

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: OR

APPLICATION YEAR: 2005

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

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

C. ASSURANCES AND CERTIFICATIONS

Assurance and certifications are on file in the Office of Family Health.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

In 1999-2000, the Title V Agency placed emphasis on community and stakeholder input through the needs assessment process. This included regional meetings to discuss issues, problems, barriers and solutions. The Center and CDRC works closely with the MCH subcommittee of the Conference of Local Health Officials (CLHO). General public comments on the FY 2001 Application will be accepted in writing the week of July 24, 2000.

/2003/ The Office of Family Health involves communities, stakeholders, and program participants, including those from the CSHCN in policy and program decision making at many levels. The priorities, budgeting and expenditures, performance measures trends and outcomes, are presented and reviewed stakeholder and program participants of MCH and family health services across Oregon. //2003//

/2004/ The Title V programs continues to engage broad state and community involvement in program and policy decision making. //2004//

/2005/ The Title V Programs continues to seek out proactive involvement of partners, stakeholders, and families as described in 2003 and 2004 above. Public Notice to review the 2005 Oregon Block Grant Application (and 2003 Report) was placed in three major newspapers in Oregon in July 2004. THE CDRC has secured public input through 2 community forums and 9 family focus groups throughout Oregon. Family involvement has grown in the Title V CSHCN program through the hiring of a total of three family staff members. //2005//

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Mission and Goals: The Title V Agency for Oregon is the Center for Child and Family Health (OFH), Oregon Health Division (OHD), Department of Human Services, located in Portland, Oregon. The Child Development and Rehabilitation Center (CDRC) administers the Oregon Services for Children with Special Health Needs (OSCSHN) Title V Program at the Oregon Health and Science University (OHSU). The agencies work together under an interagency agreement to achieve the goals set forth by the Title V legislation.

/2003/ The 2001 Legislature revised statutes that reorganized the Department of Human Services (DHS) and eliminated the separate divisions, including the OHD. The Center for Child and Family Health has been renamed the Office of Family Health (OFH), located within the Health Services branch of the DHS. The OFH is the Title V Agency for Oregon. The CDRC continues as the Oregon program serving Children with Special Health Care Needs (CSHCN).

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

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

The OFH is composed of seven sections that work closely together on maternal and child health issues. The sections represent programs and services that provide infrastructure, consultation, and technical assistance to local and state organizations working to improve health of the MCH population.

Women's and Reproductive Health Section: This section promotes the health and well-being of Oregon women and ensure that pregnancies are intended and well-timed. The program assures reproductive health services are available across the state; provides funding and technical assistance to local family planning clinics that offer contraceptive services and screening for breast and cervical cancer, infections, anemia, and other conditions; administers a family planning benefit program for low-income Oregonians, Family Planning Expansion Project (FPEP), under a HCFA 1115 waiver; and promotes awareness of women's health issues among the public and health providers.

Perinatal Health: This section seeks to improve the health of pregnant women through promotion of optimal prenatal care for all pregnant women. This section develops statewide policy and funding for improving the health of pregnant women. Activities include: supporting local health departments to plan, manage and deliver perinatal including outreach, advocacy, systems development, nurse home visiting, and community-based health education; promoting early prenatal care through the Oregon MothersCare program; and administering the Pregnancy Risk Assessment Monitoring System (PRAMS).

Child Health: This section promotes health improvement for infants and youth along a continuum of optimal development from birth to adolescent. This section develops statewide policy and funding for child health improvement through a variety of programs and activities including: coordinating public health nurse home visits through the Babies First! Program; providing statewide training and technical assistance on nutrition issues, such as the use of periconceptional folic acid, breastfeeding promotion, and physical activity promotion; assessing community needs and developing a statewide plan in genetics services; coordinating the implementation of newborn hearing screening services; and promoting healthy child care through nurse consultation.

Genetics Program: The project's goals are to: assemble a broad-based genetics and ethics advisory council; conduct a statewide genetics needs assessment; develop a state public health genetics plan;

and to further develop, expand and integrate a child and family health information system. /2004/ A grant from CDC to implement Genomics program was approved in 2003. This grant will increase genetics program capacity to address emerging genomics issues in public health and disease prevention programs. //2004//

Early Hearing Detection and Intervention Program: This program promotes early detection of hearing loss with appropriate follow-up and referral to early intervention services. The legislature passed HB 3246, effective July 1, 2000, mandating all hospitals with more than 200 live births per year are required to provide hearing screening tests to all babies born in their hospitals. /2003/ /2004/ In 2003 Legislative Session, SB 401 was passed and signed by the Governor, mandates d the development of a hearing registry, tracking and recall system, to be funded by existing grants from HRSA and CDC. In the reporting year July, 2001-June, 2002, 91.5% of all births in Oregon were screened for hearing, and 97% of all births in the mandated hospitals were screened. //2004//

Adolescent Health Section: The goal of the adolescent health section is to maximize the health and functioning of Oregon's adolescent population. The section provides technical assistance to local coalitions to work on the statewide Teen Pregnancy Prevention Action Agenda; work with state and local partners to identify effective practices to implement a male involvement teen pregnancy prevention strategy; develop and coordinate the School-Based Health Center (SBHC) programs by providing technical assistance to local communities for planning and operating SBHCs and maintaining a statewide database on services; developing health promotion and statewide policy on nutrition and physical activity issues for adolescents and eating disorders; and partnering with the Oregon Dept. of Education to promote a coordinated school health program model. /2004/ The state level School-Based Health Centers Program was discontinued in March, 2003 due to state general fund budget reductions. //2004//

Immunization Program: The Immunization program provides leadership in preventing vaccine-preventable diseases by reaching and maintaining high lifetime immunization rates. Activities include implementing Oregon's school immunization law; administering funding to local health departments and migrant health centers for child immunizations; operating Oregon's Immunization ALERT registry to track vaccinations provided in public and private health provider settings; providing free vaccines to public and private providers for children aged birth through 18 in certain population groups; coordinating a WIC-Immunization integration project for low income infants and children; providing technical assistance to private and public providers through AFIX, a continuous improvement methods for improving clinic practices to achieve high immunization levels; promoting and providing technical assistance to increase immunizations to adolescents and adults.

/2003/ **Oral Health Section:** The Oral Health Program was organized into a separate section in 2002, and a State Dental Director identified as manager of the section, currently a vacant position. The Program is responsible for developing policies, programs, and data surveillance systems to make progress on the oral health status of Oregonians. The program has received the resources through a CDC Oral Health Grant to implement recommendations from the Association of State And Territorial Dental Directors Site Visit, 2000, including building a surveillance system, holding an Oral Health Summit to develop a statewide strategic plan, work on increasing the number of fluoridated community water systems, and implement a sealant program in the schools. /2004/ The Oral Health Section continues to grow by securing grant funds to build statewide infrastructure, increase sealants in school-age children, implement early childhood cavity prevention programs for pregnant women and children up to age two. //2004//

Women, Infants and Children (WIC): The Oregon WIC program is a public health nutrition program designed to improve health outcomes and influence lifetime nutrition and health behaviors in a targeted, at risk population. The program offers technical assistance to local WIC programs in areas of nutrition standards and policy, staff training, food delivery system, data systems, fiscal and caseload management, and outreach coordination. The program contracts with grocers in all communities and monitors them to assure appropriate foods are available, pricing is appropriate, and the relationship between stores and WIC client is positive. WIC contracts with farmers' markets to

provide coupons to participants to promote fresh fruits and vegetables. The new data system, TWIST, will be rolled out in late 2001, and will provide important data to assist the women, infant and child population using WIC for a variety of risk factors and needs.

/2002/ Strategic Planning of OFH: The Office of Family Health has been involved in an inclusive strategic planning process. The management staff identified five areas to work on over the course of two years. The vision of the strategic direction is:

1. Demonstrating strong leadership for all child and family health policies and programs
2. Leading improved health for all Oregonians
3. Producing measurable results through dynamic utilization and management of data
4. Building and expanding our critical health partnerships
5. Led by a strong, dynamic OFH management team

For each of the following directions, launch actions, follow-on actions, and victory were developed:

1. Before launching any other Strategic Directions, bring together and build the entire Center staff as a cohesive, focused, unified team
2. Explore how best to apply the core public health functions and ten essential services
3. Build, expand and lead critical health partnerships outside OFH
4. Identify data needs, create and improve data collection, and develop means to more effectively utilize data
5. Establish an environment for a more dynamic and unified OFH leadership team, with strong management skills.

For each of the five areas, staff work groups have developed strategies for implementing and monitoring the plan. In 2001-2002, the strategic directions will be reviewed and evaluated to determine if adjustments need to be made.

/2004/ The Office of Family Health (OFH) continues to work on this strategic plan, through leadership and involvement of both management and staff. The products from this process included a strategic plan for data collection, coordination, use and training for county partners. A list of partnerships for each program was developed to help coordinate partnership development between programs, and a training tool on the core functions and essential services was developed for internal use. //2004//

/2005/ The OFH-Child Health Section developed a vision, mission, and then focus areas to utilize as a framework for assessment and planning in child health improvement. The document will be used as a basis for the next five-year needs assessment and will provide the resources to develop similar vision and missions for other population groups, such as women and adolescents. //2005//

Cultural Competency: In 2002, the OFH created a cultural competency strategic plan to train staff to provide technical assistance developing and delivering program services at both the state and local levels. A "charter" has been drafted to establish a Cultural Competency Coordinating Team in the Office of Family Health to work on increasing internal education and knowledge about designing and delivering culturally competent services. The staff contributed to an assessment of cultural competency through a survey and focus groups. As a result, trainings will be given on areas staff felt deficiency. The process and products are being documented as a pilot for the Department of Human Services at large, and the new knowledge gained by Title V and other programs in OFH will be applied in the design, development and evaluation of state and county programs. /2004/ The Cultural Competency efforts are in the Action Plan stage to improve the cultural competency of OFH staff and management. The model has been expanded to other DHS offices including the Children, Adult and Families -- child protective services. The outcomes of the cultural competency action plan will be documented, and the model used in other DHS offices. //2004//

Child Development and Rehabilitation Center: The mission of the CDRC is to ensure that persons in Oregon with developmental disabilities and other chronic disabling conditions are identified and receive exemplary services through programs of public health, clinical service, education, and research. The CDRC serves as the state's Title V Agency for children with special health needs (CSHN); serves as an education and research center for health professionals; provides

interdisciplinary clinical services for persons with developmental disabilities and other special health care needs; and supports the philosophy of partnership with families, health care providers and, the community. Work will continue toward five-year goals mapped out in a 1999. The team identified goals, next steps for each area and regular monitoring of progress for the first six months. This long range planning has resulted in important developments in each of the areas.

Education: The CDRC has modified the data collection of staff/faculty use of time to collect information on the amount of time dedicated to teaching. Faculty are looking at ways to increase recognition and funding for teaching, and clarify their role to the university and the state.

Health Care: Staff continues to examine models of health care services, looking for ways to increase clinical productivity and efficiency. The CDRC is increasingly moving to a cost center model with increased accountability for time, revenue, and resources. Shortages of pediatricians continue to create problems for staffing of clinical operations. The CDRC is recruiting for a developmental pediatrician who will head the Portland Child Development Program and participate with the Clinic Management Team to develop and implement a strategic plan to increase fiscal accountability. Staff has made progress in identifying additional sources of revenues and potential strategies to collect for mental health services provided through tertiary clinics. The CDRC is also addressing fiscal issues such as a markup on purchasing of supplies, reimbursement recovery rates, and increased use of contracts for services.

Research and Evaluation: The CDRC grants program continues to grow, with approximately \$6 million in grants annually. The CDRC has been successful in increasing in the amount of indirect cost recovery coming back to the unit and these resources are being dedicated to supporting the grants program. NIH funding has been targeted for the future. Faculty have submitted several NIH proposals. The CDRC has substantially increased the amount of foundation funding to almost \$200,000 this year.

/2003/ A search is underway to recruit and hire an epidemiologist to develop a program of public health or population studies in relation to children with special health needs. This position will achieve independent research grant funding within three years. The Office on Program Evaluation and Research has expanded to include the epidemiologist and a doctoral level research analyst. A new database manager position will be filled soon. //2003//

/2005/ The CDRC Office of Program Evaluation and Research has hired an epidemiologist. Start date is September 1, 2004. This position will carry out both independent research as well as provide consultation to programs and projects at CDRC. The position will greatly strengthen the internal staff development and research development as well as contribute to the current projects within CDRC. A database analyst was hired and has already made significant contributions to the research efforts within the CDRC. Two research databases are in development with operation scheduled for Fall 2004. //2005//

Outreach: The CDRC continues to expand the scope and service of its outreach program and to improve collaboration with other units of OHSU and the community. The OHSU School of Nursing and the Area Health Education Center participated with CDRC community-based programs in providing continuing education for community providers. CaCoon staff joined three other OHSU programs and applied for a Ford Family Foundation grant to develop an OHSU Rural Health Initiative. The Oregon Department of Education, the Oregon Pediatric Society, Family Voices, the Oregon Office of Family Health, and other community agencies provided joint conferences during the year. Staff actively developing the capacity to conduct distance learning and telemedicine consultation for improved outreach and service to rural areas throughout Oregon.

Infrastructure: Central to activities this year has been the search for a new director of the CDRC. It is anticipated that a new director will be named by Fall of 2001.

/2003/ In July 2001 Clifford (Jerry) Sells, M.D., M.P.H., CDRC Director, retired. He served in an

interim capacity until the new director started on January 1, 2002. The new Director is Brian T. Rogers, M.D. Dr. Rogers convened an ad hoc committee to develop a five year plan for the CDRC. The charge to the committee was to develop new goals and objectives. A vision statement will be written. The vision will include a clear statement of collaboration within CDRC: Title V, Clinical Programs and Oregon Institute on Disability and Development. The committee has met and begun its work. //2003//

/2004/The Ad Hoc Planning Committee developed a vision, mission, and values statements. Beginning in September, 2002, the rest of the CDRC staff was brought into the process by participating in departmental brainstorming discussions about what we wanted to see happen at CDRC in the future and how we saw CDRC changing and adapting.

In December, 2002, a two-day Strategic Planning Leadership Retreat was attended by the Ad Hoc Planning Committee and the leadership of CDRC. Major areas of emphasis for our agency were identified. The entire CDRC staff was then given the opportunity to participate in Town Hall Meetings to provide input. The culmination of all of these efforts came with the rollout of the Strategic Plan at an all-staff meeting. All of the workgroups summarized their work to make the plan achievable, relevant and meaningful. Work will continue on the action plans identified:

1. Self-Sufficiency - CDRC to increase revenue and decrease costs.
2. Identity and Visibility - changing the name of the agency and devising a marketing plan.
3. Lifespan - our agency encompasses more than children and in many areas already serve adults.
4. Internal Integration - ways for us to know more about each other, both personally and professionally.
5. Partnership/Diversity - relationships with other OHSU areas and community agencies.
6. Formal Education - formal offering of a training program in developmental disabilities. //2004//

/2005/ The Future's Planning process at the CDRC continued. A new Administrative Leadership Team was formed with representatives from the major divisions of CDRC. This team was charge with identifying standing workgroups, developing action plans with performance indicators and monitoring the implementation of the Strategic Plan. //2005//

The Title V Oregon Services for Children with Special Health Needs (OSCSHN) section of CDRC has been involved in a strategic planning process. In July 2002, as a result of the 2001 State of Oregon budget reductions, CDRC was forced to make some critical financial decisions that included elimination of the business office and data processing support for the OSCSHN financial assistance program for low-income families. The loss of this administrative infrastructure necessitated closing the program. Thus, the planning process was initiated to develop guidelines for redirecting these Title V Block Grant funds from paying for direct health care to supporting enabling, population-based and infrastructure activities. Based on the Healthy People 2010 Outcomes, four overarching areas were identified:

1. Develop a common definition of children with special health needs in Oregon.

/2004/ An 18-month public-private process addressed the challenge of developing a common definition and method for identifying children and youth with special health needs(CYSHN). These efforts resulted in proposed new criteria to identify the population at the systems level, to assist physicians and other practitioners to identify CSHN in their patient population, and to assess the level of complexity of those patients for planning to meet their needs. //2004//

/2005/ The validated list of diagnostic codes has been shared with the DHS-Office of Family Health and is being incorporated into the statewide FamilyNet data system. This will allow children with special health needs to be identified by ICD-9 codes. We anticipate that birth certificate information will be linked to FamilyNet so recorded ICD-9 codes can be collected. The ICD-9 codes will be shared with other state Title V CSHN programs through the new technical assistance network operated by the Utah State Champions for Progress grant. //2005//

2. Define a continuous quality improvement program for the Title V supported programs: CDRC tertiary clinics, CaCoon and Community Connections. /2004/ A small work group was convened to develop a mechanism for assuring programs are working for families and providers and to develop a

process to help identify improvements. The six national core measures were framework for the work. Indicators were developed, sources for data-based decision making were identified, and a quality assurance process was recommended. The culmination of these efforts came with the presentation of the model and the commitment of CDRC administration to implement monitoring activities. //2004//
/2005/ Each clinical program at CDRC was charged with measuring and monitoring three outcomes and one of their indicators.

Core Measure # 1: Families of children with special health care needs will partner in decision making at all levels, and will be satisfied with the services they receive.

Indicator 1.1: At each visit, parent/youth concern(s) are invited, directly addressed and documented.

Core Measure #2: All children with special health care needs will receive coordinated ongoing comprehensive care within a medical home.

Indicator 2.1: A medical home is identified.

Core Measure #5: Community-based service system will be organized so families can use them easily.

Indicator 5.1: Responsible parties are identified and notified for follow-up on recommendations.

With the assistance of OHSU Quality Management, each program developed a CQI project that included data collection and a final report to the CDRC Administration. Some programs developed a short parent satisfaction survey for all patients receiving clinic services during a two-week period. For the medical home measure, the compliance level was acceptable for most programs; the other two indicators had compliance levels outside 80%. Next steps included: standardized the format CDRC clinic reports, develop a mechanism to communicate clinic recommendations to the child's medical home and train CDRC clinicians on information required in clinic reports. //2005//

3. Design a community-based needs assessment. /2004/ An interagency committee with strong family representation was formed and the CSHN survey was designed. This information will help to improve services through planning meetings occurring at the community and state level over the next two years. A copy of the needs assessment is available from the Oregon CSHCN program. //2004//
/2005/ The Needs Assessment has been piloted in two counties. It is receiving a final pilot and will begin full statewide implementation this year. Families and community partners will assist in the distribution of the surveys within the communities. Results of the survey will be summarized for community-based work and statewide trends. //2005//

4. Determine the role/responsibility for OSCSHN in funding family support services (FSP). /2004/ FSP was developed in response to the elimination of the OSCSHN Financial Assistance Program and the continued expression of a need for the Title V program to provide some level of support to families. An expanded definition of medical and financial eligibility will allow more children to qualify for services. By giving priority to those children who are served by an OSCSHN program, the hope is to mitigate the number of requests for limited funds. Providers will identify need and connect families with critical supports, potentially improving access to care and help assuring that children benefit from the recommended specialized services. //2004//

/2005/ June 2004 marks the end of the first year of the new OSCSHN Family Support Program which provides payment of support services and products. A patient representative involved in one of the Title V programs, CDRC clinics, Community Connections Clinics, Medical Home Project and Care Coordination, is responsible for submitting funding requests. This process insures that the appropriate eligibility screening occurs and that funding requests include a justification as to how the child will benefit from the service or product. //2005//

/2004/ OSCSHN continued it's planning process and worked on each on the major activities. Title V staff attended a retreat to identify priorities for OSCSHN and to determine how those priorities would integrate with the CDRC strategic plan. Five workgroups were formed: Strengthening Family Involvement, Integrating Community-based Programs into a Community System of Services, Increase Capacity of Providers, Visibility, and Office Operations. Three of the groups have started to meet and will have a plan formulated and a report submitted to Dr. Rogers by the end of the calendar

year. //2004//

/2005/ In June 2003 a Task Force was created and chaired by Dr. Dale Garell, to develop a comprehensive community-based system of CSHN Services (CaCoon, CCN, Medical Home Project, Family Involvement and FISHs project). The goal was to develop a single, integrated Title V CSHN system that links with tertiary care centers and community providers across the state; that effectively uses Title V CSHN staff, CDRC clinicians and faculty; that builds the capacity of community providers and families; that offers an opportunity for training; and, includes families in all aspects of the program including policy planning, evaluation and program development.

The group met monthly, reviewed existing programs, made recommendations regarding the structure and function of local and state programs, created a matrix to use as a framework, made a number of recommendations for implementation and submitted a formal report to the CDRC Director.

Among the guiding principles of the Task Force was the belief that existing CSHN programs would be improved by integrating services at the community level, by creating follow up and continuity through identification of a single responsible CSHN liaison at the state level and one Title V individual responsible at the local level. The group identified formal ways to involve families at all levels. Recommendations from the group were implemented during the planning process instead of waiting for completion of the Task Force. This led to planning teams that put together proposals that were presented to the Title V staff for the formulation of recommendations for ultimate program design. Final decisions were forwarded to the newly organized Community-Based Services Group that is beginning to practice new roles and implement the recommended activities. //2005//

State Demographics Population Estimates. /2002/ Demographic data and information prior to 2000 is available from the Oregon DHS, Office of Family Health. (<http://www.dhs.state.or.us/publichealth/>)
/2005/ Previous Demographic reports has been moved to III.F. Health Systems Capacity Indicators//2005//

Status of the MCH Population. /2002/ Information about MCH population status is available from the Oregon DHS, Office of Family Health. (<http://www.dhs.state.or.us/publichealth/>)

Infant death rates have declined steadily since 1990, and deaths from Sudden Infant Death Syndrome (SIDS) have declined every year except 1995. The infant death rate went from 8.3 deaths per 1,000 live births in 1991 to 5.4 in 1997. SIDS deaths declined from 2.6 per 1,000 births in 1991 to 1.2 in 1996 (1997 and 1998 rates are not yet available by cause).

Teen Pregnancy: The number of female Oregonians ages 15-17, per 1,000, that are pregnant, has been steadily dropping since the mid-1990's. In 2000, the rate for females aged 15-17 was 35.2 per 1,000, and in 2002, the rate was 26.7 per 1,000 females.

Intended Pregnancy: For those women who intended pregnancy, results from PRAMS, which surveys women who have just given birth, 39% of respondents in 2000 wanted to get pregnant later or not at all. About 73% of those who were younger than 20 had wanted to get pregnant later or not at all, compared to 35% of those who were 20 or older. The percentage of pregnancies that were unintended or were terminated remain about the same at 52% between the years 1998 and 2002.

/2005/ From 1998 to 2002, Oregon's teen pregnancy rate has been dropping every year, meeting or exceeding Oregon Benchmarks. The aggregate rate of teen pregnancies per year over the five year period was 35.1 for every 1,000 females between the ages of 15 and 17. The rate has dropped from 47.9 per 1,000 females in 1993 to 27.6 per 1,000 females in 2002. //2005//

Domestic Violence: The percentage of women subjected to domestic violence in the past year in 2002 was 2.8%, and is considered an underestimate of the problem. Based on PRAMS data from 2000, almost 4% of women aged 20 or older reported having been pushed, hit, slapped, kicked, choked or

physically hurt in another way during the 12 months before becoming pregnant. About 2.6% reported being physically hurt (in one of those ways) during the pregnancy. ***//2005/ The Oregon PRAMS survey showed that 2.6 percent of Oregon's pregnant women were physically hurt by their husband or partner in 2000. It also estimates that 3.6 percent of mothers surveyed were physically hurt by their husband or partner before they became pregnant. //2005//***

Adolescent Suicide: The rate of suicide for youths aged 15 through 19 years was 6.7 per 100,000 in 1998, rising to 13 per 100,000 in 2000, and is 10.6 per 100,000 in 2002. According to the 2002 Oregon Teens Survey, 19% of 8th graders and 21% of 11th graders felt so sad or hopeless almost every day for two weeks that they stopped doing some usual activities. More than 14% of 8th graders and 13% of 11th graders seriously considered attempting suicide in the previous 12 months, and more than 7% of 8th graders and almost 6% of 11th graders actually attempted suicide in that time.

Prenatal Care: The percentage of low-income women who receive prenatal care in the first 4 months of pregnancy was 78.7% in 2001 and 85.8% in 2002. The percent of live births with 80% or more of expected number of prenatal care visits on the Kotelchuck index was 71.2% in 1999 and rising steadily and strongly to 79.5% in 2001, and dipping slightly in 2002. The percent of Oregon Health Plan (Medicaid) births with 80% or more of expected number of visits rose more strongly than percentages for non-Medicaid women from 62.5% in 1999 to 76.6% in 2001. This improvement stopped in 2002, when percentages dipping to 75.7% (Oregon Vital Statistics). African American and American Indian births showed less adequate and early prenatal care (first 4 months, and 80% of expected visits) than White and Asians. The percentage of births whose mothers began prenatal care in the first trimester for 2001 is 81.5% for all races, and 79.7% for African Americans and 70.7% for American Indians (Vital Statistics). The percentage of women who smoked at all during their pregnancy resulting in a live birth was 13.3% in 2000 and 12.8% in 2001 (Vital Statistics). ***//2004//***

//2003/ The Oregon Title V program has begun looking at the rural population to better analyze disparities between rural areas of the state and the urban and urban/rural mixed areas. Some of the results of this analysis appear below. The OFH and CDRC plan to use this information to conduct more thorough assessment and evaluation of program delivery systems with a goal to improve MCH programs to fit the uniqueness of Oregon's rural areas.

- Oregon is primarily a frontier-rural state: of 36 counties - 26 counties have a population density of .5 to 59 persons per square mile; 8 counties have a density of 60 to 250 persons per square mile; 2 counties have a density of 620 to 1521 per square mile.
- 97.2% of Oregon's counties are designated as a Health Professionals Shortage Area (HPSA) by the Office of Primary Care compared to 82.2% of counties nationally.
- 9 rural hospitals in Oregon have closed since 1992 - 3 in frontier areas - and 1 mixed-rural area has no hospital.
- Specialty providers are almost non-existent in frontier and rural areas, especially in-patient substance use treatment providers, pediatricians to serve children with special health needs, and dentists.
- Mothers in frontier and rural counties are less likely to receive early, adequate or comprehensive prenatal care than mothers in mixed rural-urban and urban counties.
- Children with disabilities/birth defects have less access to services in rural areas.
- As of December 2001, 5.5% more students in Oregon K-12 schools were enrolled in special education than in 1999; approximately 19% of those students received services for severe, low incidence disability.
- The number of children aged 0-5 years enrolled in Early Intervention and Early Childhood Special Education increased by 4% between 2000 and 2001.
- A child living in a frontier area with a cleft lip and palate traveled approximately 9700 miles over 4 years to receive appropriate services in the Portland metropolitan area, the location of Oregon's only two specialty care centers.

//2004/ Region X states, in collaboration with AMCHP, is finalizing the report and recommendations regarding services and systems needs for providing maternal and child health services in rural, frontier and remote areas. ***//2004// //2005/ The Final Report on MCH Rural Services has been***

published by AMCHP and can be found on the website at <http://www.amchp.org/news/index.htm>. Efforts are underway to pursue resources for policy research and development.

In addition, the OFH and the Office of the Public Health Officer have embarked on an initiative, "Enterprise for Healthy Rural Oregon," a collaboration of state and local health leaders and other interested community stakeholders. The project resources are made up of existing state staff, part-time, and use of existing funds (such as public health preparedness funds) to convene stakeholders, discuss activities and pursue funding and resources to support the goals of the Enterprise. The goals are: 1) Promote public health excellence; 2) Promote availability and access; and 3) Promote integration of medical care and public health. The first Enterprise was convened in Northeastern Oregon and was sponsored with federal public health preparedness funds jointly with county funds to support a full-time regional coordinator. The next Enterprise is proposed for the Oregon coastal region, and will be supported by the Office of Family Health with potentially using commitment of staff resources to support a regional coordinator. This is expected to be launched in Fall 2004. //2005//

Status of the CSHCN population: The CDRC estimates that at least 15% of Oregon children under the age of 21 years have special health needs. The prevalence of chronic illness and disability continues to increase due to advances in science and technology. /2000/ More youth and young adults with disabilities are living longer and assuming productive lives. Fewer than 30% of young adults with special health needs are employed. They may have no experience managing their own health and are unaware of resources that could help them. The number of children and youth who received special education services for disabilities has increased from 1997 to 1999 to 73,887 students (Oregon Dept. of Education - ODE), a 7% increase. It is estimated that there are about 6,500 students between the ages of 13 and 21 served in Oregon schools who experienced a primary physical or mental health disability and at least another two thousand youth of the same age who experience a significant secondary disability. Approximately 19% of the 73,887 received services for a severe, low incidence disability including vision and hearing impairments, orthopedic and health impairments, autism, dual sensory impairments and multiple disabilities. As of the 1999 ODE Child Census, 6,246 children, 0 - 5 years, were enrolled in Early Intervention and Early Childhood Special Education. The number of children enrolled in Early Intervention (2,073) has increased by 17% (more than 305 students) during the last years. Congenital anomalies remain a major contributor to the functional categories above. In 1999, 537 (1.1%) of 45,193 live births were associated with congenital anomalies. //2002// /2003/ In summer, 2002, tandem mass spectrometry (MS/MS) technology will be integrated into the Oregon Newborn Screening Program, adding approximately 23 additional metabolic conditions to the newborn screening panel. The program will also add congenital adrenal hyperplasia (CAH) to the screening panel this summer. //2003//

/2004/ In 2001, 592 (1.3%) of 44,726 births were associated with a congenital anomalie(s). Heart and genitalia malformations were reported as the highest incidence (14%). //2004//

/2003/ The number of children and youth who received special education services for disabilities continues to increase. As of December 2001, 78,000 students were enrolled in special education (Oregon Department of Education), a 5.5% increase over 1999. The number of children enrolled in Early Intervention and Early Childhood Special Education, 0 - 5 years of age, has increased 4% from 6,795 in 2000 to 7,086 in 2001. In some districts the Early Intervention enrollment has increased as much as 9%. //2003//

/2004/ As of December 2002, 16% of the 79,033 students received special education services for a severe, low incidence disability. The number of children enrolled in Early Intervention and Early Childhood Special Education, 0 - 5 years of age, has increased 10% from 7,086 in 2001 to 7,800 as of March 2003. Oregon provides services to only 1.3% of the 0 -- 3 year-old population. (Oregon Department of Education). //2004//

//2005/ According to the SLAITS National Survey, 13.34% of Oregon children and young adults have a special health need. An analysis of the SLAITS dataset for Oregon is being conducted by the Oregon Health Policy Institute at OHSU. Characteristics of the children with special

health needs population such as severity, age, sex, urban vs. rural, are being examined. In 2002, 576 (1.3% of the 45,190 births were reported on the birth certificate as having a congenital anomalie(s). Malformed Genitalia (14%), cleft lip/palate (12%) and heart malformations (12%) were reported as the highest incidence.

Tandem mass spectrometry technology adds approximately 23 additional metabolic conditions to the newborn screening panel. In 2003, a total of 62 infants were detected to have a clinically significant metabolic, endocrine, or hemoglobin disorder by newborn blood spot screening, including those detected using MS/MS technology. The program added congenital adrenal hyperplasia (CAH) to the screening panel early in 2004.

For 2003-2004, 77,922 students received special education services for a severe disability. The number of children enrolled in Early Intervention and Early Childhood Special Education, 0 - 5 years of age, has decreased from 7,800 as of March 2003 to 7,158 for the 03-04 school year. Oregon provides services to only 1.4% of the 0 -- 3 year-old population. 4.86% of Oregon children age 3 -- 5 receive Early Childhood Special Education Services. (Oregon Department of Education). //2005//

In 2000, the CDRC provided 24,973 tertiary level evaluation and management services to 5942 children and young adults. The number of services provided through the CDRC's community-based programs continue to increase. In 2000, CaCoon nurses provided 6,886 services; a 5% increase from 1999.

/2003/ In 2001, the CDRC provided 40,245 services to 9,375 children and young adults, a 24% increase in patients seen and a 20% increase in the number of services provided through the clinics. The number of services provided through the CDRC's community-based programs has remained steady. In 2001, 6,898 services were provided to 1,487 CSHN through the CaCoon program. //2003//
/2004/ In 2002, CDRC provided a total of 41,331 services to 7,944 children and youth, a 3% increase in services provided through the CDRC clinics. The number of children seen and the services provided through CDRC's community-based programs has remained steady: 7,515 services to 1,405 CSHN through the CaCoon program and 1,389 services to 228 children through Community Connections. //2004//

//2005/ In 2003, CDRC provided 41,549 services to 8,083 children and young adults through specialty clinics in Eugene and Portland and by the community-based programs. In addition, 133 families received financial assistance for services and supplies. These data represent 7,462 unduplicated clients. //2005//

Families of color experience a disproportionate rate of disabilities. CaCoon reported 2,035 contacts to 351 Hispanic children and their families during 2000, 23% of the CaCoon Nurses' caseload, contrasted with about 13% of the total infant and child population who are identified as Hispanic. In some counties more than 50% of the families followed by the nurses are of Hispanic origin. Families in poverty experience a higher rate of disabilities. The Oregon Health Plan (OHP), a Section 1115 waiver for mandatory managed care for the Medicaid population, currently enrolls almost 236,000 children. Approximately 3.5% are reported to be blind or disabled or in foster homes. 70% of children less than 21 years of age visited by the CaCoon nurses received their health insurance through Medicaid. According to the Social Security Administration report, 5,860 children received SSI as of December 2000 and therefore, were eligible for Medicaid.

//2005/ It is estimated that the Hispanic population in Oregon has increased 12% since the 2000 Census. The Title V Programs recognize the impact this growth has on community based services and has responded with continued support of Promotoras in the Cacoon Program, Spanish translation of materials and inclusion of interpreter services in outreach forums in FISHS and the Oregon Medical Home Program, and a bi-lingual Spanish support staff in the Title V Office. //2005//

/2003/ The OHP currently enrolls 287,342 children, a 21% increase since 1999. Approximately 3.5% of

these children are reported to be blind or disabled or in foster homes. During 2001, 73% of children served by CaCoon were insured through Medicaid. According to the Social Security Administration report, 6,230 children (a 6% increase since 2000) received SSI as of December 2001, and therefore, were eligible for Medicaid. //2003//

/2004/ 197,700 children, 0 through 20 years old, were enrolled in Medicaid. Approximately 4.5% of these children are reported to be blind or disabled or in foster homes. During 2002, 65% of the services provided by CaCoon were to children insured through Medicaid. According to the Social Security Administration report, 7,160 children (a 15% increase since 2001) received SSI as of December 2002, and therefore, were eligible for Medicaid. //2004//

/2005/ During the past year 304,608 children, 0 -- 20 years of age, were enrolled in the OHP. Approximately 10% of those children are reported to be blind or disabled or in foster homes. During 2003, 74% of the services provided by CaCoon were to children insured through Medicaid. According to the Social Security Administration December report 7,508 children under 18 years of age received SSI and were eligible for Medicaid. CDRC continued the agreement with DDS to provide evaluations to determine SSI eligibility. The Portland CDRC provided 54 assessments to 48 children. Evaluations included 26 pediatric, 9 psychology, 9 special education, 7 speech, 1 ENT, 1 audiologist and 1 occupation therapy. The Eugene CDRC provided 49 evaluations to 44 patients: 21 speech, 11 pediatric, and 17 psychology. //2005//

B. AGENCY CAPACITY

State MCH Programs and Services: The OHD is responsible for collaborating and coordinating its programs and services with other public and private agencies committed to the health of women, children, and families. Federally funded programs, such as Family Planning (Title X), Immunization (CDC), and WIC (USDA), are within the authority of the Title V Director and have close programmatic ties with Title V programs. The organizational structure assures cooperation among all programs providing services and funding to local health departments and primary care service agencies. The OFH continues to have close working relationships with other OHD offices committed to working in research, epidemiology, community health, primary care, and minority issues. OFH also collaborates extensively with other agencies working on issues affecting families and children, such as the Oregon Department of Education Early Intervention and Special Education programs, the Oregon Commission on Children and Families, the Office of Medical Assistance Programs (OMAP, the Title XIX Agency), the Office for Alcohol and Drug Abuse Prevention, Oregon Mental Health Services Division, and Adult and Family Services.

/2003/ OFH has worked with three other agencies, the CDRC, the Oregon Department of Education (ODE) Early Intervention/Early Childhood Special Education (EI/ECSE), the Oregon Commission on Children and Families (OCCF) to develop the Early Childhood System of Services and Supports, as well as FamilyNet. Within DHS, OFH has worked most closely with the Office of Medical Assistance Programs (OMAP, the Title XIX Agency), the Office for Alcohol and Drug Abuse Prevention, Oregon Mental Health Services Division, and Adult and Family Services. //2003//

/2004/ The OFH continues to sustain, facilitate and build systems of collaboration, coordination and leadership with programs, agencies and organizations providing services for women, children and families through the Title V Federal-State Partnership. //2004//

/2005/ The Early Childhood System Planning project in OFH is working with the Partners for Children and Families and its Early Childhood Team, to achieve the goals of the project in the five focus areas: medical home, psycho-social and emotional health, early education and care, parent education and family support. Activities will include surveying medical providers, developing an environmental scan, holding community conversations, and developing implementation strategies. This project has given the MCH programs the capacity to determine strengths, weaknesses and needs in the system of services for young children and their families; and the results will inform multiple program areas in public health, social services and education.//2005//

Oregon Children with Special Health Needs Program: The Child Development and Rehabilitation

Center (CDRC) is a statewide service program that provides health and rehabilitative care for children with special health needs and their families. The CDRC includes a tertiary clinical program, the Title V Oregon Services for Children with Special Health Needs (OSCSHN), and the Oregon Institute on Disability and Development. The CDRC has offices in Portland and Eugene where a variety of tertiary care clinics are offered. These clinics are housed in Doernbecher Children's Hospital in Portland and at the Regional Service Center in Eugene in conjunction with the University Affiliated Program at the University of Oregon. The CDRC also administers two community-based programs for CSHN: CaCoon (CAre COordination) is an exemplary statewide care coordination program that provides public health nursing services in communities where families live and Community Connections Network (CCN) coordinates 14 community clinics.

/2003/ OHSU experienced severe budget reductions during the 2001 Legislative Session and was forced to make reductions and adjustments. These included: elimination of the OCSCSHN financial assistance program for low income families; elimination of funding for prenatal tests for high risk women; elimination of the orthopedic clinic; elimination of the CDRC librarian position; delay in filling vacant positions including a developmental pediatrician and psychologist, and reducing clinical staff. Although the full impact of the reduction in the financial assistance program is not yet known, 1000 services were funded for 650 children in 2001. These families are non/underinsured and most are not eligible for other public financial resources. In addition, 300 children who were followed in the orthopedic clinic will need to be reassigned for their specialty orthopedic care.

/2005/ CDRC was faced with severe budget reductions from rising costs and diminishing reimbursement for healthcare services and decreased state general fund support. This resulted in the loss of some services, including: Assistive Technology; Genetics outreach program and reduction of Craniofacial and Spina Bifida services in Eugene; reduction of developmental pediatrics, speech language pathology, nutrition and social work services and program support staff. In addition, some multi-specialty clinics have been replaced with selected single discipline assessments. //2005//

/2004/ The Family Support Program (FSP) was approved and implemented in June 2003. The FSP will not fund direct health care services but will assist families in paying for support services. This program is available to children with special health needs who are under 21 years old, enrolled in a Title V program and meet the established eligibility criteria. //2004//

/2005/ Between July 1, 2003 and May 31, 2004, the Family Support Program for CHSCN enrolled 140 children. Examples of sponsored services and products include adaptive equipment, assistive technology, disposable medical supplies, medical equipment, specialized nutrition, lodging and travel reimbursement and orthotics. Program enrollment steadily increased from approximately 12 children in July to over 30 in May. //2005//

/2003/ County Health Departments experienced substantial cuts in programs because of the poor economy and subsequent loss of state and county revenue. This loss has threatened public health nursing services to the maternal and child health population including children with special health needs. County Health Departments have responded by reducing public health nursing FTE and reorganizing programs and service delivery. The impact is evident in the decrease in the number of children followed in the Babies First and CaCoon Program for 2001-2003. //2003//

/2005/ County Health Departments continued to explore ways to meet ongoing budget challenges yet continue to provide services to our population of families. Although FY 03 data does not show a significant decrease in the number of children receiving services, some health departments have prioritized caseloads: by age, and are only following preschool aged children; some are only providing services to those children insured through Medicaid so they can bill for approved services; other counties are limiting the number of visits per child. //2005//

Client Data Information: The OFH is developing a state deployed, locally operated encounter-based data system, FamilyNet, and an MCH Monitoring System with support from the State Systems Development Initiative (SSDI) grant. The monitoring system will provide information at the county and state levels for assessing health status, monitoring trends in population health, evaluating MCH strategies for health promotion and disease prevention, and providing baseline, progress, and outcome data on public health program interventions. The foundation of the MCH Monitoring System is a multi-year base of MCHB and State performance measures and health status indicators combined with Oregon's Benchmarks for the MCH population and program measures currently in use to access population health. FamilyNet goals include:

- Reduce service fragmentation by providing a method to evaluate linkages between health service programs
- Create/strengthen a public health partnership between state and local agencies by modernizing management information systems
- Support public policy development for both state and county health departments
- Improve coordination of client care between counties, across program and agency boundaries, and among public and private sector providers
- Provide unduplicated counts of services provided and clients served
- Eliminate duplication and overlap in data collection
- Provide timely access to data for both state and county health departments
- Increase accountability for state and federal program conditions, including program and fiscal assurances.

/2002/ The Oregon Childrens Plan, adopted by the 2001 Legislature directed the development of an Early Childhood Services module as the data support for Oregon's coordinated, local systems of care that involves state and local agencies serving infants, young children, and their families. /2003/ The Family and Child Module of FamilyNet (formerly called the Early Childhood Services module) is being planned to support existing perinatal, infant, and child health programs administered by the OFH, the CDRC, the OCCF, and the ODE-including the new Oregon Children's Plan (OCP). The SSDI Coordinator is facilitating the development of the FCM and its integration with FamilyNet's WIC and Immunization modules for counties that will use FamilyNet. The FCM and the central FamilyNet database will also exchange data with local systems in those counties that maintain their own data systems (called "self-automated counties"). Planning and design participants include the lead managers of OFH and MCH programs, local health department administrators and staff, other local agency partners, and the Commission of Local Health Officials (CLHO).

/2003/ To achieve broader ECDS goal while supporting OFH programs, including Newborn Hearing and Genetics, the FamilyNet and MCH Monitoring System development plans were revised to change the sequence of development steps for the Family and Child Module and the MCH Monitoring System. Newborn hearing screening, metabolic screening, and birth certificate data are being linked, and will identify newborns needing further screening, assessment, or diagnostic services-including hearing screening, diagnosis, and early intervention or other special health needs. FamilyNet data will also link to program impact and outcome data from other local service data systems, including Medicaid, alcohol and drug treatment programs, mental health services, and home visiting programs. The linked data, with personal identifiers removed will be available to DHS staff and OCP evaluators for monitoring of programs in the system of services offered through the OCP. The aggregated (de-identified) health risk, status, and program performance data will be available for health assessment and performance measurement. These data will be linked to other MCH program data in the MCH data warehouse for development of measures for the MCH Monitoring System.

/2004/ Work was completed on the strategic plan for the future development of FamilyNet. It is a high-level roadmap that defines "the what" for the system for the next 3-4 years. Community and state agency representatives will be involved in joint application development sessions to create an optimally functional system for all users of the system and the database. FamilyNet data system will improve the process for service providers so they can easily find client information needed to provide accurate information and services. Roll-out on the first Family and Child Module is expected sometime in 2004. CDRC and the Office of Family Health have signed a contract specifying the scope of work and the common application process required for a CSHN subset of the Child and Family Module of the FamilyNet consolidated health data system. The system level definition of CSHN

developed by the OSCSHN Defining CSHN workgroup will be the cornerstone of the subset. //2004//

/2005/ The design and development of the FamilyNet system and the Family & Child Module (FCM) continue. OFH staff completed the rollout of the FamilyNet modules for WIC and Public Health Immunizations in 2003 and began revisions to better link those two systems and add functionality. The FamilyNet strategic plan was updated in 2004. The FamilyNet Steering Committee is maintaining the plan as an ongoing agenda item to assure that it stays current and complete. The linked newborn data pilot test was concluded and Statistical Analysis System (SAS) software was deployed for the Early Hearing Detection and Intervention (EHDI) program. The FCM design process has taken longer than anticipated. The core development team is working to complete the design by the end of 2004 and build and pilot test the system in 2005. The delays allow design staff to include system access flexibility and web-based design that will assure a more responsive, more up-to-date product when the FCM rolls out. Staff from OFH and CDRC have worked together on designing the individual screens that will be used to collect the data. The system will be previewed in Summer 2004. //2005//

/2001/ The Outcome Assessment through Systems of Integrated Surveillance (OASIS) project, originally funded by CDC, makes existing data sets available for integrated analysis in a single "data warehouse." OASIS operates as a data mart; it contains vital statistics, HIV/STD data, and survey data from the Behavioral Risk Factor Survey System (BRFSS) and the Youth Risk Behavior Survey (YRBS). The Information For Health Outcomes (InFHO) conducts projects to improve and expand the capacity to link databases to better assess the health status of specific population groups. The Public Health Medicaid Assessment Initiative, funded by a five-year grant from CDC intends to facilitate the availability and use of data about the health risks, health status, preventive services, and clinical outcomes for Medicaid population. /2003/ Funding for the OASIS and InFHO projects was not secured, so those projects are moving forward more slowly. The experience and products from these projects in will be used in MCH data warehouse development. //2003//

/2003/ CDRC was awarded a three-year MCHB Integrated Community Systems grant. One of the objectives of the project is to develop a database for children with special needs. CDRC will contract with the DHS/Office of Family Health for the actual creation of the data set which will become a part of the FamilyNet. The Defining Children with Special Health Needs Task Force will address the particular data needs of providers who care for this population. The Task Force's definition of CSHN will provide the framework for the work of a data subcommittee. //2003//

MCH Epidemiology: The MCH epidemiologist, Dr. Ken Rosenberg, is working in the OFH under a grant from the Centers for Disease Control (CDC), to provide consultation and surveillance of MCH population health status to OHD programs and other local and state organizations. Dr. Rosenberg (MCHE) has a lead role in implementing PRAMS (Pregnancy Risk Assessment Monitoring System) in Oregon. The first survey results were available in the summer of 2000. PRAMS has enhanced the Center's ability to identify problems, and develop and track health status indicators and performance measures. Other topics include SIDS, breastfeeding, and immunization projects, in addition to improving the MCH data infrastructure, to allow OFH to improve its ability to use data to develop policy and assess program performance.

/2002/ The OHD has received a CDC grant for Pregnancy Risk Assessment Monitoring System survey (PRAMS) and will be adjusting the survey to new questions. The OHD has been conducting PRAMS since 1998, and is joining the CDC system starting with the October 2001 surveys. The PRAMS has been collecting data on use of dental services during pregnancy, unintended pregnancies among women who had live births, infant sleep position, breastfeeding at ten weeks, peri-conceptional use of multivitamins with folic acid.

A Western Regional MCH Epidemiology Conference was held in June 2001 with participation of 15 western states. The conference was made possible with a small grant from CDC and Title V funds. Approximately 150 people attended this conference, which was held following the joint meeting of the

Council of State, and Territorial Epidemiology (CSTE) and the Association of Public Health Laboratories (APHL). The target audience was MCH program managers and epidemiologists from state and local health departments and tribal health agencies in 15 western states (HI, AK, WA, OR, CA, ID, WY, MT, ND, SD, CO, NV, UT, AZ, NM). Plenary sessions covered maternal and child health epidemiology, nurse home visiting (Dr. David Olds), folic acid use to prevent birth defects, and emergency contraception. //2002//

/2003/ MCH Epidemiology program has worked on the following activities:

- Joined the CDC PRAMS system, writing an Oregon protocol to meet CDC specifications.
- Completed or added modules for analyses for issues using PRAMS data. These include: newborn hearing screening, prenatal tobacco and alcohol, emergency contraception, infant sleep position, tobacco, prenatal care, breastfeeding, oral health, intimate partner violence, periconceptional folic acid use by Hispanic women, pregnancy intendedness, and exploring the possibilities of replication the Louisiana study of SIDS by creating a case cohort study
- Made presentations to national and state audiences on topics related to improving access to emergency contraception, maternal smoking and breastfeeding, risk factors for not breastfeeding at 10 weeks, access to newborn hearing screening, and peri-conceptional use of folic acid. //2003//

/2004/ MCH epidemiology activities include efforts to continue to update PRAMS to include questions about emerging issues in Oregon, such as around women's and perinatal mental health. Oral health surveillance system building will be a major focus in 2004. Dr. Rosenberg will continue work on OFH-MCH research activities in topics such as immunization, WIC, oral health, women's' health, reproductive health, and nurse home visiting. Ongoing projects include studying outcomes related to periconceptual folic acid use among Hispanic women, infant sleep position, unintended pregnancy, access to emergency contraception for rape victims in Oregon emergency rooms, and relapse among postpartum women who have quit smoking during pregnancy. //2004//

/2005/ MCH Epidemiology activities are focused on the analysis of PRAMS data on issues such as: periconceptional folic acid, oral health, infant sleep position, perinatal physical abuse, smoking cessation, breastfeeding, unintended childbearing, prenatal care access for Mexican women, perinatal alcohol use, prepregnancy obesity, gestational diabetes, rural health, teen prenatal care access, HIV testing and Hispanic folic acid. This information is provided to state and local programs for use in program services design and delivery. PRAMS data used to support the following OFH programs: Perinatal Smoking, Latina Prenatal Care, Performance Measurement and Surveillance, Folic Acid, Emergency Contraception. Completed development and consensus on new PRAMS questions for 2004-2008 in collaboration with OFH Oral Health program and ODPE Chronic Disease program.

A collaboration with the University of Washington and other western states is in progress to create a 3rd Western MCH Epidemiology Conference in Portland (May 2005).

The MCH Epidemiologist has prepared publications and presentations on a number of topics. These include: the results of a survey of access to Emergency Contraception in Emergency Departments: presented and being prepared for publication; analysis of linked birth certificate/Medicaid data about prenatal care access for Mexican women - being prepared for MPH thesis at University of Illinois at Chicago; pregnancy intendedness and the use of periconceptional folic acid; trends in HIV testing among pregnant women, Oregon; perinatal physical abuse; dental care during pregnancy; early weaning and perinatal cigarette smoking; risk factors for smoking cessation relapse after pregnancy; maternal obesity; breastfeeding assessment methods; infant sleep position.

The MCH Epidemiologist is leading a collaborative development of a longitudinal Oregon Toddler Survey (TOTS) that will begin surveying women later this year. It is similar to a survey that is currently in place in Oklahoma. Women who responded to the PRAMS survey will be resurveyed when their babies are two years old. Among the likely topics will be well child care, chronic disease, immunization, breastfeeding, nutrition, physical activity, development, domestic violence, stress and social support, and tobacco and alcohol use.

The Early Childhood Systems Planning SPRANS grant is supporting assessment activities as part of its planning process. One of the activities is a survey of medical providers to determine the current status of comprehensive, coordinated early childhood healthcare services in Oregon; determine barriers to and feasibility of implementing comprehensive, coordinated early childhood healthcare; and to identify recommendations to improved coordination between public and private healthcare and other early childhood supports. //2005//

POLICY DEVELOPMENT CAPACITY

/2003/ The CDRC began a private public partnership to develop a statewide definition of children and youth with special health needs. /2004/ The primary goal of the partnership activities was to recommend a way to identify CYSHN by state policy-makers and health plan administrators. The workgroup believes that using a common list will allow health plans and agencies to effectively use current system-level data to identify a population of children for special attention. //2004//

//2005/ Defining the CSHCN population is progressing with the identification of diagnostic codes to be incorporated into FamilyNet. Children with special health needs will be identified by ICD-9 codes based on the work of the Defining Oregon's Children with Special Health Needs Workgroup. Similarly the ICD-9 codes will be shared with other state Title V CSHN programs through the new technical assistance network operated by the Champions for Progress grant out of Utah. The Oregon Title V CSHN office will further its efforts to collaborate with private/public partners in the identification of and service provision to families and children with special health needs. //2005//

/2002/ The OFH has worked closely with the Commission for Children and Families to implement SB555, Phase II Coordinated Planning. Local commissions are required to develop coordinated plans between a variety of health, social, and justice services impacting children aged 0-18. /2003/ Each Local Commission for Children and Families completed their priority setting and plans for their communities, identifying high level and intermediate level outcomes (performance measures). /2004/ The state general fund support for Coordinated Planning was significantly reduced in 2003. The Coordinated Planning has moved into the Implementation phase, where the local plans will begin implementation and evaluation of best practices selected as priorities, though is dependent on Legislative appropriations. //2004//

/2003/ The Oregon Children's Plan (OCP) was adopted by the 2001 Legislature with the goal to take a multi-agency, statewide approach to identify risks early in every child's life and address risks before they become problems. The 2001 legislation directed DHS, Oregon Dept. of Education, and the Oregon Commission on Children and Families to develop a plan for local systems of care serving infants, young children, and their families. The OCP will attempt to offer standardized screening to all newborns and their families and target resources toward those children with the highest risk. //2003//

/2003/ All 36 counties have an Early Childhood Team to facilitate or conduct screenings of health and psycho-social risk in prenatal and postnatal health care settings; establish partnerships with the medical, public health, and social services community; and develop a process for connecting families to information, assessment, and services in the community. The OFH and the CDRC are primary partners in implementing the plan by providing expertise in nurse home visitation and data collection systems.

The Oregon Children's Plan also directs the Commission for Child Care to create a Task Force on Financing Quality Child Care. The plan will provide an early childhood system with these goals supportive of Title V and other identified state outcomes. //2003//

/2004/ Although Oregon has a new governor, the interest and commitment to children remains high. The emphasis remains on improving and strengthening the services for children and development and maturation of an early childhood system. OFH continues to work in collaborative networks to promote

efforts such as the early childhood system standards, collaborative trainings for systems building, cultural diversity training, and related activities. //2004//

/2005/ Governor Kulongoski has initiated a Children's Charter for Oregon to address the following goals: every child in Oregon is safe, healthy and has adequate food and shelter; every younger child in Oregon is ready to enter school; and every older child in Oregon graduates from high school and is ready to join the workforce or go on to college. This charter will work on principles to improve funding for K-12 education, decrease hunger experienced by children and their families, and improve Oregon Health Plan coverage for children.

In early July 2004, Governor Kulongoski also announced two steps to expand health care for children in Oregon, a new employer-sponsored, Children's Group Plan that will begin in January 2005. He directed the Department of Human Services (DHS) to develop a pilot project to improve outreach efforts to uninsured children, and to change the current asset limit for the state's Children's Health Insurance Plan (CHIP) program from \$5000 to \$10,000. The goal of this initiative is to decrease the number of uninsured children by providing an incentive to employers, who currently do not provide health insurance for their employees, to purchase this low cost plan for their employees' dependents. Low-income working families with incomes up to 185% of the federal poverty level also may be eligible for a subsidy to purchase the Children's Group Plan through their employer.

The Governor also created an Office of Rural Policy to coordinate the formulation of rural policy for the state and will serve as a clearing house for the collection and dissemination of information about issues that are of special interest to rural Oregon. The office will also serve as a liaison between elected officials in rural Oregon, the executive branch and the state legislature. //2005//

ASSURANCE CAPACITY

Toll-free Telephone Numbers: Oregon's MCH Hotline (SafeNet) was established in April 1991, and is funded jointly by the Title V and Title XIX Agencies. The service is provided through an interagency agreement with Multnomah County Health Department and the Office of Medical Assistance Programs. The state's Maternal & Child Health hotline, SafeNet, is designed to link low income Oregon residents with health care services in their communities; assist in identifying and prioritizing needs of callers with immediate, multiple health care concerns; match provider callers with appropriate information concerning options; track and document service gaps; and provide follow-up and advocacy to insure that clients statewide are able to access available services. Outreach for SafeNet occurs through Medicaid card messages and inserts (WIC, prenatal, flu, and dental), and through statewide Yellow Pages advertising, AFS offices, OHP staff, local health departments, private providers, managed care plans and social service agencies. Special advertising campaigns designed to move particular target audiences to call SafeNet for particular time-sensitive information is conducted periodically. Discussion is underway to utilize SafeNet as a part of other nutrition and food assistance programs such as in Adult and Family Services. /2003/ The food stamp program and SafeNet have a contract and are have put the SafeNet phone number on outreach materials to help people get to the right place to apply for food stamps. Automated databases track multiple presenting needs, client demographics, and call volume by day and time. Presenting need, county, publicity, and percent of poverty level, age, gender, ethnicity, and referral collects data. /2004/ Budget cuts have affected the funding structure for SafeNet, however the toll-free line will continue with different support structure. Title V funds will continue to provide support, and the database of phone calls will also continue. //2004//

/2005/ Oregon SafeNet is developing a partnership with 211Info to continue services. While funding has been restructured and staff reduced, the quality and continuity of SafeNet will continue. //2005//

/2004/ Medicaid Administrative Match: Efforts are underway to leverage Medicaid Administrative Match (MAC) for county health department programs. Approximately ten counties are participating the first year. //2004//

/2005/ The OFH has developed technical assistance for counties to leverage funding through Medicaid Administrative Claiming (MAC). A manual and training on MAC has been implemented, with seventy-five percent of county health departments participating . These funds augment the Targeted Case Management funds for services to children under the age of 4 years. CDRC staff met with the DHS Director's Office to discuss the possibility of CDRC becoming a MAC participant. //2005//

/2002/ Workforce Development A Public Health Nursing Practice and Education consortium composed of public health nursing practice, education and the state health agency has been meeting for over a year //2002//

/2004/ A conference was held in Fall 2002 to begin identifying priorities and standard protocols for nurses working in MCH programs. Four priority areas were identified: access to care, home visiting, birth control, immunizations, and well-child care. Nursing standard protocols will be developed from these priorities, including training workshop for implementation and evaluation of the measures. //2004//

CDRC provides ongoing training for professionals who work with children with special health needs and their families. A series of self-directed learning modules for public health nurses are being developed through grants from four foundations, to better prepare Public Health Nurses to provide care coordination services. */2004/ The self-directed learning modules are continuing to improve the quality of care at the community level. In addition to working with the OHSU School of Nursing to include these modules into the nursing curriculum, we are working with the LEND program to incorporate the nursing content and guidelines into an interdisciplinary training program in developmental disabilities. //2004//*

/2005/ Three CSHCN learning modules have been completed and published: Cerebral Palsy, Congenital Heart and Cleft Lip & Palate. The modules provide public health nurses with basic information about the condition, the diagnostic process, the common effects that a diagnosis can have on a child and his family and appropriate guidelines for care coordination. The modules were showcased and sold at a statewide conference; requests from across the country have been received. //2005//

LEND promotes leadership, research skills, and clinical expertise among graduate-level health care professionals who will devote their careers to working with persons with disabilities and special health needs and their families.

/2005/ LEND trainees regularly participate in Title V activities, including providing direct clinical services in Community Connections Network clinics, making referrals to CaCoon nurses, sitting on Title V committees and consulting with nursing staff about research projects and clinical problems, and working closely with the Family Consultants in Title V to include the family perspective in the LEND core curriculum. This past year, LEND Interdisciplinary Seminars broadcast two LEND programs to CaCoon and CCN communities. The two topics presented were Cerebral Palsy and Advances in Newborn Screening. Up to 6 sites linked up with the broadcasts. Communities were informed of the topics to be presented and were helped to make the necessary technology connections. LEND trainees will participate in surveying Title V employees across the state to ascertain topics of interest for future broadcasts. //2005//

C. ORGANIZATIONAL STRUCTURE

Oregon's Title V Agency is the Oregon Health Division, a division of the Oregon Department of Human Services under the Governor of Oregon. The OHD is located in Portland, Oregon's largest city. Important partners of the OHD in carrying out the mission of Title V are the thirty-four local health departments (LHDs) and the CDRC at OHSU. Organizational charts for the OHD, OFH, and The CDRC are available from the Title V office. The Title V Director, Donalda Dodson, R.N., M.P.H.,

serves as Assistant Administrator of the Oregon Health Division and as Director of OFH. The OFH delivers its programs serving the MCH population through county health departments, other state and local partnerships, and in coordination with the CSHN program at the CDRC.

/2003/ The OHD was eliminated in Oregon statutes in the 2001 Legislative Session. As was noted above, the Oregon Title V Agency is the Office of Family Health in the Health Services branch of the DHS. The OFH continues in the same building and programs have not changed under the reorganization. Donaldda Dodson, RN, MPH, continues as Administrator, Office of Family Health. The new DHS organization brings together all health-related divisions under one Assistant DHS Director, Barry Kast. These include the divisions responsible for Medicaid (Oregon Health Plan), Substance Use Treatment and Services, Mental Health Treatment and Services, including public psychiatric hospitals, and all the offices of the former Oregon Health Division. /2004/ The Title V program continues in the Office of Family Health in DHS. //2004// **/2005/ No significant changes in DHS, Office of Family Health in 2004 //2005//**

The programs included in the Office of Family include the Federal/State Partnership programs and other federal grant programs:

Perinatal Health: maternity case management, Oregon MothersCare outreach, Smoke Free Mothers and Babies, PRAMS survey

Child Health: Babies First! home visiting program, EHDI-Early Hearing Detection and Intervention, nutrition and physical activity consultation, breastfeeding promotion, Healthy Child Care America, Genetics Planning and implementation; public health nurse consultation, child injury prevention (SafeKids), Newborn Metabolic Screening (Public Health Lab).

Adolescent Health: Coordinated School Health Program, Teen Pregnancy Prevention consultation, Healthy Teen Survey, **/2005/School-based Health Centers have been reinstated in OFH //2005//**

Oral Health: Oral Health Improvement Project, Sealant Program, fluoride supplement program, early childhood cavity prevention project

Womens and Reproductive Health: Family Planning (Title X), Family Planning Expansion Project, Womens Health, domestic violence and rape prevention

WIC: Nutrition Education and Supplemental Food Program, Farmers Market, Senior Farmers Market, Breastfeeding Promotion **/2005/ TWIST, the new WIC data System, rolled out successfully in 2004 //2005//**

Immunization: Immunization Program, Vaccines for Children, ALERT Immunization Registry

MCH Services: MCH Epidemiology, medical consultation, program development and planning, FamilyNet (client database) development and implementation, MCH Monitoring system, Children with Heritable Conditions-newborn data linking project.

Children with Special Health Needs Program

The Oregon Child Development and Rehabilitation Center is housed in the Oregon Health and Science University. The CDRC (ORS 444.110) has responsibility to provide services to children with special health needs. The Federal-State Block Grant partnership is strengthened by the participation of the CDRC Director, Clifford (Jerry) Sells, M.D., M.P.H., on important state and national committees and boards. These include recent membership on the Association of Maternal and Child Health Programs (AMCHP) Board of Directors and work, as one of four pediatricians with the American Board of Psychiatry and Neurology and the American Board of Pediatrics to develop Boards in Neurodevelopmental Pediatrics. Services for children with special health needs are met through the joint efforts of the OHD and the CDRC. Under state legislative mandates, the OHD has responsibility to support all families in their effort to care for family members, including those with disability or

chronic illness.

/2003/ The new CDRC Director, Brian T. Rogers, M.D, reports directly to the President of OHSU and is a member of the University's Executive Committee. He has already become active in CDRC/OHSU committees, clinics and his visionary planning for CDRC. Dr. Rogers continues to participate on national committees including the Society of Developmental Pediatrics, the American Board of Pediatrics, and the Board of Psychiatry and Neurology.

/2004/ Dr. Rogers was appointed prof, Dept of Pediatrics, OHSU. He is chief of the Division of Developmental Pediatrics.//2004//

/2005/ Two people in key leadership positions within OSCSHN retired: Catherine A. Renken, R.N., M.P.H., Assistant Director of OSCSHN, will be leaving in July, 2004; Kathleen S. Williams, Program Manager for Community Connections, also retired during 2004. Dr. Robert Nickel, M.D., has been named the new Director of OSCSHN; he will serve on the CDRC Administrative Team and will report directly to Dr. Rogers. Dr. Nickel has been the Regional Director of the Eugene CDRC. A search has begun for a new Community Services Manager who will administer the community-based multidiscipline assessment teams, the public health nursing care coordination and incorporate the medical home concept into the community-based service system. Rebecca Adelman, one of the Title V Family Consultants, has been functioning as the interim Manager.

An application for establishing the OSCSHN as the Oregon Center for Children with Special Health Needs has been submitted to the OHSU Provost. //2005//

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

Organizational charts are available from the Title V Director's office. Oregon Dept of Human Services, Office of Family Health charts are available on the website
<http://www.dhs.state.or.us/aboutdhs/structure/orgcharts.html>

Information on the Child Development and Rehabilitation Center is available on the website:
<http://cdrc.ohsu.edu/oscsn1/index.html>

D. OTHER MCH CAPACITY

Office of Family Health -- MCH Programs

The OHD Center for Child and Family Health (/2003/now called the DHS, Office of Family Health) employs approximately 100 permanent and temporary staff, with expertise and skills in all program areas. The direct delivery of MCH programs is provided by staff at local health departments, funded by Title V and other federal and state funds through grants to counties. There are approximately 1,700 county public health staff persons in Oregon, not including staff at non-profit or tribal health centers. This includes 28 health department administrators, 510 public health nurses and nurse practitioners, and 130 other health professional staff in Oregon LHDs. The OFH Office of Community Health Services assists in recruitment and orientation of local agency administrators. This Office

coordinates the OFH local Agency Review process on a three-year on-site cycle to provide consultation for local public health services.

The leadership for Title V Programs includes Donalda Dodson, RN, MPH, Administrator, Office of Family Health is the Oregon Title V Director and Brian Rogers, MD, is Director, Child Development and Rehabilitation Center and Cathy Renken, RN, MPH, is Assistant Director for Oregon Children with Special Health Needs Program.

The lead management staff in the Office of Family Health includes section managers for Perinatal Health, Child Health, Adolescent Health, Oral Health, Womens and Reproductive Health, Immunization and WIC. Each section is staffed with many years experience in public health program planning, implementation, and evaluation, and includes research analysts to evaluate data from a variety of data sources. In addition, lead consultants are available to OFH and to CDRC in MCH Epidemiology, MCH data monitoring, program planning and evaluation, family medicine, and dental health.

Title V Programs are delivered through local health departments. Implementation of the following programs occurs through grant awards, contract assurances, guidelines and program standards agreed to between the state Office of Family Health and the Conference of Local Health Officials, representing county health departments.

- Perinatal Health Program includes Maternity Case Management and Oregon MothersCare (OMC). An OMC site is contracted by OFH to provide outreach, health plan enrollment, and information and referrals. Oregon MothersCare increases consumer, community, provider, facility, and agency responsibility for adequate perinatal care and creates partnerships and collaboration to find solutions for assuring women receive first trimester care./2002/About \$800,000 per year of Title V funds are provided to LHDS for perinatal services. MCH and Oregon MothersCare has increased activities in reducing tobacco use in women./2002// /2003/ A Smoke Free Mothers and Babies Project, funded by Robert Wood Johnson, is providing training and implementation of an assessment protocol by public and private providers for smoking cessation among pregnant women./2003//

- Babies First! Program: The "Babies First!" goal is to identify high-risk infants (as defined by risk factors associated with poor physical and emotional health/developmental outcomes) and then to improve the health outcome of these vulnerable children through prevention or early identification of problems. OHD provides state general fund grants to LHDs for public health nurse visits. Approximately 9,000 infants received nearly 25,000 public health nursing home visits in 1998-99./2002/Several Olds model replications are occurring in Oregon in rural Morrow and Umatilla Counties and in urban Multnomah County.

- Injury Prevention: The lead on injury prevention has been relocated in the Center for Disease Prevention and Epidemiology, Title V funds continue to support the Child Injury Prevention Coordinator and works closely to achieve OHD's injury prevention goals.

- Breastfeeding, Nutrition, and Physical Activity: Local health departments promote nutrition education and promotion through their WIC and MCH programs to identify clients needing referrals based on the client's health history and diet assessment. People who need other services are referred to TANF, food stamps and other food resources, drug and alcohol counseling, smoking cessation programs, parenting, breastfeeding support, and Head Start programs. Representatives from OFH and county health departments serve on the Oregon Partners in Breastfeeding Promotion coalition./2003/OFH nutritionists developed a strategic plan for integrating nutrition and physical activity messages and activities in program delivery./2004/The OFH Nutrition and Physical Activity Plan will be implemented./2004//

- WIC services: County health departments and some tribes offer WIC clinics at multiple sites and evening and weekend hours to provide easy access for women, infants, and children, as well as in multiple languages.

- School Based Health Centers: Thirteen counties currently participate in the operation of state certified SBHCs. County public health staff routinely sit on community planning groups and sometimes participate directly in the implementation or delivery of programs in the areas of tobacco use and teen pregnancy prevention. /2004/All state funding support for school-based health centers was eliminated in state general fund budget cuts./2004// **/2005/ School Based Health Center**

funding was restored in the 2003 general Legislative Session. //2005//

Children With Special Health Care Needs Program

The CDRC employs 244 faculty, classified or administrative staff; 216 are located in Portland at OHSU and 28 work at the CDRC Regional Office on the University of Oregon campus in Eugene. CDRC sponsors interdisciplinary clinics in fourteen communities across the state through the Community Connections Network (CCN), including 20 pediatricians or family practice physicians, 1 orthopedic surgeon, and 1 psychiatrist.

*//2003/CDRC employs 227 faculty, classified and administrative staff. Community-based staff: 38; CaCoon PHN: 41; CaCoon Promotoras: 3; CCN Contracted Staff: 36. //2003// /2004/CDRC employs 241 faculty, classified and administrative staff, 213 in Portland and 28 in Eugene. The CCN and CaCoon have maintained staff levels in communities. 1,405 children received 7,515 contacts. //2004// **//2005/CDRC employs 255 faculty, classified and administrative staff, 225 in Portland and 31 in Eugene. The CCN added two communities this year increasing the number of contracted staff: 40 community-based professionals (20 pediatricians or family practice physicians, 15 coordinators and 5 staff) provide services. Signed contracts with 34 county health departments are in place for the CaCoon program. All 36 counties provide public health nursing services with one health department serving 3 counties. In 2003, 1677 children and young adults received 9,112 services through the community-based system: CCN provided 1,764 services to 237 children; 1,440 children received 7,348 services through CaCoon (32 counties reporting). To date for FY 2004, 995 children have received 4641 services through these two programs.//2005//***

//2003/In CDRC, Nineteen staff (12.25 FTE) receive salary support from the Block Grant. A nurse consultant for the Early Hearing Diagnostic Intervention Project was hired through a contract with the DHS/Office of Family Health. /2004/Twenty-one staff (14.2 FTE) have OSCSHN responsibilities and are supported by the Block Grant or grant funded projects such as the Medical Home Project and the Integrated Community Systems Project.//2004// Staff include a developmental pediatrician, registered nurses with public health experience, an evaluator, parent consultants, a social worker, and a nutrition consultant.//2003// /2004/The elimination of the Purchase Care Program reduced staff and shifted duties to remaining staff. //2004//

//2005/ In CDRC, Twenty-three (16.25 FTE) have OSCSHN responsibilities and are supported by the Block Grant (13.60 FTE) or grant funded projects (2.56 FTE). Two 0.5 FTE parents were hired to develop a network or families throughout the state to increase family involvement and leadership. Two nurses were added to assure that families experience continuity of care and a smooth transition between tertiary health and community-based care: one will work with tertiary hospitals and the other will focus on the CDRC Child Development Clinic. //2005//

The CDRC Tertiary Care Clinics: The CDRC administers tertiary level clinics in Eugene and Portland. Interdisciplinary teams provide diagnostic assessments, consultation, and management for children and young adults with established or suspected disabilities. Some of the clinical programs are "unique," providing a service that is unavailable elsewhere in Oregon: the Metabolic, Hemophilia, Genetics and Assistive Technology clinics./2003/In 2001, 29,907 services were provided to 7,365 children and young adults through the tertiary specialty clinics: 24,584 services to 6,191 children in Portland and 5,323 services for 1,174 children in Eugene. /2004/In 2002, 32,427 evaluation and management services were provided to 6,590 children and young adults through the tertiary specialty clinics: 26,376 services to 5,531 children in Portland and 6,051 services to 1,059 children in Eugene.//2004//

//2005/In 2003, 32,437 evaluation and management services were provided to 6,356 children and young adults through CDRC specialty clinics in Portland and Eugene: 29,043 services to 5,616 children in Portland and 3,394 to 740 children in Eugene.//2005//

Dr. Dale Garell has consulted with the OSCSHN program and met with various leaders in the state to strengthen relationships with the CDRC. /2003/Dr. Garell continues to be a valuable resource to the OSCSHN program. He participates on the committee to develop a common definition for CSHN and

the CQI committee to develop indicators for measuring and monitoring outcomes for CSHN followed through Title V supported programs.//2004/Dr. Garell is chairing the workgroup, Integrating Community-based programs.//2004//

//2005/Dr. Garell chaired the Community-based Service System Task Force to its completion in May 2004. He wrote the Final Report, Toward a State-wide Community Based System of Care: An Integrated Approach to Care by the CDRC's Title V Services. The report with recommendations was submitted to the CDRC Director for approval and dissemination. Dr. Garell will continue to work with CDRC in the months to come.//2005//

Number and role of parents of special needs children: The CDRC employs people with disabilities and parents of CSHN in a variety of roles. Parents are employed in project evaluation, project coordination and program support. Parent input on issues and needs related to the CDRC clinics is also given through the DCH Family Advisory Committee. A parent administers the gift fund. Two parents coordinate the state Family Voices organization. One parent is on staff with the CDRC and has multiple roles focusing on consumer involvement; health care and family support projects. Parents provide input to CDRC planning, implementing and evaluating programs and policies. They will disseminate information in local communities, facilitate meetings and educational events and provide the "parent prospective" on issues impacting CSHN.

//2005/ CDRC employs parents of children with special needs in a variety of roles, including project management, family consultants, grant planning and evaluation, oversight for family support programs and gift funds and as consultants to grants, project advisories, and training initiatives. Through the Family Involvement Network (FIN), three family members hold part time positions specifically to assist the program with broad parent perspectives, to enhance connections throughout the state with parents of children and youth with special needs, and to assist and arrange for training opportunities for both families and professionals. CDRC continues a strong relationship with Family Voices in Oregon and with other parent driven organizations. One of the state Family Voices coordinators is on staff in the OSCSHN office as the parent coordinator of FIN. As well, this individual was appointed the interim Manager for OSCSHN Community Based Services. Through the FIN staff, Medical Home and FISHs grants, community-based liaisons and teams, and the Multicultural Task Force, CDRC continues to make family professional partnerships and participatory action initiatives a high priority. FIN is recruiting families to expand and enhance a statewide network of families. OSCSHN will support training and other educational opportunities to help families gain skills and leadership abilities. FIN will collaborate with staff, Family Voices, and other family organizations to provide training that will increase the number of families active in health related issues and efforts in their own communities and at the state level. //2005//

E. STATE AGENCY COORDINATION

The OHD, as the state Title V Agency, extensively facilitates and promotes collaboration and coordination among state, local and non-profit agencies as ongoing development and maintenance of a system of care for the maternal and child health population. The CDRC administers the Oregon Services for Children with Special Health Needs Title V Program at Oregon Health & Science University. /2002/ The 2001 Legislature approved reorganization of DHS eliminating all division names, and organizing into 3 clusters: Health, Social, and Disabilities. /2004/ The reorganization of DHS has resulted in Health Services including the OMAP (Medicaid agency), Office of Mental Health and Addiction Services (OMAHAS), and the public health offices (formerly Oregon Health Division). Title V programs or other programs in the Office of Family Health continue with partnerships and joint initiatives with other Health Services offices. //2004//

Collaborative efforts of OHD and CDRC include:

1. Babies First! and CaCoon: Babies First! and CaCoon coordinate program components and procedures and implement the programs at the local level. The programs use common developmental screening tools and data reporting forms and a statewide data system. Joint training classes are presented for the nurses and program managers.

2. Early Child System of Services and Support: OFH staff are assigned to be a part of the Governor's Interagency Coordinating Team to implement an Early Childhood System of Services and Support in Oregon. /2004/ Development of the Family and Child Module of FamilyNet is underway with planning sessions including participants from the Early Childhood System, DHS, and local health departments. //2004//

3. Public Health Nursing Education: A group of nursing leaders from the state, schools of nursing and local health departments are working together to discuss the challenges and opportunities for partnership surrounding public health nursing practice. /2004/ The collaborative public health nurses group drafted minimum standards for maternal and child health programs. A conference supported by Title V Technical Assistance funds was convened to create a plan for improving services delivered by MCH nurses by developing standards, outcomes and performance measures. //2004//

4. Newborn Hearing Screening: OHD and the CDRC partnered with other agencies to draft and advocate for newborn hearing legislation, which passed in 1999. The bill mandates, as of July 1, 2000, all hospitals with more than 200 live births per year are required to provide hearing screening tests to all babies born in their hospitals. /2003/ Early Hearing Diagnosis and Intervention Program (EHDI) is established in the OFH, and leads a multi-disciplinary advisory committee to provide direction for the entire newborn hearing screening process. HRSA funding provided support for a Nurse Consultant at CDRC to work with community health nurses, the pediatric health care community and Early Intervention programs. /2004/ The EHDI project is continuing and coordinating with Oregon FamilyNet for Children with Heritable Conditions, recently funded by HRSA. //2004//

5. Metabolic Screening: The Public Health Laboratory provides newborn metabolic screening to all Oregon infants. Newborn screening follow-up, program consultation, quality assurance and education are provided by the CDRC. Through this agreement, all infants suspected of having metabolic problems are referred to the CDRC for follow-up.

6. Statewide Genetics Coordinator and Genetics Planning Grant: OHD and the CDRC are collaborating in the MCHB-funded genetics planning project. /2004/ "Oregon's Strategic Plan for Genetics and Public Health" and the Oregon State Public Health Genetics Needs Assessment have been completed and are posted on the Internet. The statewide Genetics Coordinator position is funded by CDRC at 0.25 FTE. The OFH received funding from the CDC Cooperative Agreement for Genomics, which will support implementation of the Genetics Plan. //2004//

7. /2003/ Defining Children with Special Health Needs: CDRC and the Office of Family Health are collaborating on a committee to develop a common definition for CSHN in Oregon. Partners include OMAP, Regence BlueCross/BlueShield, Kaiser Permanente and other health care plans, Providence Child Center, Oregon Department of Education, Oregon Commission of Children and Families, and parents. /2004/ The workgroup developed and recommended two approaches and associated sets of tools to define CSHN. A validated list of diagnostic codes is recommended as a common method for identifying CSHN at the systems level and screening and complexity level tools are recommended for use at the practice level. The recommendations and both sets of tools have been disseminated to partners. //2004// **/2005/ The work of the Task Force has served to set the foundation for an exciting and productive slate of work for the future. The members of the group receive periodic updates regarding the on-going activities that utilize the work. //2005//**

8. /2003/ MCH in Rural and Remote Areas: CDRC and the OFH collaborated on compiling information on MCH Services in Rural Health. The findings highlighted the issues and barriers in delivering MCH services, including community building, assessment, and planning. /2004/ Region X states are collaborating with AMCHP, for inclusion in policy discussions. A presentation at the 2003 AMCHP annual meeting included a survey of other states to determine the range of issues and interest in addressing MCH needs in rural areas across the country. //2004//

Interagency and Intra-agency Coordination Efforts: OHD and CDRC coordination efforts are listed below in separate sections. OHD Interagency Coordination:

1. Adult and Family Services: Community-Based Application Assistance project (to expand access to OHP and early prenatal care), Students Today Aren't Ready for Sex (STARS) Abstinence Program, Teen Pregnancy Prevention

2. Office of Medical Assistance Programs: Lead Screening, Community-Based Application Assistance Project, Dental Health Services, Preschool and Adolescent Immunization, Vaccine for Children, Family Planning Expansion Project, School-Based Health Centers, VISTA Health Links, Oregon MothersCare, Maternity Case Management, Babies First! CaCoon; Childhood Cavity Prevention,

definition of CSCHN, early child mental health

3. Services for Children and Families: Child Fatality Review (STAT), Fetal Alcohol Affected Project, Oregon Children's Plan, and Early Childhood Data System. /2003/ STAT was eliminated in the 2001-2003 Legislative Approved Budget

4. Office of Alcohol and Drug Abuse Prevention: Youth Risk Behavior Survey /2003/ The YRBS is now called the Teen Health Survey

5. Mental Health Division: Fragile Children Program, Suicide Prevention, Start Smart

6. State Fire Marshal: SafeKids Program

7. Oregon Commission on Children and Families: Oregon's Child Everyone's Business Campaign, Oregon MothersCare, African American Infant Mortality Project, Oregon's Healthy Start, Lighted Schools Project, Early Childhood Systems, CaCoon

8. /2004/ Oregon Dept of Education: Coordinated School Health //2004//

9. /2004/ Child Care Division: Healthy Child Care America -- Nurse Consultation //2004//

OHD Intra-Agency Coordination:

1. The Immunization ALERT program works closely with the Oregon Health Systems In Collaboration (OHSIC) to build a statewide immunization registry among private and public providers.

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

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

4. Oregon's MothersCare is an initiative to build partnerships to streamline, coordinate and promote access to early prenatal care through coordination of referral systems which link women to the state toll-free hotline (SafeNet), pregnancy test sites, local health departments, OHP (Medicaid), Maternity Case Management, WIC and other agencies that provide prenatal services.

5. The School-Based Health Center, Suicide Prevention and Immunization programs collaborated on a communications and marketing package that were sent to primary care physicians linking changes in the state immunization laws to opportunities in providing a more comprehensive preventive health visit for adolescents.

6. The Title V and Title XIX agencies, with other private and public providers, participate on joint committees to facilitate the coordination of services with common clients.

7. The Childhood Injury Prevention Program, in CDPE, chairs the Area Trauma Advisory Boards to coordinate activities across a variety of public and private organizations.

8. The CDRC is the contract agency to deliver the Title V services to children with special health care needs.

9. The OHD contracts with the State Perinatal Center at Oregon Health Sciences University (OHSU) to provide technical assistance, on-site consultations, chart reviews, and bimonthly continuing education to the prenatal clinics at LHD's. In addition, it participates as a partner with the OHD to address perinatal technical policy issues for the state. /2003/ This contract was discontinued in 2001.

10. The OHD contracts with the Department of Pediatrics at OHSU to provide medical consultation on newborns who are screened by the Public Health Laboratory. This program consultation involves specific test results as well as laboratory and clinical evaluation policies.

11. The OHD also maintains contractual arrangements through a grant award system with all LHDs. The OHD monitors and evaluates the delivery and quality of services through the review of annual plans submitted to the OHD each year and tri-annual site reviews.

12. The OHD has agreements with a variety of schools to provide a school fluoride rinse program. This includes the provision of fluoride supplies to schools and training programs for teachers, professionals, and volunteers. /2004/ Dental sealant programs are beginning under funding provided by CDC. //2004//

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

Interagency Agency Coordination for CDRC (Children with special health needs programs)
The CDRC continues to strengthen partnerships developed over the years through working interagency agreements with the following:

1. The CDRC contracts with 33 county health departments for implementing the CaCoon

program. /2003/ CDRC initiated contracts with CCN sites around the state for a professional staff person to assist with coordination of the local program. **/2005/ Signed contracts with 34 county health departments are in place for the CaCoon program. One health department serving 3 counties. //2005//**

2. /2004/ Personal services contracts through the Medical Home Project were initiated to create a statewide network of parent and professional Resource Teams. Seven physicians, four CaCoon Nurses and fifteen parents are currently working on this goal. //2004// **/2005/ Contracts with six private practice offices were in place. //2005//**

3. Office of Medical Assistance (OMAP): The CDRC's Interagency Agreement addresses reimbursement rates for services provided at the CDRC tertiary clinics for children covered by a Medicaid Fee for Service Card. /2004/ OMAP Medical Director continues to participate on CDRC committees including the Medical Home Advisory Committee and the Task Force on Care Coordination Reimbursement. An OMAP representative was a member of the Oregon Title V team attending the Tri-regional meetings in Portland and presented an update on Medicaid programs at the CaCoon Inservice. //2004// **/2005/ Representatives from OMAP continue to participate on CDRC committees including the newly formed Child Find Task Force to assure that children with special health needs are identified early and linked to community services. //2005//**

4. Oregon Department of Education (ODE): CDRC is on the State Interagency Coordinating Council for Early Intervention/Early Childhood Special Education. CaCoon Nurses participate on the Local Interagency Coordinating Councils. /2004/ ODE and CDRC continue to work together on issues that cross health and education including adolescent transition, early referral from NICUs to community-based programs, child find, and personnel preparation. //2004// **/2005/ CDRC continues to have a strong relationship with the Early Intervention and transition programs of the ODE. A joint conference on Adolescent Transition is being planned. Representatives from ODE continue to participate on committees and CDRC staff continue on the State Interagency Coordinating Council. //2005//**

5. Oregon Pediatric Society (OPS): The CDRC Director and staff serve on the OPS Committee on Children with Disabilities (CCWD) and the OPS Executive Committee, and present at the annual Spring OPS meeting. The members of the CCWD continue to collaborate with the state planning group on the Medical Home to implement parent and provider Medical Home surveys. /2004/ OPS continues to be represented on the Committees and has regularly attended annual medical home trainings. //2004// **/2005/ CDRC's Oregon Medical Home Project received a Community Service Award from the OPS at their 2004 annual meeting. The OPS and CDRC are also co-sponsoring a survey of Oregon's pediatricians and health plans on coding and reimbursement. //2005//**

6. Oregon Mental Health and Developmental Disabilities (MHDD): An MHDD staff member participates on the interagency team addressing adolescent transitioning. /2003/ A CDRC staff member was appointed by the Governor to serve a term on the Oregon Council on Developmental Disabilities. **/2005/ The Title V representative a member of the Family Issues Committee. //2005//**

7. Vocational Rehabilitation Division (VRD) and the Social Security Administration (SSA): The CDRC, SSA and the Disability Determination Services (DDS) of VRD educate providers about Childhood SSI eligibility, outreach to potentially eligible families, and ensure that families who apply for SSI receive information about available services. /2004/ Representatives from DDS and SSA participated in the annual CaCoon conference. //2004//

/2005/ A representative from VRD has been on the team planning the up-coming conference on transition for adolescents with special health needs. The conference will include VRD partners at local sites to discuss resources within their own communities. //2005//

8. Shriners Hospital for Children: The CDRC and Shriners Hospital collaborate on adolescent health transitioning and medical home issues, and CDRC pediatricians regularly staff clinics at the Shriners Hospital. /2003/ A Parent Survey was completed through joint efforts, regarding parents' perception of a medical home. /2004/ Shriners care coordinators participated in the CaCoon Inservice. //2004// **/2005/ The Title V nurse liaison has met with the care coordinator at Shriners Hospital to discuss ways to facilitate referrals to local public health nurses. //2005//**

9. Oregon Commission on Children and Families (OCCF): The CDRC works with the Commission at the state and local levels to avoid duplication and to train all home visitors. A unique collaboration between Healthy Start and CaCoon exists in one of the counties. The Healthy Start paraprofessional has been hired as the Promotora and works with the CaCoon nurse to provide services to CSHN in

their Hispanic community. ***/2005/ The OCCF and CDRC continue to work on children's issues. They have a representative on the Child Find Task Force. //2005//***

10. Hospital NICUs and Pediatric ICUs: The CDRC has worked with hospitals throughout the state to educate case managers, discharge coordinators and social workers about community-based programs for CSHN. ***/2003/ NICU personnel participated in a meeting to review the status of discharge planning and linking families to community resources. An updated pre-eligibility form for Early Intervention was distributed to facilitate early referrals to community services. /2004/ NICU case managers from Legacy Emanuel Children's Hospital and Doernbecher Children's Hospital presented at the CaCoon in-service to highlight changes in hospital discharge planning and to problem solve ways to assist families make a smooth transition from the hospital setting to community services. //2004// /2005/ The Title V nurse liaison attends NICU rounds at OHSU gives in-service trainings for discharge coordinators at other hospitals and collaborates with parent support groups for NICU babies. A brochure for parents about community resources has been developed. Updates about specific babies are given to local public health nurses and other appropriate community services. //2005//***

11. Family Organizations: The CDRC participates with these groups to plan a parent-to-parent network for families who have a child with a special need. CDRC staff members participate on various local task forces and committees such as Arc, United Cerebral Palsy (UCP), early intervention councils, community service clubs, and neighborhood meetings. ***/2004/ COPE is now the Oregon Parent Training and Information Center, and are part of the collaboration of Family Voices, Family Action Coalition Team, and other family organizations. //2004// /2005/ CDRC partners with parent organizations and is developing collaborative relationships with additional groups including Precious Beginnings, for families whose children/youth have mental health concerns), the IEP Partners project of the Oregon Parent Training and Information Center, and the newly forming Oregon Parent to Parent Network. //2005//***

12. Pacific Northwest Regional Genetics Group (PacNoRGG): PacNoRGG is a consortium of genetics service providers, public health professionals, and consumers working to improve genetics services in Alaska, Idaho, Oregon and Washington, funded by MCHB and housed at the CDRC. ***/2003/ Federal funding for PacNoRGG decreased significantly this past year and will end completely 8/31/02. The network will continue some of its communication and collaboration activities next year, including maintaining the PacNoRGG web site, sponsoring an electronic mail network and holding an annual meeting. Committees will continue without staff support, and states will hold periodic conference calls. /2004/ PacNoRGG maintains a web site, publications, conference calls, and electronic mail list. //2004// /2005/ Maintenance of the PacNoRGG website and electronic versions of publications continued. Information was occasionally disseminated via the listserv. //2005//***

13. Oregon Regional Hemophilia Center: The Oregon Regional Hemophilia Treatment Center based at the CDRC has been the designated federal regional core center in Region X since 1976. Subcontractors are in each of the four Region X states and a satellite hemophilia program is in Spokane. Two hundred and fifty-four children and young adults were seen through the Center. Team members visit work sites, physicians offices, emergency rooms, and local health departments.

14. ***/2003/ Providence Child Center (PCC): CDRC staff have participated on the Monitoring Outcomes for CSHN Advisory Board. /2004/ PCC continued to collaborate on the development of the needs assessment. //2004// /2005/ Results of the needs assessment pilot will be shared with the PCC and modifications will be made to the survey accordingly. //2005//***

15. ***/2003/ Respite Care: A representative from the CDRC participated in the development of the Multnomah County Lifespan Respite Network, to assist caregivers in locating respite services for family members with medical, developmental, physical, or emotional needs. /2004/ A registry database was developed with a total of 146 caregivers listed.//2004/ /2005/ Lifespan worked with an AmeriCorps member who coordinates faith-based outreach for families and groups. The second annual Multnomah County Caregiver Conference took place in May, 2004 and was attended by thirty caregivers. Respite opportunities are shared with caregivers and professionals via the network newsletter. A total of 338 families are listed in the Lifespan Registry.//2005//***

16. Oregon Development and Disability Institute (OIDD): Cooperation between OIDD, and the LEND Program works together toward common goals of training, excellence in service and development of health policy, and consultation to community-based CCN teams, CaCoon Nurses, and annual

conferences. /2003/ The Nutrition Consultant and Evaluation Coordinator shares staff between OIDD and LEND /2005/ **LEND trainees regularly participate in Title V activities, including providing direct clinical services in CCN clinics, making referrals to CaCoon nurses, sitting on committees, and consulting with nursing staff about research projects and clinical problems.** //2005//

17. OHSU and Doernbecher Children's Hospital Faculty: OHSU faculty and CDRC staff collaborate and present at conferences. The School of Nursing faculty provide training for CaCoon home visiting nurses. /2003/ A nursing faculty member serves on an advisory committee for self-directed learning modules for nurses. Practicing public health nurse consultants present content for core curricula seminars and workshops on public health nurse practice.

18. Distance Learning Initiative: WEB-based distance learning technical assistance was provided through a grant from MCHB with the goal to develop staff expertise to provide training opportunities in a distance learning format. /2003/ Health Care professionals serving rural areas in eastern and southern Oregon participated in learning opportunities. /2005/ **Through a LEND Distance Learning activity Health care professionals in 6 CaCoon and CCN sites were linked to two broadcast topics: Cerebral Palsy and Advances in Newborn Screening. The communities were informed of the topics to be presented and were helped to make the necessary technology connections. CDRC will expand our use of videoconferencing.** //2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

Oregon follows the core functions and essential services of public health to evaluate capacity of public health. Through the framework of assessment, policy development and assurance, the Title V program in the Office of Family Health assesses needs, develops programs and strategies, and evaluation. The ten essential services, as core public health actions, provide the baseline for evaluating the capacity of Oregon's Title V program and federal/state partnership to show progress on the "Systems Capacity" Indicators.

Oregon's data capacity to measure the eleven indicators is contingent on access to a number of data sources. The OFH currently has access to data from FamilyNet client data, OMAP (Office of Medical Assistance Programs) Oregon Health Plan (Medicaid) data, ALERT Immunization Registry, linked newborn screening and birth certificate data, PRAMS surveys, BRFSS surveys, hospital discharge data, and Teen Health Survey data. Data improvement projects are underway including linking metabolic screening, with newborn hearing screening, birth certificates, client data, and genetics data.

OFH, under the umbrella DHS, Health Services agency, has a successful history of collaborations and coordination with the OMAP (Office of Medical Assistance Programs -- Medicaid agency) to assess the utilization of health services for the Medicaid eligible population, as well as implement population-based prevention and health promotion programs through its managed care and dental care organization contracts. For children with special health needs programs, located at the Child Development and Rehabilitation Center at OHSU, Oregon Health Plan data is available to track early intervention, screening, diagnosis, referral and follow up for a variety of health and oral health issues.

/2002/The racial distribution of the 2000 population shows about the same proportion of other races as in the past: 1.6% Black or African American; 1.3% American Indian or Alaskan Native; 3% Asian; 0.2% Native Hawaiian or other Pacific Islander; 4.2% some other race; and 3.1% two or more races. The distribution of races mentioned alone or in combination with other races yields some different percentages, however. The persons identifying themselves in each racial category either alone or in combination with other racial categories yielded the following: 2.1% Black or African American; 2.5% American Indian or Alaskan Native; 3.7% Asian; 0.5% Native Hawaiian or other Pacific Islander; and 5.2% some other race.

Of the families living in households in 2000 (97.7% of the Oregon population according to the Census), 9.8% were female householders with no husband present; 6.2% were women in this category who had their own children (less than 18 years old) living with them. Thus, about 63% of

single woman households were made up of single mothers with children less than 18 years. The percentage of all households having any individuals under 18 years old was 33.4%.

/2003/ According to the 2000 census, Oregon's population was 3,436,750. The Hispanic/Latino population is among the fastest growing, representing 10.8% of the total population in 2000 and 16.2% of all births that year. There was little change in racial diversity between the estimates and the final census data: persons of color made up 12.8% of the 2000 population: 3.4% were Asian/Pacific Islander; 3.2% American Indian/Alaskan Native; 2.2% African American/Black; and 4.0% "Other." A higher rate of births to American Indian/Alaskan Native and African American/Black women accounts for part of this increase in cultural diversity in Oregon. Those birth rates have tended to increase, although not as consistently or rapidly as for Hispanic women/Latinas. The rate of births to Asian/Pacific Islander women may be declining, although the trend is not clear.

The biggest demographic change is the unemployment rate in Oregon, which has been around 7.2% compared to 5.4% in the rest of the U.S. The economic downturn in Oregon has not only affected families and an increase need for public services, but also a state general fund revenue shortfall for the 2001-2003 biennium at about \$1 billion. Economic problems are accompanied by high proportions of uninsured in the population; 12% to 13% of the 2000 population was uninsured, and increases in Medicaid enrollment would suggest an increase in the percent uninsured since then. Among Hispanics/Latinos, 22% to 27% were uninsured in 2000, as were about 14% of persons of color. Given Oregon's economy, the disparities in access, care, and outcomes among women and children of color (as evidenced by Medicaid vs. non-Medicaid measures discussed later in this report) are of particular concern.

/2004/ Oregon's unemployment rate was 8.2 percent in May, 2003, the highest reading since 8.4 percent was posted for January 2002. Oregon's unemployment rate continues to be above the national unemployment rate of 6.1 percent. (Oregon Employment Dept). The Oregon revenue shortfall for the 2003-05 biennial budget is over \$2 billion, causing reductions in health and social service programs, including eligibility and benefits of the Oregon Health Plan for adults, though children aged 0-18 and pregnant women are considered the priority population for coverage. //2004//

/2005/ Oregon's economic situation is showing slow improvement. In May, 2004 the unemployment rate was 6.8%, down from 8.6% in May 2003, but still higher than the U.S. rate of 5.6% (Oregon Employment Dept., May 2004). The Oregon Health Plan (Medicaid) has experienced critical budget reductions, reducing the number of people with Standard coverage from 50,000 to about 25,000 by July 2005. Pregnant women and children are eligible for coverage at 185% of the federal poverty level; all others are eligible at the 100% of poverty level. In addition, the Oregon Medical Association completed a survey About 10 percent of doctors, and 13 percent of those in primary care, accept no new patients, according to the Oregon Medical Association survey, which was filled out by more than 4,700 doctors, nearly half of those practicing in Oregon. Only one in three primary care doctors accepts all patients, the survey found. (The Oregonian, June 22, 2004). //2005//

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

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

The Child and Family Health Needs Assessment identified data in specific areas as a priority need for which state Title V and family health programs will be focused over the next five years. OFH and Oregon Title V programs will continue enhancing and developing data collection and analysis capacity. In measuring performance of current and planned MCH activities or health status of Oregon Title V population, if there is no intervention that OFH can identify as effective (based on prior research or program evaluation), analysts are may not be able to directly to link program activity to a performance measure or the desired health outcome to demonstrate effective program focus and performance in as short a time as five years. Where these intervention-outcome links can be identified, the measure is useful at all levels. For example, one of the new state measures is the percent of women who took folic acid most days in the month before becoming pregnant. Preconceptual use of folic acid has been demonstrated to reduce the risk of neural tube defects. With this prior evidence, it is reasonable to evaluate the ability of OFH ability to disseminate information about folic acid use, develop or collaborate on other interventions, and effect relevant behavior changes. As OFH develops programs to address Oregon's critical needs, and conducts and monitors relevant research, program managers and analysts can identify appropriate interventions and, therefore, appropriate performance measures. As this process is refined, OFH can begin to identify state-specific outcome measures as well.

State Performance Measures

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

B. STATE PRIORITIES

The Child and Family Needs Assessment identified five priority issues and three major needs that cross five issues: access, education and data. From this assessment, the following priority objectives were selected for developing State Negotiated Performance Measures and represent key indicators for which data is currently available and which will help Oregon measure accomplishment to meeting

the needs. See the Needs Assessment Content for discussion on needs and recommendations for public health to address these needs.

1. Increase the percent of pregnancies among women 15 to 44 that are intended.
2. Increase the prevalence of folic acid use among women prior to their becoming pregnant.
3. Reduce the number of women who use tobacco during pregnancy.
4. Increase the observed number of children aged 0-4 riding in cars restrained in child safety seats
5. Increase the proportion of 8th graders free from tobacco use during the previous month
6. Increase the number of Oregonians who live in a community with fluoridated water systems.
7. Increase the number of students with access to services at a certified school-based health center.
8. Increase access to appropriate care coordination services for CSHCN in Oregon.
9. Develop a statewide data system to support early childhood program needs through multiagency collaborative efforts.
10. Increase the percent of identified programs/providers who have signed a collaborative working agreement with the Oregon children with special health care needs program.

/2004/ The progress on addressing the priority needs are reflected in the activity reports for each of these state negotiated measures, in agency capacity, and coordination. Programs, pilot projects, and policy development activities have been initiated to address the three overall needs: access, education and data.

Examples of activities include:

Access: Early childhood cavity prevention pilot projects; WIC farmers market; Oregon MothersCare; Coordinated School Health projects; Nurse Consultation in child care.

Education: Newborn Handbook distributed to parents of all newborns, with information covering immunizations, breastfeeding, child care, sleep position, growth and development, in English and Spanish. Other family-based education materials have been developed for the public and for providers.

Data: Client data information system, FamilyNet, continues in development. The MCH Monitoring system tracks intermediate and high level outcomes for continuous assessment of outcomes for Title V population and service levels. //2004//

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

- Oregon requires 100% of newborns to be screened regardless of ability to pay, unless a parent seeks an exemption for religious reasons. Without a method to link the individual births with screening data, it remains difficult to determine if any and which children are missed.
- During 2003, progress continued on developing a mechanism to link newborn metabolic screening data with other newborn and child-related information in a system to assure that all children born in Oregon receive appropriate screening. A pilot test of a process to link birth certificates, newborn hearing screening data and newborn metabolic screening data was completed in 2003. As a result, the newborn screening identification number is now encoded in a bar code that is routinely used as a unique identifier linking these data sources.
- Oregon's Newborn Screening follow-up program, a partnership between the Oregon State Public Health Laboratory (OSPHL) and follow-up/medical consultant staff at Oregon Health and

Science University, continued its success in assuring that all newborns needing follow-up testing and referral received those services in a timely manner. Follow-up staff continued to work with hospitals, midwives and other providers to improve accuracy and timeliness of specimen submission and to improve rates of second screening.

- Strong connections between the OSPHL Newborn Screening Program and OFH were maintained through joint activities, including OFH participation on the Newborn Screening Program Advisory Committee.

- 2003 marked the first complete year of expanded newborn metabolic screening. Twenty new disorders were added to the newborn screening panel using tandem mass spectrometry.

Oregon continued to be a national leader in newborn screening by being the only state routinely completing a full first and second screen for each infant.

- Screening for congenital adrenal hyperplasia was implemented for all Oregon newborns in July 2003.

- The Oregon Newborn Screening Program has updated testing technology for congenital hypothyroidism to reduce the use of highly regulated radiochemicals by using an automated, fluorescence-based system that improves the sensitivity and specificity.

- Revisions to the Oregon Practitioner's manual and parent brochure were completed in 2003. Changes include information on expanded screening using tandem mass spectrometry and testing for congenital adrenal hyperplasia.

- The OSPHL, OFH and CDRC started collaborative efforts on a HRSA grant: Long Term Follow-Up of Infants Identified by Newborn Screening in Oregon and Idaho.

b. Current Activities

- Technology updates for other newborn screening tests continue in 2004.

- The OSPHL, OFH, and CDRC, in collaboration with regional partners, have applied for a HRSA grant to improve access to genetic services for families living outside large metropolitan areas.

- Collaborative efforts continue to focus on integrated data and service system development in the Capacity Building for Oregon's Children with Heritable Conditions Project.

- In 2004, the Oregon Practitioner's Manual will be updated with revisions reflecting the most current knowledge on the disorders screened by tandem mass spectrometry.

- In 2004, a Task Force jointly chaired by representatives from OSPHL and OFH will explore the feasibility and effectiveness of adding newborn screening for cystic fibrosis to the newborn screening test panel.

- In 2004, the OSPHL Newborn Screening Program will be represented among the members of the Association of Public Health Labs (APHL) National Newborn Screening and Genetics Committee.

- The content of the OSPHL newborn screening program website was expanded to include new general and specific NBS information, including TMS disorder fact sheets.

- The OSPHL began offering WebRad, a web-based tool giving hospitals and physicians the ability to obtain newborn screening test results and patient information for their medical clients. The OSPHL continues to improve online access to screening results by authorized persons through the WebRad system.

c. Plan for the Coming Year

- The OSPHL will provide continued representation on the APHL National Newborn Screening and Genetics Committee.

- The OSPHL plans to update testing technology for galactosemia to achieve consistency with the most current methods.

- The OSPHL will continue efforts to assure that all newborns receive both an initial screening and a second screening at two weeks of life through parent and health care provider education. Efforts will focus on education of expectant parents in prenatal care settings.

- Partners will continue collaborative work on grants to improve newborn screening systems of

service delivery, follow-up and data collection.

- The OSPHL will continue to maintain and update the web site containing general newborn screening program information and tandem mass spectrometry fact sheets.
- The OSPHL will continue efforts to provide and expand online access to screening results by authorized persons through the WebRad system.
- OFH/CDRC State Genetics Program staff will continue active involvement in newborn screening activities.
- In October 2005, Portland and the OSPHL is hosting the National Newborn Screening and Genetics Symposium, sponsored by the Association of Public Health Labs. OSPHL will be involved in the planning efforts for this major national conference, and will assist and present data and findings from the state newborn screening program during the event,
- 2005 marks the beginning of a multi-year process of planning the transition of the OSPHL and Newborn Screening Program from its current facilities into new facilities. In 2005, staff will begin the early planning process.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

a. Last Year's Accomplishments

OSCHSN objectives included increasing partnerships with parents of CSHN to meet this performance measure. Parents were employed in project evaluation, project coordination, and program support. A parent administered the gift fund that provides payment to families for equipment or uncovered services and were involved in planning the Family Support Program. Parent roles were included in the expansion and support of the on the Medical Home Project and as part of the medical home improvement efforts in six pediatric practices around the state. Parents were also included in the OSCSHN team meetings, on project management committees and in planning efforts for a variety of program and policy matters. Family perspectives were included in semi-annual statewide trainings for CaCoon nurses and Community Connections teams through parent presentations.

Staff also participated in activities of parent groups, including the State Interagency Coordinating Council, the Developmental Disabilities Council, Family Voices, Arc, and UCP's and Oregon Parent Training and Information Center's (formerly COPE) annual family conferences.

OSCSHN enjoys a close partnership with Oregon's Family Voices (OFV) and employed one of the OFV Coordinators in a part-time position. OFV participated in several initiatives including: surveys and needs assessment, the Defining CSHCN Task Force, Measuring Outcomes project, and Family Voices Partners for Children with Special Needs workgroup, the State Genetics Planning Project. CDRC supports the efforts of OFV through contributions of financial support for training activities and parent participation.

Parent involvement coordinator for OSCSHN participated in several initiatives in Oregon including: planning for quality assurance in developmental disabilities' services, an inclusive approach to early childhood learning, family leadership and partnership, and an online mentor network for families and individuals with disabilities. The coordinator partnered with several other family and disability organizations including: the Oregon's PTI, Parents in Action, Oregon Family Support Network, Arc of Oregon, the Arc of Multnomah & Clackamas Counties, and UCP of Oregon and SW Washington.

b. Current Activities

Strengthening/enhancing family involvement in OSCSHN activities and programs continued as an area of critical importance. A family workgroup addressed areas for improvement, goals, and brainstormed activities for parent participation to ensure that family perspectives are understood and addressed. The group was co-chaired by the parent coordinator and the coordinator for the Medical Home project. It identified the need for additional family staff and participated in developing job descriptions and interviewing applicants. Two additional parents were hired as part time family consultants to implement a statewide Family Involvement Network (FIN).

FIN staff now includes families with significant experience in health care, mental health, and developmental disabilities. Each staff person brings expertise about systems of care as well as significant connections with families and family organizations. Through FIN families have been involved in planning for integrated community based services. FIN staff interface regularly with families and family organizations to gather perspectives and bring broad family representation to the program. FIN now includes 20 families across the state whose children range in age from birth to adulthood and represent a variety of challenges. Information and resources are provided to families and providers through a bimonthly Title V newsletter. Families on staff serve as advisors and regular contributors to the newsletter.

With increased parent staff, family participation has extended to nearly every internal activity and initiative. Parents participate in OSCHN Family Support Program, team meetings, and in community-based services and grant steering committees. FIN has assisted in supporting family participation on the Medical Home project and has participated in trainings for medical home teams, CaCoon and CCN. The family voice is the central focus of FISHs. Families are engaged at the community level both through focus groups and community forums. FIN assisted in recruiting parent participation in the FISHs state consortium and the followup activities related to Universal Application Process coordinates local forums. Data from family focus groups in six communities and community surveys form the basis for addressing issues at the community level.

Within OSCSHN, additional emphasis has been placed on adolescent transition. Staff have participated in several training events.

Collaboration with family organizations continues to be a priority. Staff serve on advisory boards, assist in conference planning and presentations and also participate on OHSU's Multicultural Task Force, the Wagonwheel conference, UCP conference and a Portland State University conference. The family consultant co-chairs a coalition of family organizations addressing policy issues in Oregon.

c. Plan for the Coming Year

Planned activities for the coming year include enhancement of statewide recruitment and training for families. With support from OSCSHN staff, FIN is developing curricula and planning educational events to support family involvement and family professional partnerships at multiple levels. Family focused training events are planned as train the trainer workshops that will assist FIN in broadening the network of parents across the state. Trainings will also address family involvement on local community based service teams. Technical assistance and additional financial support for family involvement activities will be provided through the Champions for Progress Center at Utah State University and the incentive award received by OSCSHN.

With FIN and the community based services teams, will continue efforts in developing family/professional partnerships and family leadership at the community and state levels. Through FISHs state level planning meetings are working toward a Universal Application

process that will streamline eligibility and access to health services and supports.

Through continued close collaboration with Family Voices and FACT, FIN will continue to pursue opportunities for family leadership development to ensure programs and policies meet the needs of Oregon's children with special needs and their families. FIN's initial membership includes many of the medical home resource parents who are very knowledgeable about community and state resources and continue to be interested in building effective family professional partnerships and local teams. OSCSHN is committed to continuous quality improvement efforts with families as equal partners in the development of and implementation of high quality and accessible services.

OSCSHN will continue partnerships and supports for family initiatives and family-to-family connections within local communities, primary and tertiary health centers and among traditionally un- and underserved populations. OSCSHN will continue to partner with the LEND training program in developing a family leadership curriculum and promoting family centered care within the tertiary setting. Continued collaboration and participation with the Multi-Cultural Task Force will address issues of family and culture as well as broaden outreach to diverse and underserved families.

OSCSHN has a unique opportunity to partner with Child and Adolescent Health Measurement Initiative, formerly part of the Foundation for Accountability, which has recently joined with OHSU Pediatrics. This opportunity will help to expand use and collection of data around children with special needs. FIN staff have been involved in the national advisory to develop a data center for children with special needs and with CAHMI, SLAITS and OSCSHN data resources will be able to increase knowledge of the prevalence, issues, and needs of families with special needs in Oregon.

Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

a. Last Year's Accomplishments

In the second year of the Oregon Medical Home project, teams were added for a total of 6 teams statewide. Resource and Referral teams were established at each site and a local resource guide was completed. These teams began providing a parent-to-parent service in 3 of the practices by the end of the second year of the grant. Improving the office's ability to provide care coordination has been an interest of all practices. Two practices have funded care coordinators. Others have formalized the role of a care coordinator in existing staff. At monthly meetings attended by the Project Coordinator, each practice team continued medical home improvement based on the continuous quality improvement methodology developed by Dr Carl Cooley and Jeanne McAllister in New Hampshire.

CDRC received a grant from the American Academy of Pediatrics, which enabled practices to design medical home brochures and posters for their own offices.

We continued a number of statewide activities website expansion

(www.oregonmedicalhome.org) with tools and materials for parents, health care professionals and educators and links to state and national resources; addition of local resource guides to our web-based state and national resource guide. The project staff participated in a statewide working group on the definition of CSHN chaired by a representative of Title V. This group, which included representatives of health plans, Medicaid, Family Voices and Title V agreed on recommendations for a systems level tool for identifying CSHN and 2 practice based tools, a screener and a complexity scale. The principal investigator presented grand rounds on the medical home at OHSU and at Sacred Heart Medical Center in Eugene and wrote an article on the medical home for the Oregon Pediatric Society newsletter. We conducted a survey of Oregon pediatricians to determine how many were using electronic medical records (41% of

respondents) and what functionalities they were using to improve the care of CSHN (e.g., care reminders and care plans; not surprisingly, very few).

The annual training reinforced the teams' medical home improvement activities and focused on strategies and tools for care coordination. Dr. Rich Antonelli, a primary care pediatrician from Massachusetts, reviewed his study on care coordination. We also reviewed the chronic care model developed by Dr. Ed Wagner and associates in Seattle which emphasizes implementing computer-based care management strategies and related information systems; and had two presentations on electronic medical record systems.

b. Current Activities

This was the final year of the medical home grant, which ended on March 31, 2004; however, we have a limited amount of funds to plan for the transition of medical home activities into the on-going work of the Title V office. In this year, the practice teams focused on completion of their individual medical home improvement plans, discussed the medical home concept with other pediatricians in their practice and in their communities. A care coordination tool was piloted in all practices; however, it was not compatible with any of the EMR's used by these practices and thus was rarely used. Practice teams also participated in a brief video on Oregon's medical home improvement activities that will be used to spread the word about the importance of medical home improvement to other practices and other community professionals.

The final annual training for all of the teams was held in February 2004. It was devoted to a review of several innovative, collaborative solutions to serving children with mental health issues and then collaborative problem solving by the community teams. We also started the process of planning for the transition of many of the medical home grant activities into the on-going services sponsored by CDRC's Title V office. Of note, the physicians agreed to mentor other practices if they showed an interest in medical home improvement, but were not comfortable in recruiting other practices. The family members of our practice teams have agreed to participate in our growing statewide Family Involvement Network (FIN). Each participant also completed a self-assessment about their participation in the project over the 3 years. Parents, nurses and physicians all reported a significant gain in knowledge over the grant period. In addition, a composite analysis of all parent feedback surveys from year 3 indicated significant change in the following items: being able to get needed health care, knowledge and respect for the child and family, care planning and care coordination. The remainder of the results from the project's evaluation plan are not yet available.

In addition, we are continuing statewide activities. We have convened a working group on reimbursement. An outcome of this group is a survey of Oregon's pediatricians on which care management and under-utilized codes they are currently using, and a similar survey of Oregon's health plans on which care management activities they sponsor and which codes they will reimburse. The outcome will be an educational program for physicians and advocacy with health plans. The project coordinator attended the Spring, 2004, Oregon Pediatric Society meeting to person a table on medical home resources and preview our medical home video. She also received a Community Service Award, which was given to the Oregon Medical Home project. Other honors received by the project include our website being named "one of the best in Oregon" by the Oregonian newspaper.

c. Plan for the Coming Year

The primary focus of this year will be transitioning medical home activities and supports into the Title V program and budget. There are limited carry-over funds that will partially support this planning through October 2004. The project director and coordinator will meet with each of the 6 practice teams in the next 2 months to discuss their recommendations and priorities. At present, we plan to integrate the medical home teams and some activities into CDRC's

Community Connections Network (CCN). Four of the 6 physicians of the medical home teams are also pediatricians in the CCN. We will also continue to upgrade our web-site, e.g., by the addition of local resources from all CCN sites; establish a formal referral network linking community health care providers with developmental pediatricians at CDRC; integrate the medical home annual training into the CCN and CaCoon annual trainings and initiate a year-long learning collaborative as part of this training in Spring 2005; and include information about medical home supports into a community-based services marketing plan that will be completed in the coming year. All staff in the Title V office will participate in a staff development in-service to expand their knowledge of medical home improvement activities and supports in Oregon and nationally. Finally, we will expand our work with health plans with a focus on care coordination and care management activities and involving health plans and providers in on-going collaborative efforts to improve the systems of care in local communities.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

a. Last Year's Accomplishments

The OSCSHN task force that convened in early July 2002 continued their work in developing a program of support services for families. The efforts of this group resulted in the new Family Support Program (FSP), which provides \$500.00 a year in financial assistance to eligible families for a variety of services and products. OSCSHN not only provides the funding to assist families with the cost of support services, but also facilitates the ordering of products on behalf of the family. Program information, which included a list of covered services, eligibility criteria and procedures was provided to OSCSHN and CDRC staff, Community Connections Clinics and public health nurses throughout the State. The program implementation date was moved to July 1, 2003.

OSCSHN continued to provide financial support to the tertiary clinic program at CDRC. No changes were made in the method used to determine the level of support.

OMAP's Medical Director, Dr. Thomas Turek, and CDRC administrative staff have had frequent discussions about enhancing collaboration between Medicaid and Title V programs and to improve health care for CSHN and their families. The Oregon Medical Home Project Advisory Group was expanded to include leaders from Medicaid, managed care representatives, community organizations and CDRC groups working with the project. The Advisory Board discussions of reimbursement of primary care providers for care coordination services.

b. Current Activities

OSCSHN began accepting applications for the new Family Support Program on July 1, 2003. Requests have steadily increased over the year as knowledge of the program continues to grow. An average of twelve requests were submitted in July and August 2003 followed by more than thirty in the months of March and April, 2004. A total of 140 children enrolled in the program from July 2003 through May 2004.

Administration of the Zetosch and CDRC Gift Fund programs was transferred to the OSCSHN Office this year. Both programs provide financial assistance for children and have specific eligibility criteria. Zetosch funds are available to school age children and are limited to \$1500.00 per child, per year. Services and products covered must relate to the child's educational needs. Zetosch provided funding for 46 children this year. The CDRC Gift Fund provides \$400.00 per child, per year for those children seen in the CDRC tertiary clinics. Covered services are similar to those funded by the Family Support Program. A total of 37

children were eligible for these funds.

Consolidation of all financial assistance programs under OSCSHN allows the staff to prioritize resources and combine funding when necessary to maximize the level of assistance for the more expensive products.

A training through the Medical Home project provided information on care coordination within the primary care office. Dr. Rich Antonelli from Massachusetts presented his studies on care coordination and information on possible ways that reimbursement can be obtained for care coordination activities. Members of the Medical Home Reimbursement Task Force of the Advisory Board were present at the training in preparation for their future task force work.

c. Plan for the Coming Year

The Family Support Program task force plans to reconvene to conduct an evaluation of the Family Support Program following the first year. The purpose of the review is to determine if the program is meeting the needs of the families and to make recommendations for changes if it is determined that modifications are necessary. Feedback from family surveys and individuals who act as agents to the family will be used in the review process, as well as a review of fund utilization and overall budget.

The Medical Home Reimbursement Task Force will complete their study on reimbursement of care coordination service in Oregon and make recommendations to OMAP and other managed care plans.

The Title V OSCSHN Manager and the Title V Director will work to strengthen our collaboration with OMAP, OHP Managed Care Organizations and commercial health plans. Data collected from the Title V needs assessment and statewide family focus groups provide information to help these insurers better understand the issues families confront when accessing care for their children.

We will explore future training topics for community providers and families on understanding insurance language and discovering ways to maximize insurance benefits.

A system known as the Universal Application Process will be developed through a partnership between the Oregon Health and Science University (OHSU), Child Development and Rehabilitation Center (CDRC), the Oregon Department of Human Services (DHS), Health Services (HS), Office of Family Health (OFH), Office of Medical Assistance Programs (OMAP), Oregon Department of Education (ODE), and the Oregon Community Health Information Network (OCHIN). This system will allow families quick and easy access to preliminary screening, which will identify services for eligible families. The family will complete a universal application that will be sent electronically to the appropriate organization. The process will eliminate the duplication of information gathering for eligibility ascertainment across programs and will increase early identification of need and connect families into Oregon's service system. It is estimated that this process will streamline or facilitate existing systems to produce efficiencies that will save the State and CDRC substantial program funds.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

a. Last Year's Accomplishments

CaCoon and Community Connections Network (CCN) provided services to families who have children birth through 20 with special health or developmental needs. CaCoon is a statewide

program that partners with county health departments in Oregon to provide public health nursing services in the communities where these families live. CCN is a network of clinics across Oregon that addresses the needs of the entire child. CCN is in 14 locations but served 27 counties. CaCoon and Community Connections Network provided 9112 services to 1677 children and their families.

The Oregon Medical Home Project continued and added two physician's offices for medical home development. Also, CaCoon nurses from these counties were hired to work with the physicians and parents as part of an office Resource Team. The Team's role was to implement medical home improvement plans, to advise on care coordination and other community-based issues, and assist in the identification of local resources.

The philosophy of these community-based programs is to provide quality community-based, family-centered, and culturally appropriate services in a coordinated manner for children and their families as close to where they live as possible. It is intended to improve Oregon's services for CSHN (0-21) throughout the state. To better serve the adolescents and their families, CaCoon county contracts were increased in five communities. These funds provided additional time of the CaCoon nurse to participate in CCN and address the health and related issues of youth transitioning from pediatric to adult care.

The MCHB Community Systems Integration Grant, FISHS (Framework for Integrating Special Health Services) continued. A total of nine family focus groups were held in six regional locations throughout Oregon. The groups enabled families to come together, share their experiences and expectations regarding integration of services for their children. In addition, family and provider forums were held in two communities and both identified a community plan to develop a central resource line that was easily accessible to families and defined strategies for increased support for families. CaCoon nurses and family members assumed leadership roles to determine how a community resource line could occur and how it would be funded.

In-depth training for community-based staff and other interested community providers and families, were offered throughout the year. The goal of the training was to build capacity of community-based providers. Training focused on topics such as specific disabilities, practice guidelines, and other topics identified by the teams to enhance their community services.

b. Current Activities

In June 2003 a Task Force was created to develop a comprehensive community-based system of Title V CSHN Services (CaCoon, CCN, Medical Home Project, Family Involvement and FISHS project). The goal was to develop a single, integrated Title V CSHN system that links with tertiary care centers and community providers across the state; that effectively uses Title V CSHN staff, CDRC clinicians and faculty; that builds the capacity of community providers and families; that offers an opportunity for training; and, includes families in all aspects of the program including policy planning, evaluation and program development.

Among the guiding principles of the Task Force was the belief that existing Title V CSHN programs would be improved by integrating services at the community level, by creating follow up and continuity through identification of a single responsible Title V CSHN liaison at the state level and one Title V individual responsible at the local level. We sought formal ways to involve families in planning and implementation. Whenever possible, we started implementation during the planning process instead of waiting for completion of the Task Force. This led to active short term planning teams and a formal implementation group to begin practicing new roles and implementing initial strategies. A strategic plan was completed and submitted to the CDRC Director for approval and implementation.

To date, CaCoon and Community Connections Network provided 4,641 services to 995

children and their families.

The CCN MCHB grant, Practice-based Community Connections, ended; as a result, the private practice became a Title V funded site. Also, a CCN site was added to the northern coastal area of the state. The Medical Home Project continues to function in six primary care practices.

As part of the FISHs Service Integration Project, an initial state consortium meeting was held with representative families and leaders across the state. The data gathered from the focus groups and family forums were presented as the starting point for change at the state level. Also, community engagement activities with two additional communities have started. The Title V needs assessment is being used to gather community needs data with English speaking and Spanish speaking families. Project staff traveled to Utah to view a demonstration of the Universal Application System that they have designed and implemented. The Oregon group was excited about their product and the potential of designing a model for Oregon. Initial meetings with key partners have been held and the discussion is moving forward.

c. Plan for the Coming Year

Title V Staff will continue to work toward integrating community-based services into a service system. Staff at the state level will be cross-trained to understand various existing programs and roles; and, technical assistance will be identified for each local site planning integrated services. A pilot is scheduled to start this summer. Work teams will be constituted to address new issues and all of the Title V staff will continue to be involved to review and make recommendations for program modifications.

Community teams will continue to plan for enhancing services for the adolescent population. A regional conference is being planned; the purpose of the conference is to bring community partners together to plan for improving services to this population. Families, youth and adult providers will be recruited to participate in these efforts. In addition, technical assistance to each site will be considered to support counties to provide care coordination services to adolescents transitioning from pediatric to adult health care.

The FISHs project will continue to check in with counties to assure that their community plans have been implemented. The project will also work with one new community to develop a plan, based on the families' input, to improve the quality of care and life for their children. As well, work on the Universal Application Process will continue.

The Medical Home Project will end in September 2004; plans for transitioning the Medical Home concept into Title V will be finalized and supports for primary care providers will be incorporated into the community services system. Efforts are being made to procure additional grant funding for further expansion of the medical home concept.

Families will continue to be involved in all activities, at all levels of decision-making, to assure that the "system of services" is well thought-out before it is put into practice.

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments

Several Title V activities took place around adolescent transition including emphasis in each of the self-directed learning modules designed for Public Health Nurses. Age-specific guidelines for care coordination are presented and a list of resources is provided. .

The Framework for Integrating Special Health Services grant (FISHs), awarded June 1, 2002,

included an emphasis on transition. An Adolescent Transition Summit took place on May 2, 2003. In addition to a national speaker, Dr. Sheryl White-Scott, other presenters gave the school and family perspective. Community Connection Network (CCN) teams had an opportunity to meet together, discuss transition issues in their communities and develop plans to implement upon returning home. Participants from around the state included: pediatricians, adult providers, Vocational Rehabilitation personnel, case managers, CaCoon and school nurses. Many of the physicians attending the summit serve as the CCN physician and are also part of the Medical Home project. Once back in their communities, the teams continued planning. In addition CaCoon held a conference on May 1, 2003 and provided a presentation on adolescent transition for the nurses from around the state as well as many useful resources.

Parents of children with special health needs have begun being identified to participate in forums and focus groups across the state. Some of the parents have young adults with special health needs. Two sessions on Adolescent Transition were a part of the program for the CCN Annual Training Conference in Oct. 2002. One was a family panel, and the other was a more didactic presentation.

Through the new CQI and Quality Assurance process, developed by a team of people representing CDRC programs, adolescent transition was addressed. Each program identified ways in which they could assist clinicians to identify and address issues of transition for adolescents. Also, this has begun to be implemented in CCN. Forms have been amended to remind teams and provide an outline of how they might address issues of transition.

COIT (CDRC/Oregon Department of Education Interagency Team) addressed issues of transition each month for the year. Tools have been reviewed and recommendations as to their use have also been made. They began planning for revising the University of Washington's timelines to be appropriate for Oregon and they shared resources including websites, information about conferences, issues and barriers from the various members' perspectives. The COIT team members have invited one another to present at each other's conferences. The team developed a set of interview questions for both physicians and for Special Education Directors. The physician questionnaire was administered to the pediatricians who attended the Medical Home Project Training this June.

b. Current Activities

Title V with Family Voices, Oregon Parent Training Institute, Medical Home, CCN, CaCoon as well as the FISHs Project are continuing to identify families across the state, including those who have adolescents, to be a part of the OSCSHN family network. The families advise and work with Title V programs to identify training needs, integrate services, and assist at the family, program, and policy levels.

The process of identifying adult providers who could be available for transitioning adolescents to adult care began this past year and will continue throughout next year. Training needs are being identified and funding will be provided for internists and family practice physicians to sit on CCN teams when transition is an issue.

Local continuing education training has been provided for clinicians, pediatric and adult medical providers, CaCoon nurses, educators, vocational rehabilitation counselors, school nurses, social service providers and parents in some CCN sites during this past year: The goal of these trainings is to improve knowledge of the needs of adolescents during the transition process and resources available in the local community. Specific training needs identified by individual teams at the 2003 Summit are also being addressed.

Staff continues to work through COIT with statewide players to address adolescent transition. The team has selected tools to be used, and revised the University of Washington transition

timelines and resource list to be applicable to Oregon's resources. These are being disseminated widely to parents, providers and via conferences, mailings and the internet.

Promoting a lifespan approach to care emerged as an agency value and major theme of the CDRC Futures Planning process. The CDRC has begun a visiting professor program and the first speaker was Dr. Sheryl White-Smith who spoke on adolescent transition. Staff from Title V continues to participate in identifying the potential areas where we could promote the development of awareness, knowledge and skills of the lifespan approach for people with disabilities.

Several CCN sites have begun to see young adults around transition issues. The CaCoon nurses have participated on some of these teams. Though there have not been internists at the team meetings as yet, many other providers needed for effective transition planning have been present. Three percent of the total number of children served in CCN and CaCoon were over the age of 14 years. 57 young adults received assistance with transition services.

c. Plan for the Coming Year

We will consider a grant application to fund identification of willing OHSU internal medicine faculty to be mentors to Internists in the communities. We also plan to participate in grand rounds for CDRC and lunch programs offered for Residents around the topics of adolescent transition.

We will continue to work with communities to help identify internists and to provide training and funding necessary to engage them. We will use our already identified pediatricians and family practice physicians to assist in this identification process. The Medical Home website within the Title V website has a section on adolescent transition. Additions will continue to be made to this site.

We are in the process of contracting with two consultants in the field of adolescent transition who will go into specific communities to work with CaCoon nurses and others around how to better serve young adults and their families as they transition to adulthood, especially in the area of health. A needs assessment in the community will begin the process and the consultants will help the nurses address: how to identify those needing transition help, how to help particularly with the medical transitions, what role to play on the multidiscipline team to help with transition, what funding changes and assistance is needed by the young adult and their family. These questions and others identified by the CaCoon staff will be the basis for the training developed.

Title V staff through COIT is planning a regional training with a telehealth broadcast from a central site. We will be contracting with Betty Pressler, RN, PhD to do a presentation on adolescent transition and ask the regional participants to discuss local resources and to plan for how to work more collaboratively together. We will work to expand the numbers of youth served through the public health nursing and multidiscipline teams.

Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

a. Last Year's Accomplishments

- The Immunization Record Information System Module of FamilyNet (IRIS -- electronic medical record system for Oregon public health clinics) has completed a very successful rollout to 29

county health departments. Two hundred and twenty users statewide were trained.

- Several thousand health care and school professionals in Oregon use ALERT (statewide immunization registry) as part of their jobs to ensure that children are properly immunized. In 2003 via the internet, they quickly accessed shot records for over 200K Oregon children.
- ALERT Immunization Registry sends monthly reports to over 350 Oregon clinics for two-year-old children under their care who are overdue for shots. Oregon's Immunization Program uses ALERT data to create comprehensive reports about immunization practices for private and public clinics, and immunization quality improvement measures.
- AFIX (Assess, Feedback, Incentives, Exchange) activities included completion of: 210 public and private sector immunization assessments and dozens of conversations about how to improve immunization practice. Valuable partnerships were established with the Oregon Health Science University to improve immunization practice in rural clinics and with the New York Academy of Medicine to determine how length of enrollment in managed care affects immunization rates.

In collaboration with the Oregon Partnership to Immunize Children (OPIC), the Immunization program:

- Participated in a joint "Leadership Inquiry about Immunization Resources for Parents" in November 2003, hosted by OPIC and the Immunization Action Coalition of Washington (IACW). The Leadership Inquiry sought input from community organizations to identify parents' concerns and the appropriate resources for a communication network to address them.
- Purchased, promoted and distributed statewide, educational materials, including a 2-month television campaign, from the National Network for Immunization Information (NNii).
- Two clinicians provided multiple clinical education trainings focusing on vaccine safety, immunization techniques, and antigen-specific information.
- A study of school exemptors in one community guided the design of a joint workplan with the local health department to address parental concerns about vaccine safety and efficacy.
- Legislation passed in 2003 (effective 1/1/04) amending the registry statute to allow for interstate transfer of immunization records and collecting fees from certain authorized users (health plans) requesting ALERT data and not already voluntarily contributing.

b. Current Activities

Vaccine for Children (VFC) Provider Surveys were sent to private providers; the survey was part of the DHS Immunization Program's accountability to the Centers for Disease Control and Prevention (CDC). The results from the survey were tallied in early 2004 to assist the program in determining what improvements are needed to achieve our strategic directions. Over half of the private VFC sites in the state responded to the survey. Results showed overwhelming satisfaction with services, but much improvement needed to increased vaccine shots reported on ALERT and on-site training on use of vaccines.

In early 2004, to better serve all providers who administer publicly-funded vaccine, the Immunization Program has re-defined the duties of the program's VFC Health Educators. These Immunization Health Educators are contacts for vaccines across the lifespan, and no longer focus exclusively on the VFC program. Additionally, they serve both public and private providers in their regions.

Public health nurses through the Babies First home visitation program screen for, educate about, and administer immunizations. They also advocate for adequate community immunization coverage in various multi-agency community meetings.

All 34 WIC agencies have implemented immunization screening requirements; 50% count DTaP and 50% review the entire immunization history.

AFIX assessments will continue for certain at-risk populations and will continue to expand to other sites pending resources.

The Immunization Program held a two-day conference for all LHD immunization coordinators. The annual Oregon Partnership to Immunize Children (OPIC) Awards Breakfast was held as part of the conference. Awards were given seven categories: Volunteer-Individual, Volunteer-Organization, Innovative Partnership, Model Program, Public Health Organization, Immunization Provider and Media and Promotion.

The Program recently completed two statewide trainings via video conference (First Wednesday Workshops) covered "Adult Immunization" and "Vaccine Safety: Fact, Fiction, and the Unknown."

The Immunization Strategic Plan was updated in Spring of 2004 by the DHS Immunization Program Staff. Each direction was reviewed to: learn what has been accomplished in the last year, identified lessons learned, and prioritized to determine continuing and new directions. New directions include: 1) integrate data across all Immunization systems; 2) enhance technical infrastructure and staffing to support Immunization goals; and 3) improve surveillance, evaluation, and research capacity for populations in need to meet disease surveillance, vaccine coverage and immunization practice goals. The Plan was presented at the June 2004 Immunization Policy Advisory Team (IPAT). IPAT is scheduled to provide input and vote on the Plan at their September 2004 meeting.

c. Plan for the Coming Year

Provider education will continue to promote the free Vaccines for Children (VFC) program to eligible populations, the need for reasonable administration fees, and billing clients as appropriate.

Public/private partnerships between Local Health Departments (LHD) and private providers, particularly for ALERT and VFC, will be supported through technical assistance and consultation.

The Immunization Program will continue the rollout of the assessment/ Feedback/ Incentive/ Exchange (AFIX) model to improve immunization coverage rates across the state

Continue to market the ALERT website to schools, daycares and private providers.

Produce and disseminate adjusted statewide, county and specific populations childhood immunization coverage rates derived from ALERT registry data to identify populations of need.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

a. Last Year's Accomplishments

- The Department of Human Services Office of Family Health in partnership with Children, Adults and Families Services (CAF) worked with a variety of state and local agencies who collectively work on teen pregnancy prevention through seven statewide strategies, 1) Positive community values, 2) Comprehensive sexuality education and youth development, 3) Abstinence education, 4) Contraceptive access, 5) Male involvement and leadership, 6) Balancing health, safety and legal issues, and 7) Young Parent Services.
- The Teen Pregnancy Prevention (TPP) Coordinator in the Adolescent Health Section continued intensive site visits around the state working with community TPP coalitions and local health departments in implementing state strategies, developing resources/media for

coalition use and in promotion of teen pregnancy awareness month (May).

- Contraceptive Access demonstration project was completed in Jackson County that assessed, collected survey data and conducted community educational activities after documenting youth, parent and citizen knowledge and 'norms' regarding sexuality education, access to family planning and support to expand educational and clinical services to school or other community settings. In 2003, Jackson County partnered with the Rights, Respect, Responsibility Campaign and a local TV station to run PSAs, aimed at parents, to encourage their sexually active teens to use condoms. Jackson County also hosted a middle school male summit called STRIVE. 400 young men attended the all day forum.
- Benton and Marion counties also completed Contraceptive Access Demonstration Projects. Both counties conducted surveillance, assessed the data, and completed community education. Benton County was able to keep their MARS (Male Advocates for Responsible Sexuality) Project funded and functioning. Based upon assessment results and the pioneering work done since 2000, MARS was awarded federal funding from the Office of Population Affairs. The 5 year funding cycle will allow them to expand their project and take it statewide. Their goal is to create a model that can be replicated across the nation.
- Oregon's abstinence education program, STARS (Students Today Aren't Ready for Sex), remains as the primary abstinence education program in the state during the 2001-2003 school year. STARS is based on the PSI (Postponing Sexual Involvement) curriculum and utilizes a peer leader model.
- The TPP program published and distributed a new edition of the Rational Enquirer, a newsletter targeting teen pregnancy prevention activities to over 15,000 partners. Distribution includes adolescent pregnancy prevention agencies, lead staff, and teen leaders.

b. Current Activities

- The Office of Family Health in partnership with Children, Adults and Families Services (CAF) continues to work with a variety of state and local agencies who collectively work on teen pregnancy prevention on implementation of Oregon's Teen Pregnancy Action Agenda (2002) and the seven strategies.
- The Teen Pregnancy Prevention Leads Group, state agency partners with primary responsibility for leading a particular state strategy, began discussions with Rights, Respect, Responsibility (RRR), a state coalition led by Planned Parenthood Health Services of Southwestern Oregon, on how to better collaborate and integrate recommendations contained in their report, We Can Do Better: Oregon Team Report on Western Europe's Successful Approaches to Adolescent Sexuality with the Oregon's Teen Pregnancy Action Agenda (2002). The group has expanded to include the Oregon Teen Pregnancy Task Force (OTPTF), a non-profit group that has been in existence for 28 years. This DHS, RRR, and OTPTF group meets on a regular basis to assess and evaluate the TPP work that is conducted statewide. The group will be reviewing and revising the Action Agenda for Teen Pregnancy Prevention.
- Prevention Partners, a new work group formed with membership from DHS-Health Services, DHS-Children, Adults and Families, DHS-Alcohol, Tobacco and Other Drugs and the Oregon Commission for Children and Families, is collaborating to work best with local Prevention Coalitions. Many TPP Coalitions have combined their efforts with broader Prevention Groups in order to reduce adolescent risky behaviors. The work group is looking at the ways that broader prevention groups can impact Positive Youth Development activities in local communities and how state level staff can effectively work together towards this end.
- The Office of Family Health maintains a Teen Pregnancy Prevention (TPP) Coordinator in the Adolescent Health Section who works primarily with community TPP coalitions, developing resources/media for coalition use and in promotion of teen pregnancy awareness Month and monitoring statewide activities.
- A statewide TPP surveillance instrument was created and disseminated to all of the county TPP Coalitions to determine which coalitions were addressing the seven strategies in the TPP Action Agenda and which groups were seeking technical assistance from the statewide TPP partners.

- Oregon's abstinence education program, STARS (Students Today Aren't Ready for Sex), continues as the primary abstinence education program in the state. STARS is based on the PSI (Postponing Sexual Involvement) curriculum and utilizes a peer leader model.

c. Plan for the Coming Year

- The Office of Family Health will provide leadership and participate in all phases of implementing the Oregon Teen Pregnancy Prevention Action Agenda (revised 2002) through regular participation in the Teen Pregnancy Prevention strategy leads workgroups. It will take lead responsibilities for two strategies; Contraceptive Access and Positive Community Values and will participate in the Male Involvement and Leadership strategy and the Young Parent Services Strategy Groups .
- Develop and maintain a collaborative working relationship consistent with the Oregon Teen Pregnancy Prevention Action Agenda with Rights, Respect, Responsibility (RRR), a state coalition led by Planned Parenthood Health Services of Southwestern Oregon and the Oregon Teen Pregnancy Task Force.
- Develop a prototype of a working database to capture indicator information related to the number of Oregon counties with TPP coalitions that are addressing the seven defined strategies in the Action Agenda.
- Continue to advocate for and attempt to identify resources to staff and develop a Adolescent Male Health Program within the Adolescent Health Section to support the Male Involvement Strategy in the Action Agenda.
- Continue participation in the Coordinated School Health Initiative and implementation of the state plan. Advance policy recommendation developed in the Sexual Risk Prevention work group as incorporated into the state plan.
- Maintain a teen pregnancy prevention media campaign targeting adolescents and their parents through providing local communities with media resources to support local campaigns.
- With the Department's Children Adult and Family Services, continue to support development of the STARS Program, encourage appropriate process and outcome evaluations to evaluate effectiveness and review for consistency with other strategies.
- Work in collaboration and provide on-site technical assistance for local health departments, community-based organizations, Planned Parenthood, Community TPP Coalitions, the Oregon Teen Pregnancy Task Force, and other agencies to integrate teen pregnancy prevention services across the state.
- Publish and distribute the next edition in the series of the Rational Enquirer.
- Provide technical assistance and support to complete the Contraceptive Access demonstration program activities, collect local data and report on outcomes.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

a. Last Year's Accomplishments

According to the Oral Health Needs Assessment conducted in 1991-93, 27% of third-grade children had dental sealants in their first permanent molars.

The Oregon Smile Survey, completed in 2002, shows a significant improvement over the 1991-1993 survey (from 27% to 50% of children with sealants), but identified many areas of need for treatment.

The Oral Health Section continued to receive funding from the CDC (one of only two states) which began in the fall, 2002. The funds support efforts to develop a statewide education

campaign to increase awareness of dental sealants, to help communities sustain current activities, and to expand existing dental sealant programs.

The Oral Health Section also received a one time HRSA grant to fund four demonstration dental sealant projects.

b. Current Activities

A dental sealant capacity assessment was developed and administered to over 600 projects around Oregon. This assessment identified gaps in service and is further being used to target activities for the state oral health plan.

Ten existing projects will receive \$1000 mini-matching grants to enhance the infrastructure of their projects and strengthen community partnerships and collaboration.

Four demonstration sites have been identified based upon specific criteria: a currently operating dental sealant project, school-based or school-linked, demonstrated partnership or collaboration, serving CDC defined target populations, representative of the diversity of Oregon's communities, agreement to increase current capacity, agreement to incorporate community level sealant training into project, ability to collect data and evaluate consistent with the Oregon Oral Health Section's surveillance system, and agreement to participate in oral health coalition activities and efforts. A thorough review and report of each demonstration project will be developed and included in the state's Dental Sealant Manual. The coordinators for these sites will act as the first group of community based contacts in a resource directory of sealant projects throughout Oregon that is currently under development.

A state dental sealant manual is being created as a resource guide for new and existing dental sealant projects throughout the state. Additional supporting materials and resources are also in development.

The Oral Health Section website is being updated to include PDF and interactive materials related to dental sealants. A resource directory of contacts for dental sealant projects across Oregon and nationally will also be available online.

c. Plan for the Coming Year

The 2001 Oregon Smile Survey was stratified for both age and grade. The Oregon sealant rate for 8 year olds. is 42%. The HP 2010 rate for 8 year olds is 50% and the national average is 23%. This differs from the MCH national measure for 3rd graders, reflective of an age range of 7-9 years old. Therefore, although the rate for 3rd graders is comparable to other state rates, it cannot be compared to an HP 2010 or national average.

The Oral Health Section plans to distribute ten \$1000 mini-matching grants to existing dental sealant projects to enhance the infrastructure of their projects and strengthen community partnerships and collaboration.

The Dental Sealant Coordinator will convene several regional technical assistance meetings. These meetings will help new and established projects come up with strategies to sustain their activities, seek alternative funding, and collaborate more effectively within their communities to reach the most children in need.

A statewide dental sealant promotion campaign will educate Oregonians about the benefits and cost effectiveness of dental sealants.

Through a HRSA State Systems for Oral Health Collaborative grant, the Oral Health section will provide one-time grants to demonstration sites to identify eligible children, provide sealants, demonstrate sustainable collaboration, and capture data elements. The Oral Health Section will provide on-going technical assistance to help these sites identify sealant activities in their communities and establish and maintain strong community based collaborations and partnerships.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

a. Last Year's Accomplishments

- National Safe Kids contracted with DHS to be the sponsor of Oregon Safe Kids. The contract became effective in July of 2002.
- The Injury Prevention and Epidemiology (IPE) Program wrote a supplementary grant to fund implementation of Corazon de mi vida child safety seat and booster seat program. The application was not funded by CDC, but the stakeholders for the project will continue to look for a funding source for the concept.
- The Child Injury Prevention Program (CIPP) collaborated with the Oregon Department of Transportation (ODOT) and with Oregon Safe Kids to provide information and technical assistance to individuals, communities and the media regarding Oregon's new booster seat law.
- The CIPP Coordinator became a member of the State Child Fatality Review team and took on the role of developing prevention presentations for the afternoon session at each meeting. These sessions have been well accepted by team members and they provide a prevention focus for the activities of the team.
- Grant funds were provided by Oregon Dept. of Transportation (ODOT) to local health departments to train nurses as certified safety seat technicians. The Child Injury Prevention Coordinator was certified and participated as staff in one train the trainer session.
- Local public health practicing in home visiting programs (Maternity Case Management, Babies First, and CaCoon) provided anticipatory guidance and health education to expectant and new parents regarding child safety. They assessed need, located, and distributed car seats as needed.

b. Current Activities

The Child Injury Prevention Program is working with the Injury Prevention and Epidemiology (IPE) staff to develop a competitive grant proposal to CDC to implement Corazon di me vida, a Hispanic child safety and booster seat program.

The Child Injury Prevention Program (CIPP) completed a successful statewide Safe Kids week event at the Oregon Zoo. Over 4,000 persons attended this event in Portland.

The CIPP is encouraging local Safe Kids chapters to apply to National Safe Kids to become full coalitions. Full coalitions have access to Safe Kids grant funds, and Oregon plans to have 5 full coalitions in the state by 2005. Currently, Deschutes County, a region in Eastern Oregon, and Multnomah County are working on applications.

A grant proposal to ODOT is being developed to continue ongoing training and education to local health department staff in child safety seat education.

Local public health maternal and child health nurses practicing in home visiting programs

(Maternity Case Management and Babies First) provide safety information to low income families regarding car seat safety and participate in community wide efforts such as health fairs to promote car seat safety.

c. Plan for the Coming Year

The Injury Prevention and Epidemiology Program (IPE) will continue to seek funding options to invest in the collaborative effort to provide inspection clinics for safety seat use and for the continuation and expansion of the safety seat voucher program.

Collaboration with the Oregon Department of Transportation (ODOT) will seek to establish a plan to assure maintenance and retention of trained safety seat technicians throughout Oregon.

The IPE will work with local Child Fatality Review Teams to assess current need for child safety seats in counties and to provide funding for these seats through the voucher program.

The CIPP Coordinator will continue to collaborate with Child Safety Seat Resource Center to train additional local health departments as nationally certified child safety seat clinicians.

The CIPP will work with Safe Kids chapters to increase the number of communities applying for funds for activities and to increase the number of chapters that convert to coalition status.

OFH Child Health Nurse Consultants will work with the CIPP Coordinator to assure that local public health nurses in maternal and child health continue to have education opportunities and up-to-date information regarding child car seat safety.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

The Office of Family Health (OFH) Breastfeeding Promotion Committee continued innovative activities such as the Breastfeeding-Friendly Employer project, providing breast-feeding information in the Newborn Handbook (distributed to mothers in hospitals), tracking breastfeeding experiences through the statewide SafeNet hotline, and participating in World Breastfeeding Week.

OFH continued to promote Senate Bill 744 which affirms a women's right to breastfeed in public. Cards explaining the law were printed in English and Spanish, and distributed to hospitals, employers and the public.

OFH continued to promote and implement the Executive Order signed by the Governor stating that all state agencies must assure that breastfeeding women returning to work have a clean, private location and flexible break time to express breast milk. OFH provided technical assistance in the implementation of the Order.

Through the Healthy Child Care America grant, revision of the Oregon Child Care Health and Safety Handbook included detailed information about how to support breastfeeding in the child care setting.

WIC continued to promote and support a breastfeeding pump project and provided scholarships to health department staff for advanced training in breastfeeding support. Pumps are provided to WIC participants through funding provided by the USDA. WIC and the Breastfeeding Promotion Committee continued the Gold Ribbon Campaign, a social marketing effort that promotes breastfeeding to local health agencies and birth hospitals. A Father's Supporting Breastfeeding project was initiated to be implemented through local health

agencies.

Public health nurses practicing in statewide home visiting programs provide anticipatory guidance and health education parentally as well as assessment and support after birth in support of optimal nutrition through breastfeeding for clients enrolled in Maternity Case Management and Babies First.

Efforts to improve data quality from breastfeeding surveillance continued.

b. Current Activities

The Office of Family Health Nutrition consultants will:

- Continue to provide intensive breastfeeding training to public health professionals in all county health departments.
- Continue promotion of Gold Ribbon campaign with partners, through leadership of WIC and OFH Breastfeeding Promotion Committee.
- WIC will continue the breastfeeding pump project with local health departments (LHD).
- Finalize the revision for the Breastfeeding Training Module for WIC providers.
- Continue implementation of the Breastfeeding Friendly Employer project, update and distribute the employer packets, and put materials on the web.
- Promote and support participation in World Breastfeeding Week by local health agencies.
- Continue to promote a Father's Supporting Breastfeeding project through local health agencies.
- Improve breastfeeding surveillance, including data from WIC and the TWIST data system.
- Public health nurses practicing in statewide home visiting programs provide anticipatory guidance and health education parentally as well as assessment and support after birth in support of optimal nutrition through breastfeeding for clients enrolled in Maternity Case Management and Babies First.
- Promote breastfeeding through the state Nutrition and Physical Activity grant by supporting a statewide breastfeeding coalition, and funding a formative research project on barriers to breastfeeding by Oregon TANF clients.
- Support the national breastfeeding awareness campaign by promoting the campaign locally via the breastfeeding coalition (who received an OWH mini-grant to support this).

c. Plan for the Coming Year

The Breastfeeding Promotion Committee will continue work on improving breastfeeding initiation and duration rates by implementing activities that raise awareness and provide breastfeeding education.

The OFH will continue to promote breastfeeding-friendly work sites and child care sites to Oregon employers and child care providers. An annual list of breastfeeding-friendly employers will be published during World Breastfeeding Week. Child care providers may be provided training on the breastfeeding section of the Child Care Health and Safety Handbook.

The OFH will continue to develop, distribute and promote new breastfeeding support pieces for

the Breastfeeding Friendly Employer Project.

The WIC breastfeeding pump project, Gold Ribbon Campaign, and Fathers Supporting Breastfeeding will continue.

Oregon will participate in the World Breastfeeding Week by providing promotional materials to local health departments and WIC providers. OFH will continue to partner with the Nursing Mother's Counsel and local breastfeeding coalition by promoting the national breastfeeding awareness campaign.

Maternity Case Management and Babies First will develop public health nurse practice guidelines for breastfeeding support at the population-based individual level of practice based on nursing standards.

The OFH will provide continuing education for health professionals in breastfeeding management.

The completed formative research project with the TANF population will guide our next steps for breastfeeding promotion and support in this population.

Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.

a. Last Year's Accomplishments

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

Members of the EHDl Advisory Committee testified on behalf of Oregon Senate Bill 401 legislation to establish a newborn hearing screening registry and follow-up system. This bill successfully passed through the Senate and House, without opposition, and was signed into law on June 6, 2003 with an effective date of January 1, 2004.

EHDl program staff, working with the EHDl Advisory Committee developed administrative rules related to data collection use.

EHDl program staff, working with hospitals, diagnostic centers, early intervention centers, health care providers and local public health representatives developed and implemented statewide EHDl reporting and follow-up protocols per authority of SB 401.

Progress was continued on objectives related to EHDl program grants for the CDC (data system development) and HRSA (education and family support). The EHDl program in partnership with the DHS-Office of Information Services, the Oregon State Public Health Laboratories and the Center for Health Statistics, completed a successful pilot of newborn data linking (birth certificates, newborn metabolic screening and hearing screening) from three large hospital systems. Parent brochures were published in Spanish. An EHDl comprehensive family resource guide was published. These guides are provided to families at the time of their child's diagnosis of a hearing loss. EHDl staff made a number of presentations to health care providers and educational staff about the EHDl program.

Staffing: The EHDl Program Coordinator position was increased to a full time position. A full time EHDl Nurse Consultant was hired in August 2003 to provide follow-up and tracking through case finding (letters, phone calls, referrals to parents/ caregivers, providers and local public health) to ensure infants and their families receive appropriate follow-up and evaluations. In addition, the nurse consultant provides training and technical assistance for local public health nurse staff regarding EHDl protocols. The EHDl staff includes a full time research analyst and a part time audiologist consultant.

By authority of SB 401, Bylaws were compiled for the EHDl Advisory Committee with a goal of providing definition of role and structure in order to optimize the group's effectiveness.

b. Current Activities

The Office of Family Health/EHDI staff organizes and facilitates quarterly meetings of the EHDI Advisory Committee. Additionally there are three standing committees. They are: EHDI Goals & Sustainability Issues, Quality Assurance, and the Family Issues Committee. Each standing committee is co-chaired by an elected Advisory Committee member and an EHDI staff person.

EHDI staff is providing presentations to groups which include providers, local public health staff and other identified community partners regarding the EHDI program protocols and information about hearing loss issues and resources.

The EHDI program coordinates the Early Childhood Hearing Outreach (EHCO) Team, which was developed out of the Hearing Head Start Project. The ECHO team provides on-going technical training and assistance to Early Head Start, Migrant Head Start and Indian Health programs, who use otoacoustic emissions hearing screenings for their birth to three year old populations.

In addition, the EHDI Program works closely with the Oregon Department of Education to ensure that infants diagnosed with hearing loss receive timely referrals and enrollment in Early Intervention.

Work is currently being done on planning and implementation of an EHDI Family Conference that will be held on September 18, 2004. This project is a stated goal of the HRSA grant and is the main activity, at this time, of the EHDI Family Issues Committee.

Hospital reports are being generated that present hearing screening rates, pass/refer rates and a listing of infants needing re-screen. Data are being used to track infants needing follow-up and a record is kept of their current status on the screening-diagnosis-intervention continuum. By matching and linking files the most recently available home address and physician contact information is collected for generating follow-up letters.

System enhancements are being developed to improve the ability of staff to access EHDI data and increased system functionality for generating letters and to collect information from non-hospital newborn hearing screening facilities.

c. Plan for the Coming Year

The Office of Family Health will continue to provide technical assistance and support to screening and non-screening birth facilities/providers, diagnostic centers and early intervention sites.

By authority of SB 401, OFH EHDI staff will implement follow-up protocols for children who have not been screened, who have not passed the screening, and/or who are diagnosed with hearing loss. EHDI follow-up staff will contact families, medical home providers and local public health to assist families in navigating the system.

The Office of Family Health, EHDI Program, will focus on program sustainability during this coming year. The EHDI Sustainability Subcommittee will continue to meet and work on program sustainability.

Progress will continue on activities related in the CDC and HRSA early hearing detection and

intervention grants, related to follow-up system development, provider and parent education and family support.

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

The Oregon Health Plan (OHP) has made it possible for thousands of women and children to access medical care since the state was granted a waiver for the use of Medicaid funds. Oregon developed an OHP application that served as the channel for both OHP and CHIP, assigning children first to OHP and secondly to CHIP depending on income level and state funds available to support these insurance programs.

Progress in addressing barriers to children's health insurance during 2003 included the submission of a new Medicaid waiver for the Oregon Health plan by the Office of Medical Assistance Programs increasing eligibility from 170% of poverty to 185% of poverty for children and pregnant women. This waiver was effective in February, 2003.

Key barriers remaining to be addressed include: increasing the income guidelines to 200% of Federal Poverty Level; 12 month continuous eligibility; and, elimination of the 6 month uninsured waiting period for enrollment.

Activities accomplished through the Covering Kids and Families Robert Wood Johnson Foundation grant continued and included providing a toll-free application assistance help-line, simplifying and coordinating the application, enrollment, and re-enrollment process, and increasing collaboration around expanded access with state and local groups.

SafeNet, the MCH hotline, provided information and referral services to link low income Oregonians with health care services with their communities, including information on the Oregon Health Plan.

Public health nurses at local health departments provided families with children 0-5 years of age assistance case management services that include assistance with accessing and utilizing Medicaid services. OFH staff provided information on accessing public health services and the OPH, during training sessions for child protective case workers.

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

b. Current Activities

Funding reductions to the Oregon Health Plan (OPH) are making it more difficult to provide access to medical care for families. There is not enough General Fund to support the OHP Standard benefit package, which covers about 49,000 low-income adults who are ineligible for traditional Medicaid coverage. Efforts are underway with the Hospital Association and managed care organizations to develop a plan to use provider taxes paid by them to restore some level of service to a portion of the Standard population. If these efforts are unsuccessful, the state may be forced to terminate coverage for the Standard population on Aug. 1, 2004. Additionally, the planned expansion of the Children's Health Insurance Program medical coverage to an estimated 2,250 children in low-income households earning from 185 percent to

200 percent of the federal poverty level was not implemented.

In spite of these difficulties, the Office of Family Health continues to support outreach efforts and systems to promote Oregon Health Plan application, in addition to providing access to WIC, immunization and early prenatal access among low income clients.

SafeNet, the MCH hotline provides information and referral services to link Oregonians with health care services with their communities, including information on the Oregon Health Plan.

The Healthy Child Care Oregon project is educating childcare providers about the Oregon Health Plan and CHIP program and providing them with information and applications to distribute to their client/families.

Public health nurses at local health departments provide families with children 0-5 years of age assistance case management services that include assistance with accessing and utilizing Medicaid services.

Oregon received another three-year Covering Kids and Families grant (2003-2006) to target under-served populations related to the following goals:

- Increase OHP enrollment in under-served, under-represented communities
- Identify barriers to enrollment and simplify the OHP application process to reduce barriers and
- Increase collaborations to achieve system integration.

This Covering Kids and Families grant is utilizing outreach and retention through education, provider communities and the business community to expand coverage through insurance premium subsidies. A State Agency Council on Coordination is working toward the specific goals of OHP enrollment simplification and interagency service coordination.

c. Plan for the Coming Year

The Oregon Health Plan (OHP) was able to preserve all of the services and the entire population for the Oregon Health Plan Plus benefit package for the coming year. This benefits about 300,000 Oregonians -- foster children, people on public assistance, low-income pregnant women and people who receive federal Supplemental Security Income benefits. This will continue while it is still uncertain whether or not benefits will continue for the OHP Standard population.

The OFH will continue to support OHP outreach through collaboration with other DHS partners responsible for implementing the Covering Kids and Families Initiative.

The Community-Based Application Assistance Project will continue to provide on-site assistance with completion of the Oregon Health Plan application for pregnant women and their families.

SafeNet, the MCH hotline, will continue to provide toll-free information and referral regarding health services/issues to Oregonians throughout the state.

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

Governor Kulongoski recently announced two steps to expand health care for children in Oregon, a new employer-sponsored, Children's Group Plan that will begin in January 2005. He directed the Department of Human Services (DHS) to develop a pilot project

to improve outreach efforts to uninsured children, and to change the current asset limit for the state's Children's Health Insurance Plan (CHIP) program from \$5000 to \$10,000. The goal of this initiative is to decrease the number of uninsured children by providing an incentive to employers, who currently do not provide health insurance for their employees, to purchase this low cost plan for their employees' dependents. Low-income working families with incomes up to 185% of the federal poverty level also may be eligible for a subsidy to purchase the Children's Group Plan through their employer.

The Healthy Child Care Oregon project will educate childcare providers about the Oregon Health Plan and provide them with information and applications to distribute to their client/families.

Public health nurses at local health departments will provide families with children 0-5 assistance case management services that include assistance with accessing and utilizing Medicaid services. They will now be supported by a newly formed regional team of state public health nurses who will provide technical assistance to the counties and ensure that they have the most current information about utilization of Medicaid services.

Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

a. Last Year's Accomplishments

SafeNet, the MCH hotline, provided information and referral services to link low income Oregonians with health care services with their communities, including information on the Oregon Health Plan.

The Oregon Health Plan has contracts with 32 of the 34 local health departments. As outreach facilities, these local health departments distribute and date stamp the OHP applications as well as inquire about application status.

Public health nurses at local health departments provided families with children 0-5 years of age assistance case management services that include assistance with accessing and utilizing Medicaid services.

The Healthy Child Care Oregon project educated childcare providers about the Oregon Health Plan and provided them with information and applications to distribute to their client/families.

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

DHS, Office of Family Health and Office of Medical Assistance Programs sent a letter with Oregon Health Plan information to prenatal and pediatric providers in Oregon regarding changes in coverage for pregnant women and children.

Staff in the OFH provided information on accessing public health services and the Oregon Health Plan (OHP), during training sessions for child protective case workers.

b. Current Activities

SafeNet, the MCH hotline, provides information and referral services to link Oregonians with health care services with their communities, including information on the Oregon Health Plan.

The Community-Based Application Assistance Project provides on-site assistance with completion of the Oregon Health Plan application for pregnant women and their families.

The Healthy Child Care Oregon project is educating childcare providers about the Oregon Health Plan and providing them with information and applications to distribute to their client/families.

Public health nurses at local health departments provide families with children 0-5 years of age assistance case management services that include assistance with accessing and utilizing Medicaid services.

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

c. Plan for the Coming Year

SafeNet will continue to provide toll-free information and referral regarding health services/issues to Oregonians throughout the state.

The Community-Based Application Assistance Project will continue to provide on-site assistance with completion of the Oregon Health Plan application for pregnant women and their families.

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

The Healthy Child Care Oregon project will educate childcare providers about the Oregon Health Plan and provide them with information and applications to distribute to their client/families.

Public health nurses at local health departments will provide families with children 0-5 assistance case management services that include assistance with accessing and utilizing Medicaid services. They will be supported by a newly formed regional team of state public health nurses who will provide technical assistance to counties and ensure that they have the most current information about utilization of Medicaid services.

a. Last Year's Accomplishments

The Perinatal Program continued to use outreach, initial screening and referral, and public health nurse case management/home visiting. Services were provided through the Maternity Case Management (MCM) program, specifically targeting women at risk for low birth weight infants and placing emphasis on education about the prevention of premature labor and factors that specifically contribute to pre-term delivery and low birth weight. Among five mandatory topics were tobacco exposure and dental caries. Training and ongoing technical assistance are provided to counties on an ongoing basis.

Support is provided to counties with community-based projects that address the prevention of low birth weight as well as the needs of low birth weight infants and their families.

The Oregon Pregnancy Risk Assessment Monitoring System (PRAMS) project completed a second year of data collection using a revised postpartum survey tool, and is now in the process of analyzing the data. OFH submitted and was awarded a five-year Centers for Disease Control and Prevention grant, beginning Spring 2001, for the PRAMS project and will be modifying the current PRAMS survey to conform to CDC guidelines. This project assists in developing programs and policies related to the prevention of low birth weight.

The prenatal smoking cessation demonstration project, Smoke-Free Mothers and Babies (SFMB) funded by the Robert Wood Johnson Foundation, has continued in eight Oregon counties as a sub-program of the Maternity Case Management (MCM) program.

In an effort to serve a larger population, all county health departments had the option of applying for Title V and state funding to assist in their development of a local Oregon MothersCare (OMC) site; a first trimester pregnancy access program, in addition to traditional perinatal services. The OFH provided technical support and assistance to these local projects.

b. Current Activities

Maternity Case Management (MCM) staff continues to work closely with the Office of Medical Assistance Program to assure continuing quality improvement with the recent addition of two more topics to the list of mandated education topics for pregnant women.

The Smoke-Free Mothers and Babies (SFMB) project is in its third year and is currently completing Five As tobacco cessation intervention protocol training for the remaining prenatal care providers in the eight pilot counties.

Support and technical assistance continues to provide programs for pregnancy prevention services to reduce the number of unintended and unplanned pregnancies to women and teens at risk for premature birth (teen pregnancy prevention and family planning).

The PRAMS survey continues to collect data as it relates to planned/unplanned pregnancy and access to health care in developing programs and policy related to low birth weight, with over sampling of people of color.

In an effort to serve a larger population, all county health departments have the option of applying for Title V and state funding to assist in their development of a local Oregon MothersCare (OMC) site; a first trimester pregnancy access program, in addition to traditional perinatal services.

Title V programs will continue collaborating with the Title X program, the Family Planning Expansion Waiver (FPEP) which facilitates pregnancy planning and other health care services

such as STD prevention, treatment, and education as well as pre-conception counseling.

c. Plan for the Coming Year

The Office of Family Health (OFH) provides technical assistance and support for local health departments who provide outreach and case management/home visiting services targeting women at risk for low birth weight infants.

Maternity Case Management (MCM) staff will continue to work closely with the Office of Medical Assistance Program to assure continuous quality improvement. During the coming year, the Smoke-Free Mothers and Babies (SFMB) program will be institutionalized in MCM with the requirement of the 5 A's Tobacco Cessation Guidelines.

The Smoke-Free Mothers and Babies (SFMB) project will complete its third year with plans to disseminate statewide in the coming year, training Maternity Case Managers and prenatal care providers throughout the state in the 5 A's Tobacco Cessation Guidelines.

The PRAMS survey continues to collect data as it relates to planned/unplanned pregnancy and access to health care in developing programs and policy related to low birth weight, with over sampling of people of color. In the coming year plans are underway to begin The Oregon Toddler Survey (TOTS) a survey of mothers of two year olds that previously completed a PRAMS survey. This will provide longitudinal data on the health of young children and their families in Oregon.

The Perinatal program will continue to encourage community assessments as a tool to local health departments to assist evaluating existing and planning future services.

In an effort to serve a larger population, all county health departments have the option of applying for Title V and state funding to assist in their development of a local Oregon MothersCare (OMC) site, a first trimester pregnancy access program, in addition to traditional perinatal services. For the first time since grant funding ended in 2002, some Title V funds are being allocated specifically to support Oregon MothersCare. The DHS, HS Office of Family Health will continue to provide technical support and assistance to these local projects.

OFH will continue to provide support and technical assistance to programs that provide pregnancy prevention services to reduce the number of unintended and unplanned pregnancies to women and teens at risk for premature birth (teen pregnancy prevention and family planning).

Title V programs will continue collaborating with the Title X program, the Family Planning Expansion Waiver (FPEP) which facilitates pregnancy planning and other health care services such as STD prevention, treatment, and education as well as pre-conception counseling.

Perinatal program staff will continue to provide support and technical assistance to OMC, MCM and SFMB projects in local sites.

Perinatal program staff will continue to work closely with state and local partners around perinatal issues.

through 19.

a. Last Year's Accomplishments

The State Youth Suicide Prevention Team, composed of a variety of public and private partners, including the Title V State Adolescent Health Coordinator, met on a regular basis to discuss, plan and share information in support of implementation of A Call to Action: The Oregon Plan for Youth Suicide Prevention.

The Youth Suicide Prevention Coordinator (YSPC) worked closely with the Coordinated School Health Program, a cooperative agreement between Adolescent Health/Public Health and the Oregon Department of Education, in preparation of the Violence and Youth Suicide Prevention section of the Coordinated School Health Blueprint for Action (state plan).

Presentations were made at a variety of meetings in order to encourage community interest in the state plan strategy implementation. The State Plan was completed in 2000.

The state and local Child Fatality Review teams reviewed all youth suicides that occurred in Oregon in the year 2001. The YSPC provided case reports to the state team and recommendations on prevention during case reviews at the state level.

The YSPC worked with Injury Prevention and Epidemiology (IPE) staff and Center for Health Statistics staff to develop a plan to evaluate the Adolescent Suicide Attempt Registry.

The YSPC worked with the American Foundation for Suicide Prevention, Northwest chapter (AFSP NW) to coordinate a survivor's conference in three sites in Oregon in 2003. This is an increase from two sites in 2002.

Presentations were made at the DHS Prevention Conference in fall of 2002 to alcohol and drug prevention specialists who work in mental health, education and public health.

The YSPC partnered with other trainers in the state and implemented three trainings for suicide intervention specialists working in mental health, public health, education, juvenile justice and with survivors.

Collaborated with three state agencies and a private foundation to develop and fund SAFE TEEN, a school based youth intervention skills training.

b. Current Activities

The YSPC worked with Injury Prevention and Epidemiology (IPE) staff and Center for Health Statistics staff to evaluate the Adolescent Suicide Attempt Registry. Findings from that evaluation were presented at the STIPDA annual meeting, the CDC Core Capacity Grant meeting, and at other meetings.

A training session was hosted by the Youth Suicide Prevention Program of the SAFE TEEN program to twelve school based teams in Oregon. The YSPC will provide ongoing technical assistance to the teams.

The Youth Suicide Prevention Coordinator (YSPC) is reaching out to Native American tribes in Oregon through meetings held by the Dept. of Human Services (DHS) Director's Office. The goal is to encourage tribes to consider implementing depression screening day and a survivor's teleconference in the fall, and to train suicide intervention specialists.

The YSPC will implement 3 suicide intervention specialists trainings in sites in the state where there are currently no active suicide intervention specialists trainers.

The YSPC will collaborate with staff from local mental health and a hospital to develop a protocol for addressing the needs of youth presenting in the emergency department for a suicide attempt.

The YSPC will work with the IPE staff to develop a hospital based and local health department partnership intervention with suicide attempters identified through Oregon's Adolescent Suicide Attempt Data System. A grant application will be submitted to NW Health Foundation.

The YSPC represents the program on the State Child Fatality Review Team.

The YSPC is developing a training to train community members to talk about suicide.

The YSPC is working with the Center for Health Statistics to improve reporting of suicide attempt data from hospitals who have failed to report data each quarter.

c. Plan for the Coming Year

The State Youth Suicide Prevention Team, composed of a variety of public and private partners, including the Title V State Adolescent Health Coordinator, will continue to convene on a regular basis to discuss, plan and share information in support of implementation of A Call to Action: The Oregon Plan for Youth Suicide Prevention.

The Youth Suicide Prevention Program will work with partners to develop a program known as We Care for schools in Oregon. The YSP will partner with the SAFE TEEN sites and Centennial High School in the project.

The YSP will implement a suicide 101 course that will be used to train speakers in Oregon to talk about youth suicide.

The Youth Suicide Prevention Coordinator (YSPC) will work with the members of the State Agency Team to develop technical assistance and resources for local communities seeking to implement prevention strategies from the state plan.

All ten communities who developed community based to address youth suicide plans through the Coordinated Community Planning Process (SB555) will be contacted to provide technical assistance and resources as needed.

The Injury Prevention and Epidemiology Sections (IPE) will work to find funding for strategy implementation by developing a proposal for the 2005 legislative session and responding to requests for proposals from federal agencies when appropriate.

The YSPC will continue to support the efforts of the state and local child fatality review teams as they review youth suicide deaths and work on prevention activities.

The YSPC will provide technical assistance to demonstration sites on Violence and Youth Suicide Prevention and continue to support the implementation of the Coordinated School Health Blueprint for Action (state plan) for the Coordinated School Health Program, a cooperative agreement between Adolescent Health and the Oregon Department of Education.

The YSPC will work to implement a hospital based and local health department partnership intervention with suicide attempters identified through Oregon's Adolescent Suicide Attempt Data System. A grant application will be submitted to NW Health Foundation.

Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

a. Last Year's Accomplishments

Oregon does not have a state categorization of Level II and III NICUs and other specialty and sub-specialty perinatal services.

Although there are 56 hospitals in the state that provide obstetric care, most VLBW babies are born at 6 regional facilities. There is a lack of formal systems for transfers which are determined at the local level by various criteria.

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

b. Current Activities

Since, Oregon does not have a state categorization of Level II and III NICUs and other specialty and sub-specialty perinatal services, various methods are being examined to determine levels of care and staffing, insurance, geographic, and policy factors affecting admissions and transfers.

OFH will continue to work towards identifying and maintaining a database of designated levels of care of every neonatal intensive care unit in Oregon and to assist facilities, providers, and emergency medical services to formalize protocols and agreements addressing perinatal care and transfers.

The Office of Family Health believes that women in pre-term labor should be transported to the nearest facility, not to a facility that is experienced in the care of very low birth-weight neonates that often requires long distance travel.

Research continues to identify cost-effective programs that serve women at extreme high risk for pre-term labor who do not live near a hospital that has a level III NICU. Any new undertaking is dependent upon that established evidence-base criteria.

c. Plan for the Coming Year

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

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

a. Last Year's Accomplishments

Oregon MothersCare (OMC), a statewide initiative to improve access to early prenatal care, was expanded from 18 to a total of 19 sites. All sites were supported by general or Title V funds from the state or local funds. This program has developed partnerships among public and private agencies to streamline, coordinate, and promoted access to prenatal services. Project components include a toll-free hotline (SafeNet), a referral and support system, to assist women in finding and using prenatal services in their community, and an ongoing public awareness, outreach, and education campaign. During 2003, the program assisted 2,730 women to access prenatal services; 86% of women who contacted OMC before starting prenatal care received access assistance and initiated care in their first trimester or within 2 weeks of first calling the program.

OFH continued to provide funding and technical assistance to local health departments to support Maternity Case Management (MCM) and home visiting services to increase access to and effective utilization of prenatal care and other services.

OFH provided funding and technical assistance to local health departments to provide maternity case management to 3,372 women without public or private insurance.

b. Current Activities

The Oregon Health Plan eligibility for pregnant women remain was increased to 185% of Federal Poverty Level as of February 1, 2003.

The OMC and MCM programs continue to identify moderate to high risk women who need assistance with obtaining early prenatal care and other pregnancy related services

Planning for sustainable funding is underway to assure continued support for OMC at local health departments (LHDs).

c. Plan for the Coming Year

Oregon MothersCare (OMC), an initiative to improve access to early prenatal care, assists local health departments and other OMC access sites to: formalize partnerships with prenatal care providers and other providers offering prenatal care services, promote SafeNet, the toll-free hotline for referrals to local prenatal services; streamline systems for accessing care; and assist women to obtain a pregnancy test, OHP, a prenatal care provider, and WIC, maternity case management or other pregnancy services. OMC also supports a social marketing campaign for promoting early prenatal care. In an effort to serve a larger population, all county health departments have the option of applying for Title V and state funding to assist in their development of a local Oregon MothersCare (OMC) site, a first trimester pregnancy access program, in addition to traditional perinatal services. For the first time since grant funding ended in 2002, some Title V funds are being allocated specifically to support Oregon MothersCare. The DHS, HS Office of Family Health will continue to provide technical support and assistance to these local projects.

Collaboration and support will continue with community-based efforts to increase access to prenatal care and improve birth outcomes such as: African American Infant Mortality Coalition, Community Health Promoter sub-committee, Healthy Start, WIC, and Maternity Case Management.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed				

with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.

1. State law mandates that all newborns receive metabolic screening	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Contractual partnerships between lab and OHSU for follow-up	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Practitioner manuals are updated and distributed throughout the state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Newborn screening data linked to birth certificate data for assessment and early intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. WIC provides PKU formula and food product purchases, and transportation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Advocate and recruit for family representation in statewide committees and task forces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Assess level of family involvement through focus groups and satisfaction surveys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Educate and train parents and families in the care and support of cshcn	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Establish and support Medical Home Resource Teams in six practices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Advocate and educate private and community providers on medical home approach to care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Assure families have insurance or other funding through efforts such as the Family Support Programs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Provide direct assistance and referral for families through resource development	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Advocate, collaborate and coordinate Oregon Health Plan enrollment for CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Advocate for improved systems of services for children with special health needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide care coordination services through home visiting and other services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Convene and lead community planning and community forums to improve systems of care coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Identify families with youth in transition to adulthood to assess needs in systems and services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Training and education for clinical providers, schools, social services and other services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Advocate and provide technical assistance, consultation, and research on youth transition needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. School immunization laws in place to assure all children entering school are fully immunized	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Vaccines for Children program provides vaccines for eligible populations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Outreach about immunization disseminated through training, consultation, and health education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. ALERT Immunization registry tracks and recalls immunization status of individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. AFIX assessment for public and private providers identifies gaps and needs for populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. WIC screens and refers any participants aged 3-24 months for immunizations	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. WIC and Immunization programs collaborate and coordinate services at the state and local levels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. FamilyNet client data system links immunization and WIC client data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Collaboration with other agencies to implement teen pregnancy prevention strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Convene and maintain local coalitions working toward teen pregnancy prevention goals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Implement and coordinate actions established by Oregon Teen Pregnancy Prevention Action Agenda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Teen pregnancy prevention media campaign raises awareness of adolescents and parents	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Collaborations with schools and other programs, such as Coordinated School Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Community-based and school-linked partnerships are supported through statewide technical assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Smile Survey provides assessment data to monitor status of sealants	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Dental sealant promotion campaign to raise awareness of the benefits of sealants	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Demonstration projects increase sealants using community-based strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Safety car seats promotion occurs through state and local media, local	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

events				
2. Oregon Safe Kids provides support and technical assistance in the development of local coalitions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Home visiting programs provide anticipatory guidance and health education to parents about car seats	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Training for certified safety seat technicians occurs throughout the state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Safety seat inspections by local certified technicians assures correct use of seats	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Assessment of need for child safety seats provides information for programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Assessment development activities include PRAMS questions and links with newborn screening data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Breastfeeding-Friendly Employer project assures mothers have opportunities to breastfeed at work	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Governor's Executive Order in 2001 requires all state agencies have location for breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Education and technical assistance provided through the Newborn Handbook distribution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. WIC, Perinatal, and home visiting programs provide information to all pregnant women about benefits	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. WIC provides information and support for lactation, referrals to community organizations	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. WIC provides breast pumps at no cost to qualified participants	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Statewide campaigns raise awareness and education about breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Legislation requires all hospitals with 200 or more births to conduct newborn hearing tests	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Newborn data linking project includes diagnostic and early intervention data for children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Public education materials, such as the Newborn Handbook, provide				

information about hearing screenin	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Advocate for policies and legislation to assure screening and referral access for all newborns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Technical assistance and consultation to screening and diagnostic centers and organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Outreach and application assistance through local health department programs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Information and referral through toll-free number, SafeNet	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Coordination and collaboration in MCH programs and to simplify application	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Policy advocacy to sustain eligibility levels for Oregon Health Plan for children 0-18	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Information and referral from toll-free line, SafeNet	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Application assistance and date stamping to facilitate eligibility at local health departments	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Community education about Oregon Health Plan and services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Case management services include OHP application assistance and referrals	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Policy advocacy to sustain programs, services, and coverage for children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Outreach, screening, referral in case management and home visiting programs for LBW infants	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Education and assessment of women at risk including smoking cessation, counseling, referral	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Data analysis and program evaluation monitors trends in LBW births, through PRAMS, birth certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provider training in 5 A's protocol to promote early intervention in high risk pregnancies	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Pregnancy planning and reproductive health programs provide education and support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. State plan provides strategies for implementation at state and local levels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Training for providers, counselors, educators and others on suicide prevention strategies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Assessment and monitoring of trends in youth suicides and suicide attempts through development of su	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Coordination and collaboration between public health and education agencies	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities				

for high-risk deliveries and neonates.				
1. Advocacy for assuring systems in place to appropriately care for VLBW infants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Assessment and surveillance of VLBW infants	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Outreach and linking of women to early and adequate prenatal care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Maternity case management and home visiting services for high risk pregnant women	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Reproductive health and family planning services provide education about optimal prenatal care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. FamilyNet client data system provides data to assess status of client risk factors and needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. PRAMS surveillance provides information about utilization, access, and quality of prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Advocacy for early prenatal care system and quality improvements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. WIC and Family Planning programs refers women screening positive for pregnancy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of pregnancies among women 15-44 that are intended*

a. Last Year's Accomplishments

OFH's Family Planning Program served 84,562 clients in clinics supported by Title X and Title V funds during calendar 2003, preventing an estimated 19,632 unintended pregnancies. An additional 40,000 Oregonians received family planning services through clinics not supported by Block Grant funds but participating in OFH's Family Planning Program through the Medicaid Waiver Family Planning Expansion Program (FPEP).

In addition to contraceptive services provided and pregnancies averted, these clinical

programs provided basic preventive health care services and exams for 126,000 women and men. Nearly 58,000 pap smears and 62,000 clinical breast exams were done in Family Planning clinics during CY 2003.

Program accomplishments during 2003 include the implementation of a comprehensive strategy for service improvement specifically designed for family planning/women's health clinics called COPE (10 comprehensive COPE workshops were provided); distribution of updated birth control method pamphlets and effectiveness posters and completion of data collection workshops to meet HIPAA requirements and Region X data collection changes. Trainings were offered for family planning staff in client-centered counseling, addressing the potential for coercion in adolescent sexual relationships, male and female exam trainings, and improving fee collection strategies.

Ongoing activities included on-site program evaluations of 12 local agencies; provision of technical assistance, on-site staff training and orientation to family planning; coordination of contraceptive supply availability through central purchasing; and coordination with the state STD and BCC program.

b. Current Activities

Implementation of the second stage of the Family Planning Expansion Program (Medicaid Waiver program) began in January of 2004. Assessment of the future of family planning programs in light of potential budget cuts at the local level as well as limited state funding is ongoing, with particular attention to how family planning services are offered in primary care environments and the potential impact on access to family planning when traditional public health clinics consider establishing themselves as primary care environments.

Much work is also being done to assure the availability of consistently low-cost contraceptive supplies for all providers serving low-income populations. We continue to implement the COPE quality improvement model.

c. Plan for the Coming Year

Estimates are that more than 19,000 unintended pregnancies to low-income women were averted in 2003 because of services provided in Title X and MCH-supported clinics. Our goal is to maintain current resource levels to continue providing family planning services to over 100,000 low-income Oregonians annually.

The Family Planning Program will continue to maintain ongoing quality assurance activities to assure program standards are being met through on-site evaluations at local health agencies and by review of grant program annual plan.

The Family Planning will support the continuation of specific projects to maintain this capacity, and to improve the quality of and accessibility to clinic services. Strategies will include increased customer focus, clinic efficiency and improved counseling; and promotion of services through community mobilization.

The Family Planning Program will continue to incorporate priority requirements of the Title X program, including increasing the involvement of male partners in family planning services, encouraging family participation in the decisions of minors to seek family planning services, and providing counseling to minors on how to resist attempts to coerce them into sexual activities.

State Performance Measure 2: *Percent of women who had live births who took folic acid most days in the month before becoming pregnant.*

a. Last Year's Accomplishments

The OFH is a member of the Oregon Folic Acid Council which works on folic acid promotion: professional education, community awareness, and media.

A folic acid brochure was developed by the Oregon WIC Program for WIC participants and family planning clients.

A "10 Second Folic Acid Intervention" clinic protocol was developed and implemented in health departments to assist health care providers incorporate folic acid promotion into clinic visits by clinic staff in less than 10 seconds.

b. Current Activities

The OFH Genetics Program, in conjunction with nutrition staff, developed and presented a folic acid educational poster session that incorporates current understanding of the role of folic acid in the prevention of birth defects. This information can be used in conferences and display halls to inform health care providers.

The "10 Second Folic Acid Intervention" protocol and brochures have been distributed to family planning clinics in Oregon. Health Departments clinics are implementing the Intervention on a volunteer basis.

Twenty (20) copies of the pre-conceptual counseling self-study curriculum were purchased and distributed by local family planning nurses. Nurses are in the process of using the course. We plan on distributing 30 more to nurses statewide.

An analysis of Oregon PRAMS data on the consumption of Folic Acid was conducted. A press release highlighting the need for all women to be consuming folic acid was distributed in May 2003. Data collection continues in 2004 for that further analysis can be performed.

c. Plan for the Coming Year

2004 is the last year the OFH will be receiving funding to accomplish folic acid activities. The OFH will need to reevaluate their ability to continue activities in 2005 at the same level or pursue other funding.

Forty (40) local health department nurses will be implementing knowledge received in the Pre-Conceptual Counseling Self-Study Course. This education will improve the scope and effectiveness of their counseling for women who are or may one day want to become pregnant.

WIC, Family Planning and OB-GYN clinics are implementing the "10-Second Folic Acid Intervention" and using the accompanying brochures. We are looking for resources to evaluate the intervention's effectiveness.

OFH in collaboration with the Oregon Folic Acid Council will develop and implement an educational campaign to promote folic acid consumption in the Latino population in Oregon.

Presently we are considering purchasing Spanish photonovelas to be distributed to Latina women of child-bearing age.

OFH will continue to provide resources to Health Departments on where they can purchase affordable multivitamins for their clients.

State Performance Measure 3: *Percent of women reporting no tobacco use.*

a. Last Year's Accomplishments

Partnerships continued with OMAP, local health departments, other agencies and providers to include mandatory training, information, and education on tobacco use and exposure within Maternity Case Management services throughout Oregon and to encourage and facilitate the same through all perinatal services.

The Perinatal Program continued partnerships with the Tobacco Prevention and Education and other DHS programs, local health departments, other agencies and providers with the continuation of the Smoke-Free Mothers and Babies project, funded by the Robert Wood Johnson Foundation. This prenatal smoking cessation demonstration project has continued in eight Oregon counties as a sub-program of the Maternity Case Management (MCM) program.

Partnerships were formed with the Oregon Chapter of the American Cancer Society and Providence Health Systems.

Participation in OMAP's Project PREVENTION, a managed care quality improvement project, contributed to prenatal smoking cessation being targeted as one of three areas of focus for 2003.

b. Current Activities

The Smoke-Free Mothers and Babies (SFMB) project is in its third year and is currently completing Five As tobacco cessation intervention protocol training for the remaining prenatal care providers in the eight pilot counties.

In Spring, 2004 staff partnered with Providence Health Systems in hosting a statewide prenatal smoking cessation provider conference.

Staff continue to work with OMAP, Project PREVENTION, the Tobacco Free Coalition of Oregon's Health Systems Task Force, the American Cancer Society, Providence Health Systems, and various other agencies and organizations.

c. Plan for the Coming Year

Ongoing partnerships will continue with OMAP, local health departments, other agencies and providers to include mandatory training, information, and education on tobacco use and exposure in Maternity Case Management services throughout Oregon and to encourage and facilitate the same through all perinatal services.

The Smoke-Free Mothers and Babies (SFMB) project will complete its third year with plans to

disseminate statewide in the coming year, training Maternity Case Managers and prenatal care providers throughout the state in the 5 A's Tobacco Cessation Guidelines.

Maternity Case Management (MCM) staff will continue to work closely with the Office of Medical Assistance Program to assure continuous quality improvement. During the coming year, the Smoke-Free Mothers and Babies (SFMB) program will be institutionalized in MCM with the requirement of the 5 A's Tobacco Cessation Guidelines.

Ongoing evaluation of SFMB will assist in continuing systems improvements and will aid in state-wide dissemination of the model beginning during the coming year.

State Performance Measure 4: Percent of children age 0-4 who are observed riding restrained in child safety seats in cars.

a. Last Year's Accomplishments

The Child Injury Prevention Program (CIP) collaborated with the Child Safety Seat Resource Center to train additional local health departments as nationally certified child safety seat clinicians.

CIP provided technical assistance in developing and implementing safety seat clinics post certification.

CIP worked to strengthen local transportation safety coalitions, Safe Communities grant sites and Safe Kids coalitions to support safety seat use in counties. Funding for the voucher program is currently in need of support.

CIP Coordinator is managed National Safe Kids grant process that provided money for local chapters to provide safety seat and booster seat clinics and distribute safety equipment.

The CIP Coordinator is continuing her work with the State Child Fatality Review Team.

The CIP wrote a grant that provided funds to purchase bike rodeo equipment.

The CIP wrote a grant that provided funds for a production of a Spanish television segment on Ceta con Neeli which broadcast to Oregon and SW Washington Spanish speaking television market.

b. Current Activities

The CIP is assisting a metro area group with application to become a Safe Kids coalition. This application will be presented in the 2004 application year. Coalition status will provide Oregon communities with access to increased amounts of grant funds to support prevention activities. Oregon priorities for these prevention activities are distribution of safety seats and booster seats and safety seat clinics.

The CIP Coordinator is continuing her work with the State Child Fatality Review Team.

Under the leadership of the CIP Coordinator Oregon Safe Kids has a new strategic plan.

The CIP with the advisory board of Oregon Safe Kids will train local chapter members in an annual meeting in October of 2004.

The CIP is participating in development of a study of childhood poisonings with researchers from Oregon Health Science University.

The CIP is working to develop Walk you Child to School Day sites throughout Oregon.

The CIP will create partnerships in Oregon to provide bicycle rodeos to promote bike safety and to increase cycling skills among children.

The Child Injury Prevention Coordinator (CIPC) work plan includes preparation of a grant application to Department of Transportation for funding to continue the work of certifying local health department staff as safety seat technicians. The funding to defray the cost of health departments sending clinical staff to be trained is essential in establishing local capacity to provide this service.

c. Plan for the Coming Year

Department of Transportation funds to support local health departments end in 2004. CIP will work to find funds to maintain training status of existing health department staff and to train a limited number of new staff.

Work plans also include technical assistance in developing and implementing safety seat clinics post certification.

Work plans also address work to strengthen local transportation safety coalitions, Safe Communities grant sites and Safe Kids coalitions also supports the efforts of the local health department staff. Funding for the voucher program is currently in need of support.

The Alliance for Community Traffic Safety and Oregon Department of Transportation and the Oregon Safe Kids Coalition will implement a long term plan to retain and maintain certified technicians regionally.

State Performance Measure 5: *Percent of 8th graders who report not using cigarettes in the previous month.*

a. Last Year's Accomplishments

The percentage of 8th graders who smoke cigarettes continues to decline. In 2000, 12.8% of 8th graders reported smoking cigarettes, followed by 12.3% in 2001, 11.7% in 2002, and 10.7% in 2003. In 2002, 3% of 8th graders reported using smokeless tobacco.

During the 2003 Legislative Session, a severe budget shortfall led to tobacco control funds being redirected to the state general fund. In September 2003, tobacco funds were restored, but at a 70% reduction of previous levels. As a result, local community-based programs, multicultural networks, tribal programs, and school programs were terminated, and the Oregon Quit Line (toll-free statewide telephone-based assistance) was suspended until December.

The Coordinated School Health Initiative successfully convened a stakeholder group on Tobacco Use Prevention as part of the preparation of the statewide, the Blueprint for Action

that established goals, five bold steps and indicators of success for Tobacco Use Prevention.

The Office of Family Health School-Based Health Center (SBHCs) Program provided tobacco, alcohol, and other drug use education, individual screening, or assessments and referral for treatment when students presented with or were identified with these risk factors. Several centers have tobacco cessation programs at SBHCs.

Updated recommendations from the State Underage Drinking Taskforce to the new Governor that includes components that address vendor education and training for alcohol and tobacco sales and conducts minor decoy operations to improve compliance.

b. Current Activities

Due to budget reductions in 2003, TPEP activities continue, but at a much reduced level. In 2004, TPEP provided grants to some Local Health Departments, multicultural networks, tribes, and the Oregon Department of Education for tobacco prevention activities. Ten counties receive funds for community tobacco prevention activities and 13 counties receive funds to maintain tobacco coalitions. Four multicultural contractors and seven of the nine federally recognized tribes receive funding for tobacco prevention and education activities. The Oregon Quit Line continues to operate, though at a reduced capacity. TPEP also supports local efforts through a statewide anti-tobacco and cessation media campaign.

The Coordinated School Health Program continues to meet monthly to implement the state strategic plan (Blueprint for Action) which has established goals, five bold steps and indicators of success for Tobacco Use Prevention.

The Office of Family Health School-Based Health Center (SBHCs) Program provided tobacco, alcohol, and other drug use education, individual screening, or assessments and referral for treatment when students presented with or were identified with these risk factors. Several centers have tobacco cessation programs at SBHCs. Due to budget cuts, then followed by a restoration of the SBHC program six months later, total number of SBHCs operating and service levels, including those specific to tobacco use by youth, declined during the past year.

Dedicated resources are not available in the Office of Family Health to work directly and exclusively on tobacco, alcohol, and other drug prevention programs for the 8th grade population.

c. Plan for the Coming Year

Continue to support the efforts of the Tobacco Prevention and Education Program, primarily through the local community-based coalitions and the school programs. The goal of TPEP is to reduce disease, disability, and death related to tobacco use by: 1) preventing the initiation of tobacco use among young people; 2) promoting quitting among young people and adults; 3) eliminating nonsmokers' exposure to secondhand smoke; and 4) identifying and eliminating the disparities related to tobacco use and its effects among different population groups.

The Local Community-Based Tobacco Prevention and Education Coalitions bring partners together to develop and implement community-based tobacco control or prevention strategies; to counter the influence of the tobacco industry and the promotion of tobacco products; to create tobacco free environments; and to promote quitting for both adults and youth.

Well-implemented school programs in Oregon have significantly reduced the use of tobacco by students. The partnership between TPEP and the Oregon Department of Education will

continue to strengthen coordinated school health efforts for school-based tobacco prevention. School activities will include assisting schools in the selection of science-based tobacco education curriculum, training teachers on curriculum, and training schools on how to develop a comprehensive tobacco-free schools policy.

Maintain relationship with the Tobacco Prevention and Education Program through ongoing participation in the Coordinated School Health (CSH) Initiative state strategic planning effort co-lead by the Office of Family Health/Adolescent Health Section and State Department of Education and support implementation the goals and five bold steps identified for Tobacco Use Prevention as presented in the Strategic Plan (Blueprint for Action).

Continue participation and cooperative relationships with the state agency partners (Department of Human Services/Health Services, Oregon Department of Education, Commission on Children and Families) to advocate for the long-term sustainability of the Oregon Healthy Teens Survey (now a combined survey representing YRBS-Youth Risk Behavior, State Tobacco, State Public School Drug surveys) to monitor tobacco use and prevention activities.

Continue advocacy for population-based tobacco, alcohol and other drug screening, assessment, education, counseling and referral be reflected as a component of assuring the delivery of national recommended guidance for annual comprehensive preventive health visits for all adolescents. Continue School-Based Health Center tobacco screening, identification and expand tobacco cessation and treatment efforts specific to that model of primary care.

Continued strategic planning with the State Underage Drinking Taskforce that includes components that address vendor training for alcohol and tobacco sales and conducts minor decoy operations to improve compliance.

State Performance Measure 6: *Percent of population living in a community where the water system is optimally fluoridated*

a. Last Year's Accomplishments

The Oral Health Section continued to receive funds from the CDC to enhance the infrastructure and capacity for optimal water fluoridation, provide technical assistance in Oregon on community water fluoridation; and establish and support existing community coalitions that will advocate for optimally fluoridated water.

Oral Health Section staff provided technical assistance to local community water fluoridation coalitions.

b. Current Activities

An oral health summit was convened. The summit addressed key issues related to oral health in Oregon. The summit brought together 150 diverse stakeholders. A process for the development of a state plan for oral health has begun optimal community water fluoridation has been identified as a focus area. In addition, a foundation for a broad based state coalition is being laid throughout the state plan development process.

Several communities were recognized by the Association of State and Territorial Dental

Directors as having been fluoridated for over 50 years or for recently passing a fluoridation initiative. The city of Beaverton begin optimally fluoridating its public water system on June 1, 2004.

The Governor's office and several legislative committees requested detailed information regarding optimal water fluoridation. We continue to provide education and technical assistance to policy makers regarding this issue.

c. Plan for the Coming Year

In collaboration with the DHS Drinking Water Program, the Oral Health Section will connect Oregon to the CDC Water Fluoridation Reporting System (WFRS).

The Oral Health Section will provide technical assistance to water district operators and local councils seeking optimal water fluoridation in their systems.

Local water fluoridation coalitions will participate as specialized workgroups of a larger general oral health statewide coalition.

State Performance Measure 7: *Percent K-12 students with access to a state-certified School-Based Health Center (SBHC).*

a. Last Year's Accomplishments

The Office of Family Health, Adolescent Health Section continued to provide leadership, technical assistance, policy development, oversight, assurance, data collection, program evaluation, and reporting functions for the state School-Based Health Center (SBHC) program through March of 2003 when all program funds were eliminated as part of state budget reductions. At that time 3.5 FTE were eliminated from the state SBHC program office.

At the beginning of the fiscal year 43 SBHCs in Oregon were Certified as either CORE or EXPANDED by the state program office. Standards for Certification were reviewed and recommendations for changes continue to be pending.

The SBHC program lost all state general funds (March 2003) that supported ongoing leadership, technical assistance, policy development, oversight, assurance, certification, data collection, program evaluation, and reporting functions for the State School-Based Health Center (SBHC) Program. Services were necessarily limited to distribution of resource materials and referral to the Oregon School-Based Health Center Network (OSBHCN) and the National Assembly on School-Based Health Care (NASBHC) for technical assistance or program development pending a final state budget. Existing SBHC resources, tools and program reports were transferred to and hosted on the Healthy Kids Learn Better (State Coordinated School Health Program) website where links to national resources and limited Oregon-specific information remained available for those entities who are interested in developing the model.

Twenty of Oregon's SBHCs lost base funding from state general fund dollars. Although partnerships with various foundations to explore potential avenues of collaboration were explored at the local level for bridge funding, 5 SBHC's were forced to close and did not reopen by the end of that fiscal year.

SBHCs continued to provide a comprehensive set of primary care and preventive health services frequently combined with emotional/mental health care directly in the school setting.

Final data collection and reporting for the 02-03 service year is a function that was not provided due to loss of state infrastructure. However, prior to the state program office closure a SBHC Services Report was completed reporting on the most recent complete data available (01-02 service year).

The program continued to focus on increasing public and policymaker awareness of the SBHC health care model through the Coordinated School Health Initiative, "Healthy Kids Learn Better" a partnership between the Centers for Disease Control and Prevention, the Oregon Department of Education and DHS Health Services.

b. Current Activities

School Based Health Center Program funds for the 03-05 biennium were restored as of September 2003. Contracts to award local funding were re-established and an assessment of the impact of loss of funding on SBHC infrastructure and operations was conducted. At that time, the program office began rebuilding staff by hiring a Program Technician 2, who has focused on providing technical assistance and coordination between SBHCs and other adolescent health entities to promote sustainability and evolution of specialty services. A Research Analyst 3 was also hired, who has gathered preliminary program data for a status report for the 03-04 service year and worked with SBHCs to troubleshoot data collection systems. Certification functions and clinical oversights have yet to be re-established. A new range formula funding distribution model was successfully negotiated with stakeholders distributing dollars that now provides public health infrastructure funds to all 14 counties with certified SBHCs. The state SBHC program office recently applied for a SAMSHA grant to target capacity enhancement in specified SBHCs to prevent and treat substance abuse disorders in their clients.

The bi-annual SBHC certification period ended at the close of this fiscal year. Although support was given to SBHCs to maintain standards, the formal certification process was temporarily suspended after the state program office lost funding, and it was not able to resume during this fiscal year. Plans are for the certification process to begin by September of 2004.

Communications have been maintained with both the Oregon School-Based Health Center Network, who was awarded a grant from the Kellogg foundation to advocate for improving access to care, sustainability and restoration of funding of the SBHC model in Oregon and the Health Kids Learn Better Coalition (Coordinated School Health Program).

The relationship was maintained with the National Assembly on School-Based Health Care through the Adolescent Health Manager's participation as part of their Center for Evaluation and Quality Advisory Board to support development of national resources and best practices for SBHCs.

The Adolescent Health Manager participated in and represented SBHCs in Oregon's National Governor's Association Safety Net Task Force to define and develop policy recommendations for Oregon's system of safety net providers.

SBHCs continued to provide a comprehensive set of primary care and preventive health services frequently combined with emotional/mental health care directly in the school setting. Three of the five centers that closed when program funds were eliminated successfully reopened after funds were restored. The remaining two SBHCs plan to re-open at the beginning of the next school. Final data collection and reporting for the 03-04 service year is a function that was not provided due to loss of state infrastructure.

c. Plan for the Coming Year

The core functions of leadership, technical assistance, policy development, oversight, assurance, data collection, program evaluation, and reporting for the state School-Based Health Center (SBHC) program can fully resume since funding has been restored and the staffing pattern is expected to be complete. Certification visits will be conducted in the Fall as well as on-site technical assistance visits for data collection. Data analysis and reporting functions are expected to be fully restored. The state program office will continue to work with the Department of Human Services and the Governor's office on a proposed budget/policy package that would expand SBHC infrastructure funding to five additional counties for the 05-07 biennium.

Work will continue on the NGA Safety Net Task Force developing and advancing policy recommendations regarding SBHCs and the state funding of the safety net system.

State program office staff will be active with the Oregon Primary Care Association, with the goal of promoting and protecting health care to underserved populations, including those in rural locations. Activities will also continue with the state Youth Suicide Prevention team, and the Behavioral Health All-Hazards Preparedness Workgroup.

Communications will continue to be maintained with the Oregon School-Based Health Center Network (OSBHCN) in an effort to advocate for improving access to care, sustainability and restoration of funding of the SBHC model. With additional funding awarded to the OSBHCN from a Kellogg foundation grant, transition of responsibility for the annual state School Based Health Center conference from the program office to the OSBHCN will occur. The state program office will instead have a supportive and consultative role, including this year helping to facilitate a roundtable planning session with insurance providers with the goal of improving third party billing capability in SBHCs.

State SBHC program office will continue to be very involved with the Healthy Kids Learn Better Coalition (Coordinated School Health Program) by participating in several workgroups as well as the overarching coordinating group. Staff from our office will provide leadership for a workgroup focusing on mental health and substance use issues in schools.

A relationship will be maintained with the National Assembly on School-Based Health Care through participation as part of their Center for Evaluation and Quality Advisory Board to support development of national resources and best practices for SBHCs.

State Performance Measure 8: *Percent of CSHN receiving care coordination services.*

a. Last Year's Accomplishments

Care coordination services are provided through the CaCoon program, Community Connections Network (CCN) clinics, Medical Home Primary Care Practices and at the CDRC tertiary level clinics.

Statewide, the CaCoon program funded public health nurses (12.42 FTE) and 3 Promotoras (1.45 FTE). A minimum of 0.1 FTE was supported in the smaller counties and a maximum of 3.4 FTE in the tri-county Portland metropolitan area. 1,440 children received 7,348 CaCoon services including public health nursing home visits.

CaCoon nurses represented their communities on various planning efforts for children and families. In all counties CaCoon nurses participated on county councils including the Early Intervention Advisory Groups and the Local Commission on Children and Families to help facilitate medical educational collaboration and assure that the health needs of this population

are identified and addressed. Also, in those counties with Community Connections Clinics, the CaCoon nurses participated on the teams to develop a coordinated team plan and to assist families link to community services.

Recommending financial supports for care coordination in Oregon primary care offices continued to be the charge to a Medical Home Project Task Force. Because, there are limited funds to support re-imbursement from Medicaid, the group discussed how primary care practices could be more involved in their community, knowledgeable of community resources and link with other care providers, especially CaCoon nurses.

Title V also provided financial support to the CDRC multi-disciplinary, tertiary care clinics. These funds assured that case management services provided by social work, nursing and program support continued for the families attending the CDRC clinics in Portland and Eugene.

b. Current Activities

The CaCoon program continued to provide care coordination services to children and youth. CaCoon nurse FTE was increased in six counties to better serve the adolescents and their families. These funds provided additional time of the CaCoon nurse to participate in CCN and address the health and related issues of youth transitioning from pediatric to adult care.

The CaCoon nurses partnered with local parents to form the Resource Teams for the six primary care practices in the Oregon Medical Home Project. These Teams provided direct supports to families and facilitated a process of continuous quality improvement in practices.

Funding for Promotoras, community outreach workers, continued in three counties with a fourth Promotora added in Malheur County, an Eastern Oregon county that has experienced a significant increase in the number of Hispanic families residing in that county. This model of paraprofessional/nurse teams has proved successful in working with Spanish speaking families in three of Oregon's counties.

A Public Health Nurse consultant was added to the Title V program to work with the tertiary hospitals to assure continuity of care and a smooth transition between tertiary health and community-based care. She has met with key staff at all the major hospitals in the Portland Metro area, including Shriners hospital, and with our partners in the community to identify barriers and issues for both. Recommendations to address these concerns are forthcoming.

We continue to work with State partners to develop an integrated data system for state programs providing services to children. This system will assist programs in coordinating activities and in avoiding duplication and will also provide more complete and accurate data for measuring national and state performance measures.

A nurse practitioner was hired in the CDRC Child Development Clinic to work with families at the intake stage and determine the appropriate mix of disciplines needed to address expressed concerns and questions. Also, she will be following up with the family after the multidisciplinary team assessment to assure that clinic recommendations are understood and followed. She will connect them to the appropriate community services and, if appropriate, the CaCoon Nurse for coordination of care.

c. Plan for the Coming Year

Contracts for continuing the CaCoon Program will be extended to the county health departments. CaCoon nurses will continue to provide care coordination services through participation in the CCN clinics. Contracts with communities for CCN multidisciplinary teams will continue. We will explore the feasibility of combining all of these agreements and appoint

one entity to implement all of the Title V programs in that community.

Although County Health Departments can now bill Medicaid for eligible services through Medicaid Administrative Claiming, the economic downturn in Oregon, especially in some of the rural counties, has challenged them. The CaCoon Program staff will work with County Public Health Nursing Supervisors to look critically at how CaCoon services are provided. We will explore possible ways to restructure the program to better meet the needs of families and communities.

As the Medical Home Project ends in September 2004, we will finalize the plan for transitioning the Medical Home concept into Title V and will define how primary care providers can be connected better with the community services system. This will help assure that families receive the care coordination services they need.

We will continue to work with State partners to develop an integrated data system for state programs providing services to children. As well, we will continue to work with hospitals and communities to improve communication between the two so families experience coordinated care and providers have a point of contact for questions and consultation.

State Performance Measure 9: *Degree of participation in the collaborative effort of developing a statewide data system to support Oregon's early childhood program needs.*

a. Last Year's Accomplishments

- OFH and CDRC continue to participate on the interagency team to develop an integrated data system for state programs providing services to children. The OFH has been designated as the lead agency for developing this database as FamilyNet's Family & Child Module (FCM), which is the first phase of Oregon's planned Early Childhood Data System (ECDS). Other agencies involved in this effort are the OCCF, ODE, CLHO, local public health, Oregon Healthy Start, the DHS Offices of Oregon State Public Health Laboratories (OSPHL) and Disease Prevention and Epidemiology (ODPE), and Early Intervention agencies. This collaboration will assist programs in developing and using the FCM to coordinate activities, avoid duplication, and provide more complete and accurate data for national and state performance measures.

- Convene a workgroup to develop an operational definition of CSHCN. Members of the group included representatives from Commercial Health Plans, the Oregon Health Plan, CDRC, primary health care providers and families. The group was co-chaired by DHS Health Services and CDRC and facilitated by CDRC. This group has completed monthly meetings begun in FFY 2002 and analyzed methods for defining CSHCN. OMAP and OFH have completed an analysis of Medicaid data to determine whether a workable definition can be developed based on International Classification of Disease (ICD) coding and a suggested list has been completed.

Identify agencies representatives and service providers; convene a workgroup to complete the FCM and develop a data warehouse for collecting information on children enrolled in Oregon early childhood programs, including home visiting programs that use the FCM as their interactive service documentation and reporting system. Members include OFH, OSPHL, ODPE, CDRC, ODE, and OCCF. FCM design and/or function will include:

- Define common data elements required by all partners.
- Define subsets of the larger population.
- Expand data collection system to include missing elements.
- Address confidentiality issues when sharing information across agencies.
- Establish health outcomes for early childhood home visiting programs.

- Measure outcomes and collect data to evaluate the programs' effectiveness.
- OFH continued to lead the effort to develop the FamilyNet FCM with CDRC and other state and local agency participation. The detailed design was delayed as the core development team obtained more resources established new partnerships and trained new staff; the pilot test is now expected to begin in federal fiscal year 2005.

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- The CDRC multi-agency development of a definition of CSHCN will continued with OFH participation in the analysis of OMAP data.

b. Current Activities

- OFH continues to lead and CDRC continues to participate on the interagency team to develop FamilyNet. The Family and Child Module of FamilyNet enjoys the full support and continued participation of all team members identified above, but the State fiscal crisis continues to delay this and the larger ECDS development. OFH restarted the FCM development with new project deadlines. The FamilyNet system completed its rollout and the FCM development was restarted with the new funding obtained in FFY 2003. When this third module is complete, FamilyNet will give partners the full service delivery, followup, evaluation, and assessment functionality for all MCH populations. All agency partners continue their involvement in this effort; they are the OCCF, ODE, CLHO, local public health, Oregon Healthy Start, the DHS OSPHL and ODPE, and Early Intervention agencies. FCM staff have recruited additional representatives from birthing hospitals, family advocacy organizations and CDRC family consultants, and the Oregon Community Health Information Network (OCHIN) -- an organization that is automating the practice management and accounting systems for counties representing more than half of the Oregon population.

- The group that was formed to develop an operational definition of CSHCN has completed its work. The list of ICD-9 codes was refined for use as the first step in the operational definition. Clinical screening tools that met or exceeded the workgroup's evaluation criteria were added to the group's recommended protocol and tool set. The recommended protocol is to use the ICD-9 list to cast a net slightly broader than the CSHCN population and one of the recommended clinical screening tools to complete the operational definition of the population in a given treatment setting.

The work to develop a data warehouse was folded into the FamilyNet development because other data warehouse development efforts lacked funding to continue. While this change delayed warehouse development, the FamilyNet team includes more complete the multi-agency, state and local representation than earlier warehouse development efforts. The goals listed above remain the same.

c. Plan for the Coming Year

OFH will continue to lead the effort to develop the FamilyNet FCM with CDRC and other state and local private sector and public agency partners. The pilot test of that system is expected to begin in state fiscal year 2005. The OFH continues to seek additional funding so as to accelerate the development effort.

The CDRC multi-agency development of a definition of CSHCN will continue with OFH participation in the analysis. An increased level of participation and a permanent repository for the CSHCN definition tools in the FamilyNet data warehouse were proposed as part of the 2003-2006 SSDI grant.

a. Last Year's Accomplishments

CDRC recognizes the importance of training a broad range of professionals who provide services to CSHN. We also appreciate the fact that members of our CaCoon and CCN teams work in both programs and are often asked to come to separate trainings for each program. Although both programs have different continuing education needs, there are topics that are of interest to both groups. One of these is adolescent transition. To promote collaboration of these two programs around this important issue and to consolidate the number of trainings, a joint summit on adolescent transition was held for the CCN teams and the CaCoon nurses. The teams included school transition specialists, vocational rehabilitation counselors, parents, adult health care providers, and school nurses. Training centered around how to transition from child centered to adult services, from school to work and independent living, issues for families and community resources for adolescents. Included in the summit were presentations and team planning time for each community to create their own strategies for implementation.

CCN held a coordinator training, the annual conference, continued to provide faculty consultations to clinicians at the CCN clinic sites, and offered training and technical assistance through the regional consultants. Three Pediatric Fellows covered and worked with the teams in four sites, providing educational experience that went both directions. CCN trained 826 people this year.

CaCoon provided training for CaCoon nurses through program orientation to new nurses, on site consultations, the statewide CaCoon conference, NCAST training and the bimonthly newsletter. They, and Medical Home Project, used a list serve (group email) to disseminate education information to physicians, nurses and families. Training was also provided to 3 county Resource Teams and the physician community in these counties through the Oregon Medical Home Project. CaCoon trained 76 people this year. Medical Home trained 24.

Self-Directed Learning for Nurses modules for community-based nursing, working with CSHN have been developed. Three of the modules with completed content and guidelines were disseminated: Cerebral Palsy, Congenital Heart, and Cleft Lip and Palate. Content and guidelines for the General Disability and Spina Bifida modules are completed.

b. Current Activities

The final two learning modules for community health nurses are being completed. Publishers have granted permission to disseminate the modules outside of Oregon. CaCoon nurses are being trained to use the modules. CaCoon continues to provide training opportunities for nurses through program orientation to new nurses, on site consultations, statewide Conference, and NCAST training.

CaCoon held a one-day workshop for County Health Department Nursing Supervisors to update them on the program, its standards/expectations and to encourage their feedback on the program's operation. Training was also provided for a new promotora in Malheur county. CaCoon has trained 33 people this year.

CCN provided an annual conference this year, which included all CaCoon nurses from around the state. Though, the conference was attended by people from all disciplines, there was a time set aside for all of the physicians to meet with Brian Rogers, MD (Director, CDRC) and for the CaCoon nurses to meet with CDRC's nursing staff. CCN also held a fall coordinator training, expanded faculty consultations and other educational opportunities such as on site consultation and training. The total number trained via these approaches is over 600. Teleconferencing for consultation was explored and will be used in an adolescent transition statewide conference in the fall of 2004.

The Medical Home project has continued training the six sites on medical homeness. In addition to the on-site training, in February 32 people were trained in models of mental health programs. The FISHs program held a consortium meeting in October 2003 bringing together 59 leaders from agencies to develop plans for greater integration of services across the state.

Oregon Department of Education has had major budget cuts but we continue to work together to share resources, access each others websites, cross train personnel from our areas of responsibilities. Though a possible future topic might be Mental Health Issues for CSHN: diagnosis and management; the joint conference currently being planned is around adolescent transition. Presentations via teleconference will be broadcast to 6 sites around the state where teams of providers and families will be gathered. The teams will then share local resources and discuss how they can collaborate better for the good of the population they serve.

Title V has continued to provide training opportunities for Developmental Pediatric Fellows, LEND nurses and other discipline trainees through the CCN and CaCoon programs. Information has been provided to OHSU residents on community-based resources. Also, information has been presented on state and community-based resources for CSHN via the webpage and through the Title V newsletter.

c. Plan for the Coming Year

The Self-Directed Learning for Nurses modules will be completed and disseminated inside and outside of Oregon. Access to them will also be made via the website.

Reorganization within Title V will have a dramatic effect on our training activities. We will do much more joint training. A Title V conference is being planned for next year, which will include participants from all programs: Medical Home, CCN, CaCoon, FISHs, FIN. CCN will continue to hold a training for coordinators. Also being considered are regional conferences for all involved in Title V.

FIN will continue to train families who are identified to be a part of the network of families who will serve as a resource to other families around the state.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Percent of pregnancies among women 15-44 that are indended				
1. Family planning and reproductive health programs provide preventive clinical services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Training and education for clinic staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Outreach and referral in communities to increase access and utilization of family planning services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Technical assistance and consultation for comprehensive clinic efficiency (COPE) quality improvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Percent of women who had live births who took folic acid most days in the month before becoming pregnant.				
1. Social marketing materials and methods to increase awareness of taking folic acid prenataally	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Training and education for family planning nurses and other providers on folic acid use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. PRAMS survey analysis provides system for assessing folic acid use	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaboration with Oregon Folic Acid Counsel supports media campaign among Latino populations	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Percent of women reporting no tobacco use.				
1. Training and education of providers in 5 A's protocol in project sites	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Evaluation and assessment of project effectiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Monitoring change in population health status through analysis of PRAMS data	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Screening and referral in WIC, maternity case management, and other settings for tobacco use	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Health education and social marketing of the effects of smoking during pregnancy statewide	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percent of children age 0-4 who are observed riding restrained in child safety seats in cars.				

1. Train and certify local health department staff in child safety seat installation and use	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Promote and support events or clinics for checking and teaching public about correct seat use	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Establish local SafeKids coalitions and support with funding and technical assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Collaborate with organizations and agencies working on injury prevention activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Advocate for enforcement and strengthening of child safety and seat belt laws	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of 8th graders who report not using cigarettes in the previous month.				
1. Promote tobacco prevention among youth through school, local public health, and other organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Participate and collaborate with organizations, groups, and task forces in implementing tobacco prev	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Advocate for screening, education, counseling and referral for use of tobacco, alcohol and drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Implement Strategic Plan for tobacco use prevention through the Coordinated School Health Project	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of population living in a community where the water system is optimally fluoridated				
1. Advocate for community water fluoridation through public education and policy development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Establish and provide technical assistance in the development of community coalitions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborate with Oregon Drinking Water Systems to provide technical assistance to water districts	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent K-12 students with access to a state-certified School-Based Health Center (SBHC).				
1. Advocate for certification of school-based health centers to improve the quality and services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The state school based health center program was eliminated in 2003 due to state general fund budget	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborations and partnerships will be utilized to assure access to SBHCs and to seek funding mecha	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Distribute information and resource materials to the Oregon School Based Health Center Network	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Percent of CSHN receiving care coordination services.				
1. Care coordination provided through CaCoon, Community Connections and tertiary clinics	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate and coordinate with state and local agencies for early intervention and referral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Advocate for expanded targeted case management to support eligible families	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Degree of participation in the collaborative effort of developing a statewide data system to support Oregon's early childhood program needs.				
1. Identify and engage stakeholders in meetings and joint application development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Convene public/private multi-agency workgroup to define CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Definitions of population and system design are determined through consensus process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Meeting times, location, and format are designed for stakeholder convenience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) Percent of providers in Oregon participating in continuing education addressing CSHN.				
1. Training curriculum developed and delivered through CaCoon and CCN programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collaborate on joint education programs with Dept of Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Outreach to community-based providers and develop training to meet local needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Develop and disseminate learning modules to professional disciplines working with cshcn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. OTHER PROGRAM ACTIVITIES

Womens Health: The Women's Health Program is leading the following activities:

- coordinates the Women's Health Network (WHN), a coalition to share the goal to achieve health and healing for women in Oregon through advocacy, education, research, and networking.
- Intimate Partner Violence (IPV) and sexual assault prevention activities is one of five issues identified in the Title V Needs Assessment as a local agency priority. Activities this year have included research reviews and identification and partnership with coalitions working on violence issues

throughout the state.

- /2004/ Women's Health is in the process of developing a statewide Rape Prevention Education Plan. This involves a great deal of stakeholder input and will be the guide for our Rape prevention activities when finished.

- Women's Health is developing a proposal and is investigating models to use in developing a Statewide women's health agenda. //2004//

Oral Health Promotion: The Oral Health Program is working on water fluoridation through the State Planning and Fluoridation System Development Initiative. In a partnership with OMAP and other partners, the Early Childhood Cavities Prevention Coalition has developed and conducted educational programs and packages designed to aid care givers in caries identification in infants and toddlers and to facilitate the treatment of young children in the general dentist's office. /2004/ The Early Childhood Cavity Prevention efforts have expanded to three pilot projects funded by Robert Wood Johnson "State Action for Oral Health." //2004//

/2005/ The Oral Health Summit, held in 2003, identified priorities for creating an oral public health system in Oregon. Collaborative workgroups have been convened around the priorities to inform the final Oral Health Plan, expected in 2004 and a follow-up summit in Winter 2004-05.//2005//

Nutrition and Physical Education Action Plan: In February 2000, OFH collaborated with OHD's Chronic Disease program in sponsoring "Creating A State of Health Summit" in spring, 2000. A state-level, multi-agency nutrition consultant partnership group has convened to take specific action in developing a plan of action for promoting nutrition and physical activity. /2004/ The multi-program work group in the Office of Family Health has created an action plan to integrate and implement elements of nutrition and physical activity into all family health programs and local direct services. //2004//

Medicaid and Children with Special Health Needs: CDRC has worked collaboratively with Medicaid on issues related to CSHCN. Issues to ensure that the health needs of CSHCN are met include the definition of CSHCN within Medicaid, a reporting mechanism to collect specific data on CSHCN enrolled in OHP Managed Care, clinical guidelines for CSHCN, review Medicaid specifications for defining medical necessity, review funding of Title V home visiting services and feasibility to expand the age covered to 21 years.

Adolescent Health: Mental health: /2004/ Adolescent mental health activities continue and are varied in nature including: developing new data on the mental health systems capacity in school through the Oregon SHEPS survey; collaborating with a managed mental health care network and local health departments in developing health education messages and content for an Early Psychosis Project focusing on screening, early identification and intervention for adolescents and young adults. Coordinated School Health: The Coordinated School Health (CSH) Program (Healthy Kids Learn Better), a partnership between public health and education, continues as a major program focus. Oregon completed it's state plan, Coordinated School Health: Blueprint for Action (2003) and was recipient of a five year Center for Disease Control and Prevention Coordinated School Health Implementation Grant. The major focus of activity now shifts to implementation of the goals, activities and Bold Steps outlined in the state plan associated with the vision/mission, eight CSH program components and risk areas as well as ongoing development of the Healthy Kids Learn Better Coalition, statewide advocacy coalition dedicated to helping advance the policy agenda. //2004//

/2001/ Statewide Regional workshops were presented by the MCH Data Coordinator (SSDI Coordinator), MCH Program Specialist, and the Child Health Consultant to introduce core public health functions to local health department staff, to improve leadership in public health nursing, use of data in community assessment planning and application of public health principles in selecting community health priorities. //2001//

/2003/ The Office of Family Health has instituted a consistent workshop program that will be given on the first Wednesday, titled "First Wednesdays" five months of the year, in five regions in the state,

covering five topics The five topics for the first year cover public health planning, community support for public health and family planning programs, adolescent health preventive screening, immunization nursing techniques, and healthcare response to domestic violence. //2003//

/2005/ The Office of Family Health completed it's second year of First Wednesday workshops, January to June 2004. The sessions were delivered via video conference to increase attendance, and to cut down on travel time for the trainers and those attending. This venue proved to be an overwhelming success and plans for the third year of First Wednesday trainings will be forthcoming. //2005//

F. TECHNICAL ASSISTANCE

Technical assistance needs in 2004 are intended to support general capacity issues, to strengthen the infrastructure needed to address Title V and State performance measures. The technical assistance plan covers assessment, planning, services design and delivery, and leadership activities.

1. To understand capacity of health system collaboration and service delivery, conduct a modified or focused CAST-5 assessment of local health and other services. This will provide information needed to strengthen the Early Child System of Services and Supports, and identify needs for local health departments in delivering services to MCH populations.
2. To continue work begun in improving quality and the increasing the numbers of the public health nursing workforce, provide support and resources for national speakers and workshops to train Oregon's nurses on new public health nursing standards for MCH practice.
3. To implement and increase the cultural competency of MCH and CSHCN programs, develop materials, training modules, tools, and other resources to integrate culturally and linguistically appropriate elements in all levels of program design, delivery and evaluation.
4. To strengthen and assure consistency across the state, develop implementation and evaluation plan for the Early Childhood Systems standards for health, education and social service program delivery.
5. To improve the collaboration and leadership of partners working together on issues, provide consultation, training, and coaching in collaborative leadership evaluation tools and analysis.
- 6-8. To improve the capacity of the State Title V Agency to address existing and emerging health issues facing Oregon's adolescents through capacity assessment, professional development and planning

V. BUDGET NARRATIVE

A. EXPENDITURES

The expenditures for FY 2002 are based on expenditures to date (May, 2003) for the period October 1, 2001 to September 30, 2002. The expenditures for the Federal/State Partnership include all Title V Block Grant Funds, state General Funds not used as match for other federal programs, and Other Funds, that are typically private foundation grants (not used for match for other federal programs).

The Federal/State Partnership expenditures include:

? Pregnant Women: Perinatal Program (Block Grant and General Funds)

? Children <1 year: Babies First! (General Funds) Newborn Screening (Other Funds - Fees), WIC - food rebates (Other funds), Farmers Market (General Funds)

? Children 1-22 years: Child and Adolescent Health, Injury Prevention, Dental Health and Oral Health, Teen Pregnancy Prevention, Suicide Prevention (mix of Block Grant and General Funds); School Based Health Centers (General Funds); Immunization (Block Grant portion); RWJ All Kids Count Connections and Smoke-Free Mothers and Babies.

? CSHCN: CaCoon, Community Connections (Title V Block Grant, Clinical Fees, mandated state general fund match)

The budget development for the FY 2002 Expenditures are compiled using the same state and local programs, with changes in grants as noted. The Block Grant Expenditures for FY 2002 have not closed at the time of preparation, so all figures are not final.

B. BUDGET

The budget for FY 2004 is based on the Legislative Approved Budget for the 2001-2003 biennium, including budget reductions from Special Legislative Sessions in 2002. At the time of submission, the 2003-05 Governor's Recommended Budget was not approved by the Legislature and was a continuation of the reduced 2001-05 budget. The budgeted amounts are calculated to be half of the legislative approved spending /limitation.. The Federal/State Partnership in FY 2004 includes all Title V Block Grant Funds, all state General Funds not used as match for other federal programs, and all Other Funds, typically private foundation grants, not used as match for other federal funds. The programs included in the Federal/State Partnership for FY 2004 include:

? Pregnant Women: Perinatal Program (Block Grant and General Funds)

? Children <1 year: Babies First! (General Funds) Newborn Screening (Other Funds - Fees)

? Children 1-22 years: Child and Adolescent Health, Injury Prevention, Oral Health, Teen Pregnancy Prevention, Family Planning (Block Grant) for 35% of total clients, representing all those less than 21 years.

? CSHCN: CaCoon, Community Connections.

The allocation for the pyramid level of services is distributed according to the use of funds at the state level or the county level. The chart ? Distribution of Funds for Form 5 in Appendix displays the distribution of the Federal-State Partnership to the pyramid service levels.

The Oregon Health Division meets its 30-30 minimum requirement by transferring 30% of the Oregon Block Grant appropriation to the CDRC for serving the children with special health care needs for FY 2004; no administrative or indirect is retained prior to transfer. The required Maintenance of Effort for Oregon is \$3,950,427 and the Health Division assures this minimum through funds generated at the state and local levels that benefit the maternal and child health population. The state meets the required three-for-four dollar match. Source of funds is state general funds and county local funds, including patient fees, local revenue, and fifty-percent of Medicaid reimbursement. The state funds are appropriated on a biennial basis by the Oregon Legislature and the state appropriates funds for local grants on an annual basis.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.