEM population ages 26 and under beginning July 1, 2022.
    - Contributing to the development of Oregon's 1115 Medicaid Waiver application. The 1115 Waiver, which forms the foundation for Oregon's Medicaid program is currently moving through the renewal process with CMS. The new 5-year waiver will further Oregon's ability to address equity and social determinants of health for Oregon families. The IAA group has been central to the development of waiver concepts and concept papers, which will all have a focus on children and families.
        - The IAA group's advocacy around the need to revise Oregon's approach to EPSDT was an

important factor in Oregon's decision not to include EPSDT in the current waiver request. This critical change in state Medicaid policy clears the path for Oregon to implement a fully compliant EPSDT program. The IAA group will work closely with the new EPSDT program and policy staff and serve as key resources for development and implementation of the new EPSDT Program in Oregon.

- Developing a collaboration between OCCYSHN and the Health Evidence Review Committee (HERC) leadership to re-evaluate pediatric specific issues to ensure that children receive the care and services to which they are entitled. This issue surfaced during a quarterly review committee meeting discussion about part of the 1115 that waives EPSDT requirements and established the Health Evidence Review Committee (HERC). The purpose of the HERC is to develop a prioritized list of diagnosis/therapy pairs to be covered by the Oregon Health Plan, and establish a line on that list, below which would not be covered. The CYSHCN director, as a practicing pediatrician, has been appointed by the Governor to serve on the HERC. He is the first child health professional appointed in recent memory and will be a staunch advocate for the needs of children and youth.
- Collaborating on the creation of a Child health Policy Option Package to develop a cross-agency child health team.

State Action Plan Introduction

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

This year's State Action Plan Narrative includes reports for the first year of activity in the current 2021-2015 Block Grant Cycle (October 2020 – September 2021), as well as plans for the third year of the cycle (October 2022-September 2023).

- Both OHA MCAH and OCCYSHN reports are provided for each of the state performance measures (Toxic stress, trauma, ACES and resilience; Culturally and linguistically responsive services (CLAS), and Social Determinants of Health and Equity (SDOH-E)).
- OCCYSHN has included plans for all 3 SPMs for the coming year in the cross-cutting/systems building domain.
- Title V MCAH has developed an integrated approach to our 3 state-specific priorities: toxic stress/trauma/ACES/resilience, CLAS and SDOH-E. This integrated approach is most visible in the cross-Cutting/System Building Domain plans. Recognizing the interwoven nature of work on these 3 upstream priorities, the Title V MCAH program is approaching them as an integrated "Foundations of MCAH" priority. Work on the Foundations of MCAH, including strategies and activities at the state and local level are divided into 4 areas: policy & systems; workforce capacity & effectiveness; community, individual & family capacity; and assessment & evaluation. Plans are provided for each of these 4 areas of Foundations of MCAH work.
- Work within the domains that is supported by Title V but is not directly linked to a Title V priority is described at the end of each domain (e.g. safe sleep in the Perinatal and Infant Health domain).
- Other Title V efforts and investments which cut across priorities and domains and are described at the end of the cross-cutting section.

The graphic in Supporting document 4 illustrates the new Title V MCAH approach. The same supporting Document provides a summary of the local level strategies for each domain, as well as a table and map showing which local public health department and tribal grantees have selected to work on each priority.

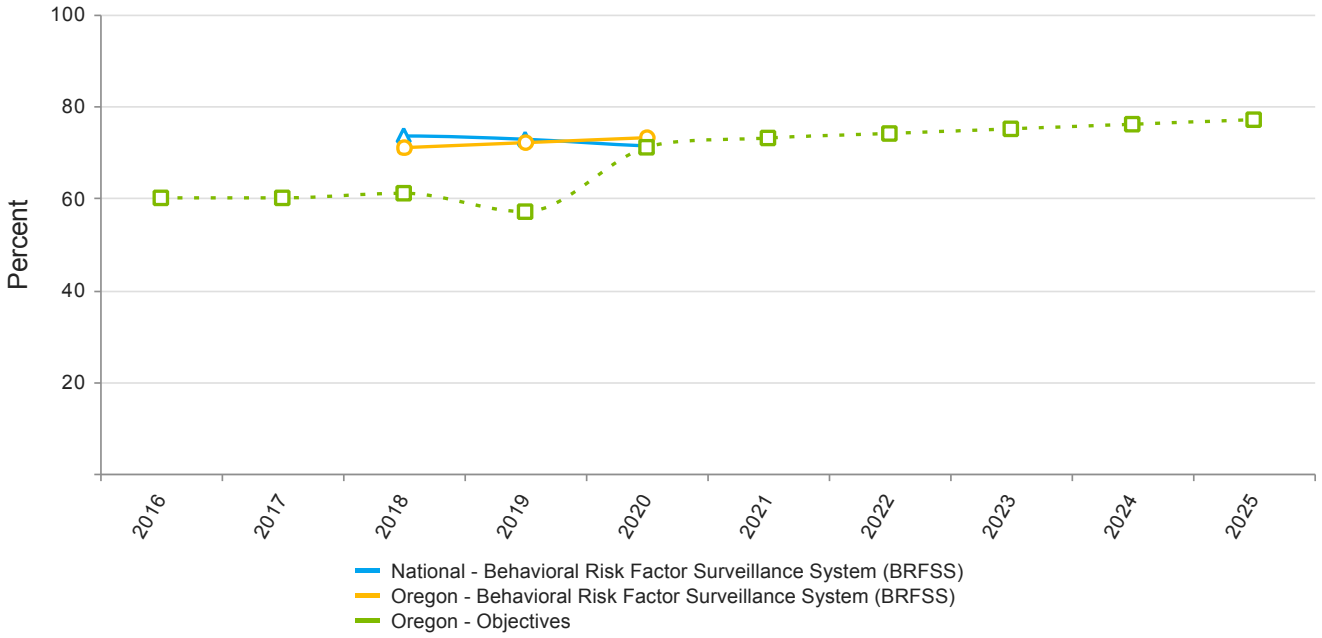
The table below gives a brief overview of which priority topics have reports and plans in each domain.

Domain	Priority	Report	Plan
Women/Maternal Health	Well Woman Care	X	X
Perinatal/Infant Health	Breastfeeding	X	X
Child Health	Injury Prevention	X	X
Adolescent Health	Bullying Prevention	X	X
Children/Youth with Special Health Needs	Medical home	X	X
	Healthcare Transition	X	X
Cross-Cutting/Systems Building	Toxic Stress/Trauma/ ACEs/Resilience	X	OCCYSHN only
	Culturally and Linguistically Responsive Services (CLAS)	X	OCCYSHN only
	Social Determinants of Health and Equity (SDOH-E)	X	OCCYSHN only
	Foundations of MCAH – Policy & Systems		OHA MCAH only
	Foundations of MCAH – Workforce		OHA MCAH only
	Foundations of MCAH – Com., Indiv., and family capacity		OHA MCAH only
	Foundations of MCAH – Assessment & Evaluation		OHA MCAH only

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				71	73
Annual Indicator			70.8	72.0	73.0
Numerator			517,099	529,410	536,467
Denominator			730,360	735,342	735,357
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	74.0	75.0	76.0	77.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of new mothers who have had a postpartum checkup.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	92.8	93.2
Numerator		
Denominator		
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	93.4	93.6	93.8	94.0

ESM 1.2 - Among local grantees who select well woman care, percent who report improved knowledge, skills, or policies based on provided technical assistance.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		81.8
Numerator		9
Denominator		11
Data Source		Local grantee database
Data Source Year		2021
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	75.0	75.0	75.0

ESM 1.3 - Completion of environmental scan of organizations and partners to facilitate determination of Title V's role in increasing diversity in the perinatal workforce.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes

ESM 1.4 - Number of OHA Office of Equity and Inclusion certified community health workers and doulas.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	604	926
Numerator		
Denominator		
Data Source	OEI	OEI
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	930.0	940.0	950.0	960.0

ESM 1.5 - Completion of environmental scan to determine role of Title V in perinatal behavioral health.

Measure Status:	Inactive - Staff capacity changed and this strategy is no longer being conducted.

Baseline data was not available/provided.

State Action Plan Table

State Action Plan Table (Oregon) - Women/Maternal Health - Entry 1	
Priority Need	
High quality, culturally responsive preconception, prenatal and inter-conception services	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
By October 1, 2025 increase the percent of women with a past year preventive medical visit from 70.8% to 76.0%, through improved accessibility, quality, and utilization.	
Strategies	
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. Support efforts to improve diversity in the workforce	
4. Ensure access to culturally responsive preventive clinical care for low income and undocumented women.	
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.	
ESMs	**Status**
ESM 1.1 - Percent of new mothers who have had a postpartum checkup.	Active
ESM 1.2 - Among local grantees who select well woman care, percent who report improved knowledge, skills, or policies based on provided technical assistance.	Active
ESM 1.3 - Completion of environmental scan of organizations and partners to facilitate determination of Title V's role in increasing diversity in the perinatal workforce.	Active
ESM 1.4 - Number of OHA Office of Equity and Inclusion certified community health workers and doulas.	Active
ESM 1.5 - Completion of environmental scan to determine role of Title V in perinatal behavioral health.	Inactive

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Women/Maternal Health Domain

Well Woman Care Report (October 2020 – September 2021)

National Performance Measure 1
Percent of women with a past year preventive visit.

NPM Trends
In 2019, according to the Behavior Risk Factor Surveillance System, 72% of women in Oregon received a preventive health care visit in the last year compared with 72.8% of women nationally. The percentage of women receiving a preventive health care visit in Oregon improved between 2018 and 2019 while nationally the percentage declined.

Well Woman Care Strategy #1:
Case-management to improve utilization of well-woman care.

Accomplishments – State level:
In collaboration with the MCH Nurse Team and MIECHV team, training and technical assistance were provided to the MCH Nurse Home Visiting and MIECHV-funded Home Visiting programs. A key activity of the home visiting programs is to provide case management to assist women in establishing a medical home and accessing preventive care. Much of the focus of the training and technical assistance was around best practices in telehealth and equity.

Accomplishments – Local level:
- Deschutes County incorporated tracking of postpartum care visits as part of their PCC (perinatal care continuum) services. The PCC team created new data points to capture referrals out to postpartum care. PCC charting is now implemented in the EPIC database as well.
- Malheur County was able to engage all of their MCH clients with a primary care physician. 100% of the women that were referred for a well woman visit received one.
- Despite changes to the availability of in-person visits, the Klamath Tribe was able to continue to provide case management services and get mothers Telehealth Appointments.

Challenges/emerging issues:
Most home visits were provided by telehealth in response to the COVID-19 pandemic and public health nurses were moved to positions supporting the COVID-19 response.
- Deschutes County had a new supervisor. There were challenges in defining what should be included in data collection and defining well women care (medical home, PP visit, family planning, well women care). The home visiting data system (Orchids) was not able to provide data so additional data sources needed to be identified. The nurse supervisor and data manager are still working to clarify the internal process, language, communications, etc. for data pulls.
- Residents in Malheur County have inadequate access to medical care and primary care providers. Most providers are not taking new clients, and there is a two month wait for the initial appointment for those that are accepting new clients. Additionally, many medical specialists are located in Idaho. Clients became discouraged when trying to attain a primary care provider.
- COVID-19 brought up many complications to providing case management for the Klamath Tribe, such as appointment scheduling. Telehealth has become a key factor for many appointments at tribal health.

Well Woman Care Strategy #2:
Use traditional and social marketing to educate the population and promote well woman care.

ESM:
1.1 Number of women reached using traditional and social marketing campaigns such as CDC Show Your Love brochures, social media including Facebook and Twitter, attendance at health fairs and community meetings, and public service announcements. (Objective: 1000)

Progress: Unable to track. Local grantees reported back number of outreach events and social media postings but did not report back on number of women reached.

Accomplishments:
- Douglas County Public Health Network (DPHN) developed and published social media posts regarding well

woman exams throughout the year, with a targeted emphasis during the month of May. Additionally, resources and information were compiled to create an informational pamphlet regarding well woman exams, intended to be used at health fairs, county fairs, etc. and was first used as a part of DPHN's booth at the Douglas County Fair, August 2021.
- Harney County was able to use Facebook and Instagram to reach out to women regarding health. They were able to post each week, and on most occasions' multiple times a week, promoting health. These posts included posts about the dangers of tobacco, what healthy foods are best for children and mothers, why people should be immunized, and many more topics promoting healthy living.

Challenges/emerging issues:
- In Douglas County, the lead staff for this strategy was intricately involved in the county's COVID-19 response, limiting capacity to complete further work on this strategy. Additionally, the lead staff accepted a new position with a different agency in March and a new lead staff was onboarded in April. DPHN's website needed to be restructured to house county COVID-19 information and create the website to house well woman care resources. With the media team focusing on COVID-19 updates, progress stalled in finalizing the well women care resources page.
- Harney County faced some pushback on posts regarding immunizations. The community is very divided about the COVID-19 vaccine and that has spread to vaccinations in general. They learned from this and tried to post in the most "nonconfrontational" way possible, with science backing anything said.
- State Title V staff paused the collaborative learning meetings for Title V grantees and partners because so many local staff were diverted to supporting the COVID-19 response.
- Communications teams at the state and local level were focused on COVID-19 communications so we were not able to coordinate activities or communications for Women's Health Week 2021.

Well Woman Care Strategy #3:
Provide education/training on preconception/interconception and well woman care for health care providers.

ESM:
1.2 Percent of local health departments receiving technical assistance to support implementation of the well woman care priority area. (Objective: 100)

Progress: 100% of Title V grantees that chose to work on well woman care received some assistance in completing their plans and reports. Other technical assistance was limited because many local grantees had staff reassigned to support the COVID-19 response.

Accomplishments – State level:
State Title V staff participated in regular meetings of the Oregon Perinatal Collaborative. The focus of the collaborative was supporting health care providers and systems during the COVID-19 pandemic.

Accomplishments – Local level:
Josephine County was able to provide virtual training for providers in collaboration with their local perinatal task force.

Challenges/emerging issues:
Many nurses and health care providers were reassigned to COVID-19 work. In addition, there were many challenges with staff turnover. It was difficult to focus on training for providers during this time. State Title V staff were available for technical assistance but did not convene trainings or learning collaboratives.

Well Woman Care Strategy #4:
Support access to well woman care through Family Planning Clinics.

ESM:
1.3 Number of state and local partners engaged to improve access to, and quality of well-woman care and reproductive health services. (Objective: 20)

Progress: 13 local public health departments and 2 tribes were engaged. The Oregon Perinatal Collaborative, local perinatal task forces in Josephine and Douglas County, and the Reproductive Health Coalition of Washington County each include many partners that were engaged in well-woman care activities.

Accomplishments:
- The Family Planning Clinic in Baker County moved Dec 30, 2020, to a more central and accessible location. Services were provided in the new location despite COVID-19, and the accessibility of the new location is

helpful for clients. A Family planning survey of clients was conducted to learn more about the needs of clients. Pregnancy bags for Spanish and English-speaking clients that were newly pregnancy were provided in collaboration with Oregon MothersCare. Staff participated in an adolescent wellness event with St. Luke's and a Family Night Out to promote family planning services. A switch of provider from male to female made a big difference in client's comfort level in accessing women's health care.
- Umatilla County was able to promote reproductive health services available in Umatilla County on social media outlets throughout the year.
- Union County had 100% of the reproductive health clients either scheduled for a wellness visit or referred for one. 97% of female STD visits were screened for pregnancy intention with One Key Question.
- The Reproductive Health Coalition of Washington County continued to meet every 2 months. Shared learning opportunities included presentations from reproductive health and education providers.

Challenges/emerging issues:
The planned expansion of family planning services was not able to move forward in Gilliam and Sherman County due to the COVID-19 response.

MCH staff were diverted to work on COVID-19 during much of the year. This included case investigation and contact tracing as well as vaccine administration and other support for MCH families. Change in staff and lack of staffing in family planning clinics meant patients had to be rescheduled and referrals slowed down. It was difficult to maintain outreach and communication with partners due to staff turnover to referrals were impacted. Champions for the Reproductive Health Coalition in Washington County have changed positions.

Well Woman Care Strategy #5:
Use of the postpartum health care visit to increase utilization of well-woman visits.

Accomplishments – State level:
- The first report of recommendations from Oregon's Maternal Mortality and Review Committee was finalized and distributed to partners January of 2021.

Accomplishments – Local level:
- All postpartum clients in Crook County were offered the opportunity to complete the screening questionnaire to identify needs around well women care and reproductive health care. Completed questionnaires were then given to the family planning nurse who followed up with clients who indicated that they were interested in family planning and/or well woman services if they had not already scheduled an appointment. An increase in services due to the follow-up from the family planning nurse was seen.
- The MCH RN for the Confederated Tribes of Warm Springs was able to help postpartum mothers navigate in obtaining an appointment which was complicated by decreased in-person appointments due to COVID-19.

Challenges/emerging issues:
COVID-19 posed challenges as not many clients were being seen in clinics. Some family planning and birth control appointments were completed over the phone or in parking lots. Postpartum visits were available in-person, but on a very limited basis. Provider turnover and shortages presented challenges.

Women/Maternal Health Domain

Well Woman Care Plan
(October 2022 – September 2023)

National Performance Measure:
Percent of women with a past year preventative visit.

Well Woman Care Strategy #1:
Strengthen early identification of and supports for women's behavioral health needs

State level activities/timeline:

1. State MCH Staff will participate in and build upon inter-/intra-agency efforts to address maternal behavioral health needs, specifically substance use disorders and depression/suicide
   Timeline: 10/1/22-9/30/23
2. MCH will partner with Oregon Department of Human Services to support Oregon's implementation of Plans of Care for infants prenatally exposed to substances as required by the Child Abuse Prevention and Treatment Act (CAPTA). The Plans of Infant Care implementation in Oregon is focused on prenatal outreach and connection to services and supports for the family to prevent involvement with Child Protective Services. We will participate in the planning and implementation of the expansion of Nurture Oregon into rural Oregon. Nurture Oregon is an integrated care model for pregnant families that includes peer support, prenatal care, substance use and mental health treatment, care coordination, and other services.
   Timeline: 10/1/22-9/30/23
3. State MCH Staff will continue to support best practices in screening and referral for perinatal mood disorders in Oregon's home visiting programs.
   Timeline: 10/1/22-9/30/23

Local level activities/timeline:

- Tillamook County plans to increase the use of the Edinburgh Postnatal Depression screening tool, completing the screen for every client at their initial visit to determine a baseline, in the 3rd trimester, and after delivery.
- Union County plans to work on implementing screening and referrals for perinatal mood disorders in all clinical settings.
  Timeline: 10/1/22 – 9/30/23

Well Woman Care Strategy #2:
Support advanced training, coaching and quality improvement activities for home visitors related to well woman care.

ESM:
1.2: Among local grantees who select well woman care, percent who report improved knowledge, skills, or policies based on provided technical assistance.

State level activities/timeline

1. In collaboration with the MCH Nurse and MIECHV teams, we will conduct a statewide survey of home visiting programs to better understand their training needs around well woman care. The results will be used to plan future trainings and quality improvement initiatives for the home visiting teams.
   Timeline: 10/1/22-1/1/23
2. The MCH Nurse Team will support the implementation of a new data collection system for some of the nurse home visiting programs. The new system will allow for an improved understanding of the needs and barriers to well woman care for home visiting clients and support quality improvement initiatives by local home visiting programs.
   Timeline: 10/1/22-1/1/23

Local level activities/timeline:

- Jackson County will provide an advanced level contraceptive training on motivational interviewing for home visiting staff.
  Timeline: 10/1/22 – 1/1/2023

Well Woman Care Strategy #3:
Support efforts to improve diversity in the workforce

ESMs:
1.3. Completion of environmental scan of organizations and partners to facilitate determining Title V's role in increasing diversity in the perinatal workforce.
1.4. Number of OHA Office of Equity and Inclusion Certified Community Health Workers.

State level activities/timeline:
1. Provide support to Oregon's Coalition of Local Health Officials as they build a strategic plan for recruiting and retaining a diverse public health workforce in Oregon.
   Timeline: 10/1/22-9/30/23
2. Partner with MCH Nurse Team and the Oregon Center for Children and Youth with Special Health Needs to develop the role of Community Health Workers (CHWs) in the Babies First! and CaCoon home visiting programs and support CHWs working in those programs.
   Timeline: 10/1/22-9/30/23

Local level activities/timeline
NA - no local grantees chose to work on this strategy.

Well Woman Care Strategy #4:
Ensure access to culturally responsive preventive clinical care for low income and undocumented women.

ESM:
1.1: Percent of new mothers who have had a postpartum checkup.

State level activities/timeline:
1. Strengthen partnership with Oregon Perinatal Collaborative to improve community engagement and equity efforts.
   Timeline: 10/1/22-9/30/23
2. Conduct a needs assessment, convene stakeholder workgroup, and implement recommended changes to refocus and revitalize the Oregon MothersCare Program.
   Timeline: 10/1/22-9/30/23
3. Promote anti-racism training and resources addressing perinatal health.
   Timeline: 10/1/22-9/30/23
4. Collaborate with state Medicaid to support access to doulas, lactation services, 12-month post-partum coverage and home visiting. Partner with Family Connects Oregon team to ensure coverage by commercial plans for universally offered newborn nurse home visiting.
   Timeline: 10/1/22-9/30/23

Local level activities/timeline:
- Josephine County will partner with organizations and shelters that serve unhoused people to ensure access for preventive reproductive care. A nurse practitioner and a clinician in the community will go out to visit and discusses the care that public health offers in family planning, well woman care, STD and STI options. Underserved women in the community are encouraged to visit the health department for any of these services and they offer referrals to other programs such as Screenwise.
- Baker County will promote the availability of well woman visits at the Health Department though outreach events and venues. In addition, they will provide customer satisfaction surveys to women who come to appointments and provide gift cards for those who fill out the survey.
- Klamath County will implement a well woman care pilot study with clinics and the local Coordinated Care Organization to identify and contact Oregon Health Plan patients to get them seen for preventive care. They will also carry out a Well Woman Care awareness campaign in collaboration with Oregon Tech's Integrated Student Health Center.
- Morrow County will provide referral and follow up for well woman care and other reproductive health services to clients who present at the Health Department.
- Polk County will attend outreach events to promote well woman care in collaboration with partners. They will be engaged in planning and relationship building between internal programs (e.g. WIC, OMC, Reproductive Health) and they will develop a standardized process for providing education and referral among programs.
  Timeline: 10/1/22 – 9/30/23

Well Woman Care Strategy #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.

State level activities/timeline:

1. Provide technical assistance and facilitate shared learning among Title V grantees in community engagement best practices.
   Timeline: 10/1/22-9/30/23
2. Support the Oregon Perinatal Collaborative in building capacity to engage clients and community-based organizations.
   Timeline: 10/1/22-9/30/23
3. Participate in the newly forming Family Partnership Collective convened by Multnomah County Health Departments.
   Timeline: 10/1/22-9/30/23

Local level activities/timeline:

- Douglas County will continue to convene a local perinatal task force.
  Timeline: 10/1/22-9/30/23

Well Woman Care Strategy #6:
Partner with state Maternal Mortality and Morbidity Review Committee (MMRC) to understand contributing factors to maternal morbidity and mortality.

State level activities/timeline:

1. Participate in state planning for the MMRC and use recommendations to inform Title V. Share information and recommendations from the Committee with Title V partners.
   Timeline: 10/1/22-9/30/23

Local level activities/timeline:
NA - no local grantees chose to work on this strategy.

Well Woman Care Strategy #7:
Explore the role of Oregon's Birth Anomaly Surveillance System (BASS) within MCH and Title V.

State level activities/timeline:

- Partner with the BASS team to identify opportunities for collaboration with Title V and Title V partners.
  Timeline: 10/1/22-9/30/23
- Support the development of a strategic plan for the BASS program.
  Timeline: 10/1/22-9/30/23

Local level activities/timeline:
NA - no local grantees chose to work on this strategy.

Critical partnerships:
Local grantees including local health departments and Tribes. The Oregon Perinatal Collaborative and local perinatal task forces. Home Visiting programs at the state and local levels. The Oregon Coalition of Local Health Officials. Oregon's Maternal Mortality and Morbidity Review Committee. Oregon Medicaid and Oregon Department of Human Services. Oregon's Birth Anomaly Surveillance System. The Oregon Health Authority's Alcohol and other Drug Alignment Team.

Other Title V Work in the Women's/Maternal Health Domain
Oregon's Title V program will continue to provide leadership for policy and system development efforts related to maternal/women's health including support for universally offered home visiting and ensuring that health system transformation addresses the need for comprehensive, culturally responsive women's and maternal health services. Title V will also continue to support programs and initiatives such as Oregon MothersCare, maternal mental health, as well as oral health for pregnant women. Additional efforts for the coming year are outlined below.

- The MCH Title V team will partner with the Oregon Department of Human Services to support Oregon implementation of Plans of Safe Care as required by the Child Abuse Prevention and Treatment Act (CAPTA). Plans of Safe Care implementation will be piloted in coordination with the expansion of Nurture

Oregon, a model of integrated maternity care and substance use disorder treatment.

- Title V staff will partner with Nurture Oregon and Oregon's Overdose Initiative Workgroup to address risk and protective factors for opioid use and overdose prevention.

- Title V will continue to support Oregon's Maternal Mortality and Morbidity Review Committee (MMRC), a governor-appointed committee that reviews deaths that occurred during pregnancy or the year after the end of pregnancy in Oregon. The committee determines issues that contributed to each death and decides upon recommendations to improve systems of care for pregnant people and ultimately decrease future deaths from happening. The MMRC is comprised of a multidisciplinary group of individuals throughout the state that have experience promoting maternal health and wellness, and includes representation from public health, mental health, community-based organizations, and healthcare professionals.

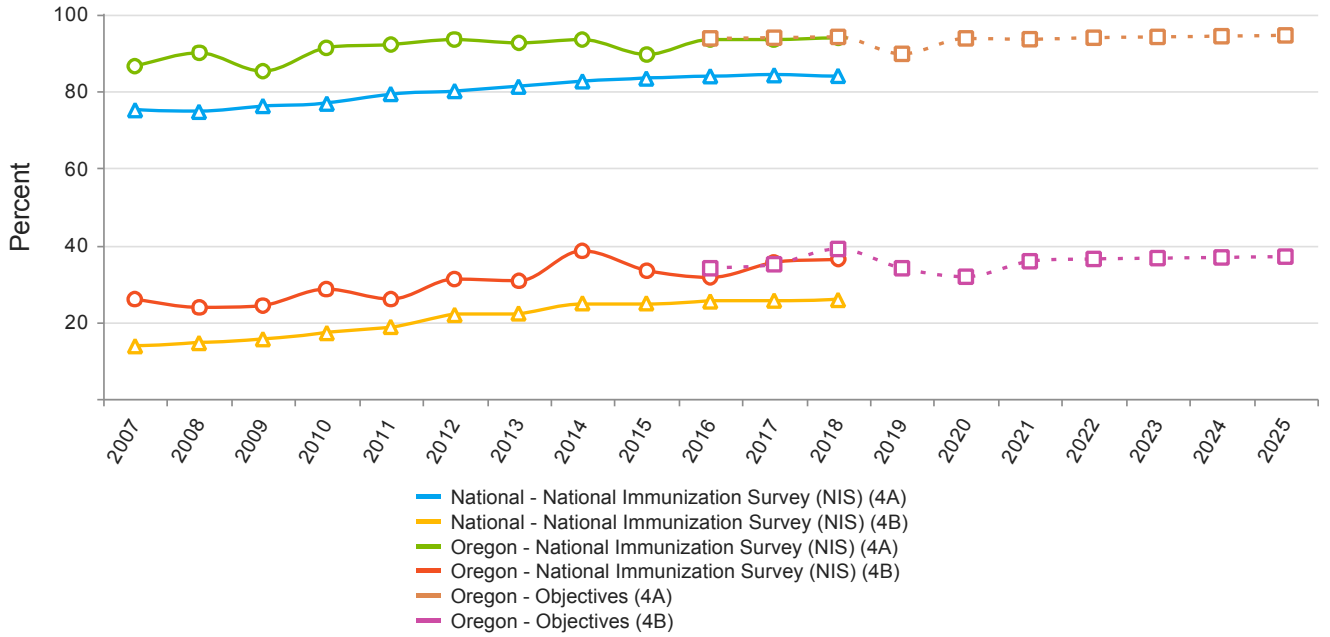
The MCH Title V staff will support Medicaid partners in implementing the new State Plan Amendment for 12-month postpartum eligibility.

Perinatal/Infant Health

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	93.8	94	89.6	93.6	93.4
Annual Indicator	93.2	89.4	93.5	93.2	93.7
Numerator	44,505	38,219	35,799	35,964	37,831
Denominator	47,759	42,729	38,275	38,600	40,359
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	93.8	94.0	94.2	94.4

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	35	39	34	31.8	35.8
Annual Indicator	38.3	33.4	31.6	35.6	36.3
Numerator	17,140	13,911	11,640	13,431	13,923
Denominator	44,757	41,664	36,894	37,678	38,346
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	36.4	36.6	36.8	37.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Breastfeeding initiation among Non-Hispanic Black mothers.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	93	94.2
Numerator		
Denominator		
Data Source	Vital statistics	Vital statistics
Data Source Year	2017	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	94.5	94.6	94.7	94.8

ESM 4.2 - Breastfeeding initiation among Non-Hispanic American Indian/Alaska Native mothers.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	89	94.4
Numerator		
Denominator		
Data Source	Vital statistics	Vital statistics
Data Source Year	2017	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	94.5	94.6	94.7	94.8

ESM 4.3 - Exclusive breastfeeding at 6 months among Non-Hispanic Black mothers.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	57	57
Numerator		
Denominator		
Data Source	PRAMS-2	PRAMS-2
Data Source Year	2017	2017
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	57.5	58.0	58.5	59.0

ESM 4.4 - Exclusive breastfeeding at 6 months among Non-Hispanic American Indian/Alaska Native mothers.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	67	67
Numerator		
Denominator		
Data Source	PRAMS-2	PRAMS-2
Data Source Year	2017	2017
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	67.5	68.0	68.5	69.0

ESM 4.5 - Among local grantees who select breastfeeding, percent who report improved knowledge, skills, or policies based on provided technical assistance.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		42.9
Numerator		3
Denominator		7
Data Source		Local grantee database
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	75.0	75.0	75.0

ESM 4.6 - Completion of environmental scan of organizations and partners to facilitate determination of Title V's role in increasing diversity in the perinatal workforce.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes

ESM 4.7 - Number of OHA Office of Equity and Inclusion certified community health workers and doulas.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	604	926
Numerator		
Denominator		
Data Source	OEI	OEI
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	930.0	940.0	950.0	960.0

ESM 4.8 - Number of providers engaged in anti-racism or cultural humility training.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		101
Numerator		
Denominator		
Data Source		State and local tracking
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	30.0	30.0	30.0	30.0

State Action Plan Table

State Action Plan Table (Oregon) - Perinatal/Infant Health - Entry 1
Priority Need
Improved lifelong nutrition
NPM
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Objectives
By October 1, 2025 increase the percent of infants who are ever breastfed from 93.5% to 94.1%; and increase the percent of infants breastfed exclusively through 6 months from 31.6% to 32.8%.
Strategies
1. Promote & support laws and policies for pregnant & breastfeeding people in the workplace. Focus on populations with additional barriers.
2. Support advanced training, coaching and quality improvement activities for home visitors related to breastfeeding.
3. Ensure that providers who serve tribal members have training in culturally specific approaches to breastfeeding promotion and support.
4. Support efforts to improve diversity in the workforce
5. Ensure access to culturally responsive preventive clinical care for low income and undocumented women.
6. 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.

ESMs	Status
ESM 4.1 - Breastfeeding initiation among Non-Hispanic Black mothers.	Active
ESM 4.2 - Breastfeeding initiation among Non-Hispanic American Indian/Alaska Native mothers.	Active
ESM 4.3 - Exclusive breastfeeding at 6 months among Non-Hispanic Black mothers.	Active
ESM 4.4 - Exclusive breastfeeding at 6 months among Non-Hispanic American Indian/Alaska Native mothers.	Active
ESM 4.5 - Among local grantees who select breastfeeding, percent who report improved knowledge, skills, or policies based on provided technical assistance.	Active
ESM 4.6 - Completion of environmental scan of organizations and partners to facilitate determination of Title V's role in increasing diversity in the perinatal workforce.	Active
ESM 4.7 - Number of OHA Office of Equity and Inclusion certified community health workers and doulas.	Active
ESM 4.8 - Number of providers engaged in anti-racism or cultural humility training.	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Perinatal/Infant Health Domain

Breastfeeding Report (October 2020 – September 2021)

National Performance Measure 4:

1. Percent of infants who are ever breastfed.
2. Percent of infant breastfed exclusively through 6 months.

NPM Trends:

Oregon continues to have initiation and duration rates well above the national average. Initiation rate is stable with vast majority of new parents starting chest/breastfeeding. Exclusive breastfeeding at 6 months increased very slightly. Oregon continues to have policies and practices in place that support chest/breastfeeding.

Breastfeeding Strategy #1:

Evaluate breastfeeding evidence-informed strategies for policy, system and environmental change impact.

Accomplishments:

Initiated evaluation of local breastfeeding strategies and activities for the past 5-year cycle. Contracted with Program Design and Evaluation Services (PDES) to conduct qualitative evaluation of successes and barriers using a spectrum of prevention frame (individual, community, institutional). Emerging themes were shared with the state Title V team to help support local agency planning for next grant cycle.

Challenges/emerging issues:

None currently; evaluation is in process.

Breastfeeding Strategy #2:

Provide technical assistance to local Title V Grantees implementing strategies to support breastfeeding in their communities.

Accomplishments:

The breastfeeding NPM is selected by 14 grantees. Individual TA calls were conducted with each grantee upon plan submission and relevant resources to accomplish their work was shared. Developed a new resource that was shared with all grantees, Oregon's 2021-2025 Title V Breastfeeding Priority, Crosswalk with Continuity of Care in Breastfeeding Support. Participated in networking calls with WIC staff who serve tribes to learn about their needs and intersection with Title V.

Challenges/emerging issues:

Many grantees continue to have capacity challenges due to Covid-19 response.

Breastfeeding Strategy #3:

Increase the number of fathers, non-nursing partner and family members, especially grandmothers, who learn about the importance of breastfeeding.

Accomplishments (state and local level):
Josephine County developed a plan to offer equitable access of services for family members to strengthen support networks for families and increase breastfeeding rates. The plan included the lactation consultant working with the Healthy Start program and the Perinatal Task Force to design and implement a monthly breastfeeding class specifically to include family members. When Covid disrupted planned services and meetings, staff pivoted to participating in virtual meetings with the Perinatal Task Force.

Challenges/emerging issues:
The staff resources needed to design and implement family support networks for breastfeeding were reallocated to COVID-19 response. All work was done remotely, and non-essential projects were put on hold. In addition, the Healthy Start program had significant staff turnover and long delays in appropriate training resulted in not meeting with Healthy Start staff.

Breastfeeding Strategy #4:

Fill unmet needs for peer support of breastfeeding.

Accomplishments:
- Clackamas continued building on work from FY 2019-2020. Prenatal education shifted to individual appointments in English or Spanish done virtually instead of in-person groups, and show rates were 62% which exceeded initial targets. All staff were trained and provided coaching about how to encourage moms to participate.
- Clatsop began the research and planning process to build infant feeding in emergencies into the county disaster plan. An initial meeting was held with the emergency manager. Also, conversations were initiated with Consejo Hispano about Spanish-speaking breastfeeding support during emergencies.
- Multnomah changed breastfeeding education program delivery from in-person groups to virtual groups due to the pandemic. Culturally specific access to breastfeeding services improved by hiring an additional staff within African American/Black culture. Started collaboration with Maternal, Child and Family Health, Healthy Birth Initiative (HBI), and WIC to provide lactation support especially for emergency response for clients discharging from the hospital. Developed a collaboration and continuum of service with HBI nurses and Community Health Specialists to support referrals for culturally specific lactation support. Collaboration with REACH and support training for HBI, Black Parent Initiative, community doulas and breastfeeding peer counselors to provide culturally specific Certified Lactation Counselor training (25 participated).

Challenges/emerging issues:
- Clackamas: show rates for appointments continue to be challenging but virtual appointments resulted in higher show rates than in-person appointments.
- Clatsop has had turnover with emergency response staff, and due to Covid-19 the development of an infant feeding plan was put on hold.
- Multnomah: COVID-19 client screening, cleaning and sanitation procedures was time-consuming and limited the number of participants for 1:1 lactation support. Covid-19 needs also impacted space available for lactation consultations. Developing a breastfeeding services strategic plan that centered race was not possible given the continually changing landscape during the COVID 19 pandemic.

Breastfeeding Strategy #5:

Educate pregnant women about breastfeeding.

Accomplishments (state and local level):

- Clackamas developed a flyer for home visiting partners to promote WIC and WIC breastfeeding services that remained available during COVID-19.
- Clatsop provided breastfeeding education during home visits to all (6) clients referred. Crook referred all breastfeeding and pregnant clients to free online classes provided by the St. Charles hospital system. The IBCLC provided Individual lactation support in-person or by phone to all clients.
- Coos conducted breastfeeding outreach through 9 social media posts, as well as brochures/materials that were developed and distributed through local businesses to encourage breastfeeding friendly workplaces. A county breastfeeding web page is dedicated to evidenced based breastfeeding information and resources. Also worked with local clinics and hospitals to distribute materials to new mothers given that breastfeeding classes were cancelled due to Covid-19.
- Grant – provided brochures to pregnant moms and those who received prenatal care at the Strawberry Wilderness Community Clinic (SWCC). Created New Mom packets in partnership with Families First and SWCC.
- Hood River - Established referral pathways for external lactation consultation so that clients were able to receive high-quality lactation support when needs couldn't be met by home visiting nurse. Communication between WIC program and home visiting nurse to support breastfeeding clients was put into place.
- Jackson - Sent 29 weekly email tips and education to home visiting staff; IBCLC organization provided tip sheets. Implemented telehealth for visits and home visitors promoted breastfeeding to all clients as appropriate.
- Polk - Successfully created an action plan based on survey results of WIC mothers. Action plan consists of 1) Strategies for Promoting Breastfeeding; and 2) a social media campaign. The Strategies for Promoting Breastfeeding is a multi-level reference guide consisting of a series of resources adaptable to client's needs that includes benefits and programs available. Additionally, it includes strategies for health departments or health systems to adopt related to increased breastfeeding support such as: tele-lactation services, and text messages support for breastfeeding. Updated 3 policies for Home Visiting, Reproductive Health & Oregon Mother's Care to include the screening of pregnant women for breastfeeding intention and offer information on lactation support as needed. The most success we had in providing breastfeeding education was with WIC pregnant and breastfeeding women since that program saw little to no disruption related to COVID-19 restrictions, as appointments shifted from in person to telephone. The social media campaign contains educational material that will be featured through monthly social media.
- Tillamook established agreements with 3 programs (WIC, BabiesFirst, CaCoon) for consistent messaging and breastfeeding support which has been essential in being able to connect with pregnant and breastfeeding clients during the pandemic. Continued breastfeeding education services through Maternity Case Management (MCM) visits, shifting from in-person to virtual visits, and increased MCM caseload. 87% of moms who received breastfeeding education attempted to breastfeed. 57% of moms who received breastfeeding education were still breastfeeding at 2 months.
- Washington - Close to 100% of clients received education and information about breastfeeding.
- Warm Springs – continued to have a strong partnership with WIC staff and provide breastfeeding education to 95% of clients. Also, coordination with the hospital lactation consultant staff provided smooth transitions from delivery discharge to Warm Springs IBCLC. During Breastfeeding Week August 2020 a PSA was promoted on a local radio station. One staff member attended trainings for continuing education in lactation.

Challenges/emerging issues:

The primary challenge for all grantees was the impact of Covid on their programs. Clackamas found that distribution

could be challenging when partners are relied upon to forward materials to their participants or employees. Clatsop: staff person leading the North Coast Breastfeeding Coalition left resulting in the coalition not meeting to work on a shared understanding of lactation support in community. Because of Covid-19, breastfeeding classes shifted to free online classes delivered through the hospital system. Individual counseling was challenging over the phone as most clients wanted to come in person and this required additional steps in the clinic to ensure safety. Coos-primary challenge was Covid-19 with many businesses shut down, limiting partnerships and outreach to support breastfeeding. Community events were cancelled so Lactation Stations were not possible. Grant had staff turnover at the SWCC so it was unclear if and how many pregnant and breastfeeding moms received education and resource brochures. Covid-19 response impacted staff capacity to track county births. Hood River - New home visiting nurse worked in multiple programs including Covid response. It was difficult to provide lactation support over the phone. Unable to track and report referrals given limited staffing and Covid response needs. Jackson - All MCH nurses and MCH manager were diverted to COVID-19 response and saw clients virtually when possible. Another significant challenge was the impact of wildfire on entire communities with over 600 still living in motels. Josephine – Staff were reallocated to Covid-19 response. Monthly virtual breastfeeding classes were offered to the public, WIC and Healthy Start clients however there was no attendance most likely due to clients having access to the breastfeeding peer counseling program through the WIC program. Polk - Due to the COVID-19 restrictions in person appointments were significantly reduced, reducing the number of clients seen across programs. Additionally, there was a significant loss of staff capacity due to ongoing COVID-19 response needs and resignations. Because of significant staff shortage only WIC participants received breastfeeding support and education. Tillamook – Covid-19 was the primary challenge, shifting from in-person to virtual visits and finding alternate ways to provide education. Washington did not need to revise breastfeeding materials in the Welcome Baby packets since materials are provided by partners and with remote services they were not needed as information was shared during the client visit. Warm Springs – staff turnover during Covid-19 was a challenge.

Breastfeeding Strategy #6:

Increase workforce support for breastfeeding through training and access to high quality servicers.

ESM:

Number of health care providers trained in breastfeeding support.

Progress: 68 health care providers were trained in breastfeeding support.

Accomplishments – State level:

State-developed partnership with Nurturely, a community-based organization focused on anti-racism training in perinatal health. During Black Breastfeeding Week, co-sponsored a screening and facilitated discussion of the film Chocolate Milk to learn and identify potential actions to address racism during lactation. Continuing education was provided for nurses and lactation professionals. There were 84 attendees, 49 from Oregon representing 12 counties. Initiated exploration of support for home visiting programs to conduct continuous quality improvement projects in breastfeeding. Engaged with home visiting nurse team and select Title V leads to explore agency workforce development gaps and opportunities across Title V and home visiting; identified a plan for next steps.

Accomplishments – Local level:

- Clatsop - The MCH Coordinator (IBCLC certified) participated in trainings needed to meet the IBCLC continuing education requirement.
- Jefferson - One staff member completed training and passed IBCLC test Sept 2020, second nurse deferred due to pandemic response. Monthly breastfeeding coalition meetings have been ongoing, including WIC, nurse home visiting and hospital lactation. The coalition updated their mission and vision, developed

materials and logo for outreach, and conducted community outreach. Financial support of community outreach was provided by the Board of County Commissioners after a presentation by coalition members.
- Washington – 17 home visit staff (100%) participated in at least one breastfeeding continuing education activity There are 3 IBCLC staff who are supported in maintaining their certification requirements.

Challenges/emerging issues:

- Jefferson - Nurse who intended to complete IBCLC training was re-assigned to Covid response so had to defer completion of the training. Latino community breastfeeding outreach event had to be cancelled due to COVID. Hospital staff were unable to assist as much as hoped due to re-assignment with COVID. This has made having a consistent lactation team difficult.
- Washington -Healthy Families staff did not attend as many trainings as planned due to staff turnover and core training requirements in Growing Great Kids.

Strategy #7:

Increase access to workplace breastfeeding support.

Accomplishments:

None to report.

Challenges/emerging issues:

NA – no locals selected this strategy

Strategy #8:

Increase the support of breastfeeding at childcare settings through policy, training and workforce development.

Accomplishments:

Clackamas continued work from previous year to deliver one childcare breastfeeding training for 7 childcare providers registered through the Clackamas Education Service District (ESD) Resource and Referral Network. Through a successful partnership with Clackamas ESD Childcare Resource and Referral, promotional flyers and social media were developed and distributed through various networks. Post-training resources were provided to participants.

Challenges/emerging issues:

Clackamas: an inherent challenge with training is getting people to sign up.

Perinatal/Infant Health Domain

Breastfeeding Plan (October 2022 – September 2023)

National Performance Measure:

- Percent of infants who are ever breastfed.
- Percent of infants breastfed exclusively through 6 months.

Breastfeeding Strategy #1:

Promote & support laws and policies for pregnant & breastfeeding people in the workplace. Focus on populations with additional barriers.

ESMs:

4.1. Breastfeeding initiation among Non-Hispanic Black mothers.
4.2. Breastfeeding initiation among Non-Hispanic American Indian/Alaska Native mothers.
4.3. Exclusive breastfeeding at 6 months among Non-Hispanic Black mothers.
4.4. Exclusive breastfeeding at 6 months among Non-Hispanic American Indian/Alaska Native mothers.

State level activities/timeline:

1. Increase awareness of current laws and policies that protect against discrimination during pregnancy and support breastfeeding via updating the breastfeeding webpage.
   Timeline: 10/1/22 – 12/31/22
2. Strengthen/develop partnerships with Bureau of Business and Industry, Oregon Law Center, community groups and others.
   Timeline: 10/1/22 – 9/30/23
3. Promote resources with grantees and provide TA as requested.
   Timeline: 10/1/22 – 9/30/23

Local level activities/timeline:

- Coos County will engage workplace leaders to develop and implement breastfeeding workforce policies that promote a workplace culture of support for breastfeeding people.
  Timeline: 10/1/22 – 9/30/23.

Breastfeeding Strategy #2:

Support advanced training, coaching and quality improvement activities for home visitors related to breastfeeding.

ESM:

4.5. Among local grantees who select breastfeeding, percent who report improved knowledge, skills, or policies based on provided technical assistance.

State level activities/timeline:

1. Support grantees in identifying resources for advanced training and coaching for home visitors.
   Timeline: 10/1/22 – 9/30/23
2. Develop plan with MCH lead for continuous quality improvement in home visiting to assess or identify breastfeeding skills and training needs of home visiting staff and possibility for CQI project.
   Timeline: 10/1/22 – 3/21/23

Local level activities/timeline:

- Six grantees will provide or sponsor home visiting staff to attend advanced training and receive coaching to promote and support breastfeeding best practices: Baker, Clatsop, Crook, Douglas, Jefferson, and Linn counties.
  Timeline: 10/1/22 – 9/30/23.

Breastfeeding Strategy #3:

Ensure that providers who serve tribal members have training in culturally specific approaches to breastfeeding promotion and support.

ESM:
4.8. Number of providers engaged in anti-racism or cultural humility training.

State level activities/timeline:
1. Strengthen partnerships with Northwest Portland Area Indian Health Board (NWPAIHB), Intertribal Breastfeeding Coalition, tribal health clinics and other tribal partners to support nutrition and infant feeding work.
   Timeline: 10/1/22 – 9/30/23
2. Engage with WIC programs in tribal health clinics to learn and develop cross-program collaboration.
   Timeline: 10/1/22 – 9/30/23

Local level activities/timeline:
- The Confederated Tribes of Warm Springs will provide training on culturally specific approaches to providers who serve tribal members.
  Timeline: 10/1/22 – 9/30/23.

Breastfeeding Strategy #4:
Support efforts to improve diversity in the workforce.

ESMs:
4.6. Completion of environmental scan of organizations and partners to facilitate determination of Title V's role in increasing diversity in the perinatal workforce.
4.7. Number of OHA Office of Equity and Inclusion Certified Community Health Workers.

State level activities/timeline:
1. Develop partnerships with community organizations who support training of community health workers, including doulas, lactation counselors, and peer-based care models.
   Timeline: 10/1/22 – 9/30/23

Local level activities/timeline:
- Two counties (Multnomah and Harney) are promoting workforce diversity through participation on community-based coalitions, serving on a leadership council and providing culturally-specific, patient-centered lactation care.
  Timeline: 10/1/22 – 9/30/23

Breastfeeding Strategy #5:
Ensure access to culturally responsive preventive clinical care for low income and undocumented women.

State level activities/timeline:
1. Identify and promote anti-racist and culturally responsive breastfeeding resources with grantees.
   Timeline: 10/1/22 – 9/30/23
2. Identify and leverage breastfeeding peer support services through programs.
   Timeline: 4/1/23 – 9/30/23

Local level activities/timeline:
- Clatsop, Harney, and Josephine counties are implementing care coordination and referral systems through partnerships and expanding access to peer support services.
  Timeline: 10/1/22 – 9/30/23

Breastfeeding Strategy #6:
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.

State level activities/timeline:
1. Provide technical assistance and facilitate shared learning among Title V grantees in community engagement best practices.
   Timeline: 10/1/22 – 9/30/23
2. Identify opportunities to build partnerships with community-based organizations.

Timeline: 10/1/22 – 9/30/23

Local level activities/timeline:

- Four counties (Clatsop, Douglas, Grant, and Josephine) will convene and participate in community based perinatal, women's and infant health advisory groups.
  Timeline: 10/1/22 – 9/30/23

Breastfeeding Strategy #7:

Evaluate the impact of breastfeeding programs and interventions.

State level activities/timeline:

1. Complete qualitative program evaluation.
   Timeline: 10/1/22 – 12/31/22
2. Develop resources based on program evaluation to share with grantees.
   Timeline: 1/2/23 – 9/30/23
3. Plan and conduct key informant interviews with grantees as next stage in program evaluation.
   Timeline: 10/1/22 – 9/30/23

Critical partnerships:

- All local grantees
- WIC program
- MIECHV program
- Nurturely
- Northwest Portland Area Indian Health Board
- Bureau of Labor & Industries (BOLI)

Other Title V Work in the Perinatal/Infant Health Domain

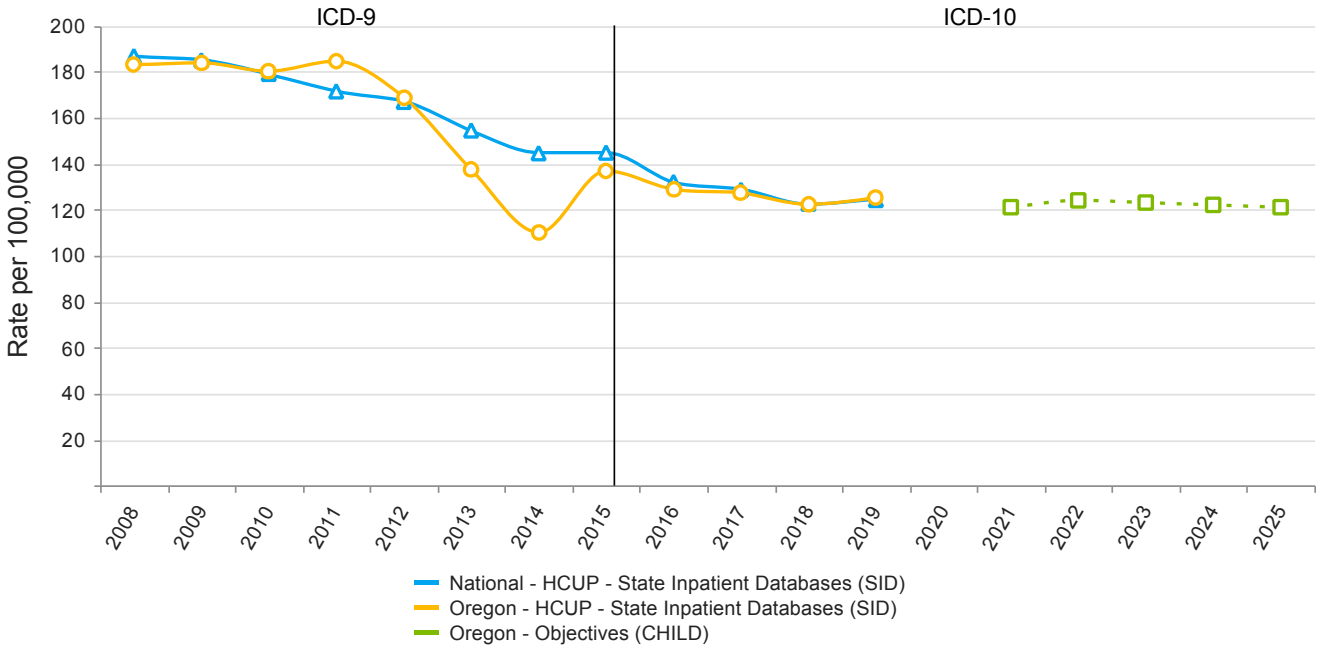
Title V will continue to provide leadership and technical assistance for linkages to prenatal care, oral health, maternal mental health, and other perinatal services; infant mortality reduction; PRAMS and ECHO surveillance systems; early hearing detection and intervention (EHDI); breastfeeding support; and integration of perinatal/infant health into programs and policies across state and local agencies. Other activities for the coming year include:

- MCH Title V will continue to partner with the Safe Sleep Advisory Committee on initiatives including providing mini grants to community-based organizations working in communities of color, and a communications campaign and website: safesleeporegon.org. Messages and communications outreach will reinforce safe sleep messages in a multitude of clinical and community settings including childcare.
- The EHDI and BASS teams are working with partners to develop innovations in Newborn Screening Inter-operability.

Child Health

National Performance Measures

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9
Indicators and Annual Objectives



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data			
Data Source: HCUP - State Inpatient Databases (SID)			
	2019	**2020**	**2021**
Annual Objective			121
Annual Indicator	127.1	122.1	125.0
Numerator	609	582	588
Denominator	479,233	476,789	470,263
Data Source	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2017	2018	2019

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	124.0	123.0	122.0	121.0

Evidence-Based or –Informed Strategy Measures

ESM 7.1.1 - Injury death rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	6.3	6.4
Numerator	87	88
Denominator	1,385,268	1,381,916
Data Source	Vital statistics and census	Vital statistics and census
Data Source Year	2018-20	2019-21
Provisional or Final ?	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	6.3	6.2	6.1	6.0

ESM 7.1.2 - Transportation injury death rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	2.2	2.5
Numerator	31	34
Denominator	1,385,268	1,381,916
Data Source	Vital statistics and census	Vital statistics and census
Data Source Year	2018-20	2019-21
Provisional or Final ?	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	2.4	2.3	2.2	2.1

ESM 7.1.3 - Drowning death rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	0.9	0.9
Numerator	20	20
Denominator	2,335,113	2,326,367
Data Source	Vital statistics and census	Vital statistics and census
Data Source Year	2016-20	2017-21
Provisional or Final ?	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	0.9	0.9	0.8	0.8

ESM 7.1.4 - Poisoning injury rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	85.9	85.9
Numerator	1,190	1,187
Denominator	1,385,268	1,381,916
Data Source	Vital statistics and hospitalization data	Vital statistics and hospitalization data
Data Source Year	2018-20	2019-21
Provisional or Final ?	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	85.0	84.0	83.0	82.0

ESM 7.1.5 - Among local grantees who select child injury prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	75.0	75.0	75.0

ESM 7.1.6 - Percent of engaged partner groups including other state agencies, local grantees, and marginalized community representatives, that report satisfaction with level of engagement in the development of a collaborative child injury report.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	80.0	80.0	80.0	80.0

ESM 7.1.7 - Completed assessment of injury prevention risk assessment, education, and remediation in Oregon's public health home visiting programs.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes

State Action Plan Table

State Action Plan Table (Oregon) - Child Health - Entry 1	
Priority Need	
Safe and supportive environments	
NPM	
NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9	
Objectives	
By October 1, 2025, decrease the rate of hospitalization of 0 to 9 year old children for non-fatal injuries from 127.1 to 117, by addressing upstream drivers of child injury.	
Strategies	
1. Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.	
2. Strengthen workforce capacity to address child injury prevention at the state and local level.	
3. Strengthen partnerships and coalitions to support child injury education, prevention plan implementation, and communication strategies.	
4. Improve data collection, analysis, interpretation and dissemination of child injury data to focus on prevention efforts.	
ESMs	Status
ESM 7.1.1 - Injury death rate among children 0 - 9 years of age	Active
ESM 7.1.2 - Transportation injury death rate among children 0 - 9 years of age	Active
ESM 7.1.3 - Drowning death rate among children 0 - 9 years of age	Active
ESM 7.1.4 - Poisoning injury rate among children 0 - 9 years of age	Active
ESM 7.1.5 - Among local grantees who select child injury prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance	Active
ESM 7.1.6 - Percent of engaged partner groups including other state agencies, local grantees, and marginalized community representatives, that report satisfaction with level of engagement in the development of a collaborative child injury report.	Active
ESM 7.1.7 - Completed assessment of injury prevention risk assessment, education, and remediation in Oregon’s public health home visiting programs.	Active

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Child Health Domain

Child Injury Prevention Report (October 2020 – September 2021)

National Performance Measure:
7A: Rate of hospitalization for non-fatal injury per 100,000 children, ages 0-9.

Trends in NPM Data:
NPM 7A. Since 2008 to 2018, Oregon has seen a steady decline in the rate of injury hospitalizations for children 0-9 years old, from 183 per 100,000 to 122.1 per 100,000 children. Oregon's improvement has been consistent with the national trend over that 10-year period. Despite these improvements, injuries are a leading cause of death for children and adolescents. The leading causes of injuries and injury deaths vary by age, and some groups experience disparities.

Child Injury Prevention Strategy #1:
By October 2020, determine state MCH staffing for the Child Injury priority and develop a cross-cutting injury team to address upstream drivers of child injury, and link to work across population domains (including safe sleep, child injury, bullying prevention, ACEs prevention, and SDOH-E). The cross-cutting injury team will research, develop, adapt or adopt an overarching theory of change for the work, in collaboration with the PHD Injury and Violence Prevention Section.

Accomplishments:
- State MCH staffing for the child injury priority was identified and state staff began meeting as a cross-cutting injury team in October 2020. Ongoing biweekly meetings provided an opportunity for staff to align work across the child injury and adolescent bullying priorities, as well as collaborate to incorporate upstream drivers of child injury. Staff worked together to plan a collaborative injury and bullying focused presentation to introduce local public health and tribal grantees to the priority topics, strategies and activities for the upcoming grant year. The presentation was delivered to local public health and tribal grantees in February 2021.
- During this grant period, MCAH staff have met with PHD Injury and Violence Prevention (IVPP) Section staff, in multiple forums and for different focuses including participation in a Shared Risk and Protective Factors learning series facilitated and led by Health Management Associates, through collaborative meetings to participate in planning for the submission of the CDC Injury Prevention CORE grant, and to better understand and align efforts across data collection, analysis and products of analysis for consistent and comprehensive use of available data.

Challenges/emerging issues:
No challenges have been identified.

Child Injury Prevention Strategy #2:
By December 2020, develop evidence-based/informed strategies and measures for child injury – including strategies that address upstream drivers of maternal, child and adolescent health. Strategies will address both state and local levels work. Engage local Title V grantees and family and community representatives in the process.

ESMs:
7.1.1 The number of strategies developed to address injury prevention among children across the spectrum of prevention.

Progress: 4 strategies were developed

7.1.2 The number of critical partners engaged in the development of upstream strategies to address child injury.

Progress: 9 partners were engaged - 2 state public health nurses representing Oregon's Home Visiting System; 3 staff from Injury and Violence Prevention Program, including IVPP program manager and epidemiologist; Oregon Safe Kids Coordinator; Adolescent and School Health Policy Lead; MCH Title V Coordinator and Policy Lead; MCH Community System Manager.

Accomplishments:
State MCH staff developed a four-strategy plan for child injury prevention that provided opportunities for local public health and tribal grantees to focus on work to drive policy change, workforce development, partnerships and collaborations, and/or data integrity and use for prevention. Each strategy includes between 1-3 activities which center on local context, culturally specific and responsive engagement, and leveraging community resources and

coalitions driving child injury prevention. Strategies were developed through an iterative process informed by published research, technical guidance from the Centers for Disease Control and Prevention, Safe States, and the Children's Safety Network, as well as other leading national injury prevention organizations. The draft plan was shared with colleagues from the PHD Injury and Violence Prevention team, the statewide Safe Kids Coalition, MCH home visiting lead staff, and other MCH colleagues for their feedback and improvements. Plans were presented to local public health and tribal grantees through webinars conducted in February 2021.

Challenges/emerging issues:
No challenges have been identified.

Child Injury Prevention Strategy #3:
By February 2021, develop and adopt a logic model for the cross-cutting child injury prevention Title V work.

Accomplishments:
After surveying local grantees about the usefulness of a logic model for their work, it was decided that this strategy was not a high priority to implement. Grantees asked instead for a focus on workshops and technical assistance related to the new strategies, the upstream drivers of maternal and child health, and a the cross-cutting theory of change that supports the work. These TA sessions were delivered in February 2021 and followed up with technical assistance as described in strategy 5.

Challenges/emerging issues:
NA – See above

Child Injury Prevention Strategy #4:
By March 2021, begin implementation and tracking of state level strategies for new cross-cutting child injury prevention Title V work and cross-priority Title V work; collect/track outcomes through monitoring of ESMs and NPMs.

Accomplishments:
State MCH staff developed a four-strategy state plan for child injury prevention which aligns with the plan developed for local public health and tribal grantees. The strategies and companion activities were developed to drive policy change, workforce development, partnerships and collaborations, and/or data integrity and use for prevention. Each strategy is paired with 1-2 ESMs for tracking and monitoring progress of the state plan.
To further the state MCH workplan for child injury prevention, the following activities have been prioritized during the funding period:

- MCH Title V staff met in June 2021 with PHD Injury and Violence Prevention Program staff to discuss alignment and opportunities to collaborate. Key areas of focus that emerged from those discussions included IVPP sharing their application for CDC funding, and discussing data systems, data sets, data visualizations, and other data products with an eye toward consistent analytic approaches and collaborative opportunities.
- The MCH child injury prevention state lead participates in the Oregon State Child Fatality Review Team (SCFRT) meetings held at least 3 times yearly. During this grant period, meetings were held October 2020, May 2021, and September 2021.
- The MCH child injury prevention state lead and MCH injury research analyst participated in monthly Safe Kids Advisory Board meetings, and in the newly created Water Safety Task Force. As part of that commitment, the MCH injury research analyst prepares an annual report of summary and trend statistics of leading causes of child injuries and deaths in Oregon. With the creation of the Water Safety Task Force, additional analyses of drowning data were performed and provided for use in prevention strategy development.
- Along with all state MCAH Title V staff, the MCH child injury prevention state lead performed TA calls with local public health and tribal grantees in May - June of 2021 to support plan refinement and implementation.
- In June 2021, the MCH child injury prevention state lead and MCH injury research analyst participated in conversations with Oregon Center for Health Statistics - Vital Records staff to learn more about drowning data reports to inform quality analysis and confidence in the strengths and limitations of Oregon's death certificate dataset.
- In August 2021, the MCH child injury prevention state lead and MCH injury research analyst participated in conversations with Oregon Center for Health Statistics - Vital Records staff to explore opportunities to expand and enhance their injury data dashboards to include more publicly accessible data about child injury deaths and racial/ethnic analyses.

Challenges/emerging issues:
No challenges identified.

Child Injury Prevention Strategy #5:
By March 2021, provide technical assistance on new injury prevention strategies and measures to Title V grantees to inform local level Title V priority selection, planning and implementation.

Accomplishments:
As noted earlier, State MCH staff worked together to plan a comprehensive technical assistance series about Title V priorities, selection, planning and implementation to support informed choice by local public health and tribal grantees. MCAH staff developed a collaborative injury and bullying focused presentation to introduce local public health and tribal grantees to the priority topics, strategies and activities for the upcoming grant year. The presentation was successfully delivered to local public health and tribal grantees in February 2021.

Challenges/emerging issues:
No challenges identified.

Child Injury Prevention Strategy #6:
April - June 2021, review and provide TA to local Title V Grantees on implementing injury prevention annual plans for July 2021– June 2022.

Accomplishments:
Ten local grantees selected child injury prevention in their Title V plans for the coming year. Along with all state MCAH Title V staff, the MCH child injury prevention state lead performed TA calls with local public health and tribal grantees in May - June of 2021 to support plan refinement and implementation.

Challenges/emerging issues:
No challenges identified.

Child Injury Prevention Strategy #7:
July 1, 2021, through September 30, 2021- Title V grantees will implement local level strategies and collect/track outcomes.

Accomplishments:
All ten local public health and tribal grantees developed and began implementing their child injury prevention plans. Local grantee work on child injury prevention was distributed across the four strategy options as follows:

- Injury prevention strategy #1: Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.
    - Marion, Wheeler: Assess child injury prevention policy gaps.
    - Wheeler: Assess child injury data to identify leading causes in community.
- Injury prevention strategy #2: Strengthen workforce capacity to address child injury prevention at the state and local level.
    - Polk County: Assess and enhance integration of injury risk assessment, education, and remediation into home visits with families. Provide or arrange for staff to participate in child injury prevention trainings.
- Injury prevention strategy #3: Strengthen partnerships and coalitions to support child injury education, prevention plan implementation, and communication strategies.
    - Benton, Columbia, Linn, Polk, Wheeler: Develop and disseminate child injury prevention messaging to the public and/or home visiting clients.
    - Crook: Provide safe storage boxes for clients who report unsafe storage of harmful substances.
    - Jackson County: Provide safe sleep anticipatory guidance to each family served through home visiting.
    - Marion, North Central Public Health District, Wheeler: Participate in Oregon Safe Kids Coalitions in region or county.
    - Confederated Tribes of Warm Springs: Perform or fund culturally specific health outreach and education. Conduct back to the board classes. Distribute car seats to families of newborns.
- Injury prevention strategy #4: Improve data collection, analysis, interpretation and dissemination of child injury data to focus on prevention efforts.
    - Wheeler: Participate in local child death review team and contribute to improved reporting

Challenges/emerging issues:
Local public health and tribal grantee capacity to undertake and implement Title V plans has been severely strained due to the ongoing impacts of the COVID-19 public health emergency. In many communities, there has been an underlying public health workforce shortage and/or staffing churn creating challenging conditions for Title V grantees.

Similarly, the state MCH capacity to support and provide technical assistance to local grantees has been limited due to vacancies and increased workloads for staff.

Child Health Domain

Child Injury Prevention Plan (October 2022 – September 2023)

National Performance Measure:
Rate of injury-related hospital admissions per population ages 0 through 19 years.

Child Injury Prevention Strategy #1:
Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.

ESMs:
7.1.1: Injury death rate among children 0 - 9 years of age.
7.1.2: Transportation injury death rate among children 0 - 9 years of age.
7.1.3: Drowning death rate among children 0 - 9 years of age.
7.1.4: Poisoning injury rate among children 0 - 9 years of age.

State level activities/timeline:
1. Continue to work with Safe Kids Water Safety Task Force to identify and assess injury prevention policy gaps around drowning prevention for possible legislative proposal for the 2023 session.
   Timeline: October 2022-June 2023
2. Identify injury prevention policy gaps and opportunities for at least one additional injury cause (motor vehicle or poisoning).
   Timeline: April-September 2023
3. Provide data and technical assistance to local Title V partners working on this strategy and related activities.
4. **Timeline:** October 2022-September 2023

Local level activities/timeline:
- Marion County: Assess opportunities to strengthen child injury prevention policies through local CCO. Focus on anticipatory guidance during WCV for car seats, booster transition, bike helmets, and carbon monoxide poisoning prevention.
- Wheeler County: Assess opportunities to strengthen child injury prevention policies in collaboration with schools and the Asher Clinic.
- Yamhill County: Convene local partners to identify policy priorities and develop plans to advance priorities related to motor vehicle safety and car seat installation.
  Timeline: 10/1/22 – 9/30/23

Child Injury Prevention Strategy #2:
Strengthen workforce capacity to address child injury prevention at the state and local level.

ESMs:
7.1.5: Among local grantees who select child injury prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance.
7.1.7: Completed assessment of injury prevention risk assessment, education, and remediation in Oregon's public health home visiting programs.

State level activities/timeline:
1. Continue review of home visiting program guidance, materials and training for injury prevention education and support to families enrolled in home visiting programs. Look for opportunities to increase consistency, identify gaps for training, and identify training resources for home visitors.
   Timeline: October 2022-September 2023
2. Provide data and technical assistance to local Title V partners working on this strategy and related activities.
   Timeline: October 2022-September 2023

Local level activities/timeline:
- Deschutes County:
  - Engage nurse family support services team to discuss use of home environmental safety screen and identify areas where training is needed.

    - Conduct trainings with nurse family support services team on identified child injury topics to enhance home environmental safety assessment and anticipatory guidance.
- Jackson County:
    - Enhance harm reduction education around bed sharing through updating the educational tools that nurses utilize with families and supporting nurses to use motivational interviewing to guide a more meaningful dialogue.
    - Assess needs of the nurse team and broader home visiting community around training and education for SUID harm reduction.
- North Central Health District: Provide or arrange for staff to participate in child injury prevention trainings.
- Wheeler County: Provide or arrange for staff to participate in child injury prevention trainings.
  Timeline: 10/1/22 – 9/30/23.

Child Injury Prevention Strategy #3:

Strengthen partnerships and coalitions to support child injury education, prevention plan implementation, and communication strategies.

State level activities/timeline:

1. Participate in Oregon Safe Kids and Water Safety Task Force meetings and related special projects.
   Timeline: October 2022-September 2023
2. Work with MCH Health Educator on coordinated social media messages with injury prevention partners.
   Timeline: October 2022-September 2023
3. Provide technical assistance to local Title V partners focusing on this strategy and related activities.
   Timeline: October 2022-September 2023

Local level activities/timeline:

- Benton County: Develop and disseminate child injury prevention messaging to the public; continue child abuse blue pin awareness campaign in collaboration with community partners; expand outreach to community; integrate across MCH team approaches.
- Cow Creek: Conduct in partnership and/or fund culturally specific health outreach and education efforts.
- Hood River County:
    - Participate in community infant safety and wellness group to coordinate prevention services.
    - Participate in multidisciplinary team that serves families involved with the DHS system.
- Marion County: Conduct or fund culturally specific health outreach and education efforts.
- Confederated Tribes of Warm Springs: Conduct culturally specific health outreach and education, with focus on car seat distribution and back to boards classes with safe sleep education for families.
- Wheeler County: Conduct outreach, education and provide prevention messaging to students and staff regarding leading causes of injury.
  Timeline: 10/1/22 – 9/30/23.

Child Injury Prevention Strategy #4:

Improve data collection, analysis, interpretation, and dissemination of child injury data to focus on prevention efforts.

ESM:

7.1.6: Percent of engaged partner groups including other state agencies, local grantees, and marginalized community representatives, that report satisfaction with level of engagement in the development of a collaborative child injury report.

State level activities/timeline:

1. Participate on State Child Fatality Review Team (SCFRT). Serve as a liaison to local fatality teams.
   Timeline: October 2022-September 2023
2. Convene with SCFRT and PHD staff to develop a plan for child injury and injury fatality report.
   Timeline: October 2022-September 2023
3. Provide data and technical assistance to local Title V partners focused on this strategy and related activities.
   Timeline: October 2022-September 2023

Local level activities/timeline:

- Benton County: Participate in Child Abuse Response Team meetings in county. Participate in child fatality review training. Develop presentation about MCH services for CART team.
- Malheur County: Participate in local child death review teams and contribute to subsequent data reporting into NCDRRS.
- Wheeler County: Participate in local child death review teams and contribute to subsequent data reporting

into NCDRRS.
Timeline: 10/1/22 – 9/30/23.

Critical partnerships:

- Safe Kids Oregon members and Local Coalitions
- State Child Fatality Review Team members
- Oregon Injury and Violence Prevention Program
- Local fatality review teams
- MCH home visiting programs and staff

Other Title V Work in the Child Health Domain

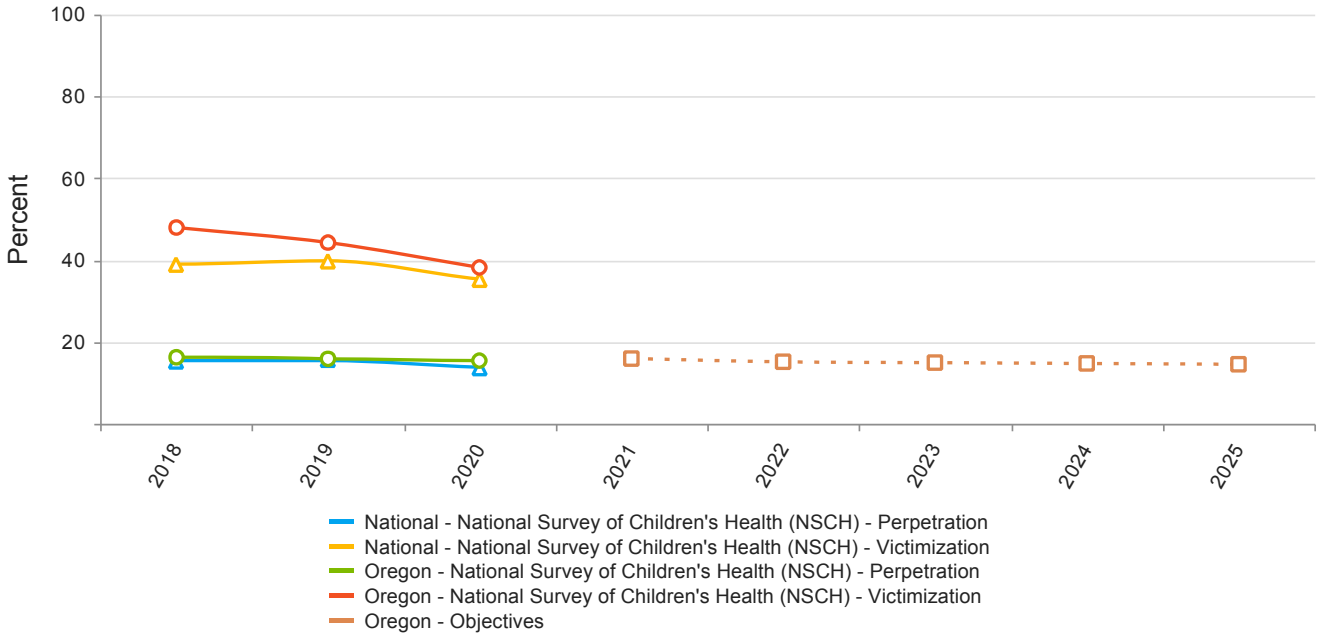
Title V's work in child health will continue to provide leadership, technical assistance and analytic expertise for the integration of child health promotion into programs and policies across state and local agencies. Title V will also continue to support work in Oral Health for children, although it is no longer one of Oregon's selected Title V NPMs. Some specific child health work that will be supported in the coming year includes:

- Title V staff will partner with Medicaid to implement the newly revitalized EPSDT program for Oregon. EPSDT was previously incorporated into Oregon's 1115 waiver, and now will be developed and implemented as a visible and comprehensive child health prevention program within Medicaid.
- The Oral Health program is collaborating with Medicaid and CCOs to increase fluoride varnish application in primary care for children ages 1-6 as part of a CMS "Advancing Prevention and Reducing Childhood Caried in Medicaid and CHIP initiative.
- Title V staff will collaborate with the OHA Transformation Center to review submitted CCO Community Health Improvement Plans for child and adolescent health impacts.
- Title V will support the Child Fatality Review Team with staffing and in-kind data assistance.
- Title V will work with OHA's Child Social Emotional Metrics Team to provide support to CCOs for implementation of this work and metric.
- Title V supported audiologist will conduct professional development with audiologists across the state.

Adolescent Health

National Performance Measures

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
Indicators and Annual Objectives



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - Perpetration			
	2019	**2020**	**2021**
Annual Objective			16
Annual Indicator	16.3	16.1	15.4
Numerator	44,259	44,099	43,323
Denominator	270,893	273,112	281,511
Data Source	NSCHP	NSCHP	NSCHP
Data Source Year	2018	2018_2019	2019_2020

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - Victimization			
	2019	**2020**	**2021**
Annual Objective			16
Annual Indicator	47.9	44.1	38.3
Numerator	129,756	120,491	108,108
Denominator	271,087	273,209	282,302
Data Source	NSCHV	NSCHV	NSCHV
Data Source Year	2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	15.2	15.0	14.8	14.6

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - Percent of 8th and 11th graders who have experienced bullying.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	24.9	11.9
Numerator		
Denominator		
Data Source	Oregon Healthy Teens Survey	Oregon Student Health Survey
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	11.8	11.7	11.6	11.5

ESM 9.2 - Percent of 8th and 11th graders who have experienced bullying due to their race or ethnicity.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	4.4	2
Numerator		
Denominator		
Data Source	Oregon Healthy Teens Survey	Oregon Student Health Survey
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	1.9	1.8	1.7	1.6

ESM 9.3 - Percent of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	4.7	3.1
Numerator		
Denominator		
Data Source	Oregon Healthy Teens Survey	Oregon Student Health Survey
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	3.0	2.9	2.8	2.7

ESM 9.4 - Percent of 8th and 11th graders who have experienced bullying due to a disability.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		2.3
Numerator		
Denominator		
Data Source		Oregon Student Health Survey
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	2.2	2.1	2.0	1.9

ESM 9.5 - Among local grantees who select bullying prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	75.0	75.0	75.0

ESM 9.6 - Completion of environmental scan of youth serving agencies.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes

ESM 9.7 - Number of activities completed that increase local access to bullying prevention resources.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	5.0	5.0	5.0	5.0

State Action Plan Table

State Action Plan Table (Oregon) - Adolescent Health - Entry 1	
Priority Need	
Stable and responsive relationships; resilient and connected children, youth, families and communities.	
NPM	
NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others	
Objectives	
By October 1, 2025, decrease the percentage of adolescents age 12-17 who bully others from 16.3% to 15.3%, and decrease the percentage of those who are bullied from 47.9% to 45.4%.	
Strategies	
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.	
ESMs	**Status**
ESM 9.1 - Percent of 8th and 11th graders who have experienced bullying.	Active
ESM 9.2 - Percent of 8th and 11th graders who have experienced bullying due to their race or ethnicity.	Active
ESM 9.3 - Percent of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity.	Active
ESM 9.4 - Percent of 8th and 11th graders who have experienced bullying due to a disability.	Active
ESM 9.5 - Among local grantees who select bullying prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance.	Active
ESM 9.6 - Completion of environmental scan of youth serving agencies.	Active
ESM 9.7 - Number of activities completed that increase local access to bullying prevention resources.	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Adolescent Health Domain

Bullying Prevention Report (October 2020 – September 2021)

National Performance Measure 9:
Percent of adolescents, ages 12 through 17, who are bullied or who bully others.

Trends in NPM Data:
The data shared below is from the 2018 and 2019 National Survey of Children's Health.

National and Oregon state Measures of Bullying Perpetration is reported at about the same percentages in both 2018 and 2019 for National measures--about 15 percent, and for Oregon state measures at about 16 percent.

The National measures of Bullying Victimization slightly increased from 38.9 percent in 2018 to 39.7 percent in 2019; this reported increase is likely undervalued in present-day given recent and current events with bullying as related to how youth identify with their race, gender, sexuality, etc.

For Oregon, the measures of Bullying Victimization decreased nearly four percent from 47.9 percent in 2018 to 44.1 percent in 2019. In present-day, youth report feeling othered as it relates to their identities and how they show-up in the world in different settings as experiences of bullying; the decrease in bullying victimization for Oregon is also likely an undervaluation in present-day 2022, especially considering how the COVID-19 Pandemic has exasperated inequities and magnified differences among different population groups.

Bullying Prevention Strategy #1:
By October 2020, determine state ASH staffing for the bullying prevention/positive youth development priority and begin to collaborate with the cross-cutting injury team to address upstream drivers of bullying and injury, and to link to work across population domains (including safe sleep, child injury, bullying, ACEs prevention, and SDOH-E). The cross-cutting injury team will research, develop, adapt or adopt an overarching theory of change for the work, in collaboration with the PHD Injury and Violence Prevention Section.

Accomplishments:
In January 2021 a member of the Adolescent & School Health team moved into the OPA3 position as a work-out-of-class to support the work of the Title V priority for the unit until a permanent hire could be made.

Challenges/emerging issues:
- COVID-19 was the priority for the Oregon Public Health Division and other state agencies, which led to priority shifts in work and staffing reassignments. Oregon Department of Education was focused on supporting virtual learning, hybrid learning and return to school safety protocols. Schools were more focused on social emotional support vs prevention efforts.
- Other state offices support crisis and acute mental health needs.
- There were many staff reassignments in the PHD to support COVID-19 response efforts. These reassignments included the Adolescent and School Health Manager and the person leading the Adolescent Health Policy and Assessment Specialist position, which leads the Title V work. Due to the shift in priorities and staffing, the Title V work was assigned to other staff but moved very slowly.

Bullying Prevention Strategy #2:
By December 2020, develop evidence-based/informed strategies and measures for bullying prevention/positive youth development – including strategies that address upstream drivers of adolescent health. Strategies will address both state and local level work. Engage local Title V grantees and family and community representatives in the process.

ESM:
9.1 The number of strategies developed to address bullying among youth with a focus on systems change, primary prevention, positive youth development, and/or enhancing social emotional learning.

Progress: 4 strategies were developed, with a focus on Youth-led Participatory Action Research (YPAR) and sexuality education, given the program's expertise and commitment to these models as well as existing partnerships.

Accomplishments:

- In May 2021 an event was held in partnership with the Oregon Department of Education called Connecting the Dots: Sex Ed is a Solution with Eva Goldfarb PhD and Lisa Lieberman PhD, the authors of the 2020 research paper Three Decades of Research: The Case for Comprehensive Sexuality Education with an emphasis on sexuality education as bullying prevention.
- May 2021 was also the release of an updated Sexual Violence Prevention Resource Map which linked Oregon's 197 school districts sexuality education policy and implementation with local county health data including bullying rates.
- In July 2021, Youth Participatory Action Research (YPAR) resources revisions process begins with the goal of creating helpful handouts and resources accessible online for partners interested in facilitating YPAR.
- In August 2021, Minor Consent and Confidentiality in Healthcare document revision process begins to update the 2016 document with considerations and inclusion of recent legislation.
- End of September/beginning of October 2021, Youth Participatory Action Research (YPAR) webpage and resources created for partners. Document(s) and presentation(s) for YPAR overview, curriculum, youth-adult partnership and decision-making best practices developed and published to Adolescent and School Health webpage.

Challenges/emerging issues:
The Adolescent and School Health Policy and Assessment Specialist position was vacant.

Bullying Prevention Strategy #3:

By February 2021, develop and adopt a logic model for the bullying prevention/positive youth development Title V work.

Accomplishments:
TA sessions were delivered in February 2021 to support local grantees

Challenges/emerging issues:
After surveying local grantees about the usefulness of a logic model for their work, it was decided that this strategy was not a high priority to implement. Grantees asked instead for a focus on workshops and technical assistance related to the new strategies, the upstream drivers of maternal and child health, and the cross-cutting theory of change that supports the work. These TA sessions were delivered in February 2021 and followed up with technical assistance as described in strategy 5.

Bullying Prevention Strategy #4:

By March 2021, begin implementation and tracking of state level strategies for bullying prevention/positive youth development Title V work; collect/track outcomes through monitoring of ESMs and NPMs.

Accomplishments:
The Public Health Division's Adolescent & School Health programs relationships with the Oregon Department of Education grew stronger through connecting with their staff focused on safe and supportive environments which included bullying prevention. Even with COVID-19 creating an incredibly stressful time for state agencies and local school districts, we began monthly meetings and building our partnership.

Challenges/emerging issues:
Oregon Department of Education (ODE) was very focused on supporting schools in COVID-19 response along with having some staffing shifts and organization. While it was very challenging to set up meetings and new teams were being created to do the bullying prevention work, the foundation was built.

Bullying Prevention Strategy #5:

By March 2021, provide technical assistance on new bullying prevention/positive youth development strategies and measures to Title V grantees to inform local level Title V priority selection, planning and implementation.

Accomplishments:
In February of 2021 all Title V grantees were invited to attend TA sessions on the varied priorities to help them with local level selection. An injury specific presentation was given focused on Bullying and Injury Prevention. One local grantee (Lake County) selected Bullying Prevention as their priority, naming it as their interest due to an increase in suicides perceived as connected to Bullying.

Challenges/emerging issues:
Due to the COVID-19 Pandemic, Oregon wildfires, and staff shortages/turnover the local grantee was unable to make significant progress. OHA staff were able to connect Lake County staff with Oregon Department of Education and suicide prevention work happening in the region, but ultimately Lake County was unable to make progress given both Oregon wildfire season and COVID-19.

Bullying Prevention Strategy #6:
April - June 2021, review and provide TA to local Title V Grantees on implementing bullying prevention/positive youth development annual plans for July 2021– June 2022.

Accomplishments:
- Meetings were scheduled and happened with Lake County.
- Adolescent and School Health Policy and Assessment Specialist position was filled by Alexis W. Phillips to support the Title V work.
- Alexis is onboarded and connected to Title V Leads, staff, and colleagues.

Challenges/emerging issues:
Due to the COVID-19 Pandemic, Oregon wildfires, and staff shortages/turnover the local grantee was unable to make significant progress. OHA staff were able to connect Lake County staff with Oregon Department of Education and suicide prevention work happening in the region, but ultimately Lake County were unable to make progress given both Oregon wildfire season and COVID-19.

Bullying Prevention Strategy #7:
July 1, 2021, through September 30, 2021- Title V grantees will implement local level strategies and collect/track outcomes.

Accomplishments:
Adolescent & School Health staff met with staff from Lake County and supported the creation of their Bullying plan related to connecting with Lake County schools.

Challenges/emerging issues:
Not only was COVID-19 a major deterrent of Title V work happening in Lake County, this time-period also included wildfire season in Oregon specifically the Bootleg fire which deeply impacted Southern Oregon and Lake County. The Public Health Department in Lake County was significantly impacted, and the challenges were overwhelming.

Other Title V-supported Adolescent Health work:
- Participation in the LGBT Workgroup of the Alliance to Prevent Suicide
- Participation in the Oregon Department of Education's Sex Ed Steering Committee
- Collaboration with Oregon Department of Education's Civil Rights Division on school-level policies related to violence prevention including bullying.
- Continued monitoring of local school district controversies related to the Oregon Department of Education's Every Student Belongs policy.
- Oct 2021 – ongoing, Monthly meetings with the Oregon School Based Health Alliance to build opportunities for connection and collaboration for supporting the health and wellness of adolescents across the state.
- August 2021 – May 2022, revise Minor Consent and Confidentiality in Healthcare document, updating with recently passed legislation and noted considerations from School Based Health Center staff and providers.
- August 2021 – September 2021, partnership meetings between Adolescent and School Health and the Alliance of Black Nurses Association of Oregon (ABANO) to build relationship, discuss and create a plan to use the COVID-19 Response and Recovery funding to support school health, school nursing, and workforce development with ABANO nurses.
- September 2021, Adolescent and School Health Foundational Priorities developed: Youth Engagement and Health Equity for the biennium.
- Shared Risk and Protective Factor workgroup within the Center for Prevention and Health Promotion.

Adolescent Health Domain

Bullying Prevention Plan (October 2022 – September 2023)

National Performance Measure:
Percent of adolescents, ages 12 through 17 years, who are bullied.

Bullying Prevention Strategy #1:
Support the workforce to understand the impact of bullying on adolescent health.

ESM:
9.5. Among local grantees who select bullying prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance.

State level activities/timeline:
1. Develop and facilitate training modules on primary prevention bullying prevention in adolescent health. Training modules should add-on to existing trainings and professional development gatherings.
   Timeline: October 2022 – January 2023
2. Develop and facilitate training modules on the impact of identity-based bullying and bullying prevention for identity-based bullying in adolescent health.
   Timeline: January 2023-March 2023
3. Develop and provide pre- and post- mini-surveys before and after each training module/presentation on bullying prevention listed above, in order to gauge improved knowledge, skills, or policies based on provided TA.
   Timeline: October 2022-March 2023

Local level activities/timeline:
- Conduct a scan of local level needs and opportunities for adolescent bullying prevention efforts.
  Timeline: October 2022-January 2023
- Develop and provide pre- and post- mini-surveys before and after each training module/presentation on bullying prevention listed above, in order to gauge improved knowledge, skills, or policies based on provided TA. (October 2022-March 2023)
  Timeline: 10/1/22 – 9/30/23.

Bullying Prevention Strategy #2:
Support bullying prevention education in schools.

ESMs:
9.1. Percent of 8th and 11th graders who have experienced bullying.
9.2. Percent of 8th and 11th graders who have experienced bullying due to their race or ethnicity.
9.3. Percent of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity.
9.4. Percent of 8th and 11th graders who have experienced bullying due to a disability.

State level activities/timeline:
1. Conduct a review of Student Health Survey (SHS) bullying-specific survey questions and provide input and/or recommendations to SHS Content Committee for question revisions/additions for identity-based bullying.
   Timeline: October 2022-December 2022
2. Present Student Health Survey bullying-specific data to local schools, school district staff, other state and local public health programs, etc.
   Timeline: October 2022-September 2023
3. Collaborate with Oregon Department of Education (ODE) Every Student Belongs initiative and align any bullying prevention programs/activities.
   Timeline: October 2022-September 2023

Local level activities/timeline:
- Umatilla County Public Health Department is one of the local Title V grantees that will be implementing Bullying Prevention this grant year. Their goal is to assess current bullying prevention efforts in schools in

alignment with K-12 health education and mental health supports to use the data from the assessment to plan and implement activities throughout the school year that support the needs of middle schoolers.
Timeline: 10/1/22 – 9/30/23.

Bullying Prevention Strategy #3:

Determine gaps and opportunities for bullying prevention partnerships and initiatives with internal and external partners.

ESM:

9.7. Number of activities completed that increase local access to bullying prevention resources.

State level activities/timeline:

1. In collaboration with local level partners, develop state-level framing, points of leverage, possible funding mechanisms and policy solutions for bullying prevention in Oregon. **Timeline:** (ongoing)
2. Facilitate Violence and Injury Prevention Learning Sessions to provide opportunities for shared learning and collaboration.
   Timeline: June 2022 – ongoing
3. Assess state-level efforts on the bullying of adolescents with disabilities, LGBTQ2SIA+ youth, Black youth, non-English speaking youth, and other groups known to be at higher risk of bullying.
   Timeline: October 2022 – September 2023
4. Review resources and data developed through the Oregon Department of Education, such as the Student Success Plans, to identify solutions to bullying by Oregon students, such as, transformative justice, affinity groups, and upstream primary prevention bullying prevention practices, etc.
   Timeline: October 2022 – September 2023
5. Coordinate/facilitate Bullying Prevention Training Sessions for local grantees, school-based health center staff, community-based organizations, youth advisory council facilitators and youth, and additional partners.
   Timeline: September 2022- ongoing

Local level activities/timeline:

- Invite local grantees who have selected Bullying Prevention as their priority this grant year (Klamath Tribes and Umatilla County Public Health Department) to attend the Bullying Prevention Training Sessions to expand knowledge, engage in shared learning, and opportunities for collaboration.
  Timeline: 10/1/22 – 9/30/23.

Bullying Prevention Strategy #4:

Support youth participatory action research on bullying prevention.

ESM:

9.6. Completion of environmental scan of youth serving agencies.

State level activities/timeline:

1. Share YPAR curriculum and developed resources with Klamath Tribes and support them through their efforts to use YPAR to assess bullying prevention and positive youth development.
   Timeline: October 2022 – September 2023)
2. Develop internal capacity to support YPAR at the local level at no cost through provision of facilitation training and curriculum. (Ongoing, Adolescent & School Health working on securing funding and staffing)
3. Support implementation of youth developed solutions to bullying and bullying prevention based on YPAR and Youth Advisory Council (YAC) priorities.
   Timeline: October 2022 – September 2023, (if applicable)
4. Connect LPHAs/tribes with any YPAR projects happening in their community.
   Timeline: (Ongoing, if applicable)

Local level activities/timeline:

- Klamath Tribes is one of the local tribal Title V grantees that will be implementing Bullying Prevention this grant year. Their plan is to support Youth Participatory Action Research by assessing local efforts of bullying prevention and capacity for YPAR in primary bullying prevention and positive youth development.
  Timeline: 10/1/22 – 9/30/23.

Critical partnerships:
Key partnerships include the Oregon Department of Education, the Oregon Alliance to Prevent Suicide, Lines for Life, local public health agencies, local school districts, the ASH Youth Advisory Council, and additional youth engagement and partnership is also a focus of each strategy within this priority.

Other Title V Work in the Adolescent Health Domain
Title V's adolescent health work will continue to strengthen policies and systems that support adolescent health in school-based health centers, schools, health systems, and communities. The program engages youth to develop policies and programs that reflect their needs through Positive Youth Development activities including youth participatory action research. Specific efforts that support both bullying prevention and broader adolescent health goals include:

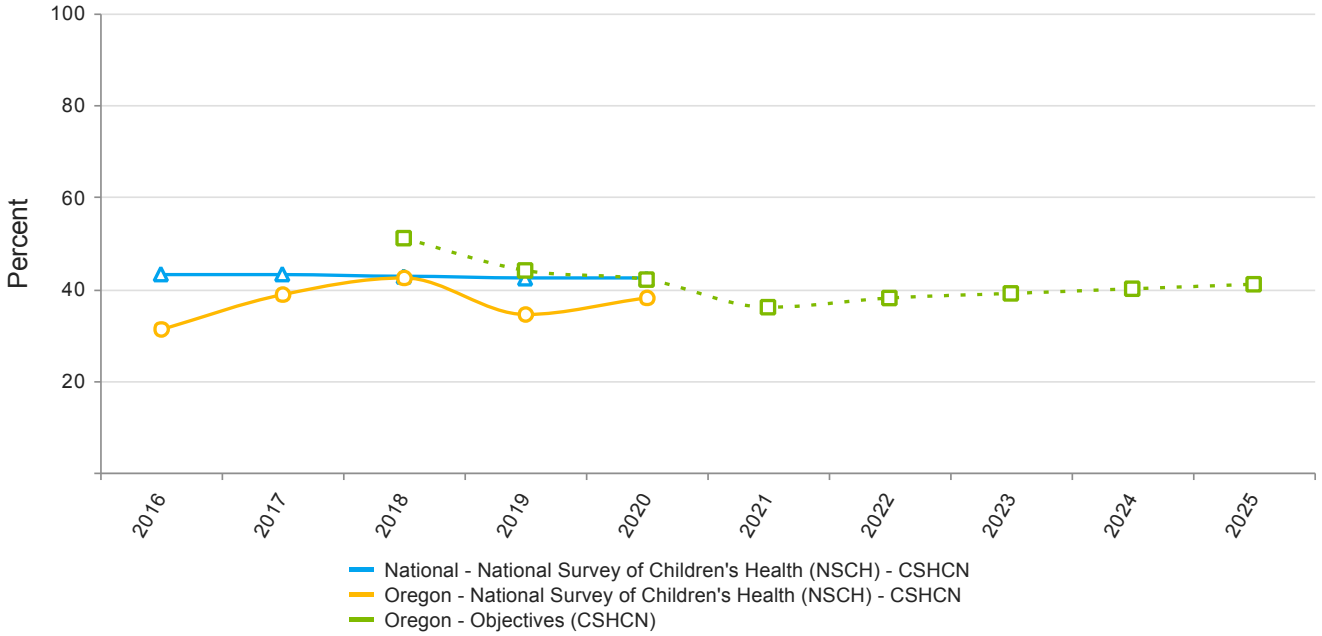
- School-based health centers, specifically mental health providers at the local level.
- School nursing program, often the first providers young people see with symptoms related to bullying (nausea, anxiety, headaches, etc.).
- Sexuality education programming through federal funding, currently focused on providing information and skills to young adults with intellectual and developmental disabilities in transition programs.
- Suicide prevention collaborative work connected to the Oregon Youth Suicide Prevention Plan with non-profit partners, other Oregon Health Authority staff, and schools.
- Racial Justice Student Collaborative work with partners.
- LGBTQIA2S+ Student Success Plan support and partnership.
- A new statewide Youth Advisory Council on which 20 youth will serve for the coming year, advising the state Adolescent Health Program on a range of policy and programmatic issues.
- OHA Adolescent and School Health is updating a resource, Understanding Minor Consent and Confidentiality in Healthcare in Oregon. This resource is geared toward providers in clinical settings; however, parents/guardians, educators, and minors may benefit from the information shared as well. This resource provides limited information about minor consent and confidentiality in school health setting in Oregon related to medical, dental, mental health, and reproductive health services. Next steps are to work on a youth-facing document or resource developed in partnership with youth and for youth.

Children with Special Health Care Needs

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		51	44	42	36
Annual Indicator	31.3	38.6	42.2	34.5	37.9
Numerator	49,675	61,991	70,156	60,052	67,509
Denominator	158,652	160,752	166,072	174,007	178,300
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	38.0	39.0	40.0	41.0

Evidence-Based or –Informed Strategy Measures

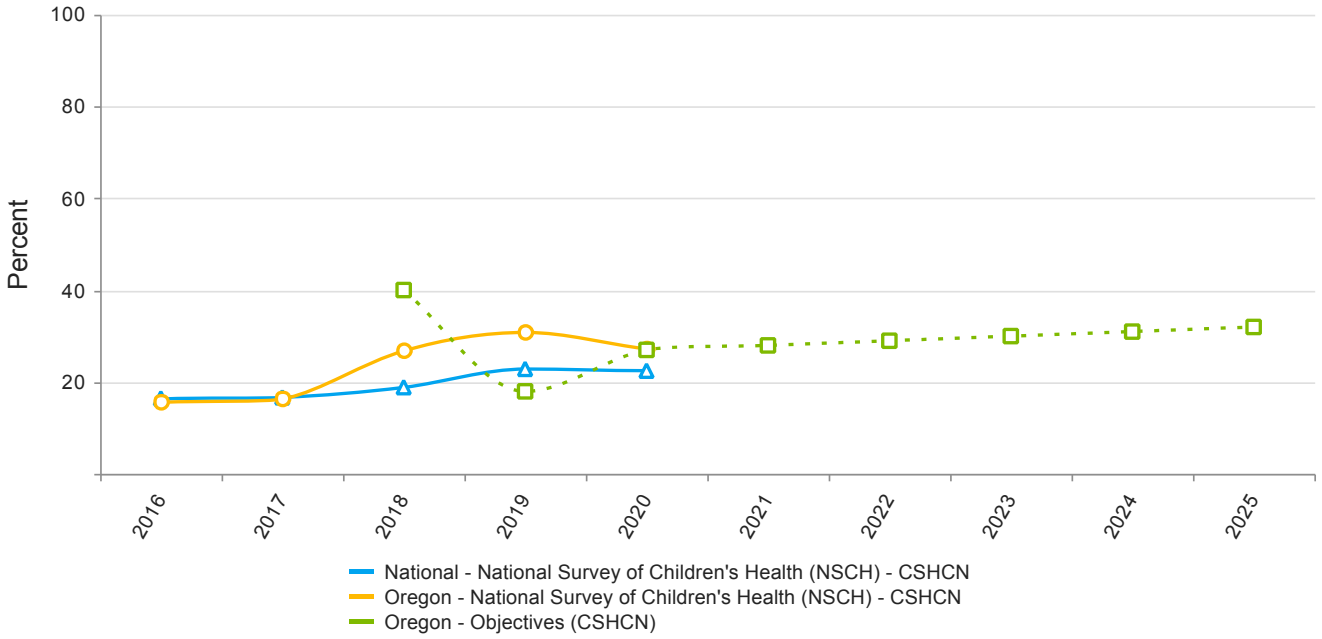
ESM 11.1 - Primary care involvement in shared care planning

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			20
Annual Indicator	34	26.9	37.8
Numerator	36	14	17
Denominator	106	52	45
Data Source	Shared Care Plan Information Form (SIF)	Shared Care Plan Information Form (SIF)	Shared Care Plan Information Form (SIF)
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.0	30.0	35.0	40.0

NPM 12 - 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
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		40	18	27	28
Annual Indicator	15.8	16.5	26.8	30.9	27.2
Numerator	12,536	11,986	18,726	24,088	22,797
Denominator	79,458	72,528	69,860	78,055	83,675
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	29.0	30.0	31.0	32.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Young adult with medical complexity/family participation in transition preparation appointments

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			20
Annual Indicator			0
Numerator			
Denominator			
Data Source			CMC CoIIN Project process tracking form
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	30.0	40.0	50.0	60.0

State Action Plan Table

State Action Plan Table (Oregon) - Children with Special Health Care Needs - Entry 1	
Priority Need	
High quality, family-centered, coordinated systems of care for children and youth with special health care needs	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
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	
Strategies	
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.	
ESMs	**Status**
ESM 11.1 - Primary care involvement in shared care planning	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

State Action Plan Table (Oregon) - Children with Special Health Care Needs - Entry 2

Priority Need

High quality, family-centered, coordinated systems of care for children and youth with special health care needs

NPM

NPM 12 - 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

Objectives

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.

Strategies

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.

ESMs	Status
ESM 12.1 - Young adult with medical complexity/family participation in transition preparation appointments	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

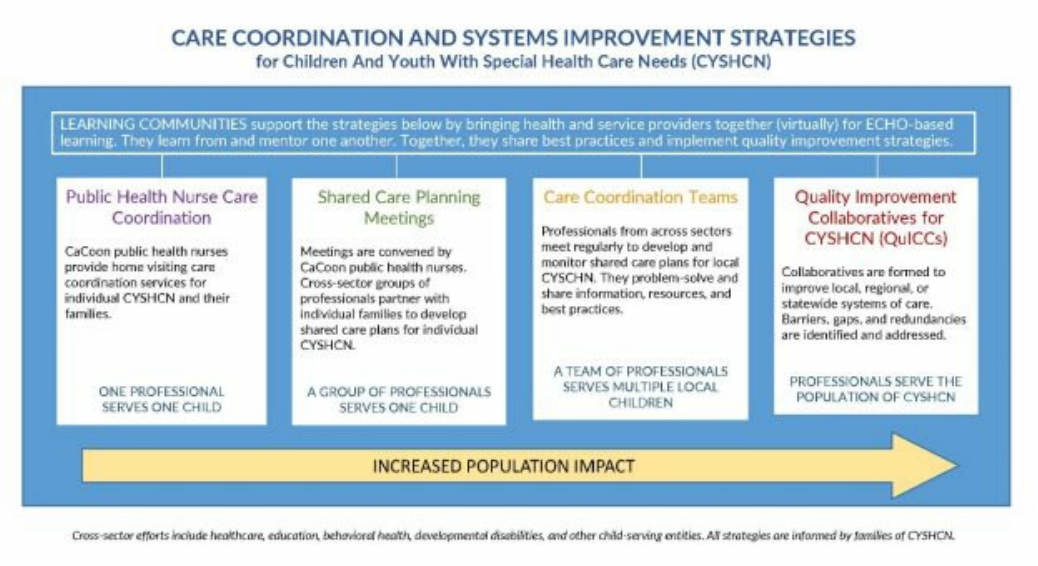
CYSHCN Domain

Medical Home for CYSHCN Report

National Performance Measure 11:
Percent of children with special health care needs (CYSHCN) having a medical home.
Report on Strategies and Activities October 2020– Sept 2021.

Strategy 11.
OCCYSHN will improve access to family-centered, team-based, cross-systems care coordination for CYSHCN and their families through workforce development and financing activities.

Activity 11.1. Quality Improvement Collaboratives for CYSHCN (QuICC)



The Regional Approach to Child Health (REACH) pilot project supported regional teams to identify gaps and barriers in health and service systems for children and youth with special health care needs (CYSHCN), and to address those issues through quality improvement (QI) processes. Though the pilot ended in 2018, the Oregon Center for Children and Youth with Special Health Care Needs (OCCYSHN) continued to leverage lessons learned from REACH to promote cross-systems care coordination. Cross-systems care coordination teams in Central and Southern Oregon benefitted from systems and policy changes implemented through REACH. These changes were sustained without financial support from OCCYSHN.
Ultimately, lessons learned from the REACH project will inform development of Quality Improvement Collaboratives for CYSHCN (QuICC). OCCYSHN will coordinate with Family Connects Systems Alignment on this work, because both efforts share the same local public health authority (LPHA) workforce. QuICCs will support LPHAs to use cross-sector team-building and shared care planning as foundations for integrating QI principles into their work. (See Activity 11.1 of the Block Grant Plan.) Opportunities to advance this work were impeded by the COVID-19 pandemic, which slowed the rollout of Family Connects.

Activity 11.2. Piloting Activate Care for Care Coordination Teams (PACCT)
The Piloting Activate Care for Care Coordination Teams (PACCT) project began in 2019 with five LPHA shared care planning teams and doubled this report year with the addition of five new teams. The ten teams represent a diverse selection of urban, rural, and frontier communities. PACCT participants were selected through an RFP process. They agreed to pilot a cloud-based care coordination platform called Activate Care for shared care planning, and to participate in monthly video calls with OCCYSHN and their LPHA peers. In Activate Care, care plans are created, shared, managed, and tracked collaboratively by professionals and family members.
Because the pandemic severely strained LPHA resources, OCCYSHN did not require LPHAs to develop standing care coordination teams, initiate quality improvement interventions within their teams, or bring prepared case scenarios to learning community meetings. Instead, the pilot pivoted to using Activate Care as a response to the inability to do home visits. The intent was to test the viability of remote care coordination for CYSHCN. OCCYSHN

learned that it was difficult for LPHAs to engage community partners due to the pandemic. We also learned that the pandemic exacerbated inequities in family access to the technology and bandwidth needed to use Activate Care.

OCCYSHN continued developing technical support products for PACCT participants. We provided them with accessible, inclusive resources for families and communities, employing health literacy best practices. Technical assistance also included interactive monthly group video calls, one-on-one virtual orientations, and virtual training sessions with LPHA teams and their selected partners.

Activity 11.3. Shared Care Planning

OCCYSHN contracted with 26 LPHAs serving 29 of Oregon's 36 counties to provide CYSHCN with shared care planning and public health nurse home visiting services (Activity 11.4). We allowed flexibility on LPHA scopes of work based on community needs, capacity, and pandemic exigencies.

We offered and supported the use of Activate Care as a platform for remote shared care planning. The pandemic impeded LPHA progress with remote shared care planning (Activity 11.2).

OCCYSHN discontinued shared care planning ECHO sessions due to pandemic-related constraints on the workforce. ECHO is an evidence-based framework of online learning communities where topical information is coupled with peer support, guidance, and feedback. Instead we worked with OHA to conduct monthly communities of practice (COPs) to respond to workforce needs related to the pandemic. We determined that the joint COPs were an effective workforce development method that we will continue. We paused formal professional development on shared care planning, although we continued providing technical assistance on an ad hoc basis.

Activity 11.4. Care Coordination (CaCoon) Public Health Nurse Home Visiting

CaCoon (short for Care Coordination) is OCCYSHN's public health nurse home visiting program. CaCoon program goals are to provide accurate information to families, ensure CYSHCN and their families can access care and services as close to home as possible, promote effective and efficient use of the health care and service systems, and promote the well-being of CYSHCN and their families. Across the state, CaCoon home visitors (Registered Nurses and community health workers) help families coordinate care for CYSHCN. They also convene shared care planning teams for CYSHCN and their families as needed.

Due to the pandemic, most 2021 CaCoon visits were virtual or by phone, with some in-person visits based on client need. Overall, CaCoon served 752 CYSHCN through 3,941 home visits. Of those served, 79% were insured through Medicaid, and 14% were transition-aged youth ≥ 12 years. Home visitors supported CYSHCN with conditions that included developmental delay, autism, prematurity, heart disease, genetic and chromosomal disorders, feeding disorders, seizure disorders, and hearing loss.

OCCYSHN provided professional development and technical support to the CaCoon workforce, and trained CaCoon home visitors on Targeted Case Management (TCM) billing, which supports LPHA funding and capacity to serve CYSHCN.

To help address social determinants of health, OCCYSHN provided LPHAs with state and federal resources on technology and bandwidth to share with families of CYSHCN. We also provided them with information about the Expanded Child Tax Credit. OHA/OCCYSHN communities of practice offered opportunities for home visiting program staff to share knowledge and ideas about how to support families and address inequities.

OCCYSHN and OHA MCH partnered to develop new home visiting program data collection instruments that will launch in Fall 2022. The purpose of the improved surveys is to support home visiting program quality, clarify outcomes, and identify gaps and barriers to care and services. A data equity workgroup was formed that included a home visiting client, home visitors serving black parents, home visitors from rural areas, a representative from the Native American Youth Association, nurses from the Black Nurses Association, a representative from the Latino Community Organization, and professionals with experience in informatics, research analyses, and evaluation. Data equity consultants from the Coalition of Communities of Color were hired to provide recommendations. The workgroup and consultants developed more robust, anti-racist data collection surveys. The resulting data will "tell the story" of home visiting in Oregon in ways that are strength-based, and that more accurately reflect the social determinants of health.

Activity 11.5. Leverage the Oregon Family-to-Family Health Information Center (ORF2FHIC)

OCCYSHN's Family Involvement Program (FIP) houses and supports the Oregon Family to Family Health Information Center (ORF2FHIC). The FIP offers support and information to families of CYSHCN, and brings the wisdom of the family experience to CYSHCN-serving care and services.

In this reporting period, ORF2FHIC offered six different virtual trainings for families and professionals about various aspects of caring for CYSHCN. We conducted 19 trainings and six listening sessions with family members of CYSHCN. Attendance was lower than in years past, due to the impacts of the pandemic. ORF2FHIC staff recorded the proceedings of the listening sessions and used learnings to inform OCCYSHN staff about the experiences of CYSHCN and their families.

Two ORF2FHIC phone lines were staffed five days a week by Parent Partners trained and supervised to provide peer support and information to family members of CYSHCN. During the ORF2FHIC program year (June 1, 2020 – May 31, 2021) we provided one-to-one phone support to 273 families and professionals. We maintained Facebook pages (with over 900 followers) in both English and Spanish, where we posted information germane to families of Oregon CYSHCN. We convened a work group that developed a toolkit for families regarding pediatric wheelchairs, and we disseminated the toolkit broadly in Spanish and English. We used social media and newsletters to reach families with timely pandemic-related information from OHSU, the Oregon Governor's office, OHA, CDC, and FEMA.

ORF2FHIC informed a variety of efforts to serve families of CYSHCN. We provided input on the intake forms and materials for OHSU Child Development and Rehabilitation Center (CDRC) Neurodevelopmental Clinics. We reviewed drafts of videos introducing families to telehealth, for the Western States Regional Genetics Network. We helped OCCYSHN's HERO Kids Registry recruit two parents of CYSHCN and one YSHCN to advise the project, using their first-hand experience with emergency medical systems (Activity 11.10). We trained 211info call center staff on our services, and on other CYSHCN-related information and resources. 211info is a statewide hotline that helps callers identify, navigate, and connect with local resources. They subsequently referred more than 100 families to ORF2FHIC.

Building family capacity to care for CYSHCN requires that ORF2FHIC have strong reciprocal relationships with other family-led organizations. We collaborated with more than 20 local, regional, and national organizations serving families of CYSHCN. We initiated a quarterly check-in between OCCYSHN and three key Developmental Disabilities programs, to strengthen communication and collaboration on policy matters. We participated in the Statewide Family Training and Outreach Collaborative, which reduced redundancy and strengthened connections. We updated a product entitled "Oregon Family Organizations," which we disseminated to families and professionals at virtual trainings and events. We also maintained a listserv of more than 80 Oregon family organizations and CYSHCN-serving programs, which we used to update stakeholders.

The pandemic necessitated huge growth in telehealth and remote care for CYCSHN. Two ORF2FHIC staff completed a Family Voices training on telehealth. Through this training and its associated community of practice, we disseminated resources aimed at reducing barriers for families unfamiliar with using telehealth. We administered a Family Voices Telehealth mini-grant that allowed us to collaborate with the Portland-area African Youth Community Organization (AYCO). With guidance from AYCO staff, we modified the Family Voices telehealth curriculum to make it more culturally appropriate for Somali families. We then offered a training about Electronic Health Records, which was attended by 13 family members and nine AYCO staff. Additionally, we conducted a family listening session with the African Family Holistic Health Organization. The main theme that emerged from that session was the need for equitable access to services and information for this underserved group.
ORF2FHIC's Familia a Familia Spanish language outreach efforts were slowed by the pandemic, and by a coordinator position that proved hard to fill. We continued operating the Spanish language ORF2FHIC phone line. We also maintained a Spanish language newsletter and Facebook page. We initiated a partnership with Oregon's "Learn the Signs. Act Early" Spanish-language Parent Mentor program. We also worked with OCCYSHN's Assessment and Evaluation unit to improve our race and ethnicity data collection, with the goal of improving outreach to communities of color.

With the help of a summer intern from Oregon State University, we began a "translation" of the OCCYSHN block grant plan into plain language. Carolyn Gleason, MCHB Regional Consultant, reviewed the draft and provided feedback. This work will serve as a springboard for future efforts to engage family block grant reviewers.

Activity 11.6. Equity
Because racism and other forms of discrimination affect the health of Oregon CYSHCN, OCCYSHN's efforts to address medical home for CYSHCN prioritized access, equity, and inclusion. In our efforts to improve systems of care for CYCSHN, we endeavored to be accountable to BIPOC communities and to other underserved populations, including LGBTQIA+ people. We continued internal and external efforts to promote health equity. We embraced cultural humility and sought guidance from diverse stakeholders. We shared learning with our partners through training, dissemination products, and communities of practice.

Details on equity-related program and policy activities are included in individual NPM 11 activity sections. Examples include the CaCoon program's data collection changes, which were informed by data equity experts (Activity 11.4), the Assessment and Evaluation unit's partnership with culturally specific organizations to conduct needs assessment activities and disseminate results (Activity 11.8), ORF2FHIC's family training partnerships with culturally specific community-based organizations, and their Spanish-language family support phone line and newsletter (Activity 11.5).

Activity 11.7. Systems & Policy

OCCYSHN was a key partner in the Title V MCH/Medicaid collaboration during this period. We agreed to work on issues related to Early Periodic Screening, Diagnosis and Therapy (EPSDT), with a special focus on how Oregon's 1115 Medicaid Waiver of EPSDT impacted Oregon CYSHCN.

OCCYSHN continually monitors health care policy and the process of public health modernization for opportunities to leverage systems change for CYSHCN. We sought strategic relationships and lent our expertise to a wide array of systems and policy activities with the potential to affect CYSHCN. Examples include:

- OCCYSHN's Director continued on the Oregon Health Authority's Patient-Centered Primary Care Home Advisory Committee to provide policy and technical expertise.
- We explored the feasibility of coding and reimbursement for primary care providers who participate in PACCT or shared care planning, with the long-term goal of making cross-systems care coordination reimbursable.
- We established a connection with an OHA Transformation Center Analyst, and worked with her to identify policy opportunities related to care coordination and health care transition.
- We provided time and expertise to OHA's Integrated Care for Kids (InCK) program, to support their care coordination and system integration efforts.

OCCYSHN continued to build and nurture relationships with CCOs. We partnered with one CCO in particular on projects affecting tens of thousands of Oregonians. We sat on their workgroup to strengthen systems of care for children aged 0-6 years, and another workgroup on implementing care coordination for Medicaid members. We consulted with a CCO on the development of their strategic roadmap and will continue that effort going forward. OCCYSHN provided key support for a bill that passed in session in 2021, requiring licensure for genetic counselors in Oregon. OCCYSHN developed a fact sheet for legislators, making a succinct argument for licensure, which allows genetic counselors to bill Medicaid for their services, thereby expanding important coverage for CYSHCN and their families.

OCCYSHN worked with traditional health worker (THW) liaisons and the Children's Health Alliance to develop written technical assistance for primary care practices interested in employing community health workers (CHWs). We presented to the THW Commission on how CHWs can support families of CYSHCN. Commission members reported that the presentation addressed an important gap in knowledge and practice.

OCCYSHN recognized the needs of parents/caregivers of CYSHCN and altered policy to allow them to become clients of the CaCoon program. Historically CYSHCN were CaCoon clients; their caregivers were not. This change (starting in 2022) allows CaCoon to address the needs of CYSHCN within their family context. It will also allow LPHAs to bill for Targeted Case Management services for caregivers, helping make CaCoon more fiscally sustainable.

OCCYSHN informed medical providers of opportunities for policy input. We referred a CDRC pediatric audiologist to the Speech and Hearing Aids Program Rules Advisory Committee (RAC) where she is now a formal member. We provided technical assistance to a CDRC developmental pediatrician to represent CYSHCN on the State's System of Care Advisory Council. The Council provides oversight of children's mental health system planning.
There will be future opportunities to build on the relationships and the policies addressed here.

Activity 11.8. Assessment & Evaluation

OCCYSHN's Assessment & Evaluation Unit (A&E) continued its program evaluation and needs assessment activities for Medical Home strategies and activities in FY21.

PACCT

Findings from analysis of PACCT's first implementation year data follow.

- Clatsop, Coos, Morrow, and Grant LPHAs collectively entered 21 shared care plans into the Activate Care platform. Of all partner types, public health most often logged into Activate Care (AC). The most frequently completed goals were introducing the family to the shared care planning process and determining readiness for a shared care plan.

- Coos and Morrow LPHAs reported using AC to communicate with their standing team members, such as primary care. Clatsop LPHA tailored their use of AC to improve transparency of the shared care planning process for families.
- Across four of five partner types, communication with cross-sector colleagues improved at the end of the first year participating in PACCT. Also, partners more often reported that they were able to share progress with their team members in real time. They reported having a greater sense of knowledge about the shared care planning process for CYSHCN, and greater comfort collaborating with cross-systems professionals on that work.
- OCCYSHN staff provided frequent technical assistance to LPHAs to resolve technical issues using AC. Activate Care may serve as a useful documentation tool to report goals for families; however, teams will need continued support to utilize the platform.

Shared Care Planning

Fifteen LPHAs, of the 26 that contracted with OCCYSHN to implement shared care planning in FY21, created or re-evaluated 45 shared care plans. Sixteen of the 45 shared care planning meetings were part of another meeting (e.g., IEP/IFSP, WrapAround). CaCoon public health nurses were the most frequent referral source. Table 11.8.1 describes characteristics of CYSHCN served.

Table 11.8.1. Number of Shared Care Plans By Age, Complexity, and Meeting Type

	Total	New	Re-Evaluation
Children Birth – 11 years	40	32	8
Young Adults 13 ≤ 21 years	5	5	0
Complex CYSHCN (i.e., ≥2 condition types (medical, behavioral, developmental, social, other)	42		

Source: FY2021 Shared care plan Information Forms from 15 LPHAs

Twelve LPHAs reported that they did not create or re-evaluate any shared care plans in FY2021, largely due to the continued need to respond to COVID-19 and a lack of capacity as a result of staff turnover. LPHAs described that the pandemic changed the way they implemented shared care planning, e.g., increased use of virtual platforms to conduct meetings and appointments, reduced meeting frequency due to limited staff capacity.

ESM/Objective 11.1:

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.

Progress: 38% (17/45) of shared care plans had a primary care representative participate in shared care planning meetings. We do not know what portion if those helped prepare for meetings, because we created this ESM for our FY2021-2025 block grant cycle. We previously collected data describing primary care participation in shared care planning, but not whether primary care helped with meeting preparation. 36 of 45 LPHAs reported that a primary care representative was part of the shared care plan team; 17 of 36 reported that the primary care representative participated in the meetings in person, by video, by phone, or by written comment. We revised our data collection instrument to fully measure ESM 11.1 progress in October 2021. (See Form 10.)

CaCoon

A&E continued to provide evaluation support to the CaCoon program (Activity 11.4). We worked with OCCYSHN's Systems & Workforce Development Unit and OHA MCAH on aligning nurse home visiting program evaluation.

Family Involvement Program

A&E provided evaluation support to OCCYSHN's Family Involvement Program and the Oregon Family-to-Family Health Information Center, the results of which appear in Activity 11.5.

Needs Assessment

In FY2021, OCCYSHN disseminated its 2020 needs assessment results with Latino Community Association (LCA) and Sickle Cell Anemia Foundation of Oregon (SCAFO) as specified in our partnership agreements with each. A key finding was that families of Black and Latino CYSHCN in Oregon experience racism when accessing health (and educational) care for their child. Specifically, we (a) finalized our needs assessment reports, (b) translated our LCA findings into Spanish, (c) prepared topical issue briefs with our Communications Specialist, (d) made numerous presentations of our findings, and (e) are working on a manuscript for submission to a peer-reviewed journal. To date, we have made six presentations, half of which occurred during FY2021. The list of our presentations and

topical briefs appears in Attachment 1. Additionally, during OCCYSHN's virtual regional meetings in spring 2021, our A&E manager facilitated a discussion about the experiences of racism in health care settings, and LPHA efforts to promote health equity and dismantle racism.

Oregon's CYSHCN population includes multiple minoritized communities for which we lack data. We undertook Participatory Needs Assessment (PNA) studies intending that if successful we would conduct additional studies with partners in other minoritized communities. LCA and SCAFO were (and continue to be) exceptional partners. We found tremendous value in the partnership, and our state and local partners valued the findings. Using our learning from the first studies, we began planning a third PNA with a culturally-specific community-based organization that serves Asian and Pacific Islander (API) communities. We selected this community for the following reasons: Asian communities (clustered together) are the fastest growing racial/ethnic population in Oregon, limited data exists about API families of CYSHCN in Oregon, analyses of national health status data for API generally show disparities compared to other racial/ethnic communities, and API experienced heightened racism as a result of the COVID-19 pandemic.

As described in Section III.C.1, OCCYSHN's A&E unit examines National Survey of Children's Health (NSCH) results with each year's release of new data, and we continue to work with OHA MCH and other state partners on the NSCH oversample of children from minoritized race and ethnicity communities. During the summer of 2021, MCHB approached Oregon Title V about purchasing a third year of oversample data. We successfully secured funding from our previous state partners, OHA Office of Health Analytics and Oregon Department of Human Services' Office of Reporting Research, Analytics and Implementation, and OHA's Child and Family Behavioral Health. This is a meaningful success for Oregon Title V. [As of the writing of this report, we are beginning to analyze 2019-2020 NSCH data, which includes our first year of oversample results. We see benefit from having more data. We look forward to reporting on this work in July 2023.]

Activity 11.9. Communications
OCCYSHN developed dissemination products and strategies to advance our Medical Home efforts. Specifics are detailed in the individual NPM 11 report sections. Examples include a series of issue briefs presenting critical findings from our 2020 Needs Assessment. We used trainings, presentations, communities of practice, and learning collaboratives to inform our partners, and to learn from them. We promoted health equity by employing health literacy best practices to communicate with families of CYSHCN, and with community partners serving that population. We disseminated research, analysis, program, and policy information to professional audiences at local, state, and national levels. We shared information with our partners and the public through a comprehensive website, social media and email.

Activity 11.10. Emergency Medical Systems for Children (EMSC) Registry for CYSHCN
OCCYSHN was awarded a HRSA EMSC Innovation and Improvement Center (EIIC) grant to further development of the HERO Kids Registry. This registry allows family members of CYSHCN to record critical information about their child's health, which is then readily available to emergency medical services (EMS) and emergency departments (EDs). With this grant and support from Title V, OCCYSHN was able to contract with a software developer, form advisory committees, and secure partnerships key to operating a statewide registry.

Development began with information-gathering. OCCYSHN convened more than 50 local and national EMS and ED providers to ensure HERO Kids Registry's data fields would provide the most useful information. To better inform the project from a family perspective, OCCYSHN's Family Involvement Program (FIP) manager sought TA from two family leaders with expertise on EMSC. She consulted with Gina Pola Money from Utah Family Voices about CYSHCN registries, and with Greta James Maxfield from the Texas Parent 2 Parent program about families' experiences of racism when using EMS. To inform the project from a community systems perspective, the FIP manager began outreach to stakeholders from six key state CYSHCN systems (Children's Behavioral Health, Education Service Districts [EI/ECSE], Children's Intensive In-home Services, Developmental Disabilities case management, primary care, foster care/child welfare and public health home visiting). OCCYSHN also participated in a national telehealth collaborative with the EMSC EIIC.

The HERO Kids Advisory Committee and subcommittees are made up of EMS and ED providers, nurses, primary and specialty care providers, community systems, family, and youth (Activity 11.5). In addition to these committees, OCCYSHN secured key partnerships with OHSU's Department of Emergency Medicine (to manage Registry operations) and Emergency Communication Center (to provide 24/7 hotline services).

Health Care Transition for CYSHCN Report

National Performance Measure 12:
Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care.

Report on OCCYSHN Strategies and Activities October 2020 – Sept 2021

Strategy 12.
We will increase the number of Youth with Special Health Care Needs (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.

Activity 12.1. Workforce Development
OCCYSHN continued to integrate health care transition (HCT) for youth with special health care needs (YSHCN) into CaCoon, shared care planning, and PACCT activities. CaCoon and Babies First! convened a data equity workgroup and included discussion of equitable HCT data collection (Activity 11.4). OCCYSHN contracted with LPHA's to implement innovative strategies for supporting YSCHN in HCT, providing technical assistance to support them.

OCCYSHN continued work on developing an online course for community health workers (CHWs), integrating HCT themes throughout. The course, Supporting Families: Navigating Care and Services for Children with Special Health Needs, provides an overview of CYSHCN, and covers topics including family-centered care, equity, cross-systems care coordination, and the major Oregon systems that serve CYSHCN. The course is designed to equip CHWs with the knowledge and skills necessary to support equitable access to services for all CYSHCN and their families. OCCYSHN's Family Involvement Program manager contributed to the course content, including offering practice situations and activities drawn from actual family experiences. The CHW course offers a variety of strategies for supporting families of CYSHCN, along with a comprehensive resource guide, and includes content and photos that reflect racial, ethnic and gender diversity. OCCYSHN developed plans to launch the course in October 2021, and to pilot it with various CYSHCN-serving professionals to assess its relevance and usefulness to them. We also developed strategies to leverage the course to promote cross-systems care coordination teams.

OCCYSHN developed guidance for nurse home visiting programs on using CHWs. This helped to clarify roles and supported the promise of expanding the home visiting workforce using CHWs.

OCCYSHN and OHA collaborated on monthly virtual Community of Practice (COP) meetings, where experts presented, and CaCoon home visitors learned from one another about topics including HCT. Equity-related COP topics included "Racism in Oregon's Health Care System" and "Supporting Care Coordination for Gender Diverse Individuals."
OCCYSHN provided professional development and technical support to the CaCoon workforce. OCCYSHN's Care Coordination Specialist conducted monthly one-to-one meetings with home visiting program supervisors in six counties to provide extended technical support. We developed and disseminated materials offering CYSHCN-related COVID-19 guidance.

Activity 12.2. Continuation of Oregon's CMC CoIIN Project
Block Grant FY21 overlapped with Implementation Years 4 (08/01/20—07/31/21) and 5 (08/01/21—09/30/21) of the HRSA-funded, Boston University-led Children with Medical Complexity Collaborative for Improvement and Innovation (CoIIN). We engaged in the following:

1. Implemented our revised QI intervention, which focused on preparation with a younger group (13-15 year old) young adults with medical complexity (YAMC) rather than on older YAMC closer to an age of transfer
2. Facilitated a BU focus group of families of YAMC led by our Family Leaders: Mrs. BranDee Trejo and Mrs. Ana Valdez,
3. Attempted to expand our QI intervention to a community-based pediatric primary care practice,
4. Applied Malawa et al's (2021) Racism as a Root Cause framework to our project,
5. Conducted the FESAT and implemented a "CoIIN bi-weekly digest" to improve project transparency for our Family Leaders,
6. Conducted strategic/sustainability planning,
7. Prepared and submitted a manuscript describing our family engagement efforts,
8. Adapted Got Transition and the College of Family Physicians' Transition Readiness Assessments to better apply to YAMC and their caregivers,
9. Participated in an interview about our team's interdisciplinary collaboration, which was published in AMCHP's Pulse,
10. Published our analysis of interviews with caregivers of YAMC in the Journal of Pediatric Nursing,

11. Collaborated with National Alliance to Advance Adolescent Health to propose testing a transition-focused value-based payment to OHA's InCK team (Activity 12.5),
12. Planned project expansion,
13. Prepared and piloted educational materials for providers,
14. Completed our BU-required Impact Statement (Attachment 1),
15. Shared project learning with the Oregon Health Policy Board and Medicaid Advisory Committee,
16. Transitioned project activities to focus on dissemination, evaluation, spread/sustainability, and
17. Onboarded a new project coordinator.

ESM/Objective 12.1:
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.
Progress: We have no data to report for this year. Our team's learning resulted in a change to the focus of our clinical QI project, the implementation of which was delayed because OHSU COVID-19 protocol required that we halt our clinical work during this period.

Activity 12.3. Leverage Family-to-Family Health Information Center Grant
The Oregon Family to Family Health Information Center (ORF2FHIC) updated our popular family training "Moving from Pediatric to Adult Health Care: An Introduction for Families." We worked with family groups to offer this training five times, serving 44 families. A college-aged intern (whose brother is significantly impacted by ASD), adapted our family-oriented curriculum on HCT for youth with disabilities. With support from ORF2FHIC staff, she got feedback on her curriculum prototype from a group of youth with disabilities, along with some of their parents.

We developed and disseminated a worksheet to help families communicate with pediatric providers about HCT processes. We featured the worksheet in our newsletter and on our website. We added condition-specific transition toolkits from the American College of Physicians to our website. We also included at least one article or resource on HCT in every ORF2FHIC newsletter.

OCCYSHN's Family Involvement Program (FIP) manager is trained in Supported Decision Making (SDM) methodology, a valuable tool to help people with disabilities make decisions. She participated in a learning community to stay current on SDM themes and resources and presented on SDM to 40 pediatric care coordinators at OHSU Doernbecher Children's Hospital. Parent Partners also coached patients and families in the OHSU's CDRC Lifespan Transition Clinic on using SDM. We helped plan and implement OHSU's Department of Pediatrics' Developmental Disabilities Month activities, which focused on SDM.

ORF2FHIC collaborated with the Child Neurology Foundation to develop an HCT workshop for parents of youth with neurologic conditions. We offered them feedback, resources, and suggestions for ways to include SDM concepts in their work.

The FIP Manager provided information about HCT gaps and barriers to Oregon's Medicaid Advisory Committee (MAC) and its Advancing Consumer Experiences subcommittee. As a result, HCT was included as a policy priority in the MAC's formal recommendations to the Oregon Health Policy Board. The FIP also provided OCCYSHN's CollN (Activity 12.2) with feedback and recommendations on HCT materials for pediatric providers.

Activity 12.4. Equity
OCCYSHN's efforts to address HCT for YSHCN continued to prioritize access, equity, and inclusion. In our efforts to improve HCT for YSHCN, we endeavored to be inclusive of, and accountable to, BIPOC communities and to other minoritized and/or underserved populations, including LGBTQIA+ people. We continued internal and external efforts to promote health equity. We embraced cultural humility and sought guidance from diverse stakeholders. We shared learning with our partners through training, dissemination products, and communities of practice.

Details on equity-related program and policy activities are included in the individual NPM 12 activity report sections. Examples include the training we developed and launched for Oregon's community health workers (CHWs) (Activity 12.1), who can improve systems of care by offering culturally and linguistically congruent HCT support to YSHCN and their families. Additionally, OCCYSHN administers an annual distribution of philanthropic funds from the Oregon Community Foundation. These funds are designated to purchase educational equipment for CYSHCN from low-income families. We were able to provide resources to 49 school-aged CYSCHN, many of them transition-aged youth from underserved rural and/or minoritized communities.

Activity 12.5. Systems and Policy
OCCYSHN joined a workgroup of state Title V participants and the National Alliance for the Advancement of

Adolescent Health (aka Got Transition) to share strategies for integrating HCT goals into special education individualized education programs, or IEPs. We also tracked opportunities to present on HCT at statewide conferences.

Our training for community health workers serving CYSHCN and their families will strengthen an important avenue for integrating culturally appropriate services into the system of care for CYSHCN. (Activity 12.1)

Got Transition and OCCYSHN proposed to OHA's Integrated Care for Kids (InCK) team that they include an HCT-focused value-based payment (VBP) approach, which would compensate pediatric and adult providers for work done to support effective transfer of care for young adults with medical complexity (Activity 12.2). OCCYSHN's CoIIN team identified the lack of payment to providers for transition preparation care as one of the causes of young adults with medical complexity (YAMC) and their families experiencing inadequate HCT support. Toward the end of FY21, we pursued incorporating HCT VBP into the 1115 Medicaid Waiver at the InCK team's suggestion. The Family Involvement Program Manager also advocated for including HCT in the waiver via her role on the Medicaid Advisory Committee (Activity 12.3).

Activity 12.6. Assessment and Evaluation

OCCYSHN's shared care planning evaluation activities (Activity 11.8) include a focus on health care transition (HCT). LPHAs submitted five Shared Care Plan Information Forms for young adults 12 to ≤ 21 years during FY21. All five were for new shared care plans, as opposed to re-evaluating existing plans. LPHA staff engaged two young adults in shared care planning to help them prepare for HCT. The assessment activities described in Activity 11.8 also include HCT.

OCCYSHN's Assessment and Evaluation unit worked with the Systems & Workforce Development unit to develop the CHW course (Activity 12.1) pre-/post-test and a course evaluation survey. The pre-/post-test quizzes participants on course content and knowledge before and after completing course modules.

Evaluation activities conducted for the CMC CoIIN project (Activity 12.2) focus on HCT. Our team interviewed participating pediatric primary care providers about their experience implementing the quality improvement project. A key finding was that the providers needed more concrete instruction on how to work with their patients on HCT. We used these findings to inform provider education content implemented during the fiscal year (Activity 12.2).

Activity 12.7. Communications

OCCYSHN developed dissemination products and strategies to advance and improve Health Care Transition (HCT) for youth with special health care needs. Specifics are detailed in the individual NPM 12 activity report sections. Examples include the CMC CoIIN Project efforts to inform and engage providers about HCT for medically complex young adults (Activity 12.2), and ORF2FHIC products and trainings aimed at HCT for YSHCN and their families (Activity 12.3).
OCCYSHN maintained a comprehensive website and used social media and email to share information with stakeholders. We developed trainings and offered presentations on HCT for YSHCN. We approached communications with an equity lens. We used current health literacy best practices to communicate with YSHCN and their families, and we promoted those practices with partners. We disseminated research, analysis, program, and policy information on HCT to professional audiences at local, state, and national levels.

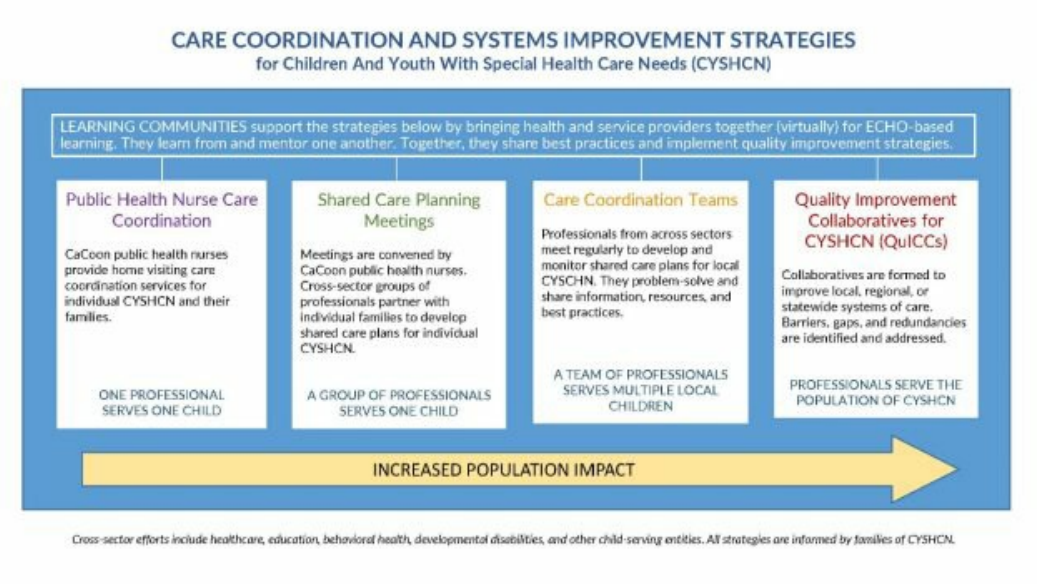
Medical Home for CYSHCN Plan

National Performance Measure 11:
Percent of children with special health care needs having a medical home

Planned strategies, ESMs and activities for Oct. 2022 – Sep. 2023

Strategy 11.
OCCYSHN will improve access to family-centered, team-based, cross-systems care coordination for CYSHCN and their families through workforce development and financing activities.

Activity 11.1.
Quality Improvement Collaboratives for CYSHCN (QuICC)



Overview: Strengthening Cross-systems Care Coordination
OCCYSHN will improve Oregon's workforce capacity to provide cross-systems care coordination for CYSHCN. We will build off of lessons learned from our REACH pilot, in which community-based teams employed quality improvement methodology to address gaps, barriers and redundancies in cross-systems care coordination for CYSHCN. This experience forms the foundation for Quality Improvement Collaboratives for CYSHCN (QuICCs). QuICC is a framework for addressing systems improvement. (See graphic above.) It provides flexibility to accommodate differences in local priorities and capacity, while encouraging collaboration and innovation. We will align our QuICC efforts with OHA's Family Connects Oregon, as that program also draws on local public health authority (LPHA) capacity. QuICCs will leverage existing LPHA shared care planning efforts (Activity 11.3) and the PACCT project (Activity 11.2 - Piloting Activate Care for Care Coordination Teams).

As LPHAs adapt to the capacity challenges engendered by the pandemic, OCCYSHN will follow the evolution of Family Connects Systems Alignment workgroups, and look for opportunities to integrate.

Not all LPHAs contracted with OCCYSHN prior to the pandemic, and during the pandemic a few more opted to discontinue their CaCoon contracts. OCCYSHN will work to understand barriers LPHAs face to implementing CaCoon. We will also gauge LPHA interest in and capacity for contracting to serve CYSHCN in other ways, like establishing innovative partnerships that benefit CYSHCN, or implementing QuICCs in their areas.

Activity 11.2. Piloting "Activate Care" for Care Coordination Teams (PACCT)
OCCYSHN will continue the Piloting Activate Care for Care Coordination Team (PACCT) project, with LPHA home visiting nurses and community health workers who participate in shared care planning. Activate Care is a cloud-based care coordination platform where care plans can be collaboratively created, shared, managed, and tracked.

Our initial vision was to expand PACCT to new LPHAs, and possibly to other interested parties who serve CYSHCN. We intend to pursue that vision, but any PACCT expansion will depend in part on regaining project momentum lost to the pandemic. LPHA capacity has been heavily impacted. It will take time for PACCT participants to re-establish the community partnerships required to get referrals, and to collaborate on shared care planning using Activate Care.

OCCYSHN has a contract with Activate Care through 2023. LPHAs in the project have access to the platform for that time, as do their invited partners, families, and youth, employing a customized shared care planning template. Participating LPHAs will continue to receive technical assistance from OCCYSHN through individual consultations and open office hours with OCCYSHN staff. We will collaborate with OCCYSHN's Family Involvement Program (FIP) on PACCT technical assistance. The FIP can provide care coordination teams with family resources, and share the perspective of family members of CYSHCN. We will also educate PACCT participants on ways community health workers can support shared care planning, including within Activate Care.

OCCYSHN will continue to develop technical support products for PACCT participants. We will employ health literacy best practices to ensure accessible and inclusive resources for families and communities. We will provide written resources in both English and Spanish, and we will advocate for more language options within the Activate Care platform.

Activity 11.3. Shared Care Planning
LPHAs will continue integrating shared care planning into their CaCoon work. CaCoon is OCCYSHN's statewide public health nurse home visiting program (Activity 11.4). CaCoon nurses identify individual CYSHCN who would benefit from shared care planning. They convene both the family of those CYSHCN and the professionals who serve them to collaboratively develop a family-centered shared care plan. The CYSHCN's primary care provider is invited to participate, as are other health, education and community service providers. We will continue offering technical assistance on shared care planning to LPHAs and other participating partners. We will also support quality improvement efforts, including use of the Family-Centered Shared Care Planning Assessment. This assessment allows shared care planning teams to reflect on how the values of family-centered care are operationalized, and to identify areas for quality improvement. The assessment includes health equity and trauma-informed care.
As LPHA capacity evolves in response to the demands of the pandemic, OCCYSHN will monitor the number of shared care plans initiated or re-evaluated to inform delivery of our technical assistance. We will gauge LPHA training needs, and ensure they include shared care planning resources, including videos, in their new-hire orientation.

OCCYSHN developed an online, on-demand course for community health workers (CHWs) in FY2020-21 (Activity 12.1). The course is called Supporting Families: Navigating Care and Services for Children with Special Health Needs, and it is available through Oregon State University's community health worker online training. The content of this CHW course has proved foundational to cross-systems care coordination for CYSHCN. It is relevant and useful to a variety of systems navigators and care coordinators. We will promote the course widely and seek to enroll pediatric care coordinators, case managers, school nurses, family resource specialists, family navigators, community outreach specialists and others. Training across systems helps lay the foundation for shared care planning and improving integration of care. We will gauge interest in new pilots supporting cross-systems shared care planning. The goal of these pilots will be to learn more about the roles of CHWs in different sectors, and to better understand how CHWs can support cross-sector care integration. A pilot could, for example, establish a collaboration among CHWs from two or three organizations, such as primary care, public health and CCOs.

Activity 11.4. Care Coordination (CaCoon) Public Health Nurse Home Visiting
CaCoon is part of the systems improvement continuum illustrated in the graphic atop Activity 11.1. OCCYSHN will continue to contract with LPHAs to provide CaCoon public health nurse home visiting services focused on care coordination for CYSHCN. CaCoon home visitors will implement shared care planning and convene cross-sector shared care planning meetings for CYSCHN. OCCYSHN will expand the target population of the CaCoon program, allowing case management services to be offered to parents and caregivers of CYSHCN. When caregivers' fundamental needs are met, they are better able to meet the needs of CYSHCN in their care.

Because multiple nurse home visiting programs are conducted by the same staff within given LPHAs, we will align efforts with the other nurse home visiting programs in the state, including Babies First! and Family Connects Oregon. We will continue supporting an integrated nurse home visiting orientation and training (Plan Activity 12.1).

Given home visiting workforce turnover issues throughout the state, OCCYSHN will implement strategies to support LPHA workforce retention. These will include improved orientation practices, workforce listening sessions to better understand local needs, and cross-county collaboration, all aimed at systems-level advocacy to support care coordination for CYSHCN and their families.

OCCYSHN will continue providing technical assistance and training to CaCoon home visitors. Emphasis will be placed on combatting racism, ableism, and other forms of discrimination experienced by CYSHCN and their families (Activity 12.1). We will also assess innovative ways to support the CYSHCN population in counties that don't have the capacity to contract with OCCYSHN for CaCoon home visiting.

We will host a statewide conference on cross-systems care coordination for CYSHCN, prioritizing health equity, diversity, and inclusion. If an in-person conference is not feasible due to pandemic concerns, we will offer virtual learning opportunities. Attendees will learn strategies and resources for working across systems to serve CYSHCN and their families, networking with other organizations doing similar work, and connecting with national and state-level experts.

OCCYSHN will monitor Coordinated Care Organization (CCO) efforts that align with CYSHCN priorities, and assess opportunities for cross-sector collaboration with CaCoon. We will seek opportunities to align CaCoon with public health modernization efforts.

Activity 11.5. Leverage the Oregon Family to Family Health Information Center (ORF2FHIC)

The Oregon Family to Family Health Information Center (ORF2FHIC) is currently funded through 2027. OCCYSHN will leverage ORF2FHIC's knowledge about the experiences of family members of CYSHCN, and of youth with special health care needs. We will investigate the barriers and inequities families encounter in health care system and apply that learning to our work.

ORF2FHIC will continue employing a team of Parent Partners who provide peer support via phone, video, and email. We will share information with family members of CYSHCN via our comprehensive family website. We will provide vetted, timely and up-to-date resources and information via social media in both English and Spanish. We will develop and disseminate at least one new topical toolkit or tip sheet for families of CYSHCN. We will partner with other family-led organizations to offer family trainings on topics related to MCHB core performance measures for CYSHCN. We will trial a new training we designed for youth on health care transition. We will offer six or more "Table Talks" for family members of CYSHCN. These are small group conversations on targeted subjects like school nursing, paying for health care, and caregiver wellness. Families who attend receive a stipend for their time and expertise. We will continue our contract with a professional writer (who is also the parent of a CYSHCN) who produces regular ORF2FHIC newsletters for families of CYSHCN.

When it is safe to do so, Parent Partners will resume outreach and tabling at community events like walk-a-thons and safety fairs. We will also re-establish tabling by Parent Partners in two of OHSU's Child Development and Rehabilitation Center clinical waiting areas. We will contact social work staff at Oregon children's hospitals and re-establish referrals sources that lost momentum during the pandemic. We will also continue training Oregon's 211 call center staff twice yearly (NPM Report Activity 11.5).

ORF2FHIC will offer support, resources, and training for family members of CYSHCN in English and Spanish. We will arrange interpretation/translation for families who speak other languages. We will disseminate ORF2FHIC's Spanish language newsletter to families, community-based organizations, and clinicians. We will conduct a quality review of our website's Spanish language pages, with the help of a workgroup of Spanish-speaking family members of CYSHCN. Our Bilingual Outreach/Training Specialist will continue outreach to Oregon's Latinx families.

ORF2FHIC will continue collaborating with refugee-serving groups, including The Refugee Emotional Support Task Force in Portland, African Youth Community Organization, and Lutheran Community Services Northwest. Our goal is to inform professionals who work with refugee, immigrant, or BIPOC communities about our services. These organizations have established credibility within their communities, and they often serve families who might benefit from ORF2FHIC. We have funds designated for translation or interpretation as requested by these agencies.

OCCYSHN's Family Involvement Program (FIP) will leverage ORF2FHIC to recruit family members to participate in systems-level work on behalf of CYSHCN. We will develop a six-hour leadership training for family members of CYSHCN, based on the Serving on Groups that Make Decisions curriculum. The training will help families promote MCHB's Standards for Systems of Care for CYSHCN at the state health care systems level. Additionally, we will convene a workgroup to review 2020 and ongoing needs assessment results, write a disparity impact statement, and draft a Diversity and Inclusion Plan for ORF2FHIC.

ORF2FHIC staff and the Family Involvement Program (FIP) manager will remain integral to OCCYSHN activities and planning. We advise OCCYSHN's workforce development, assessment and evaluation, and policy efforts. The FIP will facilitate OCCYSHN's annual family review of planned block grant activities. Parent Partners will also coordinate

listening sessions to help OCCYSHN apply family experience to our work.

The FIP manager will continue to serve as the Family Faculty to OHSU Leadership Education in Neurodevelopmental and Related Disorders (LEND) fellowship program, where she will train a clinical cohort on the principals and practice of family-centered care. She will also continue serving on state-level advisory groups including: State Interagency Coordinating Council; Advancing Consumer Experiences subcommittee of Oregon's Medicaid Advisory Committee; Insurance Advisory Committee; State Advisory Council for Special Education; Medicaid Ombudsman group; and the Durable Medical Equipment Advisory group.

Activity 11.6. Equity

Because racism and other forms of discrimination and disparity affect the health of Oregon CYSHCN, OCCYSHN's medical home efforts will prioritize access, equity, and inclusion in systems of care for CYSCHN. We will be accountable for our work to BIPOC communities and to other underserved populations, including LGBTQIA+ people. We will continue internal and external efforts to promote health equity. We will practice cultural humility, and seek guidance from diverse stakeholders. We will share learning with our partners through training, dissemination products, and communities of practice.

Plans for OCCYSHN's equity-related program and policy activities are detailed in the individual NPM 11 activity sections. Examples follow.

We will nurture the relationships we have formed with culturally-specific community-based organizations, and develop new ones (Activities 11.3, 11.5, and 11.8)). We will examine and improve our data collection for equity (Activities 11.4 and 11.8). We will expand efforts to train and inform community health workers to support CYSHCN and their families (Activity 11.3). We will provide Spanish-language family support (Activity 11.5). We will pursue equitable health care systems for CYSHCN through policy initiatives and cross-sector collaboration (Activities 11.1 and 11.7).

Activity 11.7. Systems & Policy

OCCYSHN will identify opportunities to help develop a cross-systems network of community health workers (CHWs). We will leverage the CHW online course we developed (Activity 11.3) to increase the statewide CHW workforce serving CYSHCN and their families. We will promote the course as a tool for building community capacity to serve CYSHCN. We will identify or develop innovative funding strategies to ensure equitable access to the course.

We will track the phased rollout of Family Connects Oregon, to inform development and timing of our quality improvement collaboratives (QuICCs - Activity 11.1). OCCYSHN's Director serves as the statewide medical director for Family Connects, which will facilitate a smooth integration of efforts.

OCCYSHN's Systems and Workforce Development unit will monitor public health modernization efforts and the impacts on systems of care for CYSHCN. We will track policy development, and act on opportunities to promote shared care planning (Activity 11.3), PACCT (Activity 11.2), and QuICC (Activity 11.1).

We will inform the next five-year cycle of CCO operations (CCO 3.0). We will provide input into the future of Medicaid-funded coordinated care for CYSHCN. OCCYSHN's Director will sit on the Health Evidence Review Committee, which informs Oregon's Medicaid prioritized list. Since his appointment in 2022 by Oregon's Governor, his work has led to significant revision of Oregon's Prioritized List of Health Services, which determines access to health care services and therapies for the Oregon Health Plan. Dr. Hoffman is the first child health professional to serve on this crucial public body in recent memory, and his engagement will remain important in the coming years.

OCCYSHN's Director will continue serving on Oregon's Patient-Centered Primary Care Home (PCPCH) Advisory Committee. The PCPCH program advances the medical home model in Oregon, setting standards and incentives for medical practices in Oregon to achieve a PCPCH designation. We will ensure that the needs of children, especially CYSHCN, are considered in advancing PCPCHs statewide.

Activity 11.8. Assessment & Evaluation

OCCYSHN's Assessment & Evaluation Unit will continue program evaluation and ongoing needs assessment activities for both Oregon CYSHCN national priorities: medical home and health care transition (Activity 12.6).

We will continue to monitor implementation of PACCT (Activity 11.2), shared care planning (Activity 11.3), and CaCoon (Activity 11.4). We will collect data from families participating in shared care planning and CaCoon, and we will collaborate with OCCYSHN staff to disseminate our findings. We will test and refine a patient/family-centered shared care planning assessment with Systems and Workforce Development staff. We will continue formative evaluation activities that contribute to the development of OCCYSHN's community health worker curriculum

(Activities 11.1 and 12.1). We will collaborate with OHA MCH to align home visitor program data collection and evaluation. We will collect and analyze data to monitor and report on ORF2FHIC implementation (Activities 11.5 and 12.3). We will design and implement data collections, analyze data, and contribute to dissemination products for HERO Kids Registry (Activity 11.10).

We will continue to assess the health status and needs of Oregon CYSHCN and their families through secondary data analysis using NSCH data, with a particular focus on both medical home and health care transition (Activity 12.6). The FY23 NSCH release will contain the second year of Oregon's oversample based on race/ethnicity, and we will execute analyses that we planned for during FY22 (e.g., disaggregating NPMs and other health and health care measures by CYSHCN and race/ethnicity). In addition, we will release a Request for Proposal to work with a community-based organization that serves Asian and Pacific Islander (API) families to conduct a participatory needs assessment of CYSHCN in one or more API communities.

Activity 11.9. Communications

OCCYSHN will develop communication strategies and disseminate products to improve the status of medical homes for CYSHCN. Audiences will include the CYSHCN workforce, family members of CYSCHN, youth with special health care needs, health care providers, administrators, legislators, and others engaged in research about the CYSHCN population.

OCCYSHN will maintain a comprehensive website and use social media and email to share information with stakeholders. We will support LPHA efforts to use social media to provide families of CYSHCN with information that affects them. We will use current health literacy best practices and promote those practices with partners. We will inform public health policy development and implementation by conducting research and disseminating analysis. We will share the perspectives of professionals and family members of CYSCHN with whom we partner. We will provide input and testimony on legislation impacting CYSHCN. We will advocate for CYSHCN at the local, state, and national levels.

Activity 11.10. Emergency Medical Systems for Children (EMSC) Registry for CYSHCN

OCCYSHN will launch the HERO Kids Registry in Fall 2022. HERO Kids is a voluntary, no-cost registry that will allow families to record critical details about their child's health. In an emergency, Emergency Medical Services (EMS) and Emergency Departments (EDs) will have immediate access to HERO Kids Registry information, so they can provide better-informed emergency care. In preparation for the launch, we will secure subcontracts with OHSU's Department of Emergency Medicine to manage operations of the Registry, and the Emergency Communication Center (ECC) to provide 24/7 hotline services. Monthly utilization and registration reports will be generated by Registry staff. OCCYSHN will demonstrate proof of concept with the first HERO Kids Registry annual report in September 2023. It is expected that by the end of the first year of operations HERO Kids will have registered over 1,200 children and young adults.

In addition to operating the Registry, OCCYSHN and its technology developer will launch a field access app for EMS. This cloud-based app will allow EMS to access the Registry directly with a smartphone or tablet, making access faster.

OCCYSHN will leverage its strong partnerships with community-based organizations (CBOs), professional organizations, culturally-specific CBOs, and ORF2FHIC to provide targeted education and marketing about the Registry and its mission. We will have outreach materials translated into other languages.

OCCYSHN will further emergency planning for CYSHCN by exploring potential interoperability between HERO Kids Registry and other systems, such as public safety answering points (911) and Oregon's behavioral health crisis response system (988).

Critical Partnerships

- All:Ready Network
- Black Parent Initiative
- Care Oregon
- County Local Public Health Authorities
- Coalition of Communities of Color
- Culturally-Specific Organizations (AFHHO, AHSC, AYCO, Consejo Hispano, IRCO, LCSNW, MICO, Open Doors, Salem for Refugees, Sickle Cell Anemia Foundation of Oregon Unete)
- Family Voices/LFPP
- Health Share CCO
- Health Share THW Advisory Committee
- Help Me Grow
- LEND trainees, training coordinators and mentors
- Latino Community Association
- Legacy Health Systems/Randall Children's Hospital
- National Center for Care Coordination Technical Assistance (NCCCTA)
- NW Regional ESD
- Willamette ESD
- NorthWest Senior and Disability Service
- OHA Early Hearing Detection & Intervention (EHDI) Advisory Council
- OHA Office of Equity and Inclusion
- OHA Patient-Centered Primary Care Home (PCPCH) Advisory Committee
- OHA Traditional Health Worker Commission
- OHA Transformation Center
- OHSU Care Management
- OHSU IDD/CDRC and CDRC Eugene
- OHSU Language Services
- OHSU Maternal-Fetal Medicine Clinic
- OHSU NICU
- OHSU Social Work, Women and Children's Services
- Oregon Center for Nursing
- Oregon Child Development Coalition
- Oregon Council on Developmental Disabilities (OCDD) Children's Services Advisory Group
- Oregon Deafblind Program at Western Oregon University
- Oregon Department of Consumer Business Services (Insurance Regulative Authority)
- Oregon Emergency Medical Services for Children
- Oregon Family Networks and Organizations (25)
- Oregon Health Authority Birth Anomalies Surveillance System
- Oregon Kinship Navigator
- Oregon Law Center
- Oregon Office on Disability and Health (OODH) at OHSU
- Oregon Pediatric Improvement Project (OPIP)
- Oregon Pediatric Society (OPS)
- Oregon Post Adoptive Resource Center
- Oregon State Board of Nursing
- Oregon State University (OSU)
- Oregon State University, Professional and Continuing Education (PACE)
- Pacific Source CCO
- Providence Health System
- Self Enhancement Inc.
- Sickle Cell Anemia Foundation of Oregon
- State Interagency Coordinating Council
- 211info

Health Care Transition for CYSHCN Plan

National Performance Measure 12:

Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care

Planned strategies, ESMs and activities for Oct 2022 – Sep 2023

Strategy 12.

We will increase the number of Youth with Special Health Care Needs (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.

Activity 12.1. Workforce Development

OCCYSHN will improve health care transition (HCT) for youth with special health care needs (YSHCN). We will integrate HCT into all our cross-systems care coordination efforts, including PACCT, QuICCs, shared care planning, CaCoon, and professional development for community health workers (CHWs) (Activities 11.1-11.4). We plan to offer access to the CHW course (which includes HCT) to all new CaCoon nurses and CHWs. Across projects, we will continue developing and disseminating materials that support HCT, including videos and information sheets. OCCYSHN will offer training on HCT to CHWs in navigation roles such as family resource specialists, family navigators, case managers, care coordinators, and others. We will promote the CHW course across sectors. We will identify potential post-course training needs for CHWs working for culturally specific community-based organizations.

OCCYSHN will offer local public health authorities (LPHAs) technical assistance, training, and support for HCT quality improvement. We will help LPHAs implement innovative community-based approaches to coordinating care for YSHCN and planning for HCT. Examples include integrating HCT into the work of existing community-based teams serving youth and supporting individual service providers to address HCT.
We will continue to raise awareness about the needs of youth transitioning to adult health care. We will disseminate HCT information at conferences, OCCYSHN regional meetings, and meetings with CCOs, primary care, and others. We will build off lessons learned in OCCYSHN's CoIIN project (Activity 12.2), which focuses on HCT for young adults with medical complexity. We will inform HCT policy and practice by engaging education and health systems (including individual primary care practices, CCOs, and medical associations) to promote care coordination and HCT planning for YSHCN.

We will align our effort with those of other nurse home visiting programs in the state, including Babies First! and Family Connects Oregon. We will assess feasibility of a combined nurse home visiting manual, to include HCT, and support an integrated nurse home visiting orientation. Orientation topics will include: HCT; safety; documentation; health equity; CHW role in home visiting; shared care planning; reflective practice; and more. OCCYSHN and OHA MCH will continue partnering to train home visitors on Targeted Case Management, anti-racism, anti-ableism, trauma-informed care, and health outcomes of positive childhood experiences.
OCCYSHN will prioritize health equity, diversity, and inclusion in our efforts to educate the workforce about HCT for YSCHN. The Family Involvement Program will seek family members of YSHCN from minoritized communities to inform workforce development efforts. We will present at local, state, and national conferences about the relevance and usefulness of the CHW course, including the HCT content. We will promote the CHW course on OCCYSHN's webpage. We will disseminate information about CaCoon HCT training opportunities on Basecamp, and we will continue developing and disseminating videos about HCT on our shared care planning webpage.

Activity 12.2. Continuation of Oregon's CMC CoIIN Project

OCCYSHN leads Oregon's Children with Medical Complexity Collaborative for Improvement and Innovation Network (CoIIN) team, which focuses on health care transition (HCT), specifically improving preparation for and transfer to adult providers for young adults with medical complexity (YAMC) and their families. During CoIIN year 4, we developed a five-year sustainability plan that sought to address the multiple influences on the HCT experience, including clinic practices and policies, family education, insurance payment and financing, and state metrics and policy context. We will use Title V funds to continue to support CoIIN Family Leaders (Mrs. Ana Valdez and Mrs. BranDee Trejo) and our CoIIN Medical Director (Reem Hasan, MD, PhD). We also plan to recruit two Youth Leaders to further inform the CoIIN work.

We will continue implementing tests of change focused on (a) transfer between pediatric and adult primary care, and (b) use of transition readiness assessments and documentation of transition preparation discussions in electronic health records. We will partner with Mr. Charles Smith and Dr. Claudia Bisso-Fetzer to recruit Family and Youth Leaders from Black and Latinx communities, and we will adapt our clinical approach to be culturally sensitive to both communities. We will continue to collaborate with OHSU's Department of Pediatrics transition workgroup, led by Dr. Hasan to (a) inform the build of the Epic transition module, (b) develop clinical policy that reflects Got Transition's Core Element 1 and our project learnings, (c) develop an evaluation approach for our educational workshops, and (d) share our learning, and learn from HCT efforts in subspecialty clinics.

We will continue to inform OHA Health Policy Division's (HPD) efforts to incorporate HCT into health care transformation, specifically focusing on Oregon's 1115 Medicaid Waiver (Activity 12.5). We will continue to advise OHA on methods of identifying YSHCN and YAMC, and on improving the care and services needed to support their transition to adult health care. We will continue to collaborate with HPD to inform and influence CCO roles regarding how payers can provide HCT support to YAMC, families, and providers. Additionally, we will look for opportunities to

test value-based payment methods with OHA and with OHSU Health.

We will monitor the CCO Metrics and Scoring committee and follow progress as OHA implements their plan to transition the Health Plan Quality Metrics committee into the Health Equity Quality Metrics committee. Monitoring these committees will inform our plans to advocate for a transition-focused metric.

We will continue to disseminate our learning to local and national audiences through journal manuscripts, presentations, reports, and topical briefs. We will also incorporate our learning into provider, family, and youth learning opportunities and resources.

Activity 12.3. Leverage the Oregon Family-to-Family Health Information Center Grant
Meaningful, permanent improvements to health care transition (HCT) in Oregon requires policy changes. OCCYSHN's Family Involvement Program (FIP) and the Oregon Family to Family Health Information Center (ORF2FHIC) will continue to support OCCYSHN's policy efforts to that end. We will also work "downstream," meaning we will continue to work with families of teens with special health care needs, and the teens themselves, to help them better participate in their transition from pediatric to adult health care.

ORF2FHIC will raise awareness among families and youth about the importance of planning for HCT. We will address it in all relevant training events, and in conversations with families of teens. We will maintain resources and information about HCT on the ORF2FHIC website, and in the coming year we will have the majority of those pages translated into Spanish. We will regularly post short, informational reminders about HCT on our English and Spanish Facebook pages. We will use the National Resource Center on Health Care Transition for resources and guidance and share their checklists and toolkits in both English and Spanish at outreach events. We will include a one-hour module on HCT in our forthcoming six-hour family leadership training on health care systems for CYSHCN. In response to requests from community-based organizations, we will translate HCT materials into different languages for them to share with families they serve.

We will continue to offer, in collaboration with family organizations and other community groups, a popular training entitled Moving from Pediatric to Adult Health Care, providing an array of family-friendly written products introducing key HCT activities and steps families can take. We will work with new partners at Portland Public Schools and The Abeona Group. Abeona specializes in supporting families with the financial aspects of transitioning to adulthood. Its principals are family members of youth with medical complexity. We will convene a small workgroup of monolingual Spanish speaking families to vet the HCT training curriculum and recommend improvements.

We will disseminate our newest family tip sheet: "Five Questions to Ask Your Provider," developed in concert with family leaders and health care providers from OCCYSHN's CoIIN. It will be shared with the OHSU Child Development and Rehabilitation Center's Lifespan Transition Clinic, which often refers families to ORF2FHIC for support. It will also be featured in ORF2FHIC's newsletter.

We will continue to refine a new HCT curriculum for youth, which was developed by a student intern in 2021. The student drew on her experiences as a sibling of a young adult with Autism and wrote the training script in a youth's voice. ORF2FHIC will recruit a young adult to serve as a co-trainer, and contract with that person to conduct a number of trainings with youth around Oregon and consult on training improvement. We will develop a process for getting parental consent to allow minors to participate in the trainings. These efforts mark the start of a renewed commitment from OCCYSHN to working directly with YSCHN.

ORF2FHIC will complete the first draft of a family training on integrating HCT concepts into Individual Education Plans. We will collaborate with Oregon's Parent Training Center (FACT Oregon) to provide this training to families. We will offer at least one Table Talk, in English and Spanish, on the subject of HCT, and use families' expressed concerns, opinions, and suggestions to inform our work going forward.

Activity 12.4. Equity
Because racism and other forms of discrimination affect the health of Oregon CYSHCN, OCCYSHN's efforts to address HCT for YSHCN will prioritize access, equity, and inclusion. In our efforts to improve systems of care for YSCHN, we be accountable to BIPOC communities and to other underserved populations, including LGBTQIA+ people. We will continue internal and external efforts to promote health equity. We will practice cultural humility and seek guidance from diverse stakeholders. We will share learning with our partners through training, dissemination products, and communities of practice.

Plans for OCCYSHN's equity-related program and policy activities are detailed in the individual NPM 12 activity sections. Some examples follow.

We will nurture the relationships we have formed with culturally-specific community-based organizations and develop new ones (Activities 12.1 – 12.3). We will examine and improve our own data collection efforts through an equity lens (Activities 12.1 and 12.6). We will recruit Youth Leaders from communities of color to advise our CoIIN Project (Activity 12.2). ORF2FHIC will offer Spanish-language family support and information (Activity 12.3). We will pursue equitable health care systems for YSHCN through policy initiatives and cross-sector collaboration (Activity 12.5).

Activity 12.5. Systems and Policy

OCCYSHN will continue to work with other state Title V programs and Got Transition (National Alliance to Advance Adolescent Health) to share ideas for integrating HCT into Oregon Administrative Rules specific to educational transition planning.

We will develop relationships with partner organizations and the Oregon Department of Education to encourage integrating health care transition (HCT) into Individualized Education Programs. OCCYSHN will promote the community health worker course we developed (Activity 11.3) to school nurses, school-based health centers, and education-based community health workers to improve student success, and to support YSHCN who are transitioning to independent or supported living.

We will continue to work with OHA's Health Policy Division to inform the 1115 Medicaid Waiver's inclusion of HCT, and we will advocate for other state policy efforts to include HCT (Activity 12.2).

Activity 12.6. Assessment and Evaluation

OCCYSHN's Assessment & Evaluation Unit will continue to assess the health care transition (HCT) needs of CYSHCN and their families as described in Activity 11.8. We will continue to evaluate medical home (Activities 11.1-11.4), workforce development (Activity 12.1), and family involvement (Activity 12.3) activities that incorporate HCT efforts, as well as OCCYSHN's HCT health care systems work begun as part of the Children with Medical Complexity CoIIN (Activity 12.2).

Activity 12.7. Communications

OCCYSHN will develop communication strategies and disseminate products to raise awareness and to advance successful health care transition (HCT) for YSCHN. Audiences will include the youth themselves, their families, the YSHCN workforce, administrators, legislators, and others engaged in research about the CYSHCN population. Specifics efforts are detailed in the individual NPM 12 activities.

Examples include CMC CoIIN Project plans to inform and engage providers about HCT for medically complex young adults (Activity 12.2), and Family Involvement Program products and trainings aimed at HCT for YSHCN (Activity 12.3).

OCCYSHN will maintain a comprehensive website and will use social media and email to share information with stakeholders. We will support LPHA efforts to use social media to disseminate HCT information to YSCHN and their families. We will use current health literacy best practices and promote those practices with our partners. We will inform public health policy and administration by conducting research and disseminating analysis, and by sharing the perspective of the many professionals and family members of YSCHN with whom we partner. We will offer input or testimony on legislation or administrative decisions that affect HCT for YSHCN. We will advocate at the local, state, and national levels to support successful HCT for YSHCN.

Critical Partnerships

- Abeona Group
- Child Neurology Foundation
- County Local Public Health Authorities
- Culturally-Specific Organizations (AHSC, AFHHO, AYCO, Consejo Hispano, IRCO, LCSNW, MICO, Open Doors, Salem for Refugees, Sickle Cell Anemia Foundation of Oregon, Unete)
- Department of Education Youth Transition Programs
- Dr. Reem Hasan, MD, PhD, OHSU Internal Medicine/Department of Pediatrics
- Dr. Mortuma Murray, DNP, OHSU Doernbecher Children's Hospital Hematology-Oncology Clinic
- Family Organizations (25)
- Families of YSHCN
- Family Voices/LFPP
- Latino Community Association
- LEND trainees, training coordinators, and Family Mentors
- Mr. Charles Smith, MSW
- Ms. Danielle Sullivan, OHSU Doernbecher Children's Hospital General Pediatrics and Adolescent Health Clinic
- Mrs. Ana Valdez
- Mrs. BranDee Trejo
- National Alliance for Advancing Adolescent Health (NAAAH) Got Transition
- OHA Health Policy Division
- OHA Transformation Center
- OHSU Department of Pediatrics Health Care Transition Workgroup
- OHSU Language Services
- OHSU IDD/CDRC (Portland and Eugene)
- OHSU IDD Lifespan Transition Clinic
- OHSU Social Work, Women and Children's Services
- Oregon Council on Developmental Disabilities
- Oregon Council on Developmental Disabilities (OCDD) Children's Services Advisory Group
- Oregon Child and Family Behavior Services (Children's Services Advisory Council)
- Oregon Department of Education Youth Transition Programs
- Oregon Foster Care Ombuds
- Oregon Law Center
- Oregon Medicaid Ombuds
- Oregon Office on Disability and Health at OHSU
- Oregon Pediatric Improvement Project (OPIP)
- Oregon State University, Professional and Continuing Education (PACE)
- Portland Public Schools Transition Programs
- School Based Health Centers
- The Arc Oregon
- University Center of Excellence on Developmental Disabilities at OHSU (UCEDD)
- Youth Era
- YSCHN

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Percentage of new mothers who experienced stressful life events before or during pregnancy

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	43	41	43	43	42.5
Annual Indicator	41.3	44.8	43	42.8	46.6
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	46.4	46.2	46.0	45.8

SPM 2 - Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs

Measure Status:	Active

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	90.7	94.6	93.5	94.2	93.9
Annual Indicator	94.4	93.3	94	93.8	94.3
Numerator					
Denominator					
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2016	2017	2018	2019	2019/2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	94.4	94.5	94.6	94.7

SPM 3 - Percent of children living in a household that received food or cash assistance

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			43.2
Annual Indicator	42.3	43.3	41.4
Numerator			
Denominator			
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2018	2019	2019/2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	41.3	41.2	41.1	41.0

State Action Plan Table

State Action Plan Table (Oregon) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Stable and responsive relationships; resilient and connected children, youth, families and communities.
SPM
SPM 1 - Percentage of new mothers who experienced stressful life events before or during pregnancy
Objectives
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%.
Strategies
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.

State Action Plan Table (Oregon) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Enhanced equity and reduced MCAH health disparities.

SPM

SPM 2 - Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs

Objectives

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%.

Strategies

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 and implementation.

MCAH Foundations - policy & systems: Develop and/or strengthen systems and partnerships to address food security and barriers to accessing food resources.

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: Ensure all Title V priority areas include a racial/ethnic and health equity focus including performance measurement and evaluation to identify and address disparities.

MCAH Foundations - assessment & evaluation: Ensure all Title V priority areas include a racial/ethnic and health equity focus including performance measurement and evaluation to identify and address disparities.

State Action Plan Table (Oregon) - Cross-Cutting/Systems Building - Entry 3

Priority Need

Enhanced social determinants of health

SPM

SPM 3 - Percent of children living in a household that received food or cash assistance

Objectives

By October 1, 2025, decrease the percentage of households with children that receive food or cash assistance from 42.3% to 41.3%.

Strategies

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 and implementation.

Foundations - policy & systems: Develop and/or strengthen systems and partnerships to address food security and 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 exploratory analysis to add to the SDOH, Equity, CLAS, and Trauma/ACEs knowledge base and improve effectiveness of Title V foundational interventions and innovations.

Cross-Cutting/Systems Building Domain

Toxic Stress, Trauma, ACEs and Resilience: OHA MCAH Report
(October 2020 – September 2021)

State Performance measure 1
1. Percentage of new mothers who experienced stressful life events before or during pregnancy.
2. Percentage of mothers of 2-year-olds who have adequate social support.

Trends in SPM data
1A. The percentage of new mothers who experienced stressful life events before or during pregnancy in Oregon is based on PRAMS data. The reporting year data for 2016-2020 reflects PRAMS data from 2014-2018. During that period, the indicator varied between 41.3 and 44.8 percent, but not did trend in either direction. Knowing that over 40% of women experience stressful life events before or during pregnancy is a reminder of the importance of Title V and other services being focused on support for women and families during the perinatal period. As our data catches up to the pandemic in future years we anticipate that it will reflect the higher levels of stressful life events that we know have accompanied the pandemic for our MCH population.

1B. The percentage of mothers of 2-year-olds who have adequate social support in Oregon is based on PRAMS 2 data. The reporting year data for 2016-2020 reflects PRAMS data from 2015-2017. Over the course of those 3 years the percent increased from 68.7 to 92.5. However, this trend should be interpreted with caution as it may be unreliably high and subject to reporting or other biases. This SPM was discontinued after the first year of the current 5-year cycle and will no longer be reported.

Toxic stress/Trauma/ACEs/Resilience Strategy #1:
Provide technical assistance to local Title V Grantees implementing toxic stress, ACEs, and resilience work in their communities.

Accomplishments – State level:
- Nine Title V grantees selected to work on ACEs, trauma and resilience during the grant period. Many of these grantees chose this priority in previous years, so had planned to build on ongoing work. Strategies selected address: community outreach and education on NEAR science (neurobiology, epigenetics, ACEs and resilience), developing trauma-informed workplace and workforce, and supporting programs that strengthen protective factors for individuals and families.
- Calls were held with local grantees to develop their local plans and assess potential needs. The ACEs/Toxic stress priority lead talked with local grantees to determine their capacity for ongoing technical assistance within the context of the ongoing COVID-19 pandemic. Unfortunately, as will be detailed throughout the report, many local grantees expressed concern about their limited capacity to engage in work outside of their community's immediate COVID-19 response.

Challenges/emerging issues:
The COVID-19 pandemic made completion of our planned activities very difficult. Many local Title V staff were pulled into their community COVID-19 responses and traditional public health programs were temporarily "paused" or scaled back during the grant year. Local Title V staff lacked the capacity to participate in regular technical assistance for Title V activities.

Strategy #2:
Promote family friendly policies that decrease stress and adversity for all parents, increase economic stability and/or promote health.

Accomplishments – State level:
- MCH staff continued to participate in the development of an OHA trauma-informed policy alongside representatives from divisions across the agency. This trauma-informed policy workgroup finalized the agency policy in December 2020 and began to develop a process to implement the policy. New agency Executive Sponsors were identified, and participants were recruited to form a new trauma-informed policy implementation workgroup during summer 2021.
- The Title V program continued to strengthen partnerships with several organizations working to reduce parental stress and promote family friendly policies, including Family Forward, an organization whose mission

is to support policy change which decreases stress for women in their roles as caregivers.
- MCH representatives participated in a cross-agency workgroup focused on Earned Income Tax Credit (EITC) and the enhanced child tax credit uptake. Partners in this workgroup include the Oregon Department of Human Services, Department of Revenue, Department of Consumer and Business Services, and local nonprofit agencies.
- Data from the Adverse Childhood Experiences (ACEs) module of Oregon's Behavior Risk Factor Surveillance Survey (BRFSS) survey, and the Pregnancy Risk Assessment Monitoring System (PRAMS) and PRAMS follow-up surveys were provided to state and local partners to inform local and state policy work.
- Oregon's Title V program supported the continued development and implementation of legislation and programming for Oregon's Universally offered home visiting program.

Accomplishments – Local level:
- Benton County supported two MCH RNs to complete the training "Promoting Maternal Mental Health During Pregnancy from Parent Child Relationship Program." One RN was able to complete an additional training "Developing Trauma Informed Clinics and Health Organizations."

Challenges/emerging issues:
- The COVID-19 pandemic presents both challenges and opportunities related to the establishment of policies to prevent and/or mediate ACEs and trauma for children and families. The increased stresses on parents and families – especially in systemically oppressed communities – are exacerbating both need and disparities. Although some short-term funding and policies to support families are being implemented, there are disparities in the reach and implementation of those policies, and the longer-term policy solutions remain in doubt.
- All local grantees expressed challenges related to the COVID-19 pandemic. Many Title V grantee staff were diverted to their local COVID-19 response or experienced staff turnover. Although previous training and professional development in trauma-informed care principles helped Title V grantees to address client and staff trauma and toxic stress, some grantees reported that no one was fully prepared to meet the challenges of the complex trauma brought on by COVID-19 and regional wildfires during this grant cycle. This continues to be a challenge that Title V grantees will work to address in the future.

Toxic stress/Trauma/ACEs/Resilience Strategy #3:
Provide outreach and education to increase understanding of, NEAR (neurobiology, epigenetics, ACEs, and resilience) science, and the impact of childhood adversity on lifelong health.

Accomplishments – State level:
- Information on toxic stress/trauma and its impact on lifelong health was provided to state and local partners as requested throughout the grant year.
- The MCH Section's Health Equity workgroup convened meetings throughout the grant year to provide a trauma-informed space for MCH staff to come together and process the personal and professional impacts of COVID-19, wildfires and racial justice uprisings.

Accomplishments – Local level:
- Lane County was able to hold a series of 4 meetings to review NEAR toolkit in detail with MCH staff. These meetings were conducted in July 2021 when COVID-19 case rates were lower and MCH staff, including the MCH Nursing Supervisor, were able to return to their regular public health work from the COVID-19 response. The team was also able to set up Tableau for Title V indicators and expand the use of the dashboard for the nurses' caseload. The grantee will continue working to chart NEAR-related issues and train staff on charting.
- Marion County reports that interest in ACEs/toxic stress has increased in their community during the COVID-19 pandemic and historic wildfires. Initial conversations were conducted during the grant period with partner agencies about potential opportunities for future collaboration.
- North Central Public Health District had planned to do intensive training for nurse home visiting staff on NEAR science. Instead, more scaled down resources were provided to all county public health staff to help them address stress and trauma, particularly during COVID-19 outbreaks. Some nurse home visiting services were able to be provided via telehealth.

Challenges/emerging issues:
- All local grantees expressed challenges related to the COVID-19 pandemic. Many Title V grantee staff were diverted to their local COVID-19 response or experienced staff turnover. Although previous training and professional development in trauma-informed care principles helped Title V grantees to address client and staff trauma and toxic stress, some grantees reported that no one was fully prepared to meet the challenges of the complex trauma brought on by COVID-19 and regional wildfires during this grant cycle. This continues

to be a challenge that Title V grantees will work to address in the future.
- Marion County was unable to complete their planned work during the grant period due to the COVID-19 pandemic and local wildfire response. The grantee is aware that both events have and will continue to have major impacts on already systemically oppressed groups within the community. Future work in this area, including prevention strategies, will be critical in helping ameliorate the health impacts of these events.
- North Central Public Health District was largely unable to complete their planned work during the grant period due to the COVID-19 pandemic. All nursing staff and support staff diverted most of their time to COVID-19 response and mass vaccination clinics.

Toxic stress/Trauma/ACEs/Resilience Strategy #4:
Engage partners to build capacity for safe, connected, equitable and resilient communities.

Accomplishments – State level:
- State Title V staff provided ongoing support and leadership to a variety of internal, as well as cross-agency trauma efforts including the Public Health Division Community Engagement Community of Practice and Trauma-Informed Oregon's Advisory Council.
- State Title V staff provided support and resources to local Title V grantees working to implement community partnerships and cross-system initiatives.
- The State Title V Program continued to fund an MCH information and referral line as well as two dedicated MCH specialists as part of Oregon's 211info service. These services provide information and referral for a wide range of health, housing, childcare, and other human service needs statewide, as well as more in-depth resources and support to families with specific MCH needs spanning parenting, child health, etc.
- Title V funding also supported local Title V grantees in delivering MCH services including Oregon MothersCare and home visiting. These programs build safe and connected communities by identifying children and families who are experiencing stress and adversity and refer them to appropriate supports and care.

Accomplishments – Local level:
Marion County participated in two local Service Integration Teams and multiple neighborhood groups. The grantee provided a prevention lens as the groups worked through the collective trauma of COVID-19 and wildfires. The grantee provided expertise and resources related to ACEs and trauma. Marion County reports that these relationships and organizations were strengthened because of the county's prominent role in the COVID-19 and wildfire response.

Challenges/emerging issues:
As with other areas of this work the COVID-19 pandemic created challenges, illuminated disparities, and also created opportunities. The diversion of MCH staff at both the state and local level to COVID-19 response work was a huge challenge, but at the same time, new relationships with community-based organizations and new systems for funding systemically oppressed communities around the state hold promise for this strategy in the coming years.

Toxic stress/Trauma/ACEs/Resilience Strategy #5:
Conduct assessment, surveillance, and epidemiological research. Use data and NEAR science to drive policy decisions. (State level only strategy)

Accomplishments – State level:
- Data from these surveys was analyzed and used in a variety of presentations throughout the grant year including presentations to the Oregon Legislature, Early Childhood partners, and Title V grantees.
- Parental stress questions from Oregon's Pregnancy Risk Assessment Monitoring System (PRAMS) were analyzed.
- The Oregon subset of the National Survey of Children's Health (NSCH) data on children's exposure to ACEs for Oregon children was analyzed and information on flourishing and ACEs, as well as other children's resiliency indicators, was disseminated to partners.
- Title V staff partnered with other state agencies to fund and implement a National Survey of Children's Health oversample for Oregon, beginning in 2020.
- Analysis of data from the Behavioral Risk Factor Surveillance System was conducted to examine the association between ACEs and adult cognitive disability. Analysis was conducted in partnership with a CSTE/CDC Applied Epidemiology Fellow and the CDC State Assigned MCH Epidemiologist. A draft manuscript is currently going through state and CDC approval processes for submission to a peer reviewed journal.

Challenges/emerging issues:
Limitations in sample size, especially for the Oregon sub-sample of NSCH data – as well as constraints on available analyst time impose limits on what can be accomplished in this strategy area. The NSCH oversample will help to address some of the data limitations.

Toxic stress/Trauma/ACEs/Resilience Strategy #6:
Develop a trauma-informed workforce, workplaces, systems, and services.

Accomplishments – State level:
- The integrated state MCH trauma-informed care and health equity work group continued development of internal systems and policies to ensure that the links between toxic stress and adversity, and racism and health equity are recognized and interwoven throughout our work.
- Work on trauma-informed workplace systems and supports shifted with the pandemic to support for telework and COVID-19 related stressors on MCH staff and their families. These included ensuring that staff had flexible schedules, understood how to access emergency leave and childcare supports, and had ways to integrate self-care and wellness into their new work settings.

Accomplishments – Local level:
- Deschutes County trained all nurses on the Family Support Services (FSS) team on the Sanctuary Training Trauma-Informed Care Modules 5-10 remotely. Two staff attended monthly meetings with the TIC Core Team and Training group. These trainings provided a formalized way to educate staff on the importance of trauma and TIC in their work. Out of the training came opportunities to join the sanctuary workgroup and continue to work with the team on implementation of the work – and also individually take accountability for being more trauma-informed in the approach to each individual's work. Refresher training was also offered in September 2021. The county reported that the shift to remote work actually improved attendance at these training opportunities. Attendees further reported an increased sense of emotional safety in the virtual environment.
- Washington County planned to build on previous work to increase awareness of ACEs/TIC among county staff and partners. Unfortunately, because of the COVID-19 pandemic, regular workgroup meetings of the coordinating committee were suspended for an extended period. The grantee spent time during the grant period developing a strategy to continue to engage staff in this work and bring their expertise to the current structure (internal MCH team).

Challenges/emerging issues:
- Challenges related to this strategy at both the state and local levels included the COVID-19 related changes in workplaces and all of the trauma-informed adjustments that those necessitated. Additionally, it is an ongoing challenge to address the complexity of developing trauma-informed systems and services, which span both how our MCH systems treat employees and workforce, as well as how we address trauma and racism and their impacts on health.
- All local grantees expressed challenges related to the COVID-19 pandemic. Many Title V grantee staff were diverted to their local COVID-19 response or experienced staff turnover. Although previous training and professional development in trauma-informed care principles helped Title V grantees to address client and staff trauma and toxic stress, some grantees reported that no one was fully prepared to meet the challenges of the complex trauma brought on by COVID-19 and regional wildfires during this grant cycle. This continues to be a challenge that Title V grantees will work to address in the future.
- Deschutes County reported that supporting staff in the implementation of TIC concepts was challenging in the remote work environment.
- Washington County had to suspend ACEs/TIC workgroup meetings during the grant period due to the COVID-19 pandemic.

Toxic stress/Trauma/ACEs/Resilience Strategy #7:
Strengthen protective factors for individuals and families through support for programs that build parent capabilities, social emotional competence, supportive/nurturing relationships, and foster connection to community, culture, and spirituality.

Accomplishments – State level:
- The Title V lead coordinated a training in partnership with the Pacific Northwest-based Open Adoption & Family Services (OA&FS) on trauma-informed pregnancy options counseling and open adoption services in early fall 2021. Approximately 25 people attended, representing local Oregon MothersCare and home visiting programs. OA&FS also shared slides and presentation materials with local partners who were not able to join the webinar.

- State MCH Title V nursing staff supported implementation of nurse home visiting programs and systems across the state, including Babies First!, Family Connects Oregon, Nurse Family Partnership, and the partnership with OCCYHN's CaCoon program. This work involved supporting programs to shift their service delivery to telehealth and partnering with the Oregon Health Authority's Senior Health Advisor team to provide guidance about how to prioritize equity and safety during the COVID-19 pandemic. This work was accomplished through collaboration with the MCH Section's nurse team, as well as the MIECV team, and early childhood home visiting systems work groups.

Accomplishments – Local level:

- Harney County began training a nurse to become a home visitor in the CaCoon and Babies First! programs. The nurse completed training and conducted a few home visits in fall 2020.
- Jackson County was able to provide a small number of Babies First!, CaCoon and Nurse Family Partnership clients via Zoom or telehealth when possible. Many families served had been displaced by the historic Southern Oregon wildfires and were living in motels. Families were supplied with pack and plays because cribs were not available in temporary housing. The home visitors were also able to supply phones to some families who had been displaced by the fires.
- Washington County provided training for home visiting staff called "strategies for self-regulation as a component of compassion." A second professional development training was completed for all staff, including Healthy Families, Nurse Family Partnership, Babies First!, CaCoon and Family Connects nurses called "Being Culturally Responsive and Promoting Racial Equity in our Work with Families."
- Yamhill County reported a stronger retention of home visiting clients than expected, despite the COVID-19 pandemic. Nurses adapted practices to meet client needs, which were very different from previous years. All visits were provided virtually during the year. A partnership with the Early Learning Hub facilitated a change in the mental health support provided through Mothers and Babies program to a virtual, one-on-one format. The grantee advocated for more fast-track housing vouchers slotted specifically for MCH population. The grantee partnered with the local housing authority to support clients through the application process and then vet applicants within Public Health and HHS so that good quality/qualified applications were sent to the housing authority. Nurses worked one-on-one with families to address bureaucratic barriers, such as missing birth certificates, so that applications could be successful. The grantee recognizes how challenging these systems are for families and have tailored their work to help buffer these systems/communication issues for families.

Challenges/emerging issues:

- All local grantees expressed challenges related to the COVID-19 pandemic. Many Title V grantee staff were diverted to their local COVID-19 response or experienced staff turnover. Although previous training and professional development in trauma-informed care principles helped Title V grantees to address client and staff trauma and toxic stress, some grantees reported that no one was fully prepared to meet the challenges of the complex trauma brought on by COVID-19 and regional wildfires during this grant cycle. This continues to be a challenge that Title V grantees will work to address in the future.
- Harney County reported that the nurse they had hired to support home visiting services quit in late 2020 and it took several months to refill the position. When another nurse was hired, she was pulled into the COVID-19 vaccination campaign and other COVID-19 community efforts. The grantee attempted to hire a nurse specifically for home visiting but did not receive any applicants for over a year. The program is currently on hold until the grantee has increased capacity.
- Jackson County reported a significant reduction in home visiting clients during the grant year because all MCH nurses were diverted to the local COVID-19 response. All home visits that were able to be completed were delivered via telehealth, except for some in-person visits to deliver supplies.
- Washington County reports that staff is in an "ongoing crisis mode" with the COVID-19 pandemic and other local emergencies. They need increased support, so county leadership has been working to share self-care options. Despite these efforts, staff report increasing burnout. Staff have continued to engage in reflective supervision and have built this practice into all teams as a standard practice.
- Yamhill County reports that different nurses have different levels of comfort with the housing component and how it integrates into nursing/home visiting practice. Poor communication between the housing authority, HHS and clients has also been challenging because all agencies have been overwhelmed by the COVID-19 pandemic. There is willingness and buy-in among leadership of these agencies, but access to the actual caseworkers who are delivering these services is limited.

Toxic Stress, Trauma, ACEs and Resilience: OCCYSHN Report

(10/2020 – 9/2021)

Strategy 1.1:

We will promote trauma-informed care for CYSHCN and their families by incorporating a family-informed, trauma-informed lens to our workforce development activities.

Activity 1.1.1. Develop OCCYSHN Internal Capacity
OCCYSHN staff took part in professional development activities related to family-informed, trauma-informed care. As we built internal capacity, we integrated our learning into our work with local public health authorities. For example, we hosted a community of practice on trauma-informed care for them. Additionally, we presented a didactic on trauma-informed care to ACCESS teams (Activity 3.2.1).

SPM ESM1.1:
The percentage of OCYSHN staff who complete at least one training about trauma-informed care.

Objective: By 2025, all OCCYSHN staff will complete at least one training about trauma-informed care.
Progress: At baseline (FY2020), 47% (8) of OCCYSHN's 17 staff had participated in at least one training about trauma-informed care. As of June 15, 2022, 70% (14) of our 20 staff had participated in at least one.

Activity 1.1.2. Develop Expertise on Pediatric Medical Trauma and CYSHCN
Plans were developed to pursue research on the topic of pediatric medical trauma in the coming grant year. In preparation, OCCYSHN's Family Involvement Program manager and an ORF2FHIC staff member were trained to use the OHSU library literature search service. ORF2FHIC disseminated (via newsletter, Facebook, and website) resources for families to help children manage anxiety about medical procedures. Examples include the Simply Sayin' App, Autism Speaks' Blood Draw Toolkit, and "Just for Me" (stories about COVID-19 vaccines). We established a folder in the OCCYSHN shared resource library to house articles and other materials on the subject of pediatric medical trauma. This resource library is available to all OCCYSHN staff.

Activity 1.1.3. Workforce Development
In collaborative OCCYSHN/OHA communities of practice, CaCoon home visitors shared strategies for mitigating pandemic-associated trauma for families of CYSHCN.
OCCYSHN shared trauma-informed resources internally and with LPHA partners. The data equity workgroup convened by CaCoon and Babies First! staff included efforts to ensure that data collection language was trauma-informed. We also started discussion about developing a cross-systems care coordination quality improvement tool, which will include strategies for trauma-informed care.

Culturally and Linguistically Responsive Services (CLAS): OHA MCAH Report
(October 2020 – September 2021)

State Performance Measure 2:
1. Percentage of children ages 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs. Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care.

Trends in SPM Data:
SPM 2A. The 2019-2020 National Survey of Children's Health reports that Oregon's rates of doctors showing sensitivity to their culture and values is comparable to national rates. Latinx families in Oregon experience cultural responsiveness from their doctors at a lower rate than Latinx families nationally (OR- 61%, US 66.1%). Black communities in Oregon experience a higher rate of cultural sensitivity from doctors than the national average (OR 88.7%, US 71.3%). Data from the 2018-2019 report suggests that cultural responsiveness among medical providers has decreased over time.

SPM 2B. Oregon PRAMS data is the source for this measure. In 2017, 10.9% of families reported experiencing discrimination in a health care setting, and in 2018 and 2019, fewer families reported this experience (9.7% and 9.4%, respectively). Oregon PRAMS 2020 data reported a slightly higher rate of discrimination in a health care setting (9.9%). Although it increased slightly in 2020 there is still an overall downward trend since 2017, which suggests that these experiences are decreasing over time. This is the last year that this measure will be reported, as it has been discontinued for future grant years.

Culturally and Linguistically Responsive Services Strategy #1:
Develop and improve organizational policy, practices, and leadership to promote CLAS and health equity.

Accomplishments – State level:
- State MCAH provided technical assistance and support to local grantees when requested, but for the most

part, this TA emphasized trauma-informed emotional support and resources for local leaders to help their staff manage their responses to being stretched too thin; attempting to fulfill grant obligations while also managing their local public health responses to the COVID-19 epidemic.

- State MCAH created a team for the next cycle called the Foundations of MCAH. This team combined the cross-cutting strategy work into foundational strategy areas to incorporate health equity, anti-racism and trauma-informed strategies across our state level work. This Foundations team consists of 5 Title V subject matter expert leads across 4 areas of work: Policy and Systems, Workforce Capacity and Effectiveness, Community, Individual and Family Capacity, and Assessment, Surveillance and Data.
- The Title V CLAS lead continued to participate in division wide efforts to improve policies and procedures to address systemic barriers to health equity. These efforts were focused on COVID-19 response, and several MCH staff provided support to statewide community engagement and equity teams tasked with reaching disproportionately impacted populations throughout the state. As the COVID-19 emergency response shifted into a recovery response, MCH Title V staff re-engaged with the broader Public Health Division Health Equity Workgroup to identify next steps for structuring equity work on the division level.
- The MCH Health Equity Workgroup continued to meet throughout the grant cycle and shifted focus to include everyone in MCH. The workgroup time became a place for MCH staff to come together and share progress and ideas on health equity strategies.
- Throughout this grant cycle, MCAH contracted with Engage to Change- an external contractor who focuses on organizational shifts towards implementing strategies to improve health equity. During this grant cycle, monthly meetings consisted of level setting and trust building among MCAH staff, and is continuing examining and breaking down barriers to systemic change.
- The state MCAH efforts on improving our website information on health equity and anti-racism strategies are still in need of work. Since we have focused on a variety of other areas of our work, our website has taken a back seat and requires more work in our next grant cycle.

Accomplishments – Local level:

- Lincoln County hired a bilingual Community Health Worker to increased outreach efforts to women that speak Spanish and provided 356 interpretation services. They also contracted with a Mam speaking interpreter to provide 155 instances of linguistically appropriate services. Providing consistent language access increased engagement and trust with Spanish speaking and Guatemalan communities. Beyond interpretation services, their CHW provided over 250 additional case management services to the Guatemalan families.
- Coos County formed an internal equity committee to establish a set of equity hiring questions for use across the agency and they are currently working on an equity tool for reviewing policies and procedures across the agency. Coos County Health and Wellness (CHW) added 3 additional Spanish speaking employees during the reporting period and purchased 2-way radio interpretation devices for when bilingual staff are not available. In response to COVID-19, CHW formed a vaccine equity committee focusing on outreach to communities of color, with an emphasis on the Latinx community. CHW added a new position – Health Equity and Promotion Specialist - with funding from MCH Title V and Public Health Modernization. The work of this position will be focused on equity across CHW.
- Multnomah County continued work with Indigenous families through the Future Generations Collaborative (FGC), which centered traditional values and collaboration in the prevention of Fetal Alcohol Spectrum Disorder (FASD). Due to COVID-19, they added supports and technical assistance beyond the Department of Human Services to more direct client and case manager support. Multnomah County MCH has also continued to support the Multnomah County Maternal and Child Health Task Force to identify and address gaps in services to vulnerable families. Additionally, they have continued to provide tribal and urban education support for CHWs, case managers, home visitors and families impacted by FASD.

Challenges/emerging issues – State level:

- COVID-19 impacted, and continues to do so, the types of support and technical assistance local grantees needed from our state level staff.
- State level work on CLAS standards and health equity work didn't stop during COVID-19, although it did look different. We worked on evaluating our efforts, including analyzing our progress thus far and what has worked well and what hasn't. This analysis of our past efforts provided the opportunity to re-engage with our action plans and identify our next areas of work (including data and surveillance, and increasing our capacity in community engagement).

Challenges/emerging issues – Local level:

- Lincoln County: COVID-19 was the challenge! Teaching Perla virtually and then providing those services virtually or by phone!
- Coos County: Challenges include the varying comfort levels of staff that impact participation and progress in areas of CLAS and health equity. They will continue in the next cycle to support spaces for

listening/understanding multiple points of view while moving this work forward.
- Multnomah: Although developing collaborative circles of care has been made more challenging without being able to be face to face frequently, providers and families are expressing appreciation for the virtual, phone, and physically distanced in person experiences they can have. Providers continue to seek technical assistance and problem solve with the FGC.

Culturally and Linguistically Responsive Services (CLAS): OCCYSHN Report
(10/2020 – 9/2021)

Strategy S2.1.
We will improve CYSHCN and their families' access to culturally sensitive and responsive care through workforce development.

Activity 2.1.1. Workforce Development
Community health workers (CHWs) can provide care that is both culturally-sensitive and responsive. OCCYSHN developed a novel online course for CHWs: Supporting Families: Navigating Care and Services for Children with Special Health Needs (Activity 12.1). This course will increase the capacity of the CHW workforce serving families of CYSHCN, introducing principles and practices to improve the health and well-being of CYSHCN and their families.

CaCoon and OHA hosted two communities of practice to improve workforce knowledge about culturally sensitive and responsive care: a) Reproductive Health Equity and b) Support and Care Coordination for Gender Diverse Individuals. We also provided participants with linguistically appropriate resources via an online collaboration platform.

The data equity workgroup convened by CaCoon and Babies First! assessed and addressed the cultural appropriateness of the data collection tools used with families in these public health home visiting programs (Activity 11.4).

OCCYSHN held our annual regional meetings with LPHAs virtually. The Assessment and Evaluation unit presented its work on antiracism at these regional meetings, and led discussions with CaCoon home visitors.

OCCYSHN's Systems and Workforce Development unit used Activate Care as a virtual care coordination platform for the PACCT Project (Activity 11.2). We communicated to Activate Care leadership specific changes that would improve the platform's cultural sensitivity and responsiveness. We expanded OCCYSHN's stock photography options with the Inclusive Stock Photography collection from the Adolescent Health Initiative. The photos reflect diverse depictions of gender identity, sexual orientation, race, ethnicity, religion, socio-economic status and ability.

SPM ESM2.1:
Culturally-specific community-based organizations reviewed our cross-systems care coordination (CSCC) strategies, and OCCYSHN modified strategies based on organization feedback (yes/no).

Objective: By 2025, we will have adapted or modified our CSCC on the basis of feedback from at least two culturally-specific community-based organizations.

Progress: This objective is still in progress. In our efforts to improve systems of care for CYCSHN, we endeavored to be accountable to BIPOC communities and to other underserved populations, including LGBTQIA+ people. We continued internal and external efforts to promote health equity. We embraced cultural humility and sought guidance from diverse stakeholders. We shared learning with our partners through training, dissemination products, and communities of practice.

Activity 2.1.2. Promotion of Culturally Appropriate Health Care
OCCYSHN promoted culturally sensitive and responsive health care through workforce development support to LPHAs (Activities 11.1-11.4).

OCCYSHN's Assessment and Evaluation Manager (Alison Martin, PhD) served as research mentor to Mr. Charles Smith, MSW, during his 2020-2021 Leadership Education in Neurodevelopmental and Related Disabilities (LEND) fellowship. Mr. Smith served as the Associate Project Director for the Sickle Cell Anemia Foundation of Oregon's 2019-2020 participatory needs assessment (PNA) study contract with OCCYSHN. Mr. Smith proposed to Dr. Martin a project focused on identifying and promoting clinics that implemented culturally-responsive care practices. OCCYSHN incorporated this idea into its 2021-2025 five year plan. Mr. Smith's LEND project sought to advance this Title V CYSHCN activity by conducting a literature search to identify clinic-level assessments of culturally responsive care. Few such assessments were found. Mr. Smith and Dr. Martin began outlining a scope of work to develop such an assessment in partnership with the Latino Community Association (OCCYSHN's other PNA partner) and families

and young adults with special health care needs who are members of Black and Latino communities.

Activity 2.1.3. Multicultural Organizations
The Oregon Family to Family Health Information Center (ORF2FHIC) expanded outreach to immigrant families of CYSHCN. We collaborated with two community-based organizations serving immigrants from Africa: The African Youth Community Organization and African Family Holistic Health Organization (Activity 11.5). We also served as a member of the Portland-based Refugee Emotional Support Task Force, where we offered CYSHCN-related information and resources to social workers and administrators who work with immigrant families.

ORF2FHIC contracted with the Immigrant and Refugee Community Organization, a local CBO, for interpretation services for family support phone lines. They primarily interpreted calls in Cantonese, Mandarin, and Vietnamese. We also re-established partnership with Unete, a farmworker advocacy program in Southern Oregon, to provide cultural broker services. They review ORF2FHIC materials for cultural appropriateness, and make recommendations for improvements. They also translate ORF2FHIC toolkits, training materials, and tip sheets.

ORF2FHIC collaborated with organizations and programs serving multicultural and culturally-specific families. These included the Sickle Cell Anemia Foundation of Oregon, Unete, Hands and Voices, Grandparents as Caregivers, and Lutheran Community Services Northwest. We reciprocally referred families and disseminated program resources and information. We developed a listserv to share information with 20 professionals serving Spanish-speaking families with limited English proficiency. Listserv members include bilingual staff at the Northwest Down Syndrome Association, Autism Society, Family and Community Together Oregon, and the Oregon Family Support Network.

ORF2FHIC supported a new F2FHIC in American Samoa with materials and suggestions for outreach and community-building. Their F2FHIC serves as a resource to us for supporting Samoan families with CYSHCN in Oregon. We provided Spanish-language materials to the Virginia Garcia Health Center. They provide health care to migrant and seasonal farm workers in Oregon, and we discussed co-sponsoring trainings there for families of CYSHCN.

OCCYSHN's Assessment and Evaluation unit continued work with SCAFO and the Latino Community Association to disseminate findings from the 2020 Five Year Needs Assessment. We jointly presented findings at an OHSU Department of Pediatrics Grand Rounds, to educate health care professionals about racism experienced in the health care system by Black and Latino/x families of Oregon.

Activity 2.1.4. OCCYSHN Equity Workgroup
OCCYSHN's Equity Workgroup monitored progress on CLAS objectives, supported CLAS-related efforts across projects and programs, and ensured CLAS principles were integrated into OCCYSHN efforts.

According to the Racial Equity Stages developed by Dismantling Racism (www.dismantlingracism.org), internal growth is an important phase of racial equity practice that informs external efforts. In that spirit, the Equity Workgroup took steps to educate ourselves and examine the impacts of racism.

Each Equity Workgroup meeting included a discussion about research on equity-related subjects, including Asian-American stereotypes and the "model minority" myth, improving culturally appropriate care using a community-based participatory research approach, and physicians' perceptions of people with disability and their health care. Discussion included how we could apply our learning to OCCYSHN's work.
The Equity Workgroup presented to OCCYSHN staff quarterly on equity-related topics, and facilitated discussion following the presentations. One presentation introduced OHSU's Inclusive Language Guide (an evolving document about appropriate terms related to sexual orientation, gender identity, race, and ethnicity). Another presentation covered data on the impacts of COVID-19 on CYSHCN of color.

The Equity Workgroup fine-tuned the process for tracking and supporting OCCYSHN's CLAS activities to make it more efficient. OCCYSHN managers reviewed CLAS activities quarterly, and requested support from the workgroup as needed. Revisiting OCCYSHN's CLAS goals and activities regularly helped ensure an ongoing focus on equity, and helped us integrate our learning into our work. Additionally, OCCYSHN implemented a policy requiring new hires and hiring managers to complete a training on unconscious bias.

Activity 2.1.5. Policy
OCCYSHN's Director, in his role as Vice Chair for Community Health and Advocacy for OHSU's Department of Pediatrics, supported institutional Equity, Diversity and Inclusion efforts. He secured funding to develop a national learning collaborative partnering children's hospital-based injury prevention programs with community-based organizations serving pregnant and parenting women from minoritized communities. The focus is on integrating

community health workers and nurse home visitors who are culturally and linguistically appropriate into promoting safe infant sleep. The Community Partnership Approaches for Safe Sleep (CPASS) program will be administered by the American Academy of Pediatrics.

OCCYSHN continued to partner with the Oregon Law Center, with a focus on addressing disparity in access to health and health care services and resources across the state. Much of the work focused on access to durable medical equipment, and addressing denials of service to those eligible for Medicaid or CHIP. We also continued our work with the All:Ready Network, whose mission is to transform early childhood by mitigating poverty, racism and ableism.
OCCYSHN, in partnership with Title V MCH, was instrumental in informing Oregon's application for 1115 waiver to CMS. One of our prime foci was the issue of the disparate impact of Medicaid on minoritized communities.

Activity 2.1.6. Assessment
In addition to the assessment and evaluation efforts detailed in Activity 11.8, Dr. Martin sat on MCHB's Six Core Outcomes Expert Steering Committee. She advocated for including measures of culturally responsive health care and discrimination experienced in health care. She also raised a concern about the ability of the National Survey of Children's Health to describe racially and ethnically minoritized populations of CYSHCN, because of small sample sizes. Due to competing priorities, Dr. Martin was unable to work on assessing OCCYSHN activities, beyond the CoIIN activities (Activity 12.2), using the Racism as a Root Cause Framework (Malawa et al, 2021), but that remains an OCCYSHN goal for future block grant years.

Social Determinants of Health and Equity: OHA MCAH Report
(October 2020 – September 2021)

State Performance Measure 3:
1. The percentage of children in low-income households with a high housing cost burden
2. The percentage of children living in a household that received food or cash assistance
3. The percentage of households with children < 18 years of age experiencing food insecurity

Trends in SPM Data:
SPM 3A. Data from the American Community Survey show 68% of children in low-income households have a high housing cost burden. This data is reported for only one year, because it was a new SPM that was subsequently discontinued.

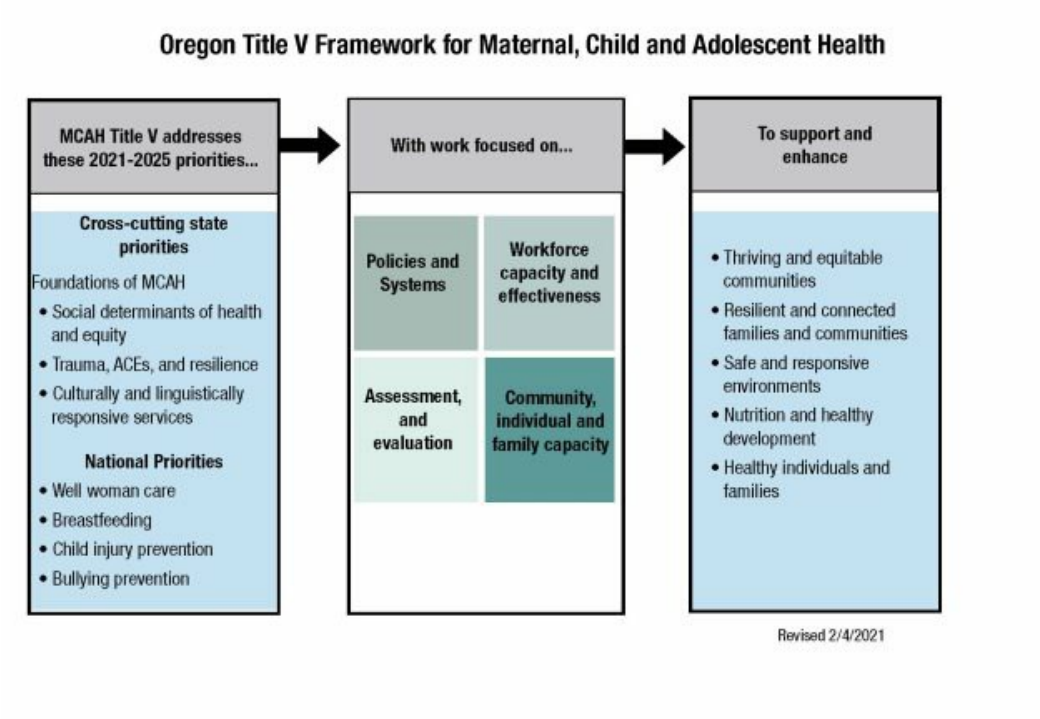
SPM 3B. The percentage of children living in a household that received food or cash assistance increased from 42.3 to 43.3% between 2019 and 2020. This reflects National Survey of Children's Health data from 2018 and 2019. This high level of need among children is concerning and an indicator of the need to focus on basic needs of the MCH population, especially as we anticipate that these needs have only increased during the pandemic (data which is not yet reflected in these numbers).

SPM 3C. Data for the percent of households with children <18 years of age experiencing food insecurity was tracked during the past 5-year Title V cycle, and in the first year of this cycle. However, the USDA data from 2003-11 was expected to be updated periodically and this has not yet happened, making it impossible to track updates and trends. The SPM has been discontinued.

Social Determinants of Health and Equity Strategy #1:
By October 2020, determine state Title V staffing for and develop a cross-cutting Title V priority team to address upstream drivers of Maternal and child health, and link work across population domains and state priorities (SDOH-E, trauma and ACEs prevention, CLAS). The team will research, develop, adapt or adopt an overarching theory of change for the work, in collaboration with the Injury Prevention and Women, Infants and Perinatal health teams.

Accomplishments:
- The MCAH Title V staff spent the Fall of 2020 in a series of retreats focused on developing a new structure for the Title V program's 2021-2025 cycle priorities.
    - Key goals of the re-designed structure were to de-silo our upstream SDOH-E, trauma and ACEs Prevention and CLAS work in recognition of the inherently inter-connected nature of these topics, as well as to facilitate integration of the SDOH-E, Trauma and ACEs prevention and CLAS work into the NPM work in the domains.
    - A decision was made to weave together implementation of the 3 upstream state priorities in a "Foundations of MCAH" priority that would focus work across the 4 key areas of: policy & systems;

workforce; community, individual and family capacity; and assessment & evaluation.
    - The new operating structure also involved the creation of 3 cross-cutting team to further integrate Title V work across priorities. The teams are: Foundations of MCAH (SDOH-E,Trauma and ACEs prevention, and CLAS); Injury Prevention (child injury prevention and bullying prevention), and Women Infant and Perinatal Health (well woman care and breastfeeding, and Oregon MothersCare)
- State level Title V leads were assigned to each of the 4 national priority areas. Since work on our 3 state specific priorities is integrated into the Foundations work as well as into each of the NPM priorities, the Foundations team jointly developed strategies in the areas of policy & systems; workforce; community, individual and family capacity; and assessment & evaluation. These strategies were then refined and cross-walked with the NPM priority strategies as staff retreats. Staff leads were assigned for each Foundations Strategy, with responsibility support implementation of the strategy across both state and local level work.
- A new theory of change document linking all Title V priorities to the Foundations work, showing the 4 major areas of work for all strategies, and high-level outcomes was developed to illustrate how the new structure with its focus on upstream determinants would work to move the needle on Title V priorities across the domains.



Challenges/emerging issues:
Limited staff capacity and the remote work environment necessitated by the ongoing COVID-19 Pandemic were the primary challenges to accomplishing this work. Team-based strategic thinking and planning work that would have normally been done in person had to be re-imagined and re-structured for the virtual environment. Some regular staff were on long-term COVID-19 assignments, so the work had to be done by those available.

Social Determinants of Health and Equity Strategy #2:
By December 2020, develop evidence-based/informed strategies and measures for SDOH-E – including strategies that address upstream drivers of maternal, child and adolescent health. Strategies will address both state and local levels work. Engage local Title V grantees and family and community representatives in the process.

Accomplishments:
- Evidence-informed strategies, measures, and suggested activities for SDOH-E were developed and integrated into the policy & systems; workforce; community, individual and family capacity; and assessment & evaluation areas of the Foundations of MCAH work during Oct – Dec 2020.
- The Foundations strategies were also cross-walked with work in the 4 NPM priority areas to ensure integration of the upstream Foundations of MCAH approach across all the Title V work.

Challenges/emerging issues:
The primary challenge to achieving this work was our very limited ability to engage local Title V grantees and other

community members in the initial strategy development due to the COVID-19 pandemic. Local Public Health and tribes, as well as community-based organizations were extremely thin on capacity and focused on meeting the COVID-19 related needs of their communities. Guidance from State Public Health Leadership to all programs was to respect this and ask only essential engagement from our local partners. Therefore, initial strategies were developed by state Title V staff, and local grantees were engaged in modifying them and developing related activities during the TA process to introduce the new cycle Title V priorities and approaches.

Social Determinants of Health and Equity Strategy #3:

By February 2021, develop and adopt a logic model for the Title V's SDOH-E work.

Accomplishments:

After surveying local grantees about the usefulness of a logic model for their work, it was decided that this strategy was not priority to implement. Grantees asked instead for a focus on workshops and technical assistance related to the new strategies, the upstream drivers of maternal and child health, and a the cross-cutting theory of change that supports the work. These TA sessions were delivered in February 2021 and followed up with technical assistance as described in strategy 5 below.

Challenges/emerging issues:

NA – see above

Social Determinants of Health and Equity Strategy #4:

By March 2021, begin implementation and tracking of Title V's state level strategies for SDOH-E; collect/track outcomes through monitoring SPMs.

Accomplishments:

- Implementation and tracking of state level strategies for SDOH-E was initiated as soon as the Foundations strategies were finalized in December 2020.
- Initial state level Foundations strategy implementation focused on a combination of support and TA for local grantees as described in this report, and development of the partnerships and collaborations, as well as environmental scans, assessments and plan development needed to build the Title V work in this new Title V priority area.

Challenges/emerging issues:

Challenges to implementing this strategy are the same as those cited for Strategies 1 and 2 above.

Social Determinants of Health and Equity Strategy #5:

By March 2021, provide technical assistance on new SDOH-E strategies and measures to Title V grantees on to inform local level priority selection, planning and implementation.

Accomplishments:

- Title V grantees were surveyed in December 2020 about their technical assistance needs related to implementation of the new 5-year Title V priorities, as well as their preferred methods for receiving TA and support for their Annual Plan development considering ongoing COVID-19 related pressures.
- Based on grantee feedback, a series of TA webinars was developed – focused on both the new upstream Foundations of MCAH approach, and the specifics of the priorities, strategies, measures, priority selection and annual plan development process.
- Title V TA webinars were held on the following dates and topics:
    - Overview webinar – Feb 18, 2021
    - Foundations of MCAH – Feb 22, 2021
    - Injury team webinar – Feb 26, 2021
    - Women's and Infants team webinar – Feb 25, 2021
- In addition to the live TA webinars, the following TA materials and supports were provided to grantees to assist them in selection of the priorities for their Title V Annual plans:
    - Recordings of each webinar were made available to grantees on Oregon's Title V MCAH website.
    - Strategy, activity, and measure tables were provided for each priority.
    - Links to additional resources for each priority were provided.
    - A planning worksheet was provided to help step them through the process of assessing community need, and selecting which priorities/strategies/activities to focus on.
    - Title V leads for each priority/strategy were available for one-on-one consultation.

Challenges/emerging issues:
Challenges to implementing this strategy are the same as those cited for Strategies 1 and 2 above.

Social Determinants of Health and Equity Strategy #6:
April - June 2021, review and provide TA to local Title V Grantees on implementing SDOH-E in their annual plans for July 2021– June 2022.

Accomplishments:
- State Title V staff assisted grantees with individual plan development and submission through one-on-one Zoom calls conducted during March and April 2021.
- State Title V staff reviewed all local grantee annual plans during May and June 2021, and proved a TA call for each grantee, as well as written feedback on each of their plans' priorities and strategies.
- Ongoing TA for plan implementation was provided to all grantees as needed/requested to assist in implementation of the new priority work beginning July 1, 2021.

Challenges/emerging issues:
Challenges to implementing this strategy are the same as those cited for Strategies 1 and 2 above.

Social Determinants of Health and Equity Strategy #7:
July 1, 2021 through September 30, 2021- Title V grantees will implement local level strategies and collect/track outcomes.

Accomplishments:
- Work on SDOH-E is woven into the new MCAH Title V Foundations strategies as described above.
- In their FY 2022 plans (July 1, 2021-June 30, 2022), local Title V grantees selected to work on a variety of Foundations of MCAH strategies across all 4 focus areas as follows: Policy & Systems (14 grantees dedicating $264,562); Workforce (9 grantees dedicating $199,314); Community, individual and family capacity (9 grantees/$522,641); and Assessment and Evaluation (3 grantees/$30,051).
- Implementation of this work began July 1, 2021 and will continue through June 20, 2022. Grantees will report on this work in their MCAH Annual Title V reports due in September 2022.

Challenges/emerging issues:
Challenges to implementing this strategy are the same as those cited for Strategies 1 and 2 above.

Social Determinants of Health and Equity: OCCYSHN Report
(10/2020 – 9/2021)

Strategy S3.1:
We will increase access to care and supports by investigating barriers that inhibit CYSHCN and their families' timely access, and we will develop family-informed activities to reduce or eliminate the barriers.

Utilizing an equity lens, we will work with our state and county partners to identify systems-level disparities. We will leverage our partnerships with local public health authorities, OHA and other state-level systems to collaboratively develop and implement interventions that mitigate those inequities.

Activity 3.1.1. Barriers to Receipt of Care
OCCYSHN engaged in several activities to address barriers to the receipt of care for CYSHCN. Medicaid redetermination is an exceptionally burdensome process for families of CYSHCN, requiring that they fill out a complex, 40-page form. ORF2FHIC staff presented the CYSHCN family experience to Oregon Health Plan Ombudsperson staff. OCCYSHN's Director led the development of a Developmental Pediatrics Collaborative, with leadership of the Portland area Children's Health Alliance (Activity 3.1.2). The collaborative seeks to reduce family wait times for autism evaluations provided by Portland metro-area health systems, and includes a Systems and Workforce Development Implementation Specialist. Lastly, we made progress toward our ESM as described below.

SPM ESM3.1:
We will complete root cause analyses for (a) DME by December 2021, (b) Autism Evaluation by June 2022, and (c) Respite care by June 2023 (yes/no).

Objective: By 2025, we will have completed root cause analyses of the barriers that inhibit CYSHCN and their families from timely access to DME, autism evaluation, and respite care.

Progress: OCCYSHN's Assessment and Evaluation Unit will present our DME root cause analysis to OCCYSHN's leadership team by September 2022, and we began a respite care root cause analysis. The

Developmental Pediatrics Collaborative continued work on streamlining autism evaluation screenings by addressing institutional barriers.

Activity 3.1.2. Systems and Policy
OCCYSHN's Director led the establishment of a Medical Legal Partnership (MLP) in OHSU's neonatal intensive care unit (NICU), the first MLP in the nation focused on serving infants and families from the prenatal to the postnatal period. The MLP instituted universal screening for social determinants/impactors of health for caregivers of all infants admitted to the NICU. Social workers review all screens, identify those in need of assistance, and meet regularly with MLP staff (two physician champions and two MLP attorneys) to identify clients. Because poverty is the leading risk factor for premature birth, patients often face issues with housing, employment, insurance, immigration status and domestic violence. During this reporting period, the MLP expanded services to include Maternal Fetal Medicine, which serves mothers whose pregnancy is complicated by a significant health condition of their fetus. Working with this population will allow the MLP to address issues prenatally, moving farther upstream to prevent toxic stress and potential adverse childhood events.

OCCYSHN continued to partner with the Oregon Law Center (OLC), a non-profit legal aid agency with a focus on addressing systems-level issues impacting children and families. Our common focus for this period was Early and Periodic Screening, Diagnostics and Treatment, in light of Oregon's waiver of that component of Medicaid, and the consequent rationing of healthcare to vulnerable populations. OCCYSHN convened regular meetings between the MLP and OLC to ensure work was aligned. Since the MLP work is focused on the interface of families and the health care system, and OLC works further upstream and at a broader systems level, we anticipate that their work will support synergistic approaches to mitigating social determinants of health for CYSHCN.

Activity 3.1.3. Strengthen and Leverage Existing Relationships
OCCYSHN collaborated with agencies and organizations across sectors to address systems-level issues affecting CYSHCN and their families. We worked with CCOs to address payment and coverage issues. In 2021, OCCYSHN's Director and staff brought together three major health systems that provide developmental/behavioral pediatric services, to begin coordinating and streamlining the referral and diagnostic process for children with developmental concerns, including autism (Activity 3.1.1). This represented the first time that these three systems were at the table together. OCCYSHN's Director continued to serve on the state's Patient-Centered Primary Care Home advisory committee, and was successful in elevating issues specific to pediatric medical homes. OCCYSHN partnered with Title V MCH as they worked with state Medicaid leaders to address disparities and inequities that impact children. This included our unique 1115 Waiver that allows Oregon to establish a prioritized list of covered services and eliminates some requirements of Early Periodic Screening Diagnosis and Treatment (EPSDT). We worked with health care providers and LPHAs to enhance the quality of pediatric medical homes, and with programs that train health and service professionals to ensure a sustainable workforce.

Strategy S3.2:
OCCYSHN will increase access to community-based autism diagnostic services through implementation of community-based autism evaluation teams.

Activity 3.2.1. Assuring Comprehensive Care through Enhanced Service Systems (ACCESS)
OCCYSHN established eight ACCESS teams in Oregon from 2013-2016, with a HRSA grant. The teams perform community-based autism evaluations for children up to age five, provide a medical diagnosis, and establish educational eligibility for autism services. ACCESS teams reduce wait times for evaluation, decrease the need for families to travel to tertiary care centers, and connect children and families to services earlier.

The ACCESS planning team met regularly during this reporting period, to ensure that teams continued to develop in alignment with project goals. Seven teams provided evaluations, an increase of one team from the previous reporting period. OCCYSHN supported teams with a) increased dedicated OCCYSHN FTE; b) professional development opportunities; c) technical assistance site visits; and) financial support. OCCYSHN provided virtual support for existing ACCESS teams and other interested providers. The newest team is in Tillamook. OCCYSHN also helped providers in Bend and Clatsop who sought guidance on establishing collaborations between health and education professionals in their areas.

OCCYSHN trained thirteen medical providers and clinicians to use the STAT autism evaluation tool, including a new provider who joined an existing ACCESS team, and multiple providers in the Bend area. This aligns with our goal to increase the capacity of health care providers to evaluate children (to age 5) for autism.

OCCYSHN formed an ACCESS provider special interest group. The group, facilitated by the ACCESS Project's medical director, met to discuss successes, challenges, and lessons learned from their autism evaluation

experiences. The group provided mentorship and technical assistance to new ACCESS providers.

SPM ESM3.2: Change in number of teams over time.
Objective: By 2025, we will expand the number of Autism Evaluation Teams by 5%.
Progress: During FY20, we had six Autism Evaluation Teams operating in Oregon. We added one team during FY22, which represents an increase of 17%.

Activity 3.2.2. ACCESS Family Involvement
The Family Involvement Program (FIP) manager participated in ACCESS leadership meetings and ECHO sessions. She shared her experience as the parent of a child with ASD. She also had time on each agenda to disseminate family and community resources. She trained 25 members of the Northwest Regional Education Service District autism team on accessing resources for family members of CYSHCN, and on using the Oregon Family to Family Health Information Center. She met individually with Parent Partners (family members of children with ASD who sit on ACCESS teams) from three ACCESS teams. She also provided technical assistance to team leaders on recruiting, hiring, and using Parent Partners in their ACCESS work.

The FIP manager worked closely with Dr. Lark Huang-Storms, the ACCESS Project's medical director, to draft a toolkit for parents about the intricacies of ASD evaluation in Oregon. This toolkit will help families understand the differences between medical and educational autism evaluations.

Activity 3.2.3. ACCESS Equity
Because racism and other forms of discrimination affect the health of Oregon CYSHCN, the ACCESS program prioritized access, equity, and inclusion in efforts to improve access to community-based autism evaluation for CYSHCN. ACCESS addresses equity by improving access to health care for rural CYSHCN.

An OCCYSHN staff member attended the ECHO Immersion Training at the University of New Mexico. OCCYSHN used the ECHO model to provide a ten-month case-based learning collaborative for ACCESS participants. ECHO session topics included trauma and IDD, promoting equity for LGBTQIA+ youth with autism, and materials for families with limited English proficiency.

Activity 3.2.4. Systems and Policy
The ACCESS Project disseminated materials to broaden the project's reach by expanding the number of teams and aligning with other systems of care. We promoted care coordination and integration for CYSHCN. We continued our advocacy for a coordinated and unified statewide process for autism diagnosis and eligibility. We identified the need for dissemination products teams could use to raise awareness of their work in the community, and began strategizing about what products are needed and how to develop them.

OCCYSHN's Director led the formation of a Developmental Pediatrics Access Collaborative to help address the shortage of diagnostic evaluation for autism in Oregon, as noted above (Activity 3.1.2).

Strategy S3.3:
We will improve agencies' knowledge of and ability to respond to CYSHCN and their families during an emergency or disaster response.

Activity 3.3.1. Assess Emergency Preparedness
OCCYSHN worked with local public health authorities to address gaps in emergency preparedness for families with CYSHCN. We contributed our expertise about CYSHCN to emergency planning efforts.

To better understand the needs of CYSHCN during an emergency, Oregon Family to Family Health Information Center (ORF2FHIC) and OCCYSHN conducted a virtual listening session with eight families of CYSHCN from across Oregon. We recruited people whose children are medically complex, and/or experience communication challenges. Using a trauma-informed approach, we discussed scenarios in which families might be required to evacuate their homes (like wildfire or extreme weather) and scenarios in which they would need to shelter in place (like an earthquake). We sought suggestions for systems-level improvements, so that we might use family wisdom to inform policy efforts. With learnings from this listening session, we worked with the Oregon Health Authority's Medical Surge Planner, sharing family experiences of gaps and barriers, and offering recommendations. Family members who participated received a stipend and an Oregon-specific emergency preparedness resource guide to thank them for their advocacy and expertise.

ORF2FHIC made available upon request hard copies of the Oregon Office on Disability and Health's emergency preparedness publication. We featured family-centered emergency preparedness resources on our website, and we

made regular ORF2FHIC Facebook posts on the subject of emergency preparedness.

SPM ESM3.3:

Number of hospital, county, and regional emergency preparedness plans that integrate the needs of CYSHCN and their families (yes/no).

Objective: By 2025, five hospital, county, or regional emergency preparedness plans, which previously did not integrate the needs of CYSHCN and their families, will do so.

Progress: At FY20 baseline, we had no knowledge of any hospital, county, or regional emergency preparedness plans that integrated the needs of CYSHCN and their families. COVID-19 limited our ability to collaborate with local partners to address emergency planning during FY21 and FY22. We may need to retire this SPM because it is infeasible. We do not have access to hospital or regional plans to potentially influence. After exploring county plans we have realized that many of them are similar to each other, following a template that does not leave room for community-specific planning. We do not anticipate any change at the LPHA-level until there is leadership buy-in.

Toxic Stress, Trauma, ACEs and Resilience: OCCYSHCN Plan

(10/2022 – 9/2023)

Strategy 1.1:
We will promote trauma-informed care for CYSHCN and their families by incorporating a family-informed, trauma-informed lens to our workforce development activities.

Activity 1.1.1. Develop OCCYSHN Internal Capacity
OCCYSHN will continue building internal capacity to support the workforce in providing trauma-informed care. We will take part in educational opportunities to build understanding of trauma-informed cross-systems care coordination. We will provide training on the topic to the LPHA workforce and ACCESS teams.

Activity 1.1.2. Develop Expertise on Pediatric Medical Trauma and CYSHCN
The National Child Traumatic Stress Network defines pediatric medical trauma as a "set of psychological and physiological responses of children and their families to pain, injury, serious illness, medical procedures, and invading or frightening treatment experiences that may occur as a response to a single or multiple medical events." OCCYSHN will engage in professional development activities to integrate components of pediatric medical trauma, and specifically its effects on children from Black communities, into our work flow and programming. The Oregon Family to Family Health Information Center (ORF2FHIC) will connect with other states' F2FHICs to request and review samples of their family materials on the subject. We will consult with two of OHSU's nationally-recognized experts in trauma associated with pain (Drs. Anna Wilson and Amy Holley), and with experts from Trauma-Informed Oregon (a collaborative organization that shares information and resources). We will integrate our learning into action on behalf of CYSHCN. Future strategies may involve training OCCYSHN's public health partners on the subject, or disseminating useful materials to families and providers to help reduce the potential for trauma in medical settings.

Activity 1.1.3. Workforce Development
OCCYSHN will review and modify cross-systems care coordination processes to align with principles of trauma-informed care. We will continue developing and promoting the Family Shared Care Planning Assessment, which includes strategies for operationalizing trauma-informed care. We will provide technical assistance to CaCoon home visitors on using the assessment. We will also continue OCCYSHN/OHA communities of practice for the home visiting workforce, and we will include trauma-informed care in the topics addressed.

Culturally and Linguistically Responsive Services (CLAS): OCCYSHN Plan

(10/2022 – 9/2023)

Strategy S2.1.

We will improve CYSHCN and their families' access to culturally sensitive and responsive care through workforce development.

Activity 2.1.1. Workforce Development
OCCYSHN evaluated the community health worker (CHW) course we developed for its relevancy and usefulness to culturally-specific CHWs in community-based organizations. Results were very encouraging. We will use the results, and our experience, to maximize the course's accessibility, thereby strengthening the capacity of the culturally-

specific workforce to serve families of CYSHCN.

We will explore collaborations and partnerships that can teach us more about culturally sensitive care coordination for CYSHCN of color. We will seek opportunities to work with partner organizations to offer training opportunities about health equity to CHWs and LPHAs.

Activity 2.1.2. Promotion of Culturally Appropriate Health Care

OCCYSHN will promote (a) culturally sensitive transition to adult health care, and (b) culturally sensitive health care more broadly. Our learning about culturally sensitive transition to adult health care will be incorporated into our clinical quality improvement activities; educational presentations for family, youth, payers, and providers; and discussions with OHA's Health Policy and Analytics Division staff. CoIIN partners Mr. Charles Smith and Dr. Claudia Bisso-Fetzer (Activity 12.2) will continue to facilitate OCCYSHN's collaboration with family and youth leaders from Black and Latinx communities.

Our learning about culturally sensitive health care generally will be incorporated into a presentation for payers, providers, and professional interpreters working in Central Oregon. We will collaborate with the Latino Community Association, Dr. Bisso-Fetzer, and family and youth leaders to prepare the presentation.

Activity 2.1.3. Multicultural Organizations

The Oregon Family to Family Health Information Center (ORF2FHIC) will expand connections with culturally-specific community-based organizations (CBOs), to support and inform their staff who work with families of CYSHCN. We will continue our work with the African Youth and Community Organization's Bridge Program per their request. We will continue to be active members of the Portland-area Refugee Emotional Support Task Force. We will reconnect with the African Family Holistic Health Organization to see if we can convene a second family listening session, to hear more from African families of CYSHCN. We will follow up on initial conversations with Oregon's newest refugee resettlement agency (Salem for Refugees) to offer resources and information. We will continue conversations with Consejo Hispano (a CBO in Washington County) about collaborating on a Health Care Advocacy family training in Spanish. We will contract with a CBO in Southern Oregon to coordinate trainings and Table Talks.

ORF2FHIC will explore co-hosting a virtual training for F2F staff in Washington, Idaho, and California to learn from the Washington-based Open Doors for Multicultural Families. We will continue contracting with trusted cultural brokers to provide translation and interpretation services for family support and training. We will partner with the Refugee Emotional Health Task Force to post and disseminate their "Oregon Welcomes You" refugee healthcare navigation map. This document provides a template for refugees seeking to establish care for themselves and their CYSHCN.

To explore the breadth and richness of Oregon's multicultural communities, and to inform our outreach strategies, ORF2FHIC will develop a database of culturally-specific CBOs that primarily serve families. We also plan to reach out to approximately five culturally specific, family-serving CBOs for the first time. If they are interested, we will collaboratively translate family products for them to share with their clientele. We will also offer to collaborate with them on family trainings.

Activity 2.1.4. OCCYSHN Equity Workgroup

OCCYSHN's Equity Workgroup will continue meeting quarterly. We understand learning about equity to be an ongoing process that includes both internal and external effort. We will continue our study of equity-related research relevant to CYSHCN, and our discussions about how we might apply learning to OCCYSHN efforts. The workgroup will present to OCCYSHN staff on equity-related topics on a quarterly basis. The workgroup will monitor OCCYSHN's progress on CLAS activities using a tool we developed for that purpose, and we will offer support for CLAS-related

efforts and projects. We will ensure that equity remains an ongoing and integrated priority across all OCCYSHN efforts.

Activity 2.1.5. Policy

Equity and justice will remain a central focus of OCCYSHN's policy efforts in 2023. OCCYSHN's Director, in his role as OHSU's Vice Chair of Community Health and Advocacy, will continue to lead work in OHSU's Department of Pediatrics and Institute on Development and Disability, in concert with the Vice Chair for Diversity, Equity and Inclusion. Much of the work will focus on training programs and curricula across OHSU, including inter-professional education. We will continue support the Medical Legal Partnership program in the Neonatal Intensive Care Unit, the only such program in the nation. We will partner with providers to improve access to behavioral health services, and to durable medical equipment for children and families in need. We will also continue advising a professional development peer-learning cohort focused on improving capacity for community engagement and systems change advocacy. The Director will co-lead the OHSU Gun Violence as a Public Health Issue task force, and will continue work with municipal leaders, including the District Attorney and head of the Office of Community Violence Prevention, to help address this epidemic. 2023 will be a long session of the state legislature. OCCYSHN will monitor legislation and provide input, comment and testimony.

Activity 2.1.6. Assessment

As part of the ongoing assessment of CYSHCN needs described in Activity 11.8, the Assessment and Evaluation unit will conduct analyses of National Survey of Children's Health data that disaggregate national priority and other health status measures by minoritized communities that include race/ethnicity and socioeconomic status. We will disaggregate data to the smallest "group" for which a sufficient sample exists. We also expect to collect data on access to culturally sensitive care as part of our participatory needs assessment with a community-based organization (CBO) that serves the Asian Pacific Islander community. We will finalize the research questions and data collection topics in partnership with the CBO.

Social Determinants of Health and Equity: OCCYSHN Plan

(10/2022 – 9/2023)

Strategy S3.1:

We will increase access to care and supports by investigating barriers that inhibit CYSHCN and their families' timely access, and we will develop family-informed activities to reduce or eliminate the barriers.

Utilizing an equity lens, we will work with our state and county partners to identify systems-level disparities. We will leverage our partnerships with local public health authorities, OHA and other state-level systems to collaboratively develop and implement interventions that mitigate those inequities.

Activity 3.1.1. Barriers to Receipt of Care

OCCYSHN's Assessment and Evaluation (A&E) Unit will complete a root cause analysis on barriers to accessing respite care for CYSHCN, informing an action plan based on the results, in the context of current Oregon policy. OCCYSHN's A&E Manager will present the root cause findings to the members of Oregon's Title V-Medicaid workgroup and lead collaborative approaches to addressing respite care barriers. OCCYSHN will also raise awareness about barriers to accessing durable medical equipment for CYSHCN, and seek opportunities to address these barriers.

OCCYSHN's Director and Systems and Workforce Development Implementation Specialist will continue to participate in the Portland-metro area Developmental Pediatrics Collaborative (Activity 3.1.2), working to improve

access to developmental pediatrics diagnostic and therapeutic services. OCCYSHN's Family Involvement Program Manager will continue to bring awareness to barriers experienced by CYSHCN and their families via her participation in Oregon's Medicaid Advisory Committee's "Advancing Consumer Experiences" subcommittee (Activity 11.5).

Activity 3.1.2. Systems and Policy

Title V leadership will continue our focus on equity by collaborating with Medicaid through our MOU. Our success in reinstating Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), which had for decades been waived via the 1115 Medicaid Waiver Process, will generate significant work. OCCYSHN's Director will serve on the Oregon Health Evidence Review Commission, the body charged with implementing EPSDT provisions, and this work will intensify over 2023. The behavioral health crisis will also remain a focus, and OCCYSHN's work on this issue with the Oregon Law Center, LPHAs, and child health providers across the state will continue. Access to diagnostic and therapeutic services for children with neurodevelopmental conditions and disabilities remains a grave concern, and we will continue our efforts to develop and nurture community-based capacity to address those needs. This will include continuing support for the ACCESS Project (Activities 3.2.1-3.2.3), as well as developing alternative approaches to the issue, including an ECHO-based learning collaborative for providers to screen and diagnose young children with concerns for autism. OCCYSHN will continue leading a Developmental Pediatrics Collaborative we convened in 2021. The workgroup is made up of representatives from three major Portland-area tertiary pediatric health systems, the Children's Health Alliance, and other stakeholders. The goal is to coordinate and cooperate to reduce barriers and streamline referrals for CYSHCN who need developmental assessment or treatment.

Activity 3.1.3. Strengthen and Leverage Existing Relationships

As noted above, there will be much work to do with Medicaid through our Title V-Medicaid MOU to implement changes resulting from the 1115 Waiver process, including the elimination of the decades-long waiver of EPSDT in Oregon. OCCYSHN's Director is also the medical director for Oregon's new universally offered infant home visiting program. This requires building relationships with LPHAs, community health and service providers, and community-based organizations. These relationships will advance OCCYSHN's priorities. Through connections to professional medical societies, a seat on the OHSU Legislative Advisory Committee, and close collaboration with OHSU Government Relations, we will strengthen relationships with local, state and federal officials. Further, we will continue our leadership of the Developmental Pediatrics Collaborative (Activity 3.1.2), to address issues of access to care for CYSHCN.

Strategy S3.2:

OCCYSHN will increase access to community-based autism diagnostic services through implementation of community-based autism evaluation teams.

Activity 3.2.1. ACCESS

ACCESS (which stands for Assuring Comprehensive Care through Enhanced Service Systems for Children with Autism Spectrum Disorders) helps communities build local education-medical autism spectrum disorder (ASD) evaluation teams for children aged 0-5. The goal is to increase local capacity to evaluate children for ASD, thereby expediting and coordinating diagnosis, treatment, and access to community services. We will seek to bring ACCESS services to more CYSHCN from minoritized populations, and those living in rural or semi-rural Oregon.

OCCYSHN will develop new partnerships, with a goal of increasing the number of ACCESS teams. We will provide technical assistance and training for new and existing teams. This will include site visits, special interest discussion groups, training on the Screening Tool for Autism in Toddlers and Young Children (STAT) and DSM-5 Interview, an ECHO virtual learning community, phone and email consultations, and participation in OCCYSHN's annual cross-

systems care coordination conference.

OCCYSHN will develop materials to help teams promote ACCESS in communities, and to engage new potential communities. We will share tools and resources on ASD screening and diagnosis with educators and health care providers to increase workforce capacity. We will also invite OHSU child psychiatry and LEND fellows to participate in the ACCESS ECHO virtual learning community, to share their clinical and systems expertise.

Activity 3.2.2. ACCESS Family Involvement

OCCYSHN's Family Involvement Program manager (in consultation with an ORF2FHIC staff member who is the parent of a child who experiences ASD), will advise the ACCESS Project. The Family Involvement Program manager will attend all planning and strategy meetings to provide a family perspective, and she will serve as a panelist at monthly ECHO trainings. She will help recruit other family members or self-advocates to participate in ACCESS. She will provide family resources, and offer technical assistance to ACCESS teams on integrating Parent Partners into their work.

Activity 3.2.3. ACCESS Equity

The ACCESS Project will increase the number of community-based ASD evaluation teams in Oregon, thereby improving equitable access to evaluations for rural CYSHCN and their families. We will promote health equity, diversity, and inclusion in the project. We will encourage teams to recruit and retain a diverse group of providers and Parent Partners. The ECHO virtual learning community series will include topics related to CLAS and health equity.

Activity 3.2.4. ACCESS Systems and Policy

OCCYSHN will disseminate information about the ACCESS Project to people and groups positioned to impact systems of care for CYSHCN, including Oregon's State Interagency Coordinating Council and Coordinated Care Organizations. Increased awareness of the ACCESS Project has potential to strengthen Oregon's system of ASD evaluation.

OCCYSHN will continue leading the Developmental Pediatrics Collaborative (Activity 3.1.2), which will explore developing a quality improvement project aimed at streamlining referrals and reducing wait times for ASD evaluations.

We will continue advocating for a coordinated and unified statewide process for ASD diagnosis and eligibility for educational services. We will help teams seek sustainable funding by developing and sharing innovative payment models. We will share information on policies related to ASD evaluation and access to services, thereby reducing barriers to care for children with ASD and their families. We will share ACCESS promotional materials, and offer guidance on how teams can collaborate with CCOs. We will position ACCESS to impact systems of care by aligning with behavioral health and kindergarten readiness efforts.

Strategy S3.3:

We will improve agencies' knowledge of, and ability to respond to, CYSHCN and their families during an emergency or disaster response.

Activity 3.3.1. Assess Emergency Preparedness

OCCYSHN will promote policy and legislation aimed at a variety of emergency preparedness measures for CYSHCN, including emergency heat relief. We will disseminate information to families on realistic ways to prepare for emergencies and disasters. Information will be shared via newsletters, Facebook, listservs, and family events.

Based on informational interviews with those LPHAs that do not currently contract with OCCYSHN, we will gauge opportunities to work with them on addressing emergency preparedness for CYSHCN. We will continue tracking LPHA efforts on emergency and disaster preparedness for CYSHCN, and look for opportunities to support those efforts. We will provide LPHAs with information, technical assistance, and training about emergency preparedness for CYSHCN.

OCCYSHN will partner with other Oregon organizations and programs to strengthen systems of care that impact emergency preparedness for CYSHCN. OCCYSHN and ORF2FHIC will initiate conversations with the Oregon Individual Support Plan (ISP) coordinator at the Arc of Oregon to discuss the feasibility of integrating suggestions gleaned from family listening sessions into the ISP process. We will continue communicating with OHA's Medical Surge Planner about addressing emergency preparedness barriers faced by CYSHCN and their families.

OHA MCAH Foundations of MCAH: Policy & Systems Plan

(October 2022 – September 2023)

As described in the introduction to this section, the plans for this domain reflect the different ways that OHA MCAH and OCCYSHCN are approaching the state-specific cross-cutting work during the coming year.

- Title V MCAH has developed an integrated approach to the 3 new state-specific priorities: toxic stress/trauma/ACES/resilience, CLAS and SDOH-E. Recognizing the interwoven nature of work on these 3 upstream priorities, the Title V MCAH program is approaching them as an integrated "Foundations of MCAH" priority. Work on the Foundations of MCAH, including strategies and activities at the state and local level are divided into 4 areas: policy & systems; workforce capacity & effectiveness; community, individual & family capacity; and assessment & evaluation.
- OCCYSHN will continue to work on CLAS, SDOH-E and Toxic stress/trauma/Aces/resilience as separate priorities.
- Other Title V efforts and investments which cut across priorities and domains and are described at the end of the cross-cutting section, for both the OHA MCAH and OCCYSHCN branches of the Oregon Title V program.

State Performance Measures:

1. SPM 1: Percentage of new mothers who experienced stressful life events before or during pregnancy
2. SPM 2: Percent of children age 0-17 years who have a healthcare provider who is sensitive to their family's values and custom
3. SPM 3: The percentage of children living in a household that received food or cash assistance

Foundations – Policy & Systems Strategy #1:

Strengthen economic supports for families through policy development and implementation.

State level activities/timeline:

1. Partner with OHA's Employee Resource Groups, MCH and CP&HP management to assess, develop, and implement equitable and family friendly policies for OHA/PHD employees (e.g., paid family leave, flexible scheduling, etc.).
   Timeline: October 2022 – September 2023
2. Conduct an environmental scan of ongoing efforts to strengthen economic supports and policies for the MCH

population across state and local Public Health – including MCH programs. (Note: this activity was planned for last year but had to be deferred due to a vacancy in the MCH staff and resultant lack of capacity).
Timeline: October 2022 – March 2023.

3. Engage families and partners in the MCH community to identify ways in which Title V can support SDOH-E, including policy and systems to strengthen economic supports for families. Note: this activity will be conducted in coordination with Assessment & Evaluation strategy #3: Engage families and communities in all phases of MCAH assessment, surveillance, and epidemiology, including interpretation and dissemination of findings; State level activity 1: Develop partnerships with culturally specific and/or responsive organizations and their constituents to engage them in all phases of MCAH research, assessment, and planning activities.
Timeline: October 2022 – September 2023.
4. Continue to articulate MCH role in addressing economic drivers for families, such as childcare and Earned Income Tax Credit ((EITC). Develop partnerships and policy priorities to advance MCH role in economic support policies and initiatives.
Timeline: October 2022 – September 2023.

No local grantees selected to work on this strategy during the upcoming grant year.

Foundations – Policy & Systems Strategy #2:

Develop and/or strengthen systems and partnerships to address food security and barriers to accessing food resources.

ESM:

Percent of partners successfully aligned in promoting food security course to build workforce competency.

State level activities/timeline: Partner with state-level organizations to support cross-collaboration with food security initiatives:

1. SNAP-Ed Advisory Council through attendance at quarterly meetings and exploring opportunities through new cultural food work groups representing different racial/ethnic populations
2. Connect with OHA Healthier Together Oregon Housing and Food work group
3. Nutrition Council of Oregon to support nutrition security initiatives and collaborations through bi-monthly meetings
4. Facilitate Childhood Hunger Coalition quarterly meetings to collaborate across represented organizations
5. Develop new partnerships to address food security initiatives
    a. Work with OHA Health Policy and Analytics to learn about implementation of SDOH & food security metrics within CCOs
    b. Develop partnership with Partners for a Hunger Free Oregon and learn about their community food insecurity listening sessions and plan
    c. Explore potential new partnership with OPIP (Oregon Pediatric Improvement Partnership)

    Timeline: Partnership development spans the entire grant year 10/1/22 – 9/30/23
6. Promote completed childhood food insecurity course with public health workforce and through partner organizations
    Timeline: 1/2/23 – 9/30/23
7. Complete qualitative evaluation of food insecurity strategies and outcomes of Title V food insecurity priority at the local level for 2015-2020; develop resources from the evaluation.
    Timeline: Report finalized 10/1/22 – 12/31/22; resources developed 1/2/23 – 9/30/23
8. Support the local grantees to implement and strengthen food security screening and referral systems.
    Timeline: 10/1/22 – 9/30/23

Local level activities/timeline:

- 2 grantees (Marion and Washington) will convene or participate in cross-sector coalitions or community partnerships to address food access barriers.
- Marion County will implement a validated food insecurity screening tool and provide referrals for food assistance.
- Confederated Tribes of the Umatilla Indian Reservation will develop and strengthen partnerships to increase access to food and food-related skills. Examples of partners include WIC, SNAP-Ed, Community Garden, FDPIR, DCFS, and others as identified. They will also provide food-related education to the community, including cooking skills, food safety and preservation.
  Timeline: 10/1/22 – 9/30/23.

Foundations – Policy & Systems Strategy #3:

Foster cross-system coordination and integration to ensure screening and referral for SDOH, and equitable access to needed services for the MCAH population.

State level activities/timeline:

1. Assess opportunities for MCH participation in state level, cross-system efforts to screen for SDOH needs and refer to social safety net supports, including local Title V representation in Community Information Exchange (CIE) networks.
   Timeline: Assessment 10/1/22 – 3/31/23
2. Support local partners to build capacity in trauma-informed SDOH needs screening implementation.
   Timeline: 10/1/22 – 9/30/23

Local level activities/timeline:

- 3 grantees (Clackamas, Columbia, Deschutes) will partner with CCOs and other community partners to integrate local LPHA and tribal MCAH programs into CIE networks. Clackamas will deepen relationships with local partners to build a strong, culturally competent and trauma-informed local referral network; Columbia will partner with CCOs and community partners to integrate local LPHA and tribal MCAH programs into CIE networks; Deschutes will train family support services on the Connect Oregon centralized referral platform, implement the referral system for sending and receiving referrals and monitor implementation.
  Timeline: 10/1/22 – 9/30/23.

Foundations – Policy & Systems Strategy #4:

Develop and implement systems that actively promote equitable, anti-racist, and trauma-informed workplaces, institutions, and services.

State level activities/timeline:

1. Scan, assess and identify systems specifically for racial equity in policies and systems, potentially bringing in an expert consultant to do this.
   Timeline: 7/2022-12/2022
2. Support continued development and implementation of MCH and OHA Trauma policies. **Timeline:** 7/2022-12/2022
3. Work with PHD HEWG and PHD Community Engagement Team to implement best practices for hiring and

retention, including checklists and accountability
Timeline: 7/2022-6/2023

4. Ensure accountability for implementation of anti-racism and anti-oppression policies and cross-system initiatives.
Timeline: 10/2022-10/2023

Local level activities/timeline:

- Lincoln County: will apply a racial equity lens to examine internal policies and procedures and make recommendations to HHS leadership. They will consult with Health Resources in Action to increase skills in equity assessment and policy changes.
- Lane County: will work during this grant cycle to build an agency response to anti-racist and trauma-informed practices. Lane County has been working on increasing awareness of racism, bias, and local history and will start to move toward action-oriented plans to address systemic barriers for the BIPOC community. They plan to work with a consultant to help move these practices forward among staff and leadership.
- Coos County: will work towards modernizing internal policies to reflect anti-racist and trauma informed practices. Much of Coos County's equity work has been individually focused. During this grant cycle their equity team will develop an equity lens policy to review all CHW policies and make recommendations to leadership.

Foundations – Policy & Systems Strategy #5:

Strengthen policies and systems that provide equitable access to safe, stable, and affordable housing for the MCAH population.

State level activities/timeline:

1. Continue to strengthen partnerships with Oregon Housing and Community Services (OHCS) and other state/community-based programs and agencies and explore opportunities for MCH Title V to support housing stability and equitable access to healthy affordable homes for all Oregon families.
Timeline: October 2022 – September 2023
2. Research the barriers, disparities, upstream causes and health impacts of housing instability and inequity on Oregon's MCH population (using established research as well as engagement of community voices). Note: this activity will be conducted in coordination with Assessment & Evaluation strategy #3: Engage families and communities in all phases of MCAH assessment, surveillance, and epidemiology, including interpretation and dissemination of findings; State level Activity 1: Develop partnerships with culturally specific and/or responsive organizations and their constituents to engage them in all phases of MCAH research, assessment, and planning activities.
Timeline: June 2022 – January 2023
3. Develop recommendations for the MCH Title V program regarding ways that the Title V program can support stable and equitable housing for the MCH population.
Timeline: October 2022 – September 2023

Local level activities/timeline: N/A State-level only strategy

Critical Partnerships:

Strategy 1: Local Public Health Authorities, Tribes, CCOs, Early Learning Division, Early Learning Hubs, Oregon

Department of Human Services, OHA Transformation Center, OHA Office of Health Information Technology, Trauma Informed Oregon, Connect Oregon (UniteUS), Help Me Grow, Aunt Bertha, Oregon Primary Care Association (SDOH screening), 211, OHA Social Determinants of Health workgroup, Healthy Families Employee Resource Group.

Strategy 2: Public Health Division – other programs including Director's Office (SHIP work), WIC program, Environmental Health, Health Promotion and Chronic Disease Prevention; OHA Health Policy and Analytics, OHA Health Services Division, Oregon Department of Human Services, Oregon State University Extension SNAP-Ed, Oregon Department of Education, Child Nutrition Programs, Moore Institute, Oregon Food Bank, Nutrition Council of Oregon members, Childhood Hunger Coalition members (including health system representatives), Association of State Public Health Nutritionist, Local grantees and tribes working on this strategy.

Strategy 3: Local Public Health Authorities, Tribes, CCOs, Early Learning Division, Early Learning Hubs, Oregon Department of Human Services, OHA Transformation Center, OHA Office of Health Information Technology, Trauma Informed Oregon, Connect Oregon (UniteUS), Help Me Grow, Aunt Bertha, Oregon Primary Care Association (SDoH screening), 211, OHA Social Determinants of Health workgroup, Healthy Families Employee Resource Group.

Strategy 4: Local Grantees, Oregon Public Health Department, PHD Community Engagement Team (CET), Oregon Center for Youth and Children with Special Health Needs, External Contractors: Engage to Change, and Whiteness @ Work.

Strategy 5: Oregon Housing and Community Services, Oregon Dept of Human Services, Healthier Together Oregon housing workgroup, Community agencies working on housing for families, Oregon Early Childhood Division, Oregon Coordinated Care Organizations.

OHA MCAH Foundations - Workforce Capacity & Effectiveness: Plan

(October 2022 – September 2023)

Foundations – Workforce Strategy #1:

Advance the skills and abilities of the workforce to deliver equitable, trauma informed, and culturally and linguistically responsive services.

ESM:

Percent of technical assistance recipients who report increased knowledge of social determinants of health and equity.

State level activities/timeline:

1. State MCH Professional Development on Foundational Topics -Monthly topic sessions
   Timeline: October 2022 – September 2023
2. Work with Engage to Change contractors to prepare state level staff experiences relating to anti-racism and trauma-informed skills
   Timeline: Ongoing
3. Contract with and offer Whiteness @ Work trainings for MCAH staff
   Timeline: Fall, 2022
4. Compile list of what Anti-Racism and trauma-informed trainings are available (detailing format, knowledge gain, and where they fit in a selected framework) and how selected opportunities will be implemented into the

program
Timeline: Ongoing

Activities focusing on supporting local grantees:

1. Prepare and present TA opportunities on these topics for Title V grantees e.g. Health Literacy Training, trauma-informed approaches, implicit bias, hiring practices. This includes reviewing local grantee plans for potential TA needs as well as conducting a survey/hosting listening sessions to identify what other anti-racism and trauma-informed TA needs not identified in their plans.
   Timeline: October 2022 – September 2023
2. Work with leads from other priority areas to identify TA needs related to health equity and trauma-informed work
   Timeline: October 2022 – September 2023
3. Create and implement a calendar of TA opportunities related to improving state and local anti-racist and trauma-informed skills for the MCAH state and local workforce
   Timeline: October 2022 – September 2023

Local level activities/timeline:

- Six grantees have chosen to work on this strategy and each grantee has a slightly different approach based on what is most needed for their staff and communities. The first five grantees listed here will participate in TA opportunities to improve knowledge and skills in equity, trauma/ACEs, and CLAS (including home visiting staff), and Washington County and the Coquille Indian Tribe will provide training and education for perinatal providers and community partners including anti-racism trainings and other SDOH areas
  Timeline: October 2022 – September 2023
- Participate in TA opportunities to improve knowledge and skills in equity, trauma/ACEs, and CLAS (including home visiting staff)
  - Coos County will provide support to key internal staff committed to working on anti-racism and trauma informed care to overcome staff and leadership resistance. They will consult with state MCAH quarterly to assess progress, identify next steps and opportunities for external trainings.
  - North Central PHD will identify and provide resources for bilingual staff to attend certification training (including financial assistance; flexible work time)
  - Benton will continue investment in the recovery of the public health workforce. Sponsor 2 additional MCH staff to participate in self-care training provided through PSU (Self-Care Course).
  - Linn will Identify and participate in TA opportunities provided through state MCAH or other external agencies
  - Morrow: will facilitate discussions at staff meetings to identify equity and trauma workforce needs and work with State MCAH staff to develop a training plan base on those needs.
  - Coquille Indian Tribe will focus on increasing understanding and skills of the long-lasting impacts of trauma on physical and mental health, with an emphasis on the profound implications of intergenerational/historical trauma on American Indians and the resultant health inequities that have affected the population. CIT will work with state MCAH to identify trauma-informed opportunities for tribal members and staff.
- Provide training and education for perinatal providers and community partners including anti-racism trainings and other SDOH areas
  - Washington will provide annual training for all home visiting staff in WA county, as well as integrate DEI into reflective supervision. Washington county will conduct training on Diversity, Education and Inclusiveness in the spring of 2023.
  - Coquille Indian Tribe will provide training and education for perinatal providers and community partners

including anti-racism trainings and other SDOH areas

Foundations – Workforce Strategy #2:

Implement standards for workforce development that address bias and improve delivery of equitable, trauma-informed, and culturally and linguistically responsive services.

State level activities/timeline:

1. Ensure 10% equity time for all MCH staff- --manager support -- accountability -- professional development plans. Support managers and consultants to develop plan and implement this policy.
   Timeline: 10/1/22-9/30/23
2. Create a Culture of Belonging to help retain staff and skills as well as provide space for lived experience. (Identify standards, activities that lead to COB and staff retention **Timeline:** 1/2023-7/2023
3. Explore opportunities to update PE 42 to incorporate trauma and equity standards into PE 42
   Timeline: 9/2022-9/2023

Local level activities/timeline:

- Assess standards currently in place, determine best practices and develop action plan for equitable workforce development and trauma informed, and culturally responsive services
- Multnomah County will continue to reflect, challenge and encourage themselves to remove barriers that hinder clients, community, and staff from reaching their greatest potential. While challenging ourselves and the systems we are immersed in, we must also understand the historical context in which we live, and how history has defined our current state of being. The Maternal Child Family Health Equity in Action team will continue to utilize and identify additional resources, including current events, to challenge ourselves and deepen our engagement and awareness.
  Timeline: October 2022 – September 2023

Critical partnerships:

- Local grantees: we will partner with local grantees requiring TA and support in these areas.
- Oregon PHD: we will work with PHD leadership; the PHD Community Engagement Team (CET), and other sections of the Public Health Division
- Oregon Center for Youth and Children with Special Health Needs
- External Contractors:
  - We will continue our work with Engage to Change throughout 2022-2023 to increase MCAH skills and understanding regarding anti-racism, health equity, and trauma informed approaches to our work
  - Whiteness @ Work: We will contract with W@W to host their learning modules as well as hiring external facilitators to help us debrief these modules

OHA MCAH Foundations - Community, Individual, and Family Capacity Plan

(October 2022 – September 2023)

Foundations – Community, Individual & Family Capacity Strategy #1:

Support/fund programs, such as home visiting, that engage families and build parent capabilities, resilience, supportive/nurturing relationships, and children's social-emotional competence.

ESM:

Number of MCAH programs supported/funded by Title V that engage families and build parent capabilities, resilience, supportive/nurturing relationships, and children's social-emotional competence.

State level activities/timeline:

1. Partner with Oregon's Maternal and Child Health Home Visiting and Early Learning Division programs to support implementation of home visiting and other early childhood programs.
   Timeline: 10/1/22-9/30/23
2. Support MCH and early childhood workforce development efforts around that state to enhance trauma informed approaches into Oregon's early childhood programs.
   Timeline: 10/1/22-9/30/23

Local level activities/timeline:

- Clackamas County will partner with all Clackamas County home visiting providers, and Help Me Grow, to build a coordinated entry system into home visiting programs.
- Jackson County will use Title V funds to stabilize the nurse home visiting programs and ensure capacity to provide the services.
- Jefferson County will be continuing to build capacity for increased coordination of home visiting services in Jefferson County. They will be focused on implementing and integrating the Family Connects model into the Family Support Services Program (Babies First!, CaCoon, Healthy Families, Oregon Mothers Care, Perinatal Care Coordination).
- Lane County will be focusing on enrollment in home visiting program by demographics, race and ethnicity so that they are able to provide services to the people in the community who need them the most regardless of who they are and where they live.
- Malheur County will partner with other home visiting programs to build a coordinated home visiting referral system.
- Marion County will use Title V funding to support expansion of the Family Connects program.
- Multnomah County is partnering with the African Family Holistic Health Organization (AFHHO) to enroll pregnant women into the Health Birth Initiatives (HBI) program. By enrolling families they are consenting to participate in Healthy Start activities and requirements. AFHHO will complete all needed documentation as required by the program. HBI and AFHHO will work together in building community between both organizations.
- Washington County will use Title V funding to support the staffing and implementation of nurse home visiting programs including Babies First!, CaCoon, Nurse Family Partnership and Family Connects.
- Yamhill County plans to create a Family Wellness Coordinator position to facilitate and streamline the MCH work and achieve more through increased efficiency. This staff person will work to coordinate the access and availability of Family Wellbeing Programs in Yamhill County.
- The Cow Creek Public Health Division is expanding their programs and services to meet the relational and public health needs of their Tribal families. This funding will be used to support their effort in engaging young families and those expecting new babies and engage them in public health services across the life span by promoting strong relationships that are culturally appropriate.

Foundations – Community, Individual & Family Capacity Strategy #2:

Build community capacity for improved health, resilience, social/cultural connection, and equity.

State level activities/timeline:

1. Engage with state level inter-agency collaborations and cross-systems initiatives that work to prevent/address trauma and ACEs and promote resilience; and promote social determinants of health and equity.
   Timeline: October 2022-September 2023.
2. Continue to partner and expand links with initiatives within MCH, CP&HP and OHA/PHD that directly fund community-based organizations and enhance CBO-LPHA partnerships to build resilient, trauma-informed communities.
   Timeline: October 2022-September 2023.
3. Explore options for revising Title V formula-based funding to support innovative equity-based funding models.
   Timeline: October 2022-September 2023.
4. Support the development of systems and programs that enhance community capacity and are accountable to the people they serve, particularly communities of color.
   Timeline: October 2022-September 2023.

Local level activities/timeline:

Multnomah County's Title V program plans to support a variety of activities conducted through the Future Generations Collaborative (FGC). The FGC centers traditional values and collaboration in the prevention of Fetal Alcohol Spectrum Disorder (FASD) in the Native community and provides lifelong support to community members who have been impacted by FASD. Specific activities include: Support for collaborative playgroups, parent support groups and assistance to families impacted by FASD; community engagement through dissemination of culturally specific family home toolkits and baby shower, and convening coalitions and initiatives; research and evaluation related to decolonizing data and building community member capacity to understand and use data; and policy/advocacy including youth and family engagement related to racism as a public health issue, early intervention, addiction recovery services, and Indigenous sovereignty.
Timeline: October 2022 – September 2023

Critical partnerships:

Critical partners for this work include: Local Public Health Authorities, Tribes, MCH Health Equity Workgroup, Engage to Change consultants, PHD Community Engagement Community of Practice, community-based organizations, PHD Director's Office, Trauma-Informed Oregon, OHA Trauma-Informed Policy workgroup, Injury and Violence Prevention Section, Adolescent Genetics and Reproductive Health Section, Health Promotion and Chronic Disease Prevention Section, fiscal staff, community members.

OHA MCAH Foundations - Assessment & Evaluation Plan

(October 2022 – September 2023)

Foundations – Assessment & Evaluation Strategy #1:

Ensure all Title V priority areas include a racial/ethnic and health equity focus including performance measurement and evaluation to identify and address disparities.

State level activities/timeline:

1. Where possible, report Title V performance measures by race and ethnicity, disability, gender, age, sexual orientation, socioeconomic status, nationality, and geographic location.
   a. Review Title V national performance measures, state performance measures, national outcome measures, and evidence based/informed strategy measures for disparities, and produce report of relevant findings for use by priority areas leads to improve program delivery.

Timeline: October 2022 to December 2022

2. Once review of all Title V programming for adherence to Oregon REALD protocol is complete, develop plan to transition to use of the protocol.
   Timeline: March 2023 – September 2023
3. Serve as data collection consultant for Babies First/CaCoon during transition to the use of new data collection forms, and a new data collection system, THEO. New data collection forms were developed with a workgroup including service providers, community partners, and expert consultants to improve Title V funded home visiting data collection; to increase the culturally and linguistically responsiveness of the questions and collection methods, and to frame the data collection using a trauma informed lens. These forms are currently being utilized in select pilot counties. Pilot counties will provide feedback on the forms, after which use of the forms will be rolled out statewide. Counties will have ongoing opportunities to provide feedback on the cultural responsiveness and trauma sensitivity of the forms, and updates can be made in response to this feedback. **Timeline:** October 2023 – September 2023

2. Expand the use of a rigorous evaluation framework and continuous quality improvement across social determinants of health, equity, culturally and linguistically appropriate services, and trauma, toxic stress, and resilience strategies.
   a. Once review of Title V program evaluation protocols is complete, develop plan to either implement new evaluations or improve current evaluation practices. **Timeline:** October 2022 – September 2023
3. Work in partnership with Title V Nutrition Consultant on Foundations, Policy & Systems Plan, Strategy #2: Complete qualitative evaluation of food insecurity strategies and outcomes of Title V food insecurity priority at the local level for 2015-2020; develop resources from the evaluation.
   Timeline: October 2022 – June 2023
4. Scan existing state and national data sources for food security with focus on equity data; identify data gaps.
   Timeline: October 2022 – June 2023

Local level activities/timeline:

- Ensure all Title V priority areas include a racial/ethnic and health equity focus including performance measurement and evaluation to identify and address disparities.
  - Lane county: Implement findings of evaluation conducted with community-based organizations during previous grant cycle, to improve equitable and trauma informed services and engagement of BIPOC community. This will include evaluating implementation of the feedback and incorporating a quality improvement focus, such as PDSA cycles.

Foundations – Assessment & Evaluation Strategy #2:

Conduct continuous needs assessment and/or exploratory analysis to add to the SDOH, Equity, CLAS, and Trauma/ACEs knowledge base and improve effectiveness of Title V foundational interventions and innovations.

State level activities/timeline:

1. In partnership with CSTE/CDC Applied Epidemiology Fellow and MCH Epidemiologist (CDC Assignee), publish manuscript on the association between adverse childhood events and cognitive disability in a peer reviewed publication.
   Timeline: October 2022 – December 2022
2. Update brief fact sheet on adverse childhood events in Oregon for public release **Timeline:** October 2022– December 2022
3. Attend monthly policy team meetings to provide data consultation and produce data briefs as necessary
   Timeline: October 2022 – September 2023

Local level activities/timeline:

No local grantees have selected this strategy for the coming year.

Foundations – Assessment & Evaluation Strategy #3:

Engage families and communities in all phases of MCAH assessment, surveillance, and epidemiology, including interpretation and dissemination of findings.

ESM:

Percent of A&E efforts conducted during the year that engaged impacted communities or families.

State level activities/timeline:

1. Develop partnerships with culturally specific and/or responsive organizations and their constituents to engage them in all phases of MCAH research, assessment, and planning activities.
    a. Partner with Foundations, Policy & Systems Strategy #1: Engage families and partners in the MCH community to discuss and identify ways in which Title V can support SDOH-E, including policy and systems to strengthen economic supports for families.
    Timeline: October 2022 – September 2023
    2. Partner with Foundations, Policy & Systems Strategy #5: Research the barriers, disparities, upstream causes and health impacts of housing instability and inequity on Oregon's MCH population.
    Timeline: June 2022 – January 2023
    3. Reengage with original recipients of needs assessment community voices grants, to explore future partnership in strategy development and program delivery. **Timeline:** October 2022 – September 2023
    4. Develop a strategy for disseminating MCAH data and jointly interpreting it with impacted communities
    Timeline: October 2022 – September 2023
    5. Continue needs assessment community voices project by partnering with American Indian/Alaska Native, Asian, and Pacific Islander communities or community-specific agencies to assess maternal and child health needs within these communities.
    Timeline: January 2023 – September 2023

Local level activities/timeline:

No local grantees have selected this strategy for the coming year.

Critical partnerships:

- CSTE/CDC Applied Epidemiology Fellowship
- Community voices mini grant recipients:
    - Casa Latinos Unidos de Benton County
    - Coos County Health & Wellness
    - Multnomah County Health Department, Healthy Birth Initiative
    - Klamath County Public Health
    - Klamath Tribal Health and Family Services
    - Oregon Health and Science University, Transgender Health Program
    - Doernbecher Gender Clinic
    - Spect-Actors Collective, Doulas Latinas International
- Lane County Public Health
- CDC MCH Epidemiology Program Sponsored Assignee to Oregon

- Association of State Public Health Nutritionists
- Culturally specific organizations that serve American Indian, Asian, and Pacific Islander communities

Other Title V Programmatic Efforts

In addition to investments in the three state-specific cross-cutting priorities, Oregon's Title V program also invests in cross-cutting system-building activities including MCAH and CYSHCN data infrastructure (epidemiology, assessment, evaluation, and informatics), communications, workforce development, and partnerships to develop MCAH policy and coordinated systems which go beyond any one priority or domain. This work is essential to carry out the core public health functions of Title V in support of Oregon's MCAH populations as outlined below. The work, housed within the Center for Prevention & Health Promotion (CP&HP) under the Title V MCH Director, and the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) under the Title V CYSHCN Director, will continue during the upcoming grant year and is described below.

Policy and System Development:

- MCAH: The Title V program's work in policy and system development includes support for adolescent health staff working on coordinated school health, confidentiality of adolescent health services across systems, and providing adolescent health expertise to cross-agency and community policy and systems initiatives. Title V MCAH policy staff work with multiple agency and health system partners to improve quality, coordination, and accessibility of a broad range of services and policy initiatives that impact health and development of the MCAH population. They also coordinate and serve on the Title V-Medicaid MOU team. Positions supported include the Title V Director, and the MCH Policy Lead/Title V coordinator, the MCH Health Educator, the Adolescent Health policy analyst, the Title V Adolescent Health Coordinator, as well as staff working on intimate partner violence, ACEs, perinatal access, and quality of care, MCAH impact of marijuana legalization, a variety of other child health policy initiatives, and work on emerging issues such as maternal mortality and opioids.

- CYSHCN: OCCYSHN advocates for systems-level improvements for CYSHCN at every level. We increase awareness about the challenges facing Oregon CYSHCN, their families, and their care providers. Our staff sits on state and local level advisory boards, committees, and workgroups to ensure the needs of CYSHCN and their families are represented. We also play an active role in OHSU's efforts to serve CYSHCN. OCCYSHN staff tracks the work of state and regional committees (e.g., Oregon Health Policy Board, Early Learning Division, Oregon Department of Education, Oregon Department of Human Services, Systems of Care Advisory council) and attend state conferences (e.g., Oregon State of Reform Health Policy Conference, Coordinated Care Organization annual conference) to inform strategic advocacy. We provide input on policy development with potential to impact CYSHCN, and we offer oral and written testimony at local, state, and national levels. We disseminate information critical to CYSHCN-serving agencies and organizations through our website and Facebook pages.

- OCCYSHN's Systems and Workforce Development unit tracks and reviews systems and policy developments and identifies opportunities to inform change. Participating in policy workgroups is essential to promoting integrated systems for CYSHCN. OCCYSHN will continue to seek such opportunities in 2022-23.

Communications, Outreach, and Community Engagement:

- MCAH: Title V supports a state-level health education and communications specialist who works on dissemination of MCAH data and educational messaging, social media outreach, as well as cultural and

linguistic accessibility of MCAH materials, and communications consultation to Local Public Health Authorities. The communications specialist is also the primary MCH liaison to the state Public Health Division team that manages the state website, as well as to the publications team. Her work ensures that MCAH programs and materials are easily accessible to the public. Title V also supports two MCH specialists at Oregon's 211info line to provide MCH warm-line information and referrals, as well as enhanced anticipatory guidance and linkage to services for MCH clients. Reports on the MCH outreach and community engagement conducted through 211info are delivered quarterly to a steering committee made up of representatives from MCH, immunizations, adolescent and reproductive health, and WIC. Working with 211info across the different programs that impact our MCAH populations ensures that clients receive comprehensive and integrated services when they contact our MCH warm line.

- CYSHCN: OCCYSHN's Communications Coordinator collaborates with staff to ensure strategic and effective communication. The Coordinator develops and disseminates OCCYSHN program guidance and products. She manages OCCSYHN's web and social media presence, and edits written public input. The Coordinator promotes health literacy standards both internally and with LPHA partners. OCCYSHN's Assessment and Evaluation unit and Family Involvement Program engage families of CYSCHN to help inform OCCYSHN's work with family perspective.

Epidemiology, Assessment, Evaluation, and Informatics:

- MCAH: Title V supports the MCH epidemiologist, research analysts, data management and informatics staff who conduct research, surveillance, and epidemiology (including PRAMS, ECHO, BRFSS, Oregon Student Health Survey, Birth Anomalies Surveillance System, and Oral Health Surveillance System), ongoing needs assessment, evaluation and data collection/management and MCAH data dissemination functions across MCAH populations and programs. A critical project that crosses SSDI and Title V work continues to be the online Title V database that is available to all Title V grantees (local public health and Tribes). This database allows grantees to enter their Title V reports, plans, measures – as well as to record how much of their Title V funds will be directed to work in each Title V priority area. Title V staff can review and analyze the grantee plan, as well as extract reports on strategies and priorities being undertaken across the state. The work of the SSDI program as well as other MCH Data work is described in detail in section III.E2.b.iii.

- CYSHCN: OCCYSHN supports an Assessment and Evaluation (A&E) unit, which is the data center of OCCYSHN. A&E is comprised of an A&E Manager, a program evaluation associate, two research associates and one research assistant. A&E is responsible for conducting ongoing and five-year assessment of the needs of Oregon CYSHCN and their families, monitoring and evaluating block grant strategies, and coordinating with other OCCYSHN units to disseminate findings. A&E ensures that OCCYSHN's goals and block grant strategies are guided and informed by empirical findings. OCCYSHN also continues to provide financial support to the ORCHIDS data system into which public health nurses record required home visiting program data, including CaCoon data.

Infrastructure and Finance:

- MCAH: Title V provides infrastructure support for management, as well as fiscal, communications and clerical staff that support both the grants management functions and clerical support needs of the Title V Director and other Title V staff.

- CYSHCN: OCCYSHN employs management, fiscal, and clerical staff required to support the Director and other OCCYSHN staff.

III.F. Public Input and III.G. Technical Assistance

III.F. Public Input

The Oregon Public Health Division Center for Prevention and Health Promotion (CP&HP) and Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) involve communities, stakeholders, and program participants, including family consultants, to provide input to Title policy and program decision-making at many levels. MCAH assessment data, priorities, strategies and performance measures, trends, and outcomes are regularly presented and reviewed by stakeholders and Title V implementing partners across Oregon. The Title V program engages and solicits input from local public health, tribal health, community-based organizations, primary care and safety-net providers and consumers in the 5-year needs assessment to inform ongoing strategy development and implementation throughout the Block Grant cycle. Mechanisms through which input is solicited include: websites (PHD and OCCYSHN), surveys, community listening sessions, webinars, online discussion forums, sessions held at conferences and partner meetings, advisory groups, and inter-agency committees and task forces. An overview of the ongoing methods used by both branches of Title V to solicit stakeholder and public input over the past year is provided below.

Oregon Public Health Division MCAH Public Input Process

Throughout the grant year, the Title V program seeks partner and public input into the development of the strategies, activities, and measures that are included in this grant application, and are being implemented as part of this current five-year grant cycle. Additionally, Title V participates in the public input process for implementation of Healthier Together Oregon (HTO) - the new State Health Improvement Plan - which has important MCAH components. The development of HTO strategic agenda had significant state and local level public input which Title V supported. This input was also used to align Title V strategies and activities to HTO. Methods used to solicit both public and stakeholder input this year have been remote and have included: presentations and dialogue at virtual partner meetings, webinars, surveys, focus groups, postings on the Title V website, and social media outreach. Specifics of key strategies used to solicit stakeholder and public input over the past year are provided below.

Engagement/input for Title V Block Grant implementation

The Title V program seeks input for overall Title V policy and implementation throughout the year from the Conference of Local Health Officials (CLHO), and from Oregon's tribes through regular SB770 state – tribal meetings.

The Title V State leads conducted one on one technical assistance calls with grantees in each community in Oregon during March and April 2022. These calls were used to deliver TA on the new Title V Annual Plan priorities and assist grantees in developing their plans, as well as to solicit input about implementation issues, strategies, activities, and measures. Program input is also solicited in writing a second time each year as part of the Title V grantee annual reporting process.

Lists of Title V strategies, maps of priority work around the state, logic models, and other resources and information related to the Title V program are publicly available on the Title V website (http://healthoregon.org/titlev), which is open for public input on an ongoing basis.

Engagement/input for ongoing Title V Block Grant Needs Assessment

Following the 2020 Needs Assessment, we had anticipated further expanding our solicitation of input on the needs of under-represented communities through a continuation of our Community Voices Grant process. However, due to the ongoing COVID-19 pandemic, neither state level staff nor community agencies had the capacity to focus on that type of research, so those plans remained on hold this past year. However, Title V was able to gather some input on changing MCAH community needs through our partnerships with the MCH Nurse Home visiting programs and the PHD Modernization and Equity Collaborative CBO funding work.

Engagement/input for the MCH Section Strategic Plan and State Health Improvement Plan

Implementation of the Maternal and Child Health Section's strategic plan, led by the Title V Director, Title V Coordinator, and MCH policy team, involves ongoing input from internal and external partners to ensure that Title V work reflects critical MCH strategic directions, as well as alignment with partner priorities and emerging opportunities. (See Supporting Documents 3 and 4).

Given the close alignment with the MCH strategic plan priorities, Title V also supports and benefits from ongoing community input and engagement in the State Health Improvement Plan (HTO) implementation process. MCH priorities feature prominently in the HTO priorities which include: institutional bias; adversity, trauma and toxic stress; economic drivers of health; access to equitable preventive health care; and behavioral health. The MCH strategic plan priorities also align with and support the OHA Performance Management System and the CCO Social Determinants of Health work.

Ongoing mechanisms for Title V public input

Public input is solicited on an ongoing basis through the Title V website (http://healthoregon.org/titlev), as well as through participation in periodic community meetings and outreach events throughout the year. Our MCH warmline contract with 211info provides another ongoing mechanism for public input, as the two MCH staff at 211info conduct or attend regular community outreach events and report on emerging issues quarterly to the 211info Steering Committee. The annual Title V application/report is posted on the website, along with data, resources, and links to contact state and local MCAH staff. The public can also use the website for timely MCH updates, apply for special funding opportunities, and to contact MCAH staff with any concerns or input.

This year the MCH Section continued to increase our visibility and engage the public through Facebook and Twitter (www.facebook.com/oregonmch and www.twitter.com/oregonmch). In the last year, we have added 68 new followers on Facebook and 21 new followers on Twitter. We have posted over 750 posts related to maternal and child health on both platforms, currently reaching over 56 thousand people through our networks (reach includes our content showing up on a user's screen). In the last year, followers have engaged with our content over 2,500 times (this means that have "liked" something, commented on a story, or clicked on a link provided). We have partnered with national and local organizations (including the National Birth Defects Prevention Network, Oregon WIC, Oregon Reproductive Health Program, Oregon Oral HPV Task Force, and many more) to co-create social media content and broaden our health message reach. We have increased the number of posts translated into Spanish, and plan to offer Spanish versions of most posts next year. We continue to build a content library by creating graphics which will be used on an Instagram page next year to increase our reach with younger individuals.

Clearly the ongoing COVID-19 pandemic has shifted the ways we receive ongoing input into the Title V program. The shift from in-person to all virtual methods has many limitations, but it has also opened opportunities to hear from communities and areas of the state that are often missed. The increase in community engagement – especially with CBOs – in relation to COVID-19 is an opportunity to listen and hear more from communities around the state about all MCH issues, and we are taking advantage of those opportunities wherever they arise. Title V staff serve in numerous outreach and communications capacities for the emergency response, ensuring that the needs of MCH populations are being considered and listening for anything we can learn to support Oregonians with COVID-19 related services.

Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) Public Input Process

OCCYSHN obtained input from essential stakeholder groups to develop its 2020-2021/2025 strategic plan. These groups included family members of CYSHCN, local public health authorities (LPHAs) and their community partners, and Children with Medical Complexity CollN Advisory and Implementation Team members. OCCYSHN also maintains a website and a general mailbox where people can submit feedback to OCCYSHN. A description of other input processes follows.

Families

The Oregon Family to Family Health Information Center (ORF2FHIC), in partnership with OCCYSHN, connects with families throughout Oregon via workshops, trainings and small group listening sessions, called Table Talks. The purpose of these events is two-fold: 1) to share information and resources with families that can help them navigate health care, and 2) to learn from families about their experiences with health care and community services their children use. Between October 1, 2020 and September 30, 2021, a total of 25 family events were held, all virtual. They were attended by 210 family members. Trainings and workshops were offered on the subjects of health care transition, health care advocacy, CYSHCN resources, and telehealth. Table Talks were about family wellness, telehealth, cultural views of disability, transition to independent living, and planning for health emergencies. In the Table Talks, ORF2FHIC Parent Partner facilitators provided conversational prompts, and took de-identified notes. These notes informed ORF2FHIC program planning and provided high-level information about families' experiences to the OCCYSHN staff.

OCCYSHN held a virtual meeting with five parents of CYSHCN in spring, 2021 to provide input on the block grant plan. In addition to ORF2FHIC Parent Partners, participants included three parents whose children are medically complex and/or experience intellectual disabilities. Families were given context and background about the block grant process before they read the plan. Using a customized feedback form with prompts, they focused their attention on National Performance Measures 11 and 12. Their comments were collated and returned to them for approval, then submitted to OCCYSHN leadership for review and reflection. Families expressed general support for OCCYSHN's activities but noted that further training and exposure is needed for them to fully contribute to the block grant application. The families were paid for their time and expertise. Each expressed interest in continuing the work in future years.

Local Public Health Authorities and other Community-Based Partners

Each year OCCYSHN holds regional meetings with contracted local public health authorities (LPHAs). OCCYSHN's 2021 Regional Meetings were held virtually due to the pandemic. The regional meetings provided an opportunity for LPHAs to hear about OCCYSHN's ongoing support during the pandemic, and to share their needs. OCCYSHN continued to partner with OHA MCH to implement a monthly virtual Community of Practice for Oregon nurse home visiting program staff. Meetings focused on topics specific to CYSHCN and home visiting, with an emphasis on cross-sector care coordination. The sessions served as an opportunity for shared learning. They also continued to serve as a mechanism for hearing about barriers to home visiting during the pandemic, which allowed for a coordinated response to the workforce needs.

Children with Medical Complexity (CMC) Collaborative Improvement and Innovation Network (CoIIN) Team Members

The CMC CoIIN Implementation Team consists of three family members of CYSHCN (including OCCYSHN's Family Involvement Program Manager), an OHSU Beaverton Primary Care Practice physician, a Doernbecher Children's Hospital General Pediatrics and Adolescent Health Clinic nurse, a pediatric Hematology-Oncology nurse practitioner, Mr. Charles Smith (Action Plan section 12.2), and five OCCYSHN staff. The Implementation Team consists of the same three family representatives, an OHSU internal medicine/pediatric physician, Doernbecher Children's Hospital General Pediatrics clinic nurse, and four OCCYSHN staff. The Implementation Team continues to co-develop and co-monitor our QI project. This work directly informed OCCYSHN's strategic planning.

Needs Assessment and Prioritization

OCCYSHN's efforts are guided by our 2020 and 2015 needs assessment results. The 2020 needs assessment engaged two culturally specific community-based organizations: the Latino Community Association (LCA) and the Sickle Cell Anemia Foundation of Oregon (SCAFO) to collect, co-analyze and co-develop dissemination products using data from Latino and Black families of CYSHCN in Oregon. The 2020 needs assessment also collected data from other families of CYSHCN, and from LPHA nursing staff statewide. These results informed our five-year strategic, and continue to inform our annual, block grant planning.

III.G. Technical Assistance

Title: Building internal capacity to address health equity
Brief description: OCCYSHN prioritizes health equity. We would benefit from training and guidance on how to build internal capacity to address health equity. Building internal capacity will better enable us to improve systems to address health equity and better equip us to support our partners in addressing health equity.
Performance measure: All, including SPMs 2.1 (CLAS) and 3.1 (Social Determinants of Health)
Proposed TA source: Massachusetts Department of Public Health and its work "Organizational Opportunities to Address Racial Inequities (AMCHP, May 2021)
Estimated Budget: TBD
Estimated Dates: TBD

Title: Racism as a Root Cause Approach
Brief description: Dr. Zea Malawa was lead author of the influential 2021 paper "Racism as a Root Cause Approach: A New Framework." We would benefit from more information on applying this solutions-centered framework for addressing racism as a root cause. This approach can help guide and structure the important work of dismantling racism so Black, Indigenous, and other racially marginalized families can finally have an equal opportunity for good health.
Performance measure: All NPMs and SPMs
Proposed TA source: Zea Malawa, M.D. from Expecting Justice
Estimated Budget: TBD
Estimated Dates: TBD

Title: Photovoice training
Brief description: To conduct needs assessments, Title V grantees rely on quantitative research methods such as surveys and analysis of secondary data. These methods are useful for capturing needs and challenges broadly but can be difficult to meaningfully disaggregate by subpopulations of CYSHCN because of small sample sizes. Such data collection methods may not align well with the cultures of these subpopulations. OCCYSHN is planning to pilot Photovoice as needs assessment as a tool, to capture the perspective of youth with special health care needs (YSHCN) to inform our NPM 12 work. Photovoice has been successfully used with youth on a variety of topics. It is well-suited to the policy environment, helping to "tell the story." If it works well, OCCYSHN will use the method with families of other populations of CYSHCN. OCCYSHN's Assessment & Evaluation (A&E) Coordinator and a Research Associate would participate in Photovoice's regular 3-day training in London, and would share learning with OCCYSHN, OHA MCAH, and OHSU UCEDD A&E staff.
Performance Measure: NPMs 11 &12, SPM 2.1 (CLAS)
Proposed TA source: PhotoVoice
Estimated budget: $14,000
Estimated dates: 11/2022

Title: Applying trauma-informed principals to public health practice for CYSHCN
Brief description: Oregon is working on both state and local levels to implement trauma-informed approaches to MCAH and CYSHCN and promote family and community resilience. To that end, the Title V program may request TA for trauma-informed workforce development activities, which may include state and/or local MCAH staff training and/or support for a statewide meeting of local MCAH programs that are engaged in developing work around ACEs and trauma. Training will also focus on the intersection of trauma and racism and the need to move anti-racism and trauma-informed approaches forward in an integrated manner. **Performance Measure:** All, especially SPM 1.1 (Toxic stress, trauma, and ACEs and Resilience)

Proposed TA source: TBD
Estimated Budget: TBD
Estimated Dates: TBD

Title: Adapting Interventions for CYSCHN to be Culturally Responsive
Brief description: OCCYSHN aims to promote culturally appropriate health care. We would benefit from technical assistance to adapt shared care planning and autism evaluations to be culturally appropriate. We anticipate that what we learn about adapting these interventions will inform the development of future interventions.
Performance measure: 2.1.2 Promotion of Culturally Appropriate Health Care.
Proposed TA source: Sandy Magaña, PhD, MSW, University of Texas at Austin
Estimated Budget: TBD
Estimated Dates: TBD

Title: Data support to local Title V grantees
Brief description: Local Title V grantees in Oregon, which include counties and tribes, are expected to select priority areas based on local needs assessment activities. Due to differing levels of local evaluation and epidemiological staff capacity, several grantees could benefit from training and guidance on how to complete these needs assessment and evaluate related Title V activities. Opportunities to provide TA may include online sessions or piggybacking on other state-wide meetings that grantees may attend during the grant year. Title V MCAH and CYSHCN will explore collaboration for this technical assistance.
Performance Measure: all
Proposed TA source: TBD
Estimated Budget: TBD
Estimated Dates: TBD

Title: Trauma informed workforce, workplaces, and MCAH systems of care
Brief description: Oregon is working on both state and local levels to implement trauma-informed approaches to MCAH and CYSHCN and promote family and community resilience. To that end, the Title V program may request TA for trauma-informed workforce development activities, which may include state and/or local MCAH staff training and/or support for a statewide meeting of local MCAH programs that are engaged in developing work around ACEs and trauma. Training will also focus on the intersection of trauma and racism and the need to move anti-racism and trauma-informed approaches forward in an integrated manner. **Performance Measure:** State Toxic stress, trauma, and ACEs performance measure
Proposed TA source: TBD
Estimated Budget: TBD
Estimated Dates: TBD

Title: Anti-White Supremacy training for State Title V staff
Brief description: Hire a contractor with experience in anti-white supremacy training and public health, to provide Oregon's Title V staff with training to use an anti-white supremacy lens to develop a plan to critically address internal processes and power structures in order to address racial disparities in Oregon.
Performance measure: State performance measures 1-3 (Toxic stress/trauma/ACEs, Culturally and linguistically accessible services, and social determinants of health and equity)
Proposed TA source: TBD – possibly Futures without Violence or Engage to Change
Estimated Budget: TBD
Estimated Dates: Sept 2021-June 2022.

Title: Technical Assistance to support alignment and integration of injury work across PHD sections
Brief description: Receive a technical assessment to understand and improve organizational efforts across infrastructure, data and surveillance, and policy and program strategies to align and integrate MCH injury prevention work across the PHD
Performance measure: NPM 7
Proposed TA source: Safe States Alliance
Estimated Budget: TBD
Estimated Dates: TBD

Title: Increasing MCH Participation in Child Fatality Reviews
Brief description: Oregon MCH Title V requests technical assistance to support state, local and tribal public health MCH staff in increasing knowledge, competence and participation in child fatality review processes to identify prevention strategies for child injuries and injury related deaths.
Related performance measure(s): NPM 7.1 – Injury hospitalization for children ages 0-9 years
Proposed TA source: National Center for Fatality Review and Prevention and/or Children's Safety Network
Estimated Budget: Unknown
Estimated Dates: FY2023-2024

Title: Trainings to support youth-adult partnership and youth engagement strategies
Brief description: Aim to provide a training series that will outline upstream approaches to bullying prevention that Title V staff, grantees, and partners can utilize in their program development and implementation. Training(s) goals/objectives: To create a learning community for aligning statewide youth engagement work to center the needs of youth most impacted by marginalization. To promote skill building for adults to partner with youth using best youth-adult partnership practices. To increase capacity for youth driven programming and specifically Youth Participatory Action Research. We believe these trainings will work as a foundation to enhance Title V staff, grantees, and partners capacity to facilitate bullying prevention efforts. **Related performance measure(s):** NPM 9
Proposed TA source: Adolescent Health Initiative and Matchstick Consulting
Estimated Budget: $8,200
Estimated Dates: FY2023-2024

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MOU between Medicaid and Title V FINAL SIGNED.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - OCCYSHN_Supplemental Doc 1.pdf

Supporting Document #02 - OCCYSHN_SupplementalDoc_2.pdf

Supporting Document #03 - Supporting Document 3 – MCAH Reports and Other Materials.pdf

Supporting Document #04 - Supporting Document 4_Title V MCAH Guiding Docs.pdf

Supporting Document #05 - Supporting Document 5 – Local Title V MCAH Grantee Information.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Combined_Org chart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Oregon

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,946,987	
A. Preventive and Primary Care for Children	$ 2,976,833	(42.8%)
B. Children with Special Health Care Needs	$ 2,084,097	(30%)
C. Title V Administrative Costs	$ 694,698	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,755,628	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 19,925,824	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 3,816,493	
5. OTHER FUNDS (Item 18e of SF-424)	$ 9,598,510	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 33,340,827	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,950,427		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 40,287,814	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 37,034,624	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 77,322,438	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 115,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 184,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 270,250
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 184,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 8,242,721
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	$ 787,727
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 384,910
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 25,463,178
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 980,000
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 422,838

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,172,689 (FY 21 Federal Award: $ 6,040,858)		$ 6,040,858	
A. Preventive and Primary Care for Children	$ 2,746,276	(44.5%)	$ 2,588,551	(42.8%)
B. Children with Special Health Care Needs	$ 1,851,808	(30%)	$ 1,812,258	(30%)
C. Title V Administrative Costs	$ 617,268	(10%)	$ 604,085	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,215,352		$ 5,004,894	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 13,276,271		$ 16,632,981	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 9,707,490		$ 3,816,493	
5. OTHER FUNDS (Item 18e of SF-424)	$ 11,838,611		$ 9,392,842	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 34,822,372		$ 29,842,316	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,950,427				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 40,995,061		$ 35,883,174	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 43,526,340		$ 34,526,065	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 84,521,401		$ 70,409,239	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 618,706	$ 384,910
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 150,000	$ 128,708
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 240,000	$ 83,789
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 190,000	$ 149,236
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 715,000	$ 976,256
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 8,500,000	$ 6,642,577
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 85,292
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 188,549
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,683,898	$ 0
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 29,630,381	$ 25,463,178
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 463,355	$ 423,570

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Projected increase of 15% from the FFY 21 Notice of Award (NOA).	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: More than 30% of funds are allocated for preventive and primary care for children population group in FFY2023.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Transfering 30% of the Oregon MCH Block Grant appropriation to the OCCYSHN for serving the children with special health care needs.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: CP&HP considers the 10% cost allocation of central support services to represent Administrative costs.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: State MCH matching funds include budgets identified as benefitting the health of the maternal, child, and adolescent populations. State general funds in the CP&HP.	
6.	**Field Name:**	**4. LOCAL MCH FUNDS**

	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: The Local MCH Funds budget includes revenues at the County level that are funded by county general funds, patient fees, third party insurance for services in local Title V agencies (county health departments).	
7.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Other Funds include the Newborn Screening Program conducted in the Public Health Lab of the Public Health Division. Though this program is not in CP&HP, it provides a critical public health service to the MCH population and is included to align with the National Performance Measures and Form 4.	
8.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: This is based on the FFY 21 Notice of Award (NOA).	
9.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: More than 30% of funds were allocated for preventive and primary care for children population group in FFY2021.	
10.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Transfering 30% of the Oregon MCH Block Grant appropriation to the OCCYSHN for serving the children with special health care needs.	
11.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

	Field Note: CP&HP considers the 10% cost allocation of central support services to represent Administrative costs. The 10% of the total budget limit is maintained by transferring excess expenses to the State general funds.	
12.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: FY 21 projected budget is based on FY 20 expenditures at the time the 2021 Block Grant application was prepared FY 21 expenditures includeded the general funds for the Universal Home Visiting and Family Planning.	
13.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: FY 21 projected budget is based on FY20 expenditures at the time the 2021 application was prepared. Most local agencies reported lower expenditures in FY 21.	
14.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: FY 21 projected budget is based on FY20 expenditures at the time the 2021 application was prepared. The estimated expenditures for newborn screeening are lower.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Oregon

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 571,284	$ 496,768
2. Infants < 1 year	$ 324,005	$ 281,744
3. Children 1 through 21 Years	$ 2,976,833	$ 2,588,551
4. CSHCN	$ 2,084,097	$ 1,812,258
5. All Others	$ 296,070	$ 257,452
Federal Total of Individuals Served	$ 6,252,289	$ 5,436,773

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 462,788	$ 462,788
2. Infants < 1 year	$ 12,418,250	$ 9,030,102
3. Children 1 through 21 Years	$ 14,120,947	$ 14,120,603
4. CSHCN	$ 1,500,000	$ 1,389,981
5. All Others	$ 4,838,842	$ 4,838,842
Non-Federal Total of Individuals Served	$ 33,340,827	$ 29,842,316
Federal State MCH Block Grant Partnership Total	$ 39,593,116	$ 35,279,089

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2021 actual expenditures with estimated increase at the time the 2023 Block Grant Application was prepared.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2021 actual expenditures with estimated increase at the time the 2023 Block Grant Application was prepared.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2021 actual expenditures with estimated increase at the time the 2023 Block Grant Application was prepared.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: The Oregon Center for Children with Special Health Care Needs budget includes the 30% Title V federal funds transferred from the Oregon Health Authority, Public Health Division, Center for Prevention & Health Promotion to OCCYSHN.	
5.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**

	Field Note: Budgets are based on the 2021 actual expenditures with estimated increase at the time the 2023 Block Grant Application was prepared.	
6.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2021 actual expenditures at the time the 2023 Block Grant Application was prepared. These budget amounts include state, local, and other funds.	
7.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2021 actual expenditures at the time the 2023 Block Grant Application was prepared. These budget amounts include state, local, and other funds.	
8.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2021 actual expenditures at the time the 2023 Block Grant Application was prepared. These budget amounts include state, local, and other funds.	
9.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: The Oregon Center for Children with Special Health Care Needs budget includes the OCCYSHN matching State General funds.	
10.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2021 actual expenditures at the time the 2023 Block Grant Application was prepared. These budget amounts include state, local, and other funds.	

11.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2023 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation of the actual NOA and necessary adjustments made at the closing of the grant budget period.	
12.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2023 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation of the actual NOA and necessary adjustments made at the closing of the grant budget period.	
13.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2023 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation of the actual NOA and necessary adjustments made at the closing of the grant budget period.	
14.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The Oregon Center for Children with Special Health Care Needs expenditures are the 30% Title V federal funds transferred from the Oregon Health Authority, Public Health Division, Center for Prevention & Health Promotion to OCCYSHN.	
15.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2023 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation of the actual NOA and necessary adjustments made at the closing of the grant budget period.	

16.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2023 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation of the actual NOA and necessary adjustments made at the closing of the grant budget period.	
17.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2023 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation of the actual NOA and necessary adjustments made at the closing of the grant budget period.	
18.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2023 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation of the actual NOA and necessary adjustments made at the closing of the grant budget period.	
19.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: The Oregon Center for Children with Special Health Care Needs expenditures includes the OCCYSHN matching state General funds.	
20.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2023 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation of the actual NOA and necessary adjustments made at the closing of the grant budget period.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Oregon

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 2,108,812	$ 1,964,303
3. Public Health Services and Systems	$ 4,838,175	$ 4,076,555
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 6,946,987	$ 6,040,858

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 29,125,650	$ 25,489,388
3. Public Health Services and Systems	$ 4,215,177	$ 4,352,928
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 33,340,827	$ 29,842,316

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: 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 are considered to be Enabling Services. Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services budgets.	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
3.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
4.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
5.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**

	Field Note: Funds that are provided to county health departments and other local agencies are considered to be Enabling Services.	
6.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services budgets.	
7.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: 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 are considered to be Enabling Services. Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services budgets.	
8.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
9.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
10.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	

11.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Funds that are provided to county health departments and other local agencies are considered to be Enabling Services.	
12.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services budgets.	
13.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: 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 are considered to be Enabling Services. Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services expenditures.	
14.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
15.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
16.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**

	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note:	
	There are no Direct Services expenditures.	
17.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note:	
	Funds that are provided to county health departments and other local agencies are considered to be Enabling Services.	
18.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note:	
	Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services budgets.	
19.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note:	
	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 are considered to be Enabling Services. Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services expenditures.	
20.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note:	
	There are no Direct Services expenditures.	
21.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2021**

	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
22.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
23.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Funds that are provided to county health departments and other local agencies are considered to be Enabling Services.	
24.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services budgets.	

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Oregon

Total Births by Occurrence: 40,847 **Data Source Year: 2021**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	40,847 (100.0%)	1,495	62	62 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Cystic Fibrosis
Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia
Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)
Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease
S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency				

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Short-chain acyl-CoA dehydrogenase deficiency	40,847 (100.0%)	0	0	0 (0%)
Fabry	40,847 (100.0%)	0	0	0 (0%)
Gaucher	40,847 (100.0%)	0	0	0 (0%)
Secondary thyroid (Hypopit)	40,847 (100.0%)	0	0	0 (0%)
DiGeorge and other immunodeficiencies	40,847 (100.0%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Long term follow up is not recorded at the Newborn Screening office. Oregon Health and Sciences University Metabolic Clinic maintains the long term follow up database and patient records for metabolic patients in Oregon. Once any case is confirmed by newborn screening with all other disorders we close to short term follow up and leave the primary care provider to care for child. Specialists such as pediatric endocrinology will have their own records for long term monitoring.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Oregon

Annual Report Year 2021

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	3,069	58.1	0.0	16.4	14.6	10.9
2. Infants < 1 Year of Age	667	0.0	43.2	3.3	0.6	52.9
3. Children 1 through 21 Years of Age	28,988	54.3	1.6	21.9	10.8	11.4
3a. Children with Special Health Care Needs 0 through 21 years of age^	10,910	57.2	0.0	41.6	0.0	1.2
4. Others	24,056	34.4	0.0	18.4	44.7	2.5
Total	56,780					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	39,820	Yes	39,820	77.7	30,940	3,069
2. Infants < 1 Year of Age	40,370	Yes	40,370	100.0	40,370	667
3. Children 1 through 21 Years of Age	1,017,276	Yes	1,017,276	10.9	110,883	28,988
3a. Children with Special Health Care Needs 0 through 21 years of age^	219,274	Yes	219,274	44.3	97,138	10,910
4. Others	3,182,213	Yes	3,182,213	0.8	25,458	24,056

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2021**
	Field Note: Pregnant individuals served by Babies First! (BF!) and Oregon Mother's Care (OMC). BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. OMC seeks to improve access to prenatal care for all people in Oregon. OMC started with five sites in January of 2000 and grew to twenty-five sites by 2018. The program connects pregnant individuals to pregnancy and prenatal information, help and services. OMC services are provided at Access Sites, typically local clinics or public health agencies. OMC Access Sites help connect pregnant people to the services they need for a healthy pregnancy. OMC sites provide these services to all clients free of charge. In 2021, BF! served a total of 909 pregnant individuals, and OMC served 2,160 pregnant individuals.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**
	Field Note: Infant served by Babies First! (BF!). BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2021, BF! served 667 infants.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**

Field Note:
Children served by School Based Health Centers (SBHCs), Babies First! (BF!), and family planning for females <22 years of age delivered by the Reproductive Health Program (RHP).

SBHCs are a vital community tool with a youth-centered model that supports young people's health and well-being. Oregon SBHCs are in schools or on school grounds and provide medical care, behavioral health services and, often, dental services. Because of these easily accessible services, school-aged youth have an equal opportunity to learn, grow and thrive. SBHCs offer services to all students in a convenient and youth-centered environment, regardless of ability to pay. SBHCs provide easy access to health care. SBHCs reduce barriers such as cost, transportation and concerns about confidentiality that keep parents and students from seeking the health services students need. In the 2020 to 2021 school year, SBHCs served 18,511 children.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2021, BF! served 1,059 children ages 1 to 4.

The RHP receives funding from three different sources to provide reproductive health services to people in Oregon. It is dedicated to ensuring all people in Oregon have access to high-quality, culturally-responsive reproductive and sexual health services, knowledge, and resources through partnerships with clinics, community organizations, and policy makers. The RHP commits to working towards racial equity by addressing racism and implicit bias, and reducing systemic barriers to care. In 2021, the RHP served 9,418 individuals below the age of 22.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**

Field Note:
CYSHCN served in FY21 through direct and enabling services: CaCoon program, Shared care planning initiative, Zetosch Charitable Gift Fund, CDRC clinical programs. Sources: ORCHIDS (Oregon Child Health Information Data Systems), OCCYSHN Zetosch database, OCCYSHN Shared Care Plan Information Form (SIF) database, and CDRC clinics. Percentage of "Sources of Coverage" is based on the following categories: Public Insurance Only, Private/Other insurance, Uninsured, and Unknown. This is taken from ORCHIDS and CDRC. Zetosch and the SIF database do not track insurance coverage.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**

Field Note:
Family planning delivered by the Reproductive Health Program (RHP) for reproductive aged women (22 to 54 years of age), and non-pregnant adult caregivers served by Babies First.

The RHP receives funding from three different sources to provide reproductive health services to people in Oregon. It is dedicated to ensuring all people in Oregon have access to high-quality, culturally-responsive reproductive and sexual health services, knowledge, and resources through partnerships with clinics, community organizations, and policy makers. The RHP commits to working towards racial equity by addressing racism and implicit bias, and reducing systemic barriers to care. In 2021, the RHP served 23,738 individuals 22 years or older.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2021, BF! served 318 non-pregnant adult caregivers.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2021**

Field Note:
Percentage includes pregnant individuals served by Babies First! (BF!); Maternal, Infant, and Early Childhood Home Visiting (MIECHV); Oregon Mothers Care (OMC); and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2021, BF! served a total of 909 pregnant individuals

OMC seeks to improve access to prenatal care for all people in Oregon. The program connects pregnant individuals to pregnancy and prenatal information, help and services. OMC helps connect pregnant people to the services they need for a healthy pregnancy. OMC sites provide these services to all clients free of charge. In 2021, OMC served 2,160 pregnant individuals.

MIECHV is a voluntary service for pregnant people and families with young children designed to improve health outcomes for parents and children, encourage positive child development and school readiness, and enhance family well-being. Home Visitors meet with families to share information and connect families to other services and supports, promote positive parent/child relationships and to support families in achieving their goals. In 2021, MIECHV served 526 pregnant individuals.

WIC serves lower-income pregnant, postpartum and breastfeeding women, infants and children under age 5 who have health or nutrition risks. The program aims to safeguard the health of low-income women, infants, and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care. In 2021, WIC served 29,525 women.

2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**

Field Note:
Percentage includes infants served by The Northwest Regional Newborn Bloodspot Screening (NWRNBS) Program, the Early Hearing Detection & Intervention (EHDI) Program, and Babies First (BF!).

NWRNBS screens newborns for endocrine, hemoglobin, cystic fibrosis, and metabolic conditions and identifies those who need immediate treatment. If a baby tests positive for one of these conditions, staff will follow up to ensure they receive appropriate medical care. These screening tests can prevent developmental problems, mental retardation or death. In 2021, 41,438 babies were screened by NWRNBS.

The goal of EHDI is to assure that all Oregon newborns receive a hearing screening by one month of age, infants who refer on newborn screening receive diagnostic evaluation by three months of age and infants diagnosed with loss are enrolled into early intervention services by six months of age. The first months of life are a critical period for developing speech and language skills. Hearing loss is the most common birth defect, occurring at a rate of three in every 1,000 children. Early identification of a hearing loss and appropriate intervention enhances a child's potential for speech and language development. In 2021, EHDI screened 40,791 infants for hearing loss.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2021, BF! served 667 infants.

3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
Percentage includes children served by School Based Health Centers (SBHCs); Babies First! (BF!); family planning for females <22 years of age delivered by the Reproductive Health Program (RHP); Maternal, Infant, and Early Childhood Home Visiting (MIECHV); and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

SBHCs are a vital community tool with a youth-centered model that supports young people’s health and well-being. SBHCs reduce barriers such as cost, transportation and concerns about confidentiality that keep parents and students from seeking the health services students need. In the 2020 to 2021 school year, SBHCs served 18,511 children.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2021, BF! served 1,059 children ages 1 to 4.

The RHP receives funding from three different sources to provide reproductive health services to people in Oregon. The RHP commits to working towards racial equity by addressing racism and implicit bias, and reducing systemic barriers to care. In 2021, the RHP served 9,418 individuals below the age of 22.

MIECHV is a voluntary service for pregnant people and families with young children designed to improve health outcomes for parents and children. Home Visitors meet with families to share information and connect families to other services and supports, promote positive parent/child relationships and to support families in achieving their goals. In 2021, MIECHV served 950 children.

WIC serves lower-income pregnant, postpartum and breastfeeding women, infants and children under age 5 who have health or nutrition risks. In 2021, WIC served 81,365 children.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**

Field Note:
We categorized OCCYSHN's strategy activities into the tiers of the MCH pyramid. Although we ultimately hope that the following activities will influence private insurer's coverage and policies, public comment on Oregon Health Care Transformation efforts, input into Oregon's 1115 Waiver, and service on the Medicaid Advisory Council will have direct influence on CYSHCN who have public insurance. According to the National Survey of Children's Health 2019-2020, approximately 65,036 (37%) CYSHCN are publically insured (CAHMI, 2022). Needs assessment activities included examination of children with medical complexity (CMC) from birth through age 21 using Oregon All Payers All Claims data from 2010 Quarter 4 through 2014 Quarter 3. Results identified that 32,100 children in this group were privately insured. Therefore, we add 32,100 to 60,410 to generate our numerator.

5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**

Field Note:
Percentage includes non-pregnant caregivers served by the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), family planning delivered by the Reproductive Health Program (RHP) for reproductive aged women (22 to 54 years of age), and non-pregnant adult caregivers served by Babies First! (BF!).

MIECHV is a voluntary service for pregnant people and families with young children designed to improve health outcomes for parents and children, encourage positive child development and school readiness, and enhance family well-being. Home Visitors meet with families to share information and connect families to other services and supports, promote positive parent/child relationships and to support families in achieving their goals. In Oregon, MIECHV funds the following evidence-based home visiting models: Early Head Start, Healthy Families America, and Nurse Family Partnership. In 2021, MIECHV served 553 non-pregnant caregivers.

The RHP receives funding from three different sources to provide reproductive health services to people in Oregon. It is dedicated to ensuring all people in Oregon have access to high-quality, culturally-responsive reproductive and sexual health services, knowledge, and resources through partnerships with clinics, community organizations, and policy makers. The RHP commits to working towards racial equity by addressing racism and implicit bias, and reducing systemic barriers to care. In 2021, the RHP served 23,738 individuals 22 years or older.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems. In 2021, BF! served 318 non-pregnant adult caregivers.

Data Alerts:

1.	Others, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Oregon

Annual Report Year 2021

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	40,847	26,164	1,042	8,101	354	2,124	331	1,542	1,189
Title V Served	3,511	2,029	103	947	60	71	38	46	217
Eligible for Title XIX	17,033	9,178	670	5,323	244	430	234	742	212
2. Total Infants in State	40,847	26,164	1,042	8,101	354	2,124	331	1,542	1,189
Title V Served	2,652	1,213	182	841	19	24	20	133	220
Eligible for Title XIX	17,033	9,178	670	5,323	244	430	234	742	212

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2021**
	Column Name:	**Total**

Field Note:
Number of pregnant individuals served by Oregon Mother's Care and Babies First clients enrolled prenatally.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems.

OMC seeks to improve access to prenatal care for all people in Oregon. The program connects pregnant individuals to pregnancy and prenatal information, help and services. OMC services are provided at Access Sites, typically local clinics or public health agencies. OMC Access Sites help connect pregnant people to the services they need for a healthy pregnancy. OMC sites provide these services to all clients free of charge.

2.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2021**
	Column Name:	**Total**

Field Note:
Infants served by Babies First! (BF!) and CaCoon.

BF! is a public health nurse home visiting program for pregnant women and children ages 0 through 4 years and their caregivers with health and social histories that put them at risk for poor health and development outcomes. The goal of BF! is to promote health and well-being during pregnancy, infancy and early childhood through prevention and early identification of problems.

CaCoon is a statewide public health nurse home visiting program. CaCoon nurses help families coordinate care for their children and youth with special health needs. The program has operated in most Oregon counties for over 20 years. Children served in the CaCoon program make fewer visits to the emergency department. They also have higher rates of immunization, annual well-child, and dental care visits. CaCoon serves children age 0-21. The most vulnerable families, such as those with a newly diagnosed infant, are prioritized for services.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Oregon

A. State MCH Toll-Free Telephone Lines	2023 Application Year	2021 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 211-0000	(800) 211-0000
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health	Maternal and Child Health
3. Name of Contact Person for State MCH "Hotline"	Ciara Doyle	Ciara Doyle
4. Contact Person's Telephone Number	(503) 416-2704	(503) 416-2704
5. Number of Calls Received on the State MCH "Hotline"		22,643

B. Other Appropriate Methods	2023 Application Year	2021 Annual Report Year
1. Other Toll-Free "Hotline" Names	211Info	211info
2. Number of Calls on Other Toll-Free "Hotlines"		155,457
3. State Title V Program Website Address	www.211info.org	www.211info.org
4. Number of Hits to the State Title V Program Website		385,806
5. State Title V Social Media Websites	facebook.com/211info; twitter.com/211info;www.instagram.com/211info; www.facebook.com/oregonmch and www.twitter.com/oregonmch); www.facebook.com/oregonmch; www.twitter.com/oregonmch	facebook.com/211info; twitter.com/211info; www.instagram.com/211info; www.com/facebook.com/oregonmch; www.twitter.com/oregonmch
6. Number of Hits to the State Title V Program Social Media Websites		27,342

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Oregon

1. Title V Maternal and Child Health (MCH) Director	
Name	Cate WIlcox, MPH
Title	Title V Director, MCH Manager
Address 1	800 NE Oregon St
Address 2	
City/State/Zip	Portland / OR / 97232
Telephone	(971) 207-1689
Extension	
Email	cate.wilcox@state.or.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Benjamin Hoffman, MD
Title	Title V CYSHVN Director
Address 1	707 SW Gaines St
Address 2	
City/State/Zip	Portland / OR / 97239
Telephone	(503) 494-2214
Extension	
Email	hoffmanb@ohsu.edu

3. State Family or Youth Leader (Optional)	
Name	Tamara Bakewell
Title	Family Involvement Coordinator
Address 1	707 SW Gaines St
Address 2	
City/State/Zip	Portland / OR / 97239
Telephone	(503) 494-0865
Extension	
Email	bakewell@ohsu.edu

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Oregon

Application Year 2023

No.	Priority Need
1.	Safe and supportive environments
2.	Stable and responsive relationships; resilient and connected children, youth, families and communities.
3.	Improved lifelong nutrition
4.	Enhanced equity and reduced MCAH health disparities.
5.	Enhanced social determinants of health
6.	High quality, culturally responsive preconception, prenatal and inter-conception services
7.	High quality, family-centered, coordinated systems of care for children and youth with special health care needs

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Safe and supportive environments	New
2.	Stable and responsive relationships; resilient and connected children, youth, families and communities.	Revised
3.	Improved lifelong nutrition	Revised
4.	Improved health equity and reduced MCAH disparities	Continued
5.	Enhanced social determinants of health	New
6.	High quality, culturally responsive preconception, prenatal and inter-conception services	Continued
7.	High quality, family-centered, coordinated systems of care for children and youth with special health care needs	Continued

Form 10
National Outcome Measures (NOMs)

State: Oregon

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	83.1 %	0.2 %	32,962	39,643
2019	82.9 %	0.2 %	34,565	41,683
2018	82.4 %	0.2 %	34,500	41,870
2017	81.4 %	0.2 %	35,224	43,299
2016	81.2 %	0.2 %	36,728	45,215
2015	80.5 %	0.2 %	36,530	45,353
2014	79.2 %	0.2 %	35,790	45,217
2013	76.3 %	0.2 %	33,898	44,400
2012	76.3 %	0.2 %	33,767	44,280
2011	75.5 %	0.2 %	33,717	44,671
2010	74.1 %	0.2 %	33,499	45,223
2009	72.6 %	0.2 %	33,917	46,698

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	72.2	4.3	285	39,473
2018	67.0	4.1	268	39,976
2017	66.7	4.1	274	41,051
2016	61.6	3.8	261	42,344
2015	67.3	4.6	215	31,962
2014	63.7	3.9	267	41,888
2013	65.4	4.0	266	40,657
2012	56.9	3.8	232	40,766
2011	50.4	3.5	213	42,264
2010	50.0	3.4	215	42,981
2009	50.3	3.4	225	44,735
2008	46.6	3.2	215	46,167

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2020	15.0	2.7	32	213,032
2015_2019	10.1	2.1	22	218,867
2014_2018	10.8	2.2	24	222,565

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.5 %	0.1 %	2,600	39,798
2019	6.7 %	0.1 %	2,801	41,841
2018	6.7 %	0.1 %	2,826	42,179
2017	6.8 %	0.1 %	2,972	43,618
2016	6.5 %	0.1 %	2,974	45,518
2015	6.4 %	0.1 %	2,919	45,634
2014	6.2 %	0.1 %	2,842	45,543
2013	6.3 %	0.1 %	2,841	45,144
2012	6.1 %	0.1 %	2,769	45,047
2011	6.1 %	0.1 %	2,764	45,140
2010	6.3 %	0.1 %	2,865	45,528
2009	6.3 %	0.1 %	2,955	47,121

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	8.2 %	0.1 %	3,259	39,799
2019	8.3 %	0.1 %	3,470	41,842
2018	7.8 %	0.1 %	3,304	42,170
2017	8.3 %	0.1 %	3,640	43,618
2016	8.0 %	0.1 %	3,620	45,520
2015	7.6 %	0.1 %	3,459	45,630
2014	7.7 %	0.1 %	3,510	45,541
2013	7.6 %	0.1 %	3,430	45,111
2012	7.5 %	0.1 %	3,388	45,008
2011	7.4 %	0.1 %	3,335	45,129
2010	7.9 %	0.1 %	3,599	45,512
2009	7.8 %	0.1 %	3,681	47,091

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	24.0 %	0.2 %	9,568	39,799
2019	23.6 %	0.2 %	9,881	41,842
2018	23.0 %	0.2 %	9,690	42,170
2017	22.5 %	0.2 %	9,816	43,618
2016	22.1 %	0.2 %	10,071	45,520
2015	21.3 %	0.2 %	9,703	45,630
2014	20.9 %	0.2 %	9,509	45,541
2013	20.6 %	0.2 %	9,307	45,111
2012	20.8 %	0.2 %	9,356	45,008
2011	21.2 %	0.2 %	9,554	45,129
2010	22.4 %	0.2 %	10,173	45,512
2009	23.5 %	0.2 %	11,061	47,091

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020/Q3-2021/Q2	1.0 %			
2019/Q4-2020/Q3	1.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	2.0 %			
2013/Q2-2014/Q1	3.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.9	0.3	206	41,954
2018	4.7	0.3	198	42,292
2017	5.8	0.4	254	43,752
2016	5.0	0.3	228	45,643
2015	5.3	0.3	241	45,767
2014	5.6	0.4	257	45,681
2013	5.6	0.4	254	45,281
2012	6.1	0.4	275	45,207
2011	5.4	0.4	245	45,285
2010	5.3	0.3	244	45,663
2009	6.0	0.4	286	47,287

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.8	0.3	203	41,858
2018	4.2	0.3	178	42,188
2017	5.3	0.4	233	43,631
2016	4.7	0.3	214	45,535
2015	5.1	0.3	235	45,655
2014	5.1	0.3	232	45,556
2013	4.9	0.3	223	45,155
2012	5.3	0.4	241	45,067
2011	4.6	0.3	206	45,155
2010	5.0	0.3	226	45,540
2009	4.9	0.3	229	47,132

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	3.1	0.3	130	41,858
2018	2.7	0.3	112	42,188
2017	3.6	0.3	158	43,631
2016	3.3	0.3	151	45,535
2015	3.4	0.3	154	45,655
2014	3.5	0.3	159	45,556
2013	3.5	0.3	159	45,155
2012	3.7	0.3	165	45,067
2011	3.0	0.3	137	45,155
2010	3.4	0.3	155	45,540
2009	3.3	0.3	157	47,132

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	1.7	0.2	73	41,858
2018	1.6	0.2	66	42,188
2017	1.7	0.2	75	43,631
2016	1.4	0.2	63	45,535
2015	1.8	0.2	81	45,655
2014	1.6	0.2	73	45,556
2013	1.4	0.2	64	45,155
2012	1.7	0.2	76	45,067
2011	1.5	0.2	69	45,155
2010	1.6	0.2	71	45,540
2009	1.5	0.2	72	47,132

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	143.3	18.5	60	41,858
2018	137.5	18.1	58	42,188
2017	183.4	20.5	80	43,631
2016	158.1	18.7	72	45,535
2015	179.6	19.9	82	45,655
2014	215.1	21.8	98	45,556
2013	186.0	20.3	84	45,155
2012	148.7	18.2	67	45,067
2011	155.0	18.5	70	45,155
2010	155.9	18.5	71	45,540
2009	144.3	17.5	68	47,132

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	98.0	15.3	41	41,858
2018	94.8	15.0	40	42,188
2017	77.9	13.4	34	43,631
2016	74.7	12.8	34	45,535
2015	92.0	14.2	42	45,655
2014	83.4	13.5	38	45,556
2013	62.0	11.7	28	45,155
2012	106.5	15.4	48	45,067
2011	68.7	12.3	31	45,155
2010	92.2	14.2	42	45,540
2009	80.6	13.1	38	47,132

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	11.6 %	1.3 %	4,897	42,265
2013	10.1 %	1.2 %	4,310	42,599
2012	8.1 %	1.5 %	3,376	41,756
2011	8.2 %	1.0 %	3,499	42,764
2010	6.9 %	0.9 %	2,977	43,216
2009	9.0 %	1.1 %	4,056	44,989
2008	7.4 %	1.1 %	3,470	46,776
2007	8.7 %	1.1 %	4,022	46,240

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	5.3	0.4	212	39,696
2018	5.7	0.4	228	40,074
2017	6.0	0.4	247	40,978
2016	6.3	0.4	266	42,213
2015	5.8	0.4	188	32,269
2014	5.6	0.4	237	42,658
2013	5.0	0.4	204	40,663
2012	4.5	0.3	185	40,863
2011	4.5	0.3	189	42,416
2010	3.5	0.3	151	42,917
2009	3.0	0.3	128	43,014
2008	2.4	0.2	105	44,661

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	12.7 %	1.3 %	104,750	823,046
2018_2019	12.9 %	1.5 %	106,464	828,406
2017_2018	12.7 %	1.7 %	104,322	818,895
2016_2017	13.8 %	1.6 %	112,021	809,162
2016	14.2 %	1.7 %	113,970	804,267

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	12.1	1.7	51	420,899
2019	11.2	1.6	48	426,951
2018	11.8	1.7	51	431,530
2017	18.0	2.0	78	432,617
2016	13.9	1.8	60	431,771
2015	10.3	1.6	44	427,431
2014	13.9	1.8	59	424,964
2013	14.6	1.9	62	424,820
2012	13.6	1.8	58	426,320
2011	19.7	2.2	84	427,236
2010	15.4	1.9	66	428,728
2009	15.0	1.9	64	426,907

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	36.0	2.7	178	494,629
2019	27.9	2.4	138	495,217
2018	31.0	2.5	154	496,049
2017	32.3	2.6	159	492,761
2016	29.9	2.5	146	487,868
2015	29.2	2.5	142	486,104
2014	28.5	2.4	138	484,709
2013	27.8	2.4	135	486,469
2012	30.1	2.5	147	487,734
2011	27.4	2.4	135	492,336
2010	26.7	2.3	133	497,413
2009	25.4	2.3	127	499,281

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	12.9	1.3	95	737,948
2017_2019	12.2	1.3	90	739,739
2016_2018	9.9	1.2	73	739,962
2015_2017	9.2	1.1	68	738,679
2014_2016	9.1	1.1	67	736,289
2013_2015	8.4	1.1	62	735,904
2012_2014	9.0	1.1	66	736,691
2011_2013	9.4	1.1	70	742,025
2010_2012	10.1	1.2	76	750,914
2009_2011	10.6	1.2	81	761,837
2008_2010	11.5	1.2	89	771,189
2007_2009	13.7	1.3	106	774,858

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	16.0	1.5	118	737,948
2017_2019	16.4	1.5	121	739,739
2016_2018	15.7	1.5	116	739,962
2015_2017	13.8	1.4	102	738,679
2014_2016	13.2	1.3	97	736,289
2013_2015	14.8	1.4	109	735,904
2012_2014	14.3	1.4	105	736,691
2011_2013	12.0	1.3	89	742,025
2010_2012	8.7	1.1	65	750,914
2009_2011	6.8	1.0	52	761,837
2008_2010	7.9	1.0	61	771,189
2007_2009	8.4	1.0	65	774,858

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	20.7 %	1.3 %	179,228	863,967
2018_2019	20.0 %	1.6 %	174,007	869,102
2017_2018	19.1 %	1.7 %	166,072	867,432
2016_2017	18.7 %	1.5 %	160,752	861,430
2016	18.5 %	1.7 %	158,652	857,791

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	14.9 %	2.2 %	26,556	178,360
2018_2019	13.9 %	3.1 %	24,149	174,007
2017_2018	15.9 %	3.8 %	26,447	166,072
2016_2017	15.7 %	3.3 %	25,297	160,752
2016	13.1 %	2.7 %	20,857	158,652

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	3.1 %	0.6 %	22,854	729,882
2018_2019	3.3 %	0.8 %	24,253	729,710
2017_2018	3.0 %	0.9 %	21,720	712,398
2016_2017	2.9 %	0.8 %	20,507	709,326
2016	3.1 %	0.9 %	22,358	719,267

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	8.5 %	1.0 %	62,167	727,364
2018_2019	8.6 %	1.2 %	62,779	728,568
2017_2018	9.4 %	1.4 %	66,599	711,121
2016_2017	8.8 %	1.4 %	62,570	708,236
2016	7.3 %	1.2 %	52,687	718,002

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	54.5 %	3.8 %	62,100	113,940
2018_2019	57.2 %	5.2 %	62,619	109,518
2017_2018	56.1 %	6.1 %	61,438	109,453
2016_2017	61.8 %	5.9 %	59,938	97,039
2016	66.6 %	5.8 %	63,764	95,752

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	90.9 %	1.0 %	784,476	863,165
2018_2019	90.6 %	1.3 %	786,368	867,625
2017_2018	90.6 %	1.3 %	783,649	864,786
2016_2017	90.9 %	1.2 %	779,686	857,685
2016	90.5 %	1.4 %	771,494	852,637

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	14.6 %	0.2 %	4,960	33,899
2016	14.7 %	0.2 %	5,079	34,485
2014	15.0 %	0.2 %	5,759	38,378
2012	15.9 %	0.2 %	6,560	41,161
2010	15.8 %	0.2 %	6,839	43,209
2008	15.3 %	0.2 %	5,774	37,805

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	13.7 %	1.8 %	53,475	389,275
2018_2019	12.9 %	2.3 %	48,478	376,608
2017_2018	11.7 %	2.4 %	41,225	353,254
2016_2017	11.4 %	2.1 %	39,128	344,559
2016	10.2 %	2.1 %	35,493	347,510

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	4.1 %	0.4 %	35,030	862,749
2018	3.8 %	0.4 %	33,420	871,296
2017	3.2 %	0.3 %	27,846	873,672
2016	3.2 %	0.3 %	27,491	865,952
2015	3.4 %	0.3 %	29,083	860,460
2014	4.3 %	0.4 %	37,005	859,220
2013	6.3 %	0.5 %	54,203	858,451
2012	5.6 %	0.4 %	48,003	860,266
2011	7.0 %	0.5 %	59,863	860,804
2010	8.8 %	0.5 %	75,704	865,557
2009	10.9 %	0.6 %	95,262	873,304

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	70.2 %	4.1 %	32,000	46,000
2016	67.5 %	5.0 %	31,000	46,000
2015	67.7 %	3.9 %	31,000	46,000
2014	58.9 %	3.7 %	27,000	46,000
2013	67.5 %	4.1 %	32,000	47,000
2012	58.7 %	4.3 %	28,000	47,000
2011	58.5 %	3.9 %	27,000	46,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	55.2 %	1.7 %	447,575	810,824
2019_2020	64.1 %	1.6 %	521,089	812,931
2018_2019	61.0 %	2.1 %	501,301	822,074
2017_2018	54.0 %	2.1 %	438,382	811,749
2016_2017	52.0 %	2.0 %	420,366	808,707
2015_2016	54.6 %	2.0 %	436,102	799,015
2014_2015	58.8 %	2.3 %	477,467	812,019
2013_2014	53.1 %	2.1 %	429,001	808,697
2012_2013	47.7 %	2.0 %	388,583	814,457
2011_2012	44.4 %	2.5 %	356,862	802,943
2010_2011	41.6 %	3.0 %	339,013	814,935
2009_2010	31.1 %	2.2 %	263,280	846,559

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	78.5 %	2.7 %	195,411	248,839
2019	74.6 %	3.3 %	183,342	245,918
2018	75.3 %	3.1 %	184,364	244,776
2017	71.2 %	2.8 %	172,801	242,645
2016	61.7 %	3.3 %	150,720	244,200
2015	64.1 %	3.0 %	155,665	242,729

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	87.4 %	2.4 %	217,539	248,839
2019	90.2 %	2.2 %	221,809	245,918
2018	86.1 %	2.5 %	210,725	244,776
2017	86.3 %	2.1 %	209,469	242,645
2016	83.2 %	2.8 %	203,105	244,200
2015	89.4 %	1.9 %	217,103	242,729
2014	88.0 %	2.2 %	215,695	245,058
2013	87.0 %	2.2 %	212,294	244,102
2012	86.0 %	2.3 %	209,754	243,916
2011	83.1 %	2.6 %	202,268	243,453
2010	66.6 %	3.1 %	160,678	241,239
2009	55.5 %	2.9 %	136,773	246,269

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	87.5 %	2.2 %	217,629	248,839
2019	85.0 %	2.7 %	209,017	245,918
2018	83.0 %	2.6 %	203,158	244,776
2017	77.0 %	2.6 %	186,951	242,645
2016	70.6 %	3.1 %	172,273	244,200
2015	75.2 %	2.8 %	182,589	242,729
2014	68.4 %	3.1 %	167,664	245,058
2013	65.3 %	2.9 %	159,346	244,102
2012	58.3 %	3.2 %	142,098	243,916
2011	55.8 %	3.4 %	135,730	243,453
2010	52.4 %	3.3 %	126,353	241,239
2009	41.6 %	2.8 %	102,330	246,269

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	10.1	0.3	1,210	119,475
2019	12.1	0.3	1,451	119,931
2018	13.3	0.3	1,598	120,144
2017	15.0	0.4	1,809	120,366
2016	16.6	0.4	2,004	120,384
2015	19.1	0.4	2,284	119,671
2014	20.1	0.4	2,390	119,166
2013	21.9	0.4	2,594	118,698
2012	23.8	0.5	2,851	119,873
2011	25.9	0.5	3,134	121,005
2010	28.3	0.5	3,496	123,416
2009	32.5	0.5	4,063	125,101

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	15.7 %	1.4 %	4,922	31,380
2019	12.7 %	1.1 %	4,986	39,104
2018	8.0 %	1.0 %	3,176	39,781
2015	9.7 %	1.1 %	4,112	42,451
2013	11.8 %	1.2 %	4,998	42,467
2012	9.5 %	1.5 %	4,040	42,498

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	3.5 %	0.5 %	29,939	860,061
2018_2019	3.0 %	0.6 %	25,945	858,779
2017_2018	3.4 %	0.8 %	29,535	858,722
2016_2017	3.3 %	0.8 %	28,486	859,837
2016	3.4 %	0.9 %	29,388	855,727

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Oregon

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				71	73
Annual Indicator			70.8	72.0	73.0
Numerator			517,099	529,410	536,467
Denominator			730,360	735,342	735,357
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	74.0	75.0	76.0	77.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	93.8	94	89.6	93.6	93.4
Annual Indicator	93.2	89.4	93.5	93.2	93.7
Numerator	44,505	38,219	35,799	35,964	37,831
Denominator	47,759	42,729	38,275	38,600	40,359
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	93.8	94.0	94.2	94.4

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	35	39	34	31.8	35.8
Annual Indicator	38.3	33.4	31.6	35.6	36.3
Numerator	17,140	13,911	11,640	13,431	13,923
Denominator	44,757	41,664	36,894	37,678	38,346
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	36.4	36.6	36.8	37.0

Field Level Notes for Form 10 NPMs:

None

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Federally Available Data			
Data Source: HCUP - State Inpatient Databases (SID)			
	2019	**2020**	**2021**
Annual Objective			121
Annual Indicator	127.1	122.1	125.0
Numerator	609	582	588
Denominator	479,233	476,789	470,263
Data Source	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2017	2018	2019

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	124.0	123.0	122.0	121.0

Field Level Notes for Form 10 NPMs:

None

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - Perpetration			
	2019	**2020**	**2021**
Annual Objective			16
Annual Indicator	16.3	16.1	15.4
Numerator	44,259	44,099	43,323
Denominator	270,893	273,112	281,511
Data Source	NSCHP	NSCHP	NSCHP
Data Source Year	2018	2018_2019	2019_2020

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - Victimization			
	2019	**2020**	**2021**
Annual Objective			16
Annual Indicator	47.9	44.1	38.3
Numerator	129,756	120,491	108,108
Denominator	271,087	273,209	282,302
Data Source	NSCHV	NSCHV	NSCHV
Data Source Year	2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	15.2	15.0	14.8	14.6

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		51	44	42	36
Annual Indicator	31.3	38.6	42.2	34.5	37.9
Numerator	49,675	61,991	70,156	60,052	67,509
Denominator	158,652	160,752	166,072	174,007	178,300
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	38.0	39.0	40.0	41.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - 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 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		40	18	27	28
Annual Indicator	15.8	16.5	26.8	30.9	27.2
Numerator	12,536	11,986	18,726	24,088	22,797
Denominator	79,458	72,528	69,860	78,055	83,675
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
2022	**2023**	**2024**	**2025**	
Annual Objective	29.0	30.0	31.0	32.0

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Oregon

SPM 1 - Percentage of new mothers who experienced stressful life events before or during pregnancy

Measure Status:	Active

State Provided Data	2017	2018	2019	2020	2021
Annual Objective	43	41	43	43	42.5
Annual Indicator	41.3	44.8	43	42.8	46.6
Numerator					
Denominator					
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2015	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives	2022	2023	2024	2025
Annual Objective	46.4	46.2	46.0	45.8

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	90.7	94.6	93.5	94.2	93.9
Annual Indicator	94.4	93.3	94	93.8	94.3
Numerator					
Denominator					
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2016	2017	2018	2019	2019/2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
2022	**2023**	**2024**	**2025**
Annual Objective	94.4	94.5	94.6	94.7

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Percent of children living in a household that received food or cash assistance

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			43.2
Annual Indicator	42.3	43.3	41.4
Numerator			
Denominator			
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2018	2019	2019/2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	41.3	41.2	41.1	41.0

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Oregon

ESM 1.1 - Percent of new mothers who have had a postpartum checkup.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	92.8	93.2
Numerator		
Denominator		
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	93.4	93.6	93.8	94.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.2 - Among local grantees who select well woman care, percent who report improved knowledge, skills, or policies based on provided technical assistance.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		81.8
Numerator		9
Denominator		11
Data Source		Local grantee database
Data Source Year		2021
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.3 - Completion of environmental scan of organizations and partners to facilitate determination of Title V's role in increasing diversity in the perinatal workforce.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data is not reported as work has not yet begun on this strategy.

ESM 1.4 - Number of OHA Office of Equity and Inclusion certified community health workers and doulas.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	604	926
Numerator		
Denominator		
Data Source	OEI	OEI
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	930.0	940.0	950.0	960.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.5 - Completion of environmental scan to determine role of Title V in perinatal behavioral health.

Measure Status:	Inactive - Staff capacity changed and this strategy is no longer being conducted.

Baseline data was not available/provided.

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Breastfeeding initiation among Non-Hispanic Black mothers.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	93	94.2
Numerator		
Denominator		
Data Source	Vital statistics	Vital statistics
Data Source Year	2017	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	94.5	94.6	94.7	94.8

Field Level Notes for Form 10 ESMs:

None

ESM 4.2 - Breastfeeding initiation among Non-Hispanic American Indian/Alaska Native mothers.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	89	94.4
Numerator		
Denominator		
Data Source	Vital statistics	Vital statistics
Data Source Year	2017	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	94.5	94.6	94.7	94.8

Field Level Notes for Form 10 ESMs:

None

ESM 4.3 - Exclusive breastfeeding at 6 months among Non-Hispanic Black mothers.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	57	57
Numerator		
Denominator		
Data Source	PRAMS-2	PRAMS-2
Data Source Year	2017	2017
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	57.5	58.0	58.5	59.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Updated data is not yet available from PRAMS-2

ESM 4.4 - Exclusive breastfeeding at 6 months among Non-Hispanic American Indian/Alaska Native mothers.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	67	67
Numerator		
Denominator		
Data Source	PRAMS-2	PRAMS-2
Data Source Year	2017	2017
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	67.5	68.0	68.5	69.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Updated data is not yet available from PRAMS-2

ESM 4.5 - Among local grantees who select breastfeeding, percent who report improved knowledge, skills, or policies based on provided technical assistance.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		42.9
Numerator		3
Denominator		7
Data Source		Local grantee database
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.6 - Completion of environmental scan of organizations and partners to facilitate determination of Title V's role in increasing diversity in the perinatal workforce.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data is not reported as work has not yet begun on this strategy.

ESM 4.7 - Number of OHA Office of Equity and Inclusion certified community health workers and doulas.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	604	926
Numerator		
Denominator		
Data Source	OEI	OEI
Data Source Year	2020	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	930.0	940.0	950.0	960.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.8 - Number of providers engaged in anti-racism or cultural humility training.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		101
Numerator		
Denominator		
Data Source		State and local tracking
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	30.0	30.0	30.0	30.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.1 - Injury death rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	6.3	6.4
Numerator	87	88
Denominator	1,385,268	1,381,916
Data Source	Vital statistics and census	Vital statistics and census
Data Source Year	2018-20	2019-21
Provisional or Final ?	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	6.3	6.2	6.1	6.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.2 - Transportation injury death rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	2.2	2.5
Numerator	31	34
Denominator	1,385,268	1,381,916
Data Source	Vital statistics and census	Vital statistics and census
Data Source Year	2018-20	2019-21
Provisional or Final ?	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	2.4	2.3	2.2	2.1

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.3 - Drowning death rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	0.9	0.9
Numerator	20	20
Denominator	2,335,113	2,326,367
Data Source	Vital statistics and census	Vital statistics and census
Data Source Year	2016-20	2017-21
Provisional or Final ?	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	0.9	0.9	0.8	0.8

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.4 - Poisoning injury rate among children 0 - 9 years of age

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	85.9	85.9
Numerator	1,190	1,187
Denominator	1,385,268	1,381,916
Data Source	Vital statistics and hospitalization data	Vital statistics and hospitalization data
Data Source Year	2018-20	2019-21
Provisional or Final ?	Final	Provisional

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	85.0	84.0	83.0	82.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.1.5 - Among local grantees who select child injury prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
This data is not yet available as local grantees have not yet reported on this priority area. Data will be available for the 2024 Title V Block Grant.

ESM 7.1.6 - Percent of engaged partner groups including other state agencies, local grantees, and marginalized community representatives, that report satisfaction with level of engagement in the development of a collaborative child injury report.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	80.0	80.0	80.0	80.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data is not reported as work has not yet begun on this strategy.

ESM 7.1.7 - Completed assessment of injury prevention risk assessment, education, and remediation in Oregon's public health home visiting programs.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data is not reported as work has not yet begun on this strategy.

ESM 9.1 - Percent of 8th and 11th graders who have experienced bullying.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	24.9	11.9
Numerator		
Denominator		
Data Source	Oregon Healthy Teens Survey	Oregon Student Health Survey
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	11.8	11.7	11.6	11.5

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
2019 data should not be directly compared to 2020 data, as the survey has been updated, and methodology changed. Data from 2020 onwards can be directly compared.

ESM 9.2 - Percent of 8th and 11th graders who have experienced bullying due to their race or ethnicity.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	4.4	2
Numerator		
Denominator		
Data Source	Oregon Healthy Teens Survey	Oregon Student Health Survey
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	1.9	1.8	1.7	1.6

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
2019 data should not be directly compared to 2020 data, as the survey has been updated, and methodology changed. Data from 2020 onwards can be directly compared.

ESM 9.3 - Percent of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	4.7	3.1
Numerator		
Denominator		
Data Source	Oregon Healthy Teens Survey	Oregon Student Health Survey
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	3.0	2.9	2.8	2.7

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
2019 data should not be directly compared to 2020 data, as the survey has been updated, and methodology changed. Data from 2020 onwards can be directly compared.

ESM 9.4 - Percent of 8th and 11th graders who have experienced bullying due to a disability.

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator		2.3
Numerator		
Denominator		
Data Source		Oregon Student Health Survey
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	2.2	2.1	2.0	1.9

Field Level Notes for Form 10 ESMs:

None

ESM 9.5 - Among local grantees who select bullying prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
This data is not yet available as local grantees have not yet reported on this priority area. Data will be available for the 2024 Title V Block Grant.

ESM 9.6 - Completion of environmental scan of youth serving agencies.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data is not reported as work has not yet begun on this strategy.

ESM 9.7 - Number of activities completed that increase local access to bullying prevention resources.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	5.0	5.0	5.0	5.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data is not reported as work has not yet begun on this strategy.

ESM 11.1 - Primary care involvement in shared care planning

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			20
Annual Indicator	34	26.9	37.8
Numerator	36	14	17
Denominator	106	52	45
Data Source	Shared Care Plan Information Form (SIF)	Shared Care Plan Information Form (SIF)	Shared Care Plan Information Form (SIF)
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	25.0	30.0	35.0	40.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: We consider these to be baseline data. Data source: Shared Care Plan Information Form (SIF) Item: How did the team member [Primary Care Provider] participate in shared care planning? In person, by phone, by video, and written comment.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The decline in volume of shared care planning meetings is reflective of LPHAs reassigning their nursing staff to respond to COVID. We've included 2019 results as baseline data to understand what shared care planning looked like prior to COVID. Data source: Shared Care Plan Information Form (SIF) Item: How did the team member [Primary Care Provider] participate in shared care planning? In person, by phone, by video, and written comment.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The decline in volume of shared care planning meetings is reflective of LPHAs continuing to respond to COVID. We've included 2019 (baseline) results to show progress prior to the COVID-19 pandemic . We started collecting data for this ESM on October 1, 2021. Data source: Shared Care Plan Information Form (SIF) Item: How did the team member [Primary Care Provider] participate in shared care planning? In person, by phone, by video, and written comment.	

ESM 12.1 - Young adult with medical complexity/family participation in transition preparation appointments

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			20
Annual Indicator			0
Numerator			
Denominator			
Data Source			CMC CoIIN Project process tracking form
Data Source Year			2021
Provisional or Final ?			Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	30.0	40.0	50.0	60.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
We have no data to report for this year. Our team's learning resulted in a change to the focus of our clinical QI project, the implementation of which was delayed because OHSU COVID protocol required that we halt our clinical work during this period.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Oregon

SPM 1 - Percentage of new mothers who experienced stressful life events before or during pregnancy
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To reduce the experience of chronic stress before and during pregnancy
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of new mothers who experienced two or more of 16 types of prenatal stress 12 months prior to giving birth, including intimate partner violence prior to or during pregnancy **Denominator:** Number of new mothers
Data Sources and Data Issues:	Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	Adults who experience violence and trauma are also at increased risk for a variety of poor health and social outcomes. Without effective support and intervention, the risk increases for inter-generational exposure to toxic stress and trauma, creating a “vicious circle” of self-reinforcing mechanisms that undermine population health and well-being. A public health approach to reducing toxic stress includes strategies for preventing or reducing extreme stress and trauma, building resilience, and providing effective care and treatment for people who have been exposed to trauma.

SPM 2 - Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To improve the cultural sensitivity and responsiveness of healthcare providers who serve children < 18 years of age
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children age 0 - 17 years who have a healthcare provider who is usually or always sensitive to their family's values and customs **Denominator:** Number of children age 0 - 17 years
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)
Significance:	The field of maternal and child health is grounded in a life course framework which recognizes the need to eliminate health inequities in order to improve the health of all women, children, and families. Health inequities are systemic, avoidable, unfair and unjust differences in health status and mortality rates that are sustained over generations and beyond the control of individuals. Institutional changes, including the development of culturally and linguistically responsive maternal and child health (MCH) services and systems are needed to address health inequities. The principal national standard for culturally and linguistically appropriate services (CLAS) is: Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

SPM 3 - Percent of children living in a household that received food or cash assistance
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	To reduce poverty among families
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children living in households that received food or cash assistance **Denominator:** Number of households with children < 18
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)
Significance:	Women and children are particularly vulnerable and overrepresented among those impacted by poverty, homelessness, unhealthy housing, employment instability, family and community violence, and other social determinants of health (SDOH). These factors amplify the impacts of adversity and inequity on women and children's health throughout the lifespan. Among SDOH, housing concerns consistently rank at or near the top of family and community concerns (including housing affordability and homelessness, health and safety of existing housing, and the neighborhood and physical environment). Recent studies show strong correlations between housing stability and child outcomes. Multiple aspects of housing quality and the social and physical environment of the home impact women and children's health. These include air quality, home safety, presence of mold, asbestos and lead. Poor-quality housing is associated with various negative health outcomes, including chronic disease and injury and poor mental health. A focus on SDOH is increasingly recognized as essential to improving the health of families and communities, achieving successful health systems transformation, and improving health equity in Oregon.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Oregon

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Oregon

ESM 1.1 - Percent of new mothers who have had a postpartum checkup.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the percent of women, particularly in marginalized communities, who access postpartum care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of new mothers who have had a postpartum checkup **Denominator:** Number of new mothers
Data Sources and Data Issues:	Pregnancy Risk Assessment Monitoring System (PRAMS)
Evidence-based/informed strategy:	Ensure access to culturally responsive preventive clinical care for low income and undocumented women.
Significance:	Postpartum care is important in the management of chronic health conditions, the facilitation of women's access to contraceptives, the early identification of postpartum health concerns, and as a connection point to increase utilization of well woman care.

ESM 1.2 - Among local grantees who select well woman care, percent who report improved knowledge, skills, or policies based on provided technical assistance.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To provide technical assistance to local grantees that leads to an increase in well woman care utilization.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of local grantees that report improvements following state technical assistance **Denominator:** Number of local grantees that selected well woman care as a priority
Data Sources and Data Issues:	Local grantee reports
Evidence-based/informed strategy:	Support advanced training, coaching and quality improvement activities for home visitors related to well woman care.
Significance:	A crucial component of state level efforts to increase women's access to well woman care is to support local grantees, by providing technical assistance and resources.

ESM 1.3 - Completion of environmental scan of organizations and partners to facilitate determination of Title V's role in increasing diversity in the perinatal workforce.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase diversity of the workforce that serves perinatal populations.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Support efforts to improve diversity in the workforce.
Significance:	Before activities to increase diversity in the perinatal workforce can be undertaken, an inventory of organizations and partners that can act as collaborators in the work needs to be completed.

ESM 1.4 - Number of OHA Office of Equity and Inclusion certified community health workers and doulas.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase diversity of the workforce that serves perinatal populations.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of OHA Office of Equity and Inclusion certified community health workers and doulas. **Denominator:**
Data Sources and Data Issues:	OHA Office of Equity and Inclusion Tracking
Evidence-based/informed strategy:	Support efforts to improve diversity in the workforce
Significance:	The certification of community/traditional health workers and doulas is a key strategy towards increasing the diversity of the workforce that serves perinatal populations.

ESM 1.5 - Completion of environmental scan to determine role of Title V in perinatal behavioral health.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Inactive - Staff capacity changed and this strategy is no longer being conducted.
Goal:	To determine where Title V can best impact perinatal behavioral health.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Strengthen early identification of and supports for women's behavioral health needs.
Significance:	Behavioral health is a key component of perinatal wellbeing, however Title V's role in this area is not well defined. In order to support perinatal behavioral health without duplication of efforts, an environmental scan will be completed of current partner efforts and opportunities to: be involved in development of new policies and implementation of policy changes; participate in state level initiatives to address perinatal behavioral health; and opportunities to attend meetings with partners relevant to perinatal behavioral health

ESM 4.1 - Breastfeeding initiation among Non-Hispanic Black mothers.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase breastfeeding among marginalized communities.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Non-Hispanic Black mothers that initiate breastfeeding **Denominator:** Number of Non-Hispanic Black mothers
Data Sources and Data Issues:	Vital statistics
Evidence-based/informed strategy:	Promote & support laws and policies for pregnant & breastfeeding people in the workplace. Focus on populations with additional barriers.
Significance:	While Oregon has a consistently high rate of breastfeeding initiation, racial/ethnic disparities in this rate persist. Examining the breastfeeding rate among marginalized communities will facilitate the evaluation of the effectiveness of laws and policies that support breastfeeding individuals.

ESM 4.2 - Breastfeeding initiation among Non-Hispanic American Indian/Alaska Native mothers.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase breastfeeding among marginalized communities.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of Non-Hispanic American Indian/Alaska Native mothers that initiate breastfeeding</td></tr><tr><td>**Denominator:**</td><td>Number of Non-Hispanic American Indian/Alaska Native mothers</td></tr></table>
Data Sources and Data Issues:	Vital statistics
Evidence-based/informed strategy:	Promote & support laws and policies for pregnant & breastfeeding people in the workplace. Focus on populations with additional barriers.
Significance:	While Oregon has a consistently high rate of breastfeeding initiation, racial/ethnic disparities in this rate persist. Examining the breastfeeding rate among marginalized communities will facilitate the evaluation of the effectiveness of laws and policies that support breastfeeding individuals.

ESM 4.3 - Exclusive breastfeeding at 6 months among Non-Hispanic Black mothers.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase breastfeeding among marginalized communities.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Non-Hispanic Black mothers that exclusively breastfeed for 6 months postpartum **Denominator:** Number of Non-Hispanic Black mothers
Data Sources and Data Issues:	PRAMS-2/ECHO
Evidence-based/informed strategy:	Promote & support laws and policies for pregnant & breastfeeding people in the workplace. Focus on populations with additional barriers.
Significance:	While Oregon has a consistently high rate of breastfeeding exclusivity at 6 months postpartum, racial/ethnic disparities in this rate persist. Examining the breastfeeding rate among marginalized communities will facilitate the evaluation of the effectiveness of laws and policies that support breastfeeding individuals.

ESM 4.4 - Exclusive breastfeeding at 6 months among Non-Hispanic American Indian/Alaska Native mothers. NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase breastfeeding among marginalized communities.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of Non-Hispanic American Indian/Alaska Native mothers that exclusively breastfeed for 6 months postpartum</td></tr><tr><td>**Denominator:**</td><td>Number of Non-Hispanic American Indian/Alaska Native mothers</td></tr></table>
Data Sources and Data Issues:	PRAMS-2ECHO
Evidence-based/informed strategy:	Promote & support laws and policies for pregnant & breastfeeding people in the workplace. Focus on populations with additional barriers.
Significance:	While Oregon has a consistently high rate of breastfeeding exclusivity at 6 months postpartum, racial/ethnic disparities in this rate persist. Examining the breastfeeding rate among marginalized communities will facilitate the evaluation of the effectiveness of laws and policies that support breastfeeding individuals.

ESM 4.5 - Among local grantees who select breastfeeding, percent who report improved knowledge, skills, or policies based on provided technical assistance.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To provide technical assistance to local grantees that leads to an increase in breastfeeding.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of local grantees that report improvements following state technical assistance **Denominator:** Number of local grantees that selected breastfeeding as a priority
Data Sources and Data Issues:	Local grantee reports
Evidence-based/informed strategy:	Support advanced training, coaching and quality improvement activities for home visitors related to breastfeeding.
Significance:	A crucial component of state level efforts to increase breastfeeding rates is to support local grantees, by providing technical assistance and resources.

ESM 4.6 - Completion of environmental scan of organizations and partners to facilitate determination of Title V's role in increasing diversity in the perinatal workforce.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase diversity of the workforce that serves perinatal populations.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Support efforts to improve diversity in the workforce
Significance:	Before activities to increase diversity in the perinatal workforce can be undertaken, an inventory of organizations and partners that can act as collaborators in the work needs to be completed.

ESM 4.7 - Number of OHA Office of Equity and Inclusion certified community health workers and doulas.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase diversity of the workforce that serves perinatal populations.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of OHA Office of Equity and Inclusion certified community health workers and doulas. **Denominator:**
Data Sources and Data Issues:	OHA Office of Equity and Inclusion Tracking
Evidence-based/informed strategy:	Support efforts to improve diversity in the workforce
Significance:	The certification of community/traditional health workers and doulas is a key strategy towards increasing the diversity of the workforce that serves perinatal populations.

ESM 4.8 - Number of providers engaged in anti-racism or cultural humility training.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To improves access to culturally responsive care for marginalized communities.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of providers engaged in anti-racism or cultural humility training. **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Ensure that providers who serve tribal members have training in culturally specific approaches to breastfeeding promotion and support.
Significance:	As part of an increased focus of addressing health equity and racial/ethnic disparities in breastfeeding rates, perinatal providers will be engaged in anti-racism and cultural humility training.

ESM 7.1.1 - Injury death rate among children 0 - 9 years of age
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To prevent deaths due to injury among children ages 0 - 9
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of deaths due to injury among children 0 - 9 years of age **Denominator:** Per 100,000 population of children ages 0 - 9
Data Sources and Data Issues:	Vital statistics and census
Evidence-based/informed strategy:	Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.
Significance:	Unintentional injuries are largely preventable, and yet unintentional injury is the leading cause of death, hospitalizations and emergency department visits for infants, children and adolescents. In Oregon, unintentional injury is the leading cause of death for children and youth over age 1. This measure is intended to complement the National Performance Measure for injury hospitalizations.

ESM 7.1.2 - Transportation injury death rate among children 0 - 9 years of age
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To prevent transportation injury deaths among children ages 0 - 9
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of deaths due to transportation injury among children 0 - 9 years of age **Denominator:** Per 100,000 population of children ages 0 - 9
Data Sources and Data Issues:	Vital statistics and census
Evidence-based/informed strategy:	Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.
Significance:	Motor vehicle/transportation is the leading cause of injury death for children 1-19 years old, and the 3rd leading cause of hospitalization for children 1-9 years old. Transportation related injuries and deaths are preventable through policy changes, education and safer environments.

ESM 7.1.3 - Drowning death rate among children 0 - 9 years of age
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To prevent drowning deaths among children 0 - 9 years of age
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of drowning deaths among children 0 - 9 years of age **Denominator:** Per 100,000 population of children ages 0 - 9
Data Sources and Data Issues:	Vital statistics
Evidence-based/informed strategy:	Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.
Significance:	Drowning is the second leading cause of death for children birth to 9, and a leading cause of death for children 10-19 years of age. Drowning is preventable through policy changes, education and safer environments.

ESM 7.1.4 - Poisoning injury rate among children 0 - 9 years of age
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To prevent poisoning injuries among children 0 - 9 years of age
Definition:	**Unit Type:** Rate **Unit Number:** 100,000 **Numerator:** Number of hospitalizations due to poisoning among children 0 - 9 years of age **Denominator:** Per 100,000 population of children ages 0 - 9
Data Sources and Data Issues:	Hospitalization Data and Census Data
Evidence-based/informed strategy:	Identify child injury prevention needs and priorities; use them to develop, promote and/or implement data-informed child injury policy.
Significance:	Poisoning is the leading cause of injury hospitalization for all ages, 0-19, and the 6th cause of death for children 1-4 years old. Poisoning is preventable through policy changes, education and safer environments.

ESM 7.1.5 - Among local grantees who select child injury prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To provide technical assistance to local grantees in the prevention of child injury.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of local grantees that report improvements following state technical assistance **Denominator:** Number of local grantees that selected child injury prevention as a priority
Data Sources and Data Issues:	Local grantee reports
Evidence-based/informed strategy:	Strengthen workforce capacity to address child injury prevention at the state and local level.
Significance:	A crucial component of state level efforts to prevent child injury is to support local grantees, by providing technical assistance and resources.

ESM 7.1.6 - Percent of engaged partner groups including other state agencies, local grantees, and marginalized community representatives, that report satisfaction with level of engagement in the development of a collaborative child injury report.
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To create a comprehensive statewide child injury report
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of engaged partner groups including other state departments, local grantees, and affected communities, that report satisfaction with level of engagement in the development of a collaborative child injury report</td></tr><tr><td>**Denominator:**</td><td>Number of partner groups engaged in the development of a collaborative child injury report</td></tr></table>
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Improve data collection, analysis, interpretation and dissemination of child injury data to focus on prevention efforts.
Significance:	An important piece in the development of a statewide injury report is the engagement of partners, to avoid duplication of efforts, and to ensure that all voices are heard, including those of marginalized communities.

ESM 7.1.7 - Completed assessment of injury prevention risk assessment, education, and remediation in Oregon's public health home visiting programs.
NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To assess injury prevention efforts in Oregon's home visiting programs.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Strengthen workforce capacity to address child injury prevention at the state and local level.
Significance:	In order to better provide technical assistance in the prevention of child injury to the home visiting workforce, Title V first needs to examine what currents efforts are, and where improvements can be made in education or referral services.

ESM 9.1 - Percent of 8th and 11th graders who have experienced bullying.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To decrease bullying.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 8th and 11th graders who have experienced bullying **Denominator:** Number of 8th and 11th graders
Data Sources and Data Issues:	2019 data from the Oregon Healthy Teens Survey. 2020 data and beyond from the Student Health Survey.
Evidence-based/informed strategy:	Support bullying prevention education in schools.
Significance:	While the Title V National Performance Measure for bullying prevention uses data from the National Survey of Children's Health, the sample size is quite small in Oregon, and disaggregation of this data in order to examine disparities is not always reliable. The Oregon based Student Health Survey has a larger sample size and can be more reliably disaggregated. The Student Health Survey also has the advantage of being asked of youth themselves, rather than relying on parent report. The results of this survey will be used to examine the rate of bullying among all students, and among specific marginalized communities of youth.

ESM 9.2 - Percent of 8th and 11th graders who have experienced bullying due to their race or ethnicity.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To decrease bullying among marginalized communities.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of 8th and 11th graders who have experienced bullying due to their race or ethnicity</td></tr><tr><td>**Denominator:**</td><td>Number of 8th and 11th graders</td></tr></table>
Data Sources and Data Issues:	2019 data from the Oregon Healthy Teens Survey. 2020 data and beyond from the Student Health Survey.
Evidence-based/informed strategy:	Support bullying prevention education in schools.
Significance:	While the Title V National Performance Measure for bullying prevention uses data from the National Survey of Children's Health, the sample size is quite small in Oregon, and disaggregation of this data in order to examine disparities is not always reliable. The Oregon based Student Health Survey has a larger sample size and can be more reliably disaggregated. The Student Health Survey also has the advantage of being asked of youth themselves, rather than relying on parent report. The results of this survey will be used to examine the rate of bullying among all students, and among specific marginalized communities of youth.

ESM 9.3 - Percent of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To decrease bullying among marginalized communities.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 8th and 11th graders who have experience bullying due to their sexual orientation or gender identity **Denominator:** Number of 8th and 11th graders
Data Sources and Data Issues:	2019 data from the Oregon Healthy Teens Survey. 2020 data and beyond from the Student Health Survey.
Evidence-based/informed strategy:	Support bullying prevention education in schools.
Significance:	While the Title V National Performance Measure for bullying prevention uses data from the National Survey of Children's Health, the sample size is quite small in Oregon, and disaggregation of this data in order to examine disparities is not always reliable. The Oregon based Student Health Survey has a larger sample size and can be more reliably disaggregated. The Student Health Survey also has the advantage of being asked of youth themselves, rather than relying on parent report. The results of this survey will be used to examine the rate of bullying among all students, and among specific marginalized communities of youth.

ESM 9.4 - Percent of 8th and 11th graders who have experienced bullying due to a disability.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To decrease bullying among marginalized communities.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 8th and 11th graders who have experienced bullying due to a disability **Denominator:** Number of 8th and 11th graders
Data Sources and Data Issues:	Bullying due to disability was not listed on the Oregon Healthy Teens Survey, so the first available data will be 2020 data from the Student Health Survey.
Evidence-based/informed strategy:	Support bullying prevention education in schools.
Significance:	While the Title V National Performance Measure for bullying prevention uses data from the National Survey of Children's Health, the sample size is quite small in Oregon, and disaggregation of this data in order to examine disparities is not always reliable. The Oregon based Student Health Survey has a larger sample size and can be more reliably disaggregated. The Student Health Survey also has the advantage of being asked of youth themselves, rather than relying on parent report. The results of this survey will be used to examine the rate of bullying among all students, and among specific marginalized communities of youth.

ESM 9.5 - Among local grantees who select bullying prevention, percent who report improved knowledge, skills, or policies based on provided technical assistance.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To provide technical assistance to local grantees in the prevention of bullying.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of local grantees that report improvements following state technical assistance</td></tr><tr><td>**Denominator:**</td><td>Number of local grantees that selected bullying prevention as a priority</td></tr></table>
Data Sources and Data Issues:	Local grantee reports
Evidence-based/informed strategy:	Support the workforce to understand the impact of bullying on adolescent health.
Significance:	A crucial component of state level efforts to prevent bullying is to support local grantees, by providing technical assistance and resources.

ESM 9.6 - Completion of environmental scan of youth serving agencies.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To facilitate Title V youth engagement in bullying prevention activities.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Support youth participatory action research on bullying prevention.
Significance:	A key focus of the Title V bullying prevention efforts is to ensure that youth are engaged in all components of the work. In order to access youth, Title V will partner with youth serving agencies, which will be identified through this environmental scan.

ESM 9.7 - Number of activities completed that increase local access to bullying prevention resources.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	To support local access to resources that decrease bullying.
Definition:	**Unit Type:** Count **Unit Number:** 20 **Numerator:** Number of activities completed that increase local access to bullying prevention resources **Denominator:**
Data Sources and Data Issues:	State tracking
Evidence-based/informed strategy:	Determine gaps and opportunities for bullying prevention partnerships and initiatives with internal and external partners.
Significance:	Activities will be completed to increase local access to bullying prevention resources. In order to optimize the efficacy of these resources, gaps and opportunities where they can best be leveraged by local agencies will be identified.

ESM 11.1 - Primary care involvement in shared care planning
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	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.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of shared care plans with a primary care representative assisting the LPHA to prepare for, or participating in, a new or re-evaluation shared care planning meeting in a given year. **Denominator:** Number of shared care plans in the same year.
Data Sources and Data Issues:	The data source for this ESM is the Shared care plan Information Form (SIF), which is a data collection administered by OCCYSHN. LPHAs complete a SIF after each shared care planning meeting. OCCYSHN contracts require LPHA participation in this data collection and request that LPHAs complete their SIF within two weeks of a shared care planning meeting. For 2019, 2020, and 2021 data, we report data from this SIF item, “How did the team member [Primary Care Provider] participate in shared care planning?” - In person, by phone, by video, and written comment. A limitation of using this item for baseline results is that it only captures part of the new ESM indicator for 2021-2025. That is, baseline results reflect primary care provider meeting participation but do not reflect primary care provider assistance to LPHAs for meeting preparation. We established objectives in June 2020, and started collecting data for this ESM in October 2021. We are still learning how COVID-19 is affecting LPHAs ability to implement shared care planning and, as a result, may have to adjust our objectives in the future.
Evidence-based/informed strategy:	This ESM measures evidence-based/informed strategy 11.1, OCCYSHN will improve access to family-centered, team-based, cross-systems care coordination for CYSHCN and their families through workforce development and financing activities (see CYSHCN State Action Plan Narrative, NPM 11, Activity 11.1.3). The National Standards for Systems of Care for CYSHCN, the National Care Coordination Standards and McAllister’s (2014) shared care planning white paper informed the development of this strategy.
Significance:	The National Standards for Systems of Care for CYSHCN identify pediatric primary care as the locus for care coordination for CYSHCN, although recognize that teams of professional and family partners provide care to CYSHCN. Not all Oregon primary care clinics well provide care coordination for CYSHCN and their families, and not all primary care-based care coordinators well coordinate care across systems. Given their community connections, local public health authorities can support primary care practices in cross-systems care coordination but need primary care to engage in the team-based work. This measure helps us monitor whether and how primary care engages in one of our cross-systems care coordination strategies.

ESM 12.1 - Young adult with medical complexity/family participation in transition preparation appointments
NPM 12 – 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

Measure Status:	Active
Goal:	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.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of enrolled YAMC patients/their families who participate in at least one of their preparation-to-transfer appointments. **Denominator:** Number of enrolled YAMC patients/their families.
Data Sources and Data Issues:	The data source for this ESM is the Children with Medical Complexity (CMC) CoIIN project process tracking form. We established objectives in June 2020. We are still learning how COVID-19 is affecting our partner's ability to implement our CMC CoIIN quality improvement primary care clinical project and, as a result, may have to adjust our objectives in the future.
Evidence-based/informed strategy:	This ESM measures evidence-based/informed strategy 12.1, OCCYSHN will increase the number of Youth with Special Health Care Needs (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 (see CYSHCN State Action Plan Narrative, NPM 12, Activity 12.1.2). OCCYSHN accessed evidence on this strategy from Got Transition and the Georgetown University Maternal and Child Health MCH Evidence Center.
Significance:	Patient/family engagement is an implementation characteristic that will affect the success of the intervention. This measure tracks patient/family engagement in the transition intervention. We are using a quality improvement framework for this work. Therefore, if patients/families are not engaging in our intervention, we will take steps to modify the intervention to increase its acceptability to them.

Form 11
Other State Data

State: Oregon

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Oregon

Annual Report Year 2021

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	More often than monthly	0		
2) Vital Records Death	Yes	Yes	More often than monthly	0	Yes	
3) Medicaid	Yes	Yes	More often than monthly	3	No	
4) WIC	Yes	Yes	More often than monthly	0	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	0	No	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	0	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	3	No	
8) PRAMS or PRAMS-like	Yes	Yes	More often than monthly	12	Yes	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) ECHO (Early Childhood Health in Oregon)	Yes	Yes	More often than monthly	12	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None