

# ***PUBLIC HEALTH***

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OHA's Public Health Division is part of the Oregon Health Authority. OHA was created in 2009 with a clear direction to improve the lifelong health of all Oregonians; increase the quality, reliability and availability of care for all Oregonians; and lower or contain the cost of care so it is affordable to everyone.

## ***Vision, Mission and Values***

The vision of the Public Health Division is lifelong health for all people in Oregon. The mission is to promote health and prevent the leading causes of death, disease and injury in Oregon.

Oregon needs a strong public health system to achieve better health outcomes at lower costs and to transform health care delivery. Public Health works with a system of federal, state, and local agencies, private organizations and other diverse partners to uphold the values of service excellence, leadership, integrity, health equity and partnership.

## ***Goals and Priorities***

Public Health has two main goals:

- 1. To make Oregon one of the healthiest states and**
- 2. To make Oregon's public health system into a national model of excellence.**

To become one of the healthiest states, Public Health will focus on:

- Reducing tobacco use**
- Reducing obesity/overweight**
- Suicide prevention**
- Reducing heart disease and stroke, and improving care**
- Family violence prevention**
- Improving community resilience to health emergencies**

To transform the Oregon public health system into a national model of excellence, Public Health will prioritize:

- **Pursuing public health accreditation**
- **Supporting the Coordinated Care Organizations**
- **Using health impact assessments**
- **Ensuring health in all policies**
- **Demonstrating excellence in epidemiology and surveillance**

### *History*

OHA's Public Health Divisions works to promote better health, address new and emerging threats such as the obesity epidemic, and transform our state system into a model of excellence.

Public Health was founded in 1903 when infectious disease outbreaks — smallpox, bubonic plague and tuberculosis — prompted the Legislature to create a State Board of Health, a public health laboratory, a vital statistics registry and county boards of health. Since then, public health has provided leadership and support to the state as it has faced a wide range of health challenges: the growing refugee populations in the 1970s; the AIDS epidemic of the 1980s; radiation exposure from Chernobyl in the Soviet Union; the nation's first bioterrorist event, with the salmonella-contaminated salad bar in The Dalles; the terrorist attacks of October 2001; the 2009-10 H1N1 pandemic; and the Japanese earthquake and nuclear power plant disaster in 2011.

New and old risks are a constant threat to the public's health in Oregon, including SARS, West Nile virus, pandemic flu, whooping cough, tuberculosis and E. coli. These risks increase the need for disease surveillance, public education and preparedness. There is also growing concern over the effects of global climate change on the public's health. An altered climate could bring severe storms, drought and changes in patterns of disease — all of which pose challenges for public health.

The greatest health challenges facing Oregonians today are not rare illnesses, but the increasing impact of chronic disease and injuries. More than 80 cents on every dollar spent on health care is spent on treating chronic diseases. Improvements in life expectancy and health experienced in the last decade have stalled. Tobacco, obesity, and suicide are the three leading causes of death in Oregon. Injury is the number one leading cause of death for children and young adults.

Public Health recently developed a strategic plan to address these challenges through community-based public health prevention and early intervention activities. One of the primary areas of focus for Public Health in the next decade will be to ensure that prevention is incorporated into a new sustainable and transformed model for health care delivery in the State.

In the coming biennium, Public Health will also continue to transform itself and the system by seeking national accreditation. Accreditation is part of the process to becoming a model of excellence and allows our communities to know that they are receiving high quality and equitable services.

### ***Investing in Better Health Outcomes***

Public health supports the goals of the Triple Aim and the transformation of the health care system in Oregon. Public health is about prevention at the community level. Public health works with communities, health care providers, schools, transportation, and businesses to create conditions that support better health.

Public health and prevention can be a valuable tool for saving health care costs, improving educational outcomes, and ensuring a ready workforce for private sector investment. 1.5 percent of OHA General Fund resources are invested in preventive and community-based public health services. In March 2012, Trust For America's Health rankings placed Oregon as 44<sup>th</sup> in the nation for state funding for public health, or the 6<sup>th</sup> lowest overall.

Efforts to prevent illness and promote healthy living can greatly reduce the burden and cost of disease. The Trust for America's Health and the Robert Wood Johnson Foundation released a report in 2008 showing that an investment of \$10 per person annually in proven, community-based public health programs could save the United States more than \$16 billion within five years—a \$5.60 return for every \$1 invested.

### ***State and Local Public Health Working Together***

As the state component of the public health system, Public Health oversees the system as a whole. Public Health serves three main functions: 1) assessment of the public's health in Oregon through data collection and investigations of disease; 2) the development of policies and programs that support improved health outcomes; and 3) the assurance that those policy and programs are achieving the intended purpose. Public Health Division operates some programs, directly. Other programs are delivered in collaboration with the 34 local health departments, which have the statutory authority to protect the public's health in their counties. Local health

departments play an important role in the delivery of many public health services, with the state providing technical support and oversight.

### ***The Future of Public Health***

In Oregon, the state and local public health system faces challenges:

- The rise chronic disease and injuries;
- The continued toll of tobacco and marketing of new tobacco products;
- The health impacts of climate change;
- The health effects of the economic downturn;
- Changes in health needs and service delivery systems as Oregon becomes more diverse;
- Large disease outbreaks and natural disasters;
- Changes in federal policy and funding;
- Aligning activities across the public health system and at the same time meeting the needs of very different communities around the state.

### ***Roadmap for the next biennium***

- Improve Oregon’s public health system;
- Support health system transformation;
- Qualify for national accreditation
- Enhance activities related to prevention of the leading preventable causes of death and disability:
  - Tobacco use, physical inactivity, poor nutrition
  - Injuries
  - Family violence
- Support health reform and early childhood efforts, and leverage them to improve population health.

The following chart outlines the Public Health Division’s major program areas and the overarching goals and priorities they support.

<b>PUBLIC HEALTH PROGRAM AREA</b>	<b>Goal 1: To make Oregon one of the healthiest states</b>	<b>Tobacco use</b>	<b>Obesity prevention</b>	<b>Suicide Prevention</b>	<b>Heart disease and stroke</b>	<b>Family violence prevention</b>	<b>Community resilience to emergencies</b>	<b>Goal 2: To make Oregon's public health system into a national model of excellence</b>	<b>Public health accreditation</b>	<b>Support CCOs</b>	<b>Health impact assessments</b>	<b>Health in all policies</b>	<b>Epidemiology and surveillance</b>
<b>Office of State Public Health Director</b>													
Public Health Officer	X	X	X	X	X	X	X	X	X	X	X	X	X
Health Security, Preparedness and Response Program	X						X	X	X	X			X
Emergency Medical Services	X						X	X	X	X			X
Performance Management Program	X							X	X	X			
Program Operations	X							X	X				
<b>Center for Health Protection</b>													
Health Care Regulation and Quality Improvement	X							X	X	X			
Medical Marijuana Program	X							X	X				
Research and Education Services	X		X					X	X	X	X	X	X
Drinking Water Services	X							X	X				X
Food, Pools, and Lodging Safety	X							X	X				X

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Radiation Protection Services	X							X	X				X
<b>Center for Prevention and Health Promotion</b>													
Nutrition and Health Screening (WIC)	X		X			X		X	X	X			
Health Promotion, Chronic Disease Prevention	X	X	X		X			X	X	X		X	X
Injury Prevention and Epidemiology	X			X		X		X	X	X			X
Adolescent Health and Genetics	X	X	X	X		X		X	X	X			X
Maternal and Child Health	X	X	X	X	X	X		X	X	X			X
Women's and Reproductive Health	X		X			X		X	X	X			
<b>Center for Public Health Practice</b>													
Community Liaison	X	X	X	X	X	X	X	X	X	X	X	X	X
Immunization	X						X	X	X	X			X
HIV/STD/TB	X							X	X	X			X
Health Statistics (Vital	X	X	X	X	X	X		X	X	X			X

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Records)													
Acute and Communicable Disease	X							X	X	X			X
Newborn Screening	X						X	X	X				X
Laboratory Compliance	X						X	X	X				
Virology/Immunology	X						X	X	X				X
Microbiology	X						X	X	X				X

***OFFICE OF THE STATE PUBLIC HEALTH DIRECTOR (OSPHD)***

***Key programs***

The Office of the State Public Health Director (OSPHD) provides policy and direction to the public health programs within the division, and ensures that the programs within and outside the division create an effective and coherent state public health system. This includes interactions with a range of state and local agencies and organizations, including those outside the health care community.

Policy, planning, performance management, and operations staff are responsible for providing division-wide administrative services to the division in areas including supporting the application for national accreditation, focusing on development of a divisional strategic plan, state level community health assessment, and state health improvement plan, contracting with the local health

departments, rulemaking, legislative support and coordination, risk management and safety, Web technology, volunteer coordination, business continuity planning, and video-conferencing.

The office also houses the Health Security, Preparedness and Response Program (HSPR), which ensures that every community and hospital has an improving level of preparedness for health and medical emergencies by supporting the development and testing of plans, training and collaboration between communities and with adjacent states. The Emergency Medical Services and Trauma Systems (EMS/TS) program certifies and regulates emergency medical care providers and emergency medical services agencies throughout Oregon. Together, these programs support the communities of Oregon and the state overall in detecting and responding to health emergencies.

Major sources of funding for OSPHD include:

- Centers for Disease Control and Prevention Public Health Preparedness and Response for Bioterrorism Grant;
- Health and Human Services Hospital Preparedness Grant;
- Federal Emergency Management Agency Chemical Stockpile Emergency Preparedness Program;
- Transfers from Medical Marijuana fees to support the Emergency Medical Services and Trauma program
- Centers for Disease Control and Prevention Preventive Health Block Grant; and

### ***Health Security, Preparedness and Response (HSPR)***

#### **Services provided**

The Health Security, Preparedness and Response program (HSPR) has two primary roles.

The program's first role is to develop emergency-ready state and local public health programs. The program assesses, implements and evaluates state and local public health capabilities to respond to emergencies arising from natural disasters, pandemic influenza, chemical releases, terrorism and other public health emergencies. These activities include interaction with federal, state, local and tribal governments, the private sector, and non-governmental organizations.

Funding for these activities comes through the Cooperative Agreement for Public Health Preparedness and Response for Bioterrorism from the Centers for Disease Control and Prevention (CDC).

The program's second role is to improve the ability of hospitals and health care systems to prepare for and respond to pandemics, bioterrorism, natural disasters, chemical releases and other public health emergencies.

Funding for these activities comes to the program through the Healthcare Preparedness Program from the Office of the Assistant Secretary for Preparedness and Response (ASPR).

### **Where service recipients are located**

Anyone, anywhere within Oregon's borders, including tribal lands — and potentially those in neighboring states — could be a recipient of services should a public health emergency event occur in the state or region. Within the Public Health Division, activities are located across program centers in:

- HSPR Operations, Planning, Liaison, Public Information, Information Technology and Administration programs (Office of the State Public Health Director);
- Preparedness Surveillance and Epidemiology Team (Center for Public Health Practice);
- Oregon State Public Health Laboratories (Center for Public Health Practice);
- Radiation Protection Services (Center for Health Protection);
- Emergency Medical Services and Trauma Systems (Office of the State Public Health Director)
- Strategic National Stockpile and Medical Countermeasures (Center for Public Health Practice).

Funding is provided to 36 counties and nine tribes to perform the activities that support the CDC grant guidance. Seven regional Hospital Preparedness Program Coalitions provide community based advising on healthcare preparedness, gaps and mitigation strategies. Over 130 health care partners receive ASPR funding to improve HPP capabilities to respond to an emergency.

### **Who receives services?**

Services are provided statewide through two mechanisms. For the CDC activities, HSPR contracts with 36 counties and nine tribes for the work activities that support the grant guidance. For the healthcare preparedness activities, HSPR contracts with over 130 healthcare system partners.

### **How services are delivered**

Services are provided by staff and employees of public health departments, hospitals, health care systems, non-governmental organizations and tribes.

### **Why these services are significant to Oregonians**

A fundamental responsibility of state government is to provide for the safety of the people of the state. This program integrates its activities with the emergency preparedness activities of other agencies and organizations, especially those of other emergency responders. The primary intent of the CDC cooperative agreement is to fund the creation, deployment and continuous improvement of a state system of public health emergency preparedness based on the fifteen CDC capabilities and using associated measures to monitor performance.

The goal of the Health Care preparedness agreement is to prepare hospitals and health care systems and response partners to deliver coordinated and effective medical care based on the eight HPP capabilities and using associated performance measures to ensure continuous quality improvement.

Oregon's hazards and vulnerabilities include risk of significant earthquake and tsunami, pandemic influenza/disease outbreaks, severe weather and flooding, chemical release, or terrorism.

### **Performance measures**

While the program does not have an OHA key performance measure, its state, local and tribal partnerships help further the OHA mission that people are healthy. This program reports to the federal government on an extensive list of measures and performance outcomes required by the grants.

## *Emergency Medical Services and Trauma Systems (EMS/TS)*

### **Services provided**

The EMS/TS provides technical assistance and support; encourages improvements in the emergency care of pediatric patients; and develops, supports and regulates systems that provide emergency care to victims of sudden illness or traumatic injury. The program:

- Ensures that agencies comply with training standards for staff and equipment in emergency vehicles;
- Ensures that emergency medical services systems are functioning efficiently and effectively;
- Performs background checks on all new and renewing applicants for certification as emergency medical providers;
- Sets standards, approves courses and instructors, and tests and certifies emergency medical technicians and first responders;
- Participates in the accreditations of Oregon colleges that offer emergency medical provider training;
- Participates in preparing for medical surge, mass casualty incidents, epidemics and catastrophic events;
- Inspects and licenses ambulances and ambulance services, including approximately 633 ambulances, 25 air ambulances and 135 emergency medical service agencies;
- Enforces professional standards for emergency medical technicians, first responders and ambulance services including issuing certifications to approximately 12,133 emergency medical technicians and first responders;
- Conducts investigations of the fitness of individuals to hold emergency medical technician (EMT) and first responder certification and of any allegations of wrongdoing (incompetence, violations of statutes or rules, etc.) by EMTs and first responders; enforces discipline when indicated;
- Provides recommendations in the development of policies, legislative actions, technological advances and resource sharing to the State Interoperability Executive Council, which coordinates and implements Oregon's public safety communications interoperability issues;
- Organizes and evaluates the system for emergency response by emergency medical providers and hospitals to traumatic injury and sudden illness; and

- Ensures trauma system standards are followed, resulting in a decrease in mortality. Maintains trauma registry data.

### **Where service recipients are located**

The EMS/TS program serves everyone in Oregon who experiences urgent illness or injury by supporting ambulance agencies located across the state.

### **Who receives services**

Direct recipients are Oregon's Emergency Medical Service providers, including EMTs and first responders, ambulance and non-transporting EMS agencies and trauma hospitals. In addition, the program indirectly serves thousands of Oregon residents and visitors by its efforts to ensure appropriate quality care is available for their urgent illness or injury.

### **How services are delivered**

EMS/TS staff provides information and assistance directly to providers. Services provided locally include education, consultation, technical assistance, and verification of compliance with state statutes and rules. EMS/TS staffs also provide oversight of EMS and trauma providers to ensure and document compliance with standards.

### **Why these services are significant to Oregonians**

The EMS/TS program furthers the OHA goal of keeping people safe by ensuring the effectiveness and coordination of the state's emergency response system for illness and injury. Many Oregonians, regardless of age, income or educational status, become patients of EMS and trauma providers. The quality and effectiveness of care is critical to successful outcomes in patient care.

### **Performance measures**

There are no OHA key performance measures applicable to this program. The EMS/TS program has one measure.

Measure: Continue implementation and evaluation of the Oregon Trauma System, the emergency medical services system. The program will evaluate the standards used to designate the levels of care available in these systems.

*Purpose:* This measure tracks the ability of the EMS/TS program to decrease the human and fiscal impact of morbidity and mortality due to trauma and sudden illness. The program uses data to develop and implement a quality improvement process for pre-hospital and in-hospital treatment of citizens and visitors who are victims of traumatic injury or sudden illness.

*How Oregon compares to other states:* Oregon was one of the first states in the nation to enact and implement an inclusive trauma system. The standards are updated regularly using the data gathered to reach the goal of decreased morbidity and mortality due to trauma injury. The funding available to provide the infrastructure has limited the ability to improve the trauma care system. A recent evaluation of the EMS system noted that Oregon lags behind in several areas, especially implementation of data systems, EMS system evaluation and quality improvement.

### **Proposed outcome measures**

Measure: Continue to implement and evaluate initial and continuing education for first responders and emergency medical technicians, course directors and coordinators.

*Purpose:* The purpose of this measure is to improve the consistency and availability of initial and continuing education for those seeking to become emergency medical technicians and first responders, as well as to enrich the available methods and practices of those responsible for education (i.e., course directors and coordinators).

*How Oregon compares to other states:* Oregon uses the U.S. Department of Transportation National Standard Curriculum for first responders, EMT-basics and paramedics. Staff have developed and implemented an Oregon-specific curriculum for EMT-intermediates to serve the rural and frontier regions of the state. Oregon is one of the nation's leaders in passing scores on the EMT-basic and paramedic written exams due largely to the stringent academic requirements of the EMS education model. The U.S. Department of Transportation National Standard Curriculum no longer will be available after 2012, so the EMS/TS program and the Oregon Medical Board's EMS Committee have established a workgroup to propose a plan for Oregon to follow when this change occurs.

Measure: Develop a statewide EMS patient encounter database that will document the care provided to critically ill and injured patients, support the provision of technical assistance and consultative services regarding quality improvement of emergency care, and encourage injury prevention activities.

*Purpose:* The purpose of this measure is to gather pertinent data on the care provided to EMS patients into one central registry system. Information will be analyzed to measure and improve the availability and quality of transportation and treatment of those citizens and visitors in need of emergent pre-hospital medical care. It can also be used to determine how to improve the quality and availability of EMS services. Through Public Health Emergency Preparedness funding, EMS purchased a data system and integrated it with the State Fire Marshal's Office in order to link information to the National Fire Incident Reporting System.

*How Oregon compares to other states:* Oregon is in the research and development stage of implementing the Oregon EMS patient encounter database. More than half of states have or are implementing EMS patient encounter databases. Washington and Idaho both established contracts for EMS patient encounter databases in 2007.

### **Quality and efficiency improvements**

Oregon's EMS/TS program implemented a new licensing and certification data system, License 2000 (L2K), with the goal of enabling streamlined processing of applications and licenses for agencies, ambulances and EMTs. This change has decreased processing time, although the cost and technical support available to implement the L2K system has slowed implementation.

Additionally, by increasing emphasis on providing technical and educational assistance to EMS agencies and pre-hospital providers, EMS/TS expects to improve overall compliance with standards and therefore improve quality of services by community providers. The EMS/TS is now conducting criminal background reviews on all initial and renewal applicants. While this will increase the resources needed to issue certifications, it will provide additional assurance that Oregon EMS providers are trustworthy.

### **Key budget drivers and issues**

The AY 2011-13 budget eliminated all EMS General Fund dollars and replaced them with revenue from the Oregon Medical Marijuana Program (OMMP). The OMMP funding, known within the program as EMS Operational Funds, was set at

a level to restore three full time equivalent positions in the Trauma Designation Program and for the mobile training unit. The mobile training unit positions are currently under recruitment and should be filled this quarter. The Trauma Designation Unit was transferred to the Health Care Regulation and Quality Improvement Program (HCRQI). The HCRQI section currently does surveys of hospitals and other healthcare facilities. It is believed that HCRQI is best positioned to help support the changes and improvements in the trauma designation process.

### ***Performance Management Program (PMP)***

#### **Services provided**

PMP's current focus is on supporting the division's application for national accreditation in fall 2012, and the development of pre-requisites for application: agency strategic plan, community health assessment and state health improvement plan. These activities include interaction with federal, state, local and tribal governments, the private sector, and non-governmental organizations. The program is also taking the lead on building a performance management system and reporting structure for the Division.

The program also supports quality improvement (QI) activities at the state and local health department levels, as well as exploring ways that the Public Health Division can better engage with non-traditional and emerging partners, as part of the divisional priority of health in all policies.

PMP currently funds 17 accreditation readiness projects in 19 local health departments. These agencies are focused on completing their pre-requisites for national accreditation, as well as conducting QI activities.

Funding for these activities comes to PMP through the Cooperative Agreement for Strengthening Public Health Infrastructure for Improved Health Outcomes from the Centers for Disease Control and Prevention (CDC).

#### **Where service recipients are located**

Public Health accreditation is a set of standards, a process to measure health department performance against those standards and recognize health departments who meet the standards. Accreditation is part of the process to becoming a model

of excellence and allows our communities to know that they are receiving high quality and equitable standards of care.

- 19 local health departments have received funds to support their accreditation preparation;
- Coalition for Local Health Officials received funding to support a local accreditation manager;
- Public Health Division staff and managers receive support in building QI competency and capacity, as well as support for cross-divisional improvement activities

### **Who receives services?**

Services are provided through grant funding for with 19 counties and direct State staff support for QI activities. Additionally, State staff directly supports the Public Health Division's accreditation preparation and QI activities that support the grant guidance.

### **How services are delivered**

Services are provided by staff and public health department employees.

### **Why these services are significant to Oregonians**

A fundamental responsibility of state government is to provide for the safety of the people of the state by ensuring they have access to efficient, effective and high quality services. National Public Health accreditation offers a standard framework for measuring agency performance at the State, local and Tribal levels. The primary intent of the CDC cooperative agreement is to support development of workforce skills and infrastructure development to support successful accreditation and the continual improvement of public health agencies.

### **Performance measures**

PMP does not have an OHA key performance measure. PMP has five grant performance measures that are reported to the CDC, as well as performance measures for the accreditation readiness grants awarded to local health departments.

## ***CENTER FOR HEALTH PROTECTION***

### ***Key programs***

The Center for Health Protection (CHP) promotes access to high-quality, safe health care by collaborating with a variety of public and private partners on policy development and program implementation. Through its regulatory activities, the center ensures that hospitals, other health care facilities and agencies, and hospital trauma systems meet established standards. The center also administers several special programs, including the Oregon Medical Marijuana Program (OMMP).

- Develops and helps set health policy and direction;
- Facilitates patient safety efforts and quality improvement activities across all provider types in Oregon;
- Regulates acute care facilities, community-based providers, and certain caregivers to ensure safe, high-quality health care;
- Regulates statewide programs and systems that provide emergency and definitive care to victims of sudden illness or traumatic injury; and
- Administers a registration system for patients, caregivers and growers eligible to participate in the Oregon Medical Marijuana Program.

CHP also houses programs that lead the state's effort to protect Oregonians from environmental health hazards in areas as diverse as drinking water, radiation, recreational waters, lead, food, occupational safety, indoor and outdoor air quality, consumer products, clandestine drug labs, and toxic chemical releases. These programs partner with local health departments, private businesses, state agencies, community groups, academic institutions, scientific and medical experts, and others to provide technical assistance, case management, public information, scientific expertise and regulatory oversight.

- The Research and Education Services section prevents or minimizes human health effects from hazardous working conditions, injuries and exposure to hazardous waste and other environmental dangers.
- The Food, Pool and Lodging Health and Safety section is home to Oregon's food-borne illness protection program and provides leadership for local health departments to ensure safety in Oregon's 23,000 full service and temporary restaurants, 3,400 public pools and 2,300 tourist accommodations.

- The Radiation Protection Services section protects both workers and the public from unnecessary and unhealthy radiation exposure, and provides Oregon’s sole public resource for radiation-related incidents, whether accidental or intentional.
- Drinking Water Services works to ensure safe drinking water by reducing the risk of waterborne disease and exposure to chemical contaminants in Oregon’s 3,600 public drinking water systems. The Health Care Regulatory & Quality Improvement Section (HCRQI) is statutorily mandated to regulate, inspect, license and/or provide Medicare/Medicaid Certification or some other form of approval for the following entities and individuals

The Oregon Medical Marijuana Program (OMMP) administers the registration program of the Oregon Medical Marijuana Act (OMMA). The act provides legal protection from state civil and criminal prosecution for qualified patients who comply with program requirements to grow and use marijuana as an alternative medicine.

CHP is currently undergoing a transition due to number of key changes. Organizational changes are underway to ensure the programs are able to effectively meet the statutory responsibilities and workload requirements of the sections.

Major funding sources for CHP include:

**Federal funds**

Environmental Protection Agency (EPA)

- Drinking water primacy
- Drinking Water State Revolving Loan Fund
- Water system operator certification
- Beach safety
- Indoor radon outreach and education
- Lead abatement training and certification
- Drinking water source protection coordination

Department of Health and Human Services Food and Drug Administration (FDA)

- Mammography facilities inspection
- Grants from DHHS Centers for Medicare and Medicaid Services.

## Centers for Disease Control and Prevention (CDC)

- Environmental Health Network
- Childhood Lead Poisoning
- Environmental Public Health Tracking Program
- Adult Blood Lead Epidemiology and Surveillance
- Worker Illness and Injury Prevention Program
- Hazardous Substances Emergency Event Surveillance
- Environmental Health Assessment Program
- Harmful Algal Blooms Surveillance
- Health Impact Assessment
- Unregulated Drinking Water Initiative
- Climate Change Initiative
- Brownfields Initiative

## Centers for Medicare & Medicaid Services

- Medicare

## **Fees and other funds**

- Fees through regulatory licensure, certifications and inspections;
- Other fees for OMMP cardholders;
- Drinking water operator certification;
- Drinking water system plan review;
- Cross connection/backflow certification;
- Water system surveys;
- Radioactive materials licensing;
- X-ray equipment licensing;
- Tanning devices registration;
- Food borne illness prevention program;
- Public swimming pool and spa program;
- Tourist accommodation program;
- Lead based paint certification program;
- Renovation, repair and painting program;
- Clandestine drug laboratory program; and

Pesticide analysis and response center

## ***Health Care Regulation and Quality Improvement (HCRQI)***

### **Services provided**

The Health Care Regulatory & Quality Improvement Section (HCRQI) is statutorily mandated to regulate, inspect, license and/or provide Medicare/Medicaid Certification or some other form of approval for the following entities and individuals:

- Ambulatory Surgical Centers
- Birthing Centers
- Comprehensive Outpatient Rehabilitation Facilities
- Dialysis Facilities
- Hemodialysis Technicians
- Home Health Agencies
- Hospice Agencies
- Hospitals
- In-Home Care Agencies
- Outpatient Physical and Speech Therapy Agencies
- Portable X-ray Providers
- Rural Health Clinics
- Special Inpatient Care Facilities
- Trauma Hospital Designations

The section is responsible for the entire licensure and certification processes for each of the above-listed individuals or entities. Other program areas include: Oregon Certificate of Need program and Facility Plans Review. HCRQI also provides licensing information to the public and other agencies.

### **Where service recipients are located**

Health care facilities and community-based providers throughout Oregon are served by HCRQI. The ultimate beneficiaries are Oregonians who are able to find access to safe, high-quality and patient-centered health care.

### **Who receives services**

Recipients of our services include the facilities and providers that are licensed, certified and/or registered by HCRQI. In addition, the Oregon Certificate of Need

and Facility Plans Review programs serve long-term care facilities regulated by DHS. Finally, the public receives services through our complaint program.

### **How services are delivered**

Regulatory services are provided by onsite visits for routine inspections and complaint investigations. Information and consultation also are provided by telephone and mail.

Other patient safety and quality improvement consultation services include working to certify the integrity of the Oregon Patient Safety Commission reporting system and partnering with other public and private entities to reduce medical errors and improve patient safety.

### **Why these services are significant to Oregonians**

Services ensure that health care facilities in Oregon meet all state and federal regulations, and thereby provide safe patient care in a safe patient environment.

### **Performance measures**

There are no OHA key performance measures applicable to this program. The program has one measure.

Measure: Annual state performance audit by federal grant partner (Medicare) includes onsite reviews by the federal government, including review of records and ongoing reviews of data submitted by the state to the mandatory federal data system, as well as staff interviews.

*Purpose:* The purpose of this measure is to ensure Oregon meets minimum grant requirements on productivity and quality.

*How Oregon compares to other states:* According to federal data, Oregon operates near the mean of other states in enforcement actions, number of surveys completed, and the percentage of complaint investigations substantiated.

### **Quality and efficiency improvements**

The section recently reorganized its management structure.

- The role of the section manager was redefined to coordinate regulatory and consultative activities for health facilities; improve oversight by surveying all providers at least once every three years; and proactively ensure compliance among acute care and community-based providers.
- A survey manager was assigned to oversee the routine regulatory work and oversee the trauma hospital designation process.
- The in-home care licensing program was substantially redesigned to handle the growing number of new applications and relicensing workload and the relatively high need for consultative services.

### **Key budget drivers and issues**

For FFY 2011, the program met minimum survey completion requirements levels for Medicare certification surveys. Additional fee funding through legislation passed in 2009 should support HCRQI operations to be able survey all facility and provider types at least once every three years.

The health care system continues to be receptive to reporting on medical errors, which bodes well for increased patient safety as hospitals, nursing facilities, pharmacies and other entities analyze and learn from those events.

As was stated earlier, the Trauma Designation Program was transferred to HCRQI with two positions: a Principal Executive Manager (PEM) D and Public Health Nurse. The Public Health Nurse position has been filled and the PEMD is currently under recruitment.

### **Key budget drivers and issues**

For FFY 2010, the program met minimum coverage levels for three of four workload tiers and initial certification surveys were provided only for a few provider types with approval from Medicare. Additional funding through legislation passed in 2010 should allow HCRQI to survey all facility and provider types at least once every three years.

The health care system continues to be receptive to reporting on medical errors, which bodes well for increased patient safety as hospitals, nursing facilities, pharmacies and other entities analyze and learn from those events.

As was stated earlier, the Trauma Designation Program was transferred to HCRQI with two positions: a Principal Executive Manager (PEM) D and Public Health

Nurse position. The Public Health Nurse position has been filled and the PEMD is currently under recruitment.

A vacant Client Care Surveyor position is currently under recruitment which will help resolve inspection delays in the program.

### ***Oregon Medical Marijuana Program (OMMP)***

#### **Services provided**

The Oregon Medical Marijuana Program (OMMP) administers the registration program of the Oregon Medical Marijuana Act (OMMA). The act provides legal protection from state civil and criminal prosecution for qualified patients who comply with program requirements to grow and use marijuana as an alternative medicine.

The OMMP:

- Conducts the administrative process of reviewing applications for the purpose of issuing a medical marijuana registry identification card;
- Maintains records in compliance with the Health Insurance Portability and Accountability Act (HIPAA);
- Provides administrative support to the Advisory Committee on Medical Marijuana, whose members are appointed by the OHA director;
- Promotes knowledge of the Oregon Medical Marijuana Act, program policies, and processes to patients, caregivers and growers by participating in advocate work group sessions;
- Promotes consistency and awareness concerning the OMMA by providing statewide training to law enforcement agencies; and
- Monitors the 24/7 electronic law enforcement verification data system to ensure OMMP cardholders receive the best protection against arrest and prosecution while providing law enforcement officers with real-time information.

#### **Where service recipients are located**

OMMP serves patients statewide. The number of patients registered with the program has increased from approximately 600 in May 2000 to more than 54,280 as of July 2012.

### **Who receives services**

A patient who has a qualifying debilitating medical condition, or a medical condition or treatment for a medical condition that produces specific side effects, may become a registered identification cardholder. These medical conditions and side effects are:

- Agitation due to Alzheimer's disease;
- Cancer;
- Glaucoma;
- HIV positive status;
- AIDS;
- Cachexia;
- Severe pain;
- Severe nausea
- Seizures; and
- Persistent muscle spasms.

Pain is the number one condition cited for participation in the program. However, the patient may have more than one of these conditions.

### **How services are delivered**

The program processes applications from Oregonians suffering from qualifying debilitating medical conditions when a physician advises that use of marijuana may provide a medical benefit.

### **Why these services are significant to Oregonians**

Since the inception of the program in 1998, the program has shown continued growth. To date, there are more than 57,386 patients in the program and more than 125,434 registered cardholders, including caregivers and growers. This includes patients, caregivers and persons responsible for a medical marijuana grow site. This program allows Oregonians suffering from debilitating medical conditions to use medical marijuana without fear of civil or criminal penalties.

### **Performance measures**

There are no OHA key performance measures applicable to this program. The OMMP has two measures.

Measure: Number of days to issue a registry identification card once an application is considered complete.

*Purpose:* Oregon statute requires that OHA shall approve or deny an application within 30 days of receipt of a completed application. A registry identification card shall be issued within five days of verification of the completed application.

Measure: Percentage of time verification system is available to authorized law enforcement personnel.

*Purpose:* Oregon statute requires a system by which authorized employees of state and local law enforcement agencies are able to verify at all times whether a person is either a lawful possessor of a registry identification card or the designated primary caregiver of a lawful possessor of a registry identification card, or an authorized marijuana grow site.

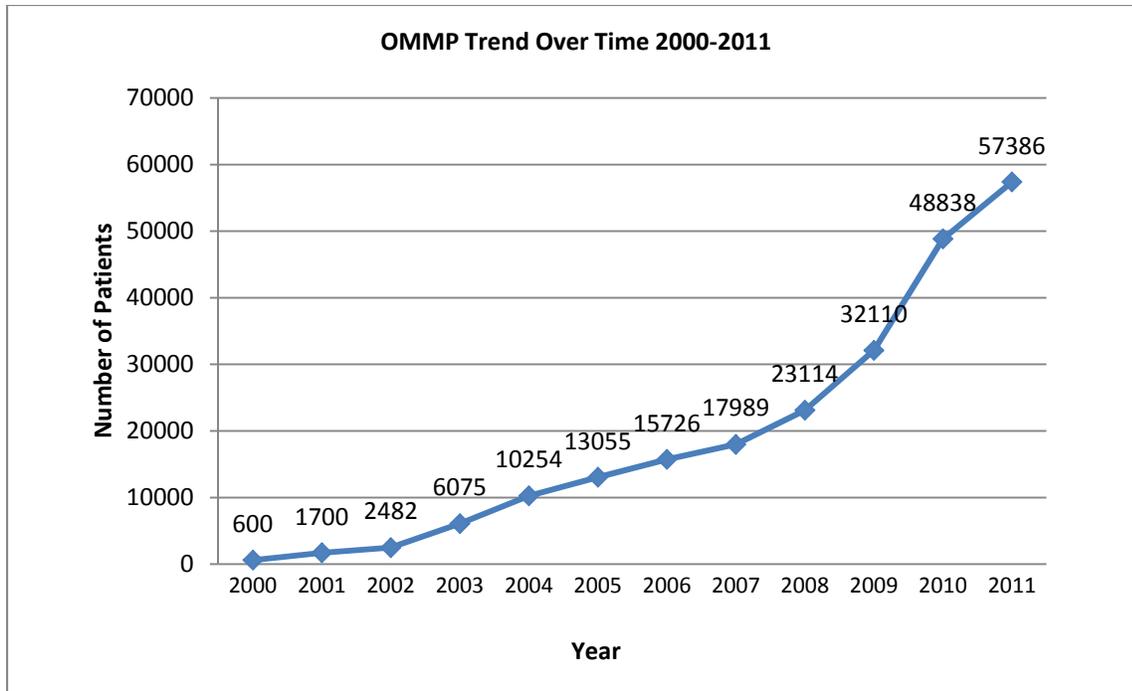
### **Quality and efficiency improvements**

The program actively pursues administrative streamlining processes in an effort to better serve patients while maintaining the highest level of confidentiality. Several states have requested information on Oregon's program to use as a model for their medical marijuana initiatives and registration systems.

The program currently is in the process of implementing a new database system for its registry. Replacing an outdated system developed for relatively small numbers of individuals, the new database system has assisted in maintaining consistent processing time, improve search capabilities for providing information to cardholders, and enhance report capabilities.

### **Key budget drivers and issues**

The program continues to see an increase in the number of applications received. The program is actively pursuing streamlining the application process and achieving efficiencies, requiring the investment of substantial resources.



***Research and Education Services (R&E)***

**Services provided**

Research and Education Services (R&E) is the state’s primary point of scientific and technical expertise on health concerns pertaining to the built and natural environments. The toxicologists, epidemiologists, program coordinators, research analysts, health educators and support staff in R&E identify and prevent occupational and environmental hazards, illnesses and injuries to Oregonians.

**Where service recipients are located**

Service recipients of all programs live in all areas of the state and include other state and local governments, tribes and businesses. Several programs, such as Oregon Beach Monitoring Program and Harmful Algal Bloom Surveillance, also provide an important service to out-of-state visitors.

R&E is home to many statewide programs located in five management groups: Healthy Communities, Healthy Workplaces, Environmental Public Health Tracking, Healthy Waters, and Healthy Homes and Schools.

## **Healthy Communities**

- The Environmental Health Assessment Program (EHAP) works with communities affected by hazardous waste sites.
- The Climate and Health Program works with communities, non-governmental organizations and other state and local agencies to understand the potential health impacts of climate change and prepare our communities to protect the health of Oregonians
- Health Impact Assessment (HIA) and Brownfields work with communities, non-governmental organizations and other state and local agencies to assess the possible individual and community health impacts of proposed developments and policies and make recommendations to improve the health of Oregonians.

## **Environmental Public Health Tracking**

- Environmental Public Health Tracking program (EPHT) presents environmental and human health data to help answer questions about the relationships between environmental and health.

## **Healthy Waters**

- Oregon Beach Monitoring Program (OBMP) monitors Oregon's coastal recreational waters for bacterial contamination.
- Harmful Algae Bloom Surveillance program (HABS) tracks the occurrence, type and duration of algae blooms on Oregon's waters, and any reported health effects in humans and animals.
- Healthy Waters staff also consult with partner programs and agencies to develop fish consumption advisories, inform drinking water provider's about chemicals of concern and review plans to safely use reclaimed wastewater.

## **Healthy Homes and Schools**

- Clandestine Drug Lab program (CDL) oversees the clean-up of properties used to manufacture illegal drugs.
- Pesticide Exposure Safety and Tracking program (PEST) investigates acute pesticide exposure cases and educates the public on ways to reduce the risk of exposure.

- Radon program provides education and outreach to Oregonians to decrease the incidence of radon induced lung cancer in the state.
- The Childhood Lead Poisoning Prevention Program works to prevent childhood lead poisoning through education and outreach.
- The Lead Paint Program works to protect Oregonians from lead-based paint exposure by regulating individuals that may disturb lead-based paint.

## **Healthy Workplaces**

- Hazardous Substances Incident Surveillance Program (HSIS) tracks, investigates, and reports on non-petroleum based releases of hazardous substances.
- Occupational Public Health Program (OPHP) monitors and reports on work place injuries and illnesses.
- Adult Blood Lead Epidemiology and Surveillance Program (ABLES) monitors, investigates and reports on lead exposures from all sources in adults.

## **Who receives services**

All Oregonians benefit from the scientific knowledge, skill and expertise of R&E staff. From Oregon's coastal waters to communities affected by harmful contaminants, staff work to help Oregonians understand the risks they may encounter from environmental hazards and the ways that individuals and communities can reduce or eliminate those risks.

R&E staff work with all levels of community including local, state and federal elected officials; citizens; academic scientists; private industry; environmental regulatory agencies; other state agencies; and environmental and community advocacy groups.

## **How services are delivered**

Most programs and services in R&E are data-driven. Data drives the investigation and assessment of the relationship between human health and the environment. Some data is collected directly. The Oregon Beach Monitoring Program (OBMP) collects samples from Oregon's coastal waters. Some programs are recipients of data from medical providers who submit mandatory reports on specific conditions such as the Child and Adult Lead Programs, which monitor and investigate

elevated blood lead levels, and the Pesticide Exposure Safety and Tracking program, which monitors, classifies and follows up on adults and children with acute pesticide exposures.

These programs use data collected by other local, state and federal agencies. The Hazardous Substances Incident Surveillance (HSIS) program collects data from a variety of sources that have a role in identifying, responding to and reporting on chemical spills and releases. The Environmental Health Assessment Program (EHAP) relies on data collected by state and federal environmental quality agencies to assess potential environmental exposures to communities. The Occupational Public Health Program (OPHP) uses data from a variety of public and private sources to determine the types, frequency, causes and severity of occupational injuries, illnesses and fatalities. The Harmful Algal Bloom Surveillance (HABS) program evaluates data collected by natural resource managers to determine whether to advise recreational water users and drinking water providers of a potential hazard. Finally, the Environmental Public Health Tracking (EPHT) program collects data from a variety of sources and makes it publicly available to scientists, communities, policymakers and the public, to better answer fundamental questions about the relationships between environmental exposures and health effects.

Several of R&E's programs place an emphasis on community education and outreach and have specific initiatives to work directly with communities impacted by environmental issues. R&E's technical staff of toxicologists, epidemiologists, industrial hygienists and health educators routinely responds to more than 200 calls each month on dozens of topics. In addition to providing individual services to Oregon residents, staff also provides technical assistance and expertise, impacting statewide environmental policy.

### **Why these services are significant to Oregonians**

These services protect the health of Oregon's recreational water users. Exposure to recreational waters contaminated with bacteria, viruses or other disease-causing organisms can result in a variety of illnesses in people using these waters. Clandestine Drug Lab services keep Oregon families safe by working to ensure that they aren't exposed to contamination due to the manufacturing of illegal drugs (primarily methamphetamine).

The services help communities and local and state agencies make informed decisions and policies to reduce or prevent exposures to harmful environmental contaminants. For example, the program has worked at sites with exposure concerns for harmful substances such as asbestos, arsenic, mercury and chlorinated solvents.

The EPHT network will strengthen Oregon's ability to track and prevent health problems linked to the environment. More specifically, communities may use data to learn about health status and the environmental influences on health in their area, scientists may use data for important research, and officials may use the data to set policy and promote activities that protect and improve health in communities.

The goal of the HSIS system is to prevent illness and death associated with acute releases of hazardous substances. The program also advocates for the substitution of less toxic/hazardous chemicals wherever possible.

The services help to identify the occupations and industries that have the highest risk of illness or injury in order to develop targeted intervention strategies to ensure that Oregon workers stay healthy and safe.

Schools, day care centers, businesses, tribes, local governments, natural resource organizations, state agencies, the medical community and the general public are served by R&E toxicologists. Services include consultation, risk assessment and expert advice regarding the potential health effects of exposure to environmental toxins or contamination.

### **Performance measures (R&E)**

Though there are no OHA key performance measures that focus directly on R&E programs, the section has performance measures that guide management actions.

### **Quality and efficiency improvements (R&E)**

Research and Education programs continually work with evaluation and facilitation experts to assess processes and products, especially as to how program activities meet the needs of partners and stakeholders.

### **Key budget drivers and issues**

The majority of R&E programs are federally funded, with the exception of CDL and the Lead-Based Paint program, which are partially funded by fees, and the PEST Program, which is funded by the Department of Agriculture. Most of these programs have been flat funded or have seen a significant decrease in federal funding during recent years. State funding to support environmental, occupational health and toxicological surveillance would be an important improvement.

### ***Food, Pool and Lodging Health and Safety Section (FPLHSS)***

#### **Services provided**

The Food, Pool and Lodging Health and Safety Section (FPLHSS) implements and maintains intervention and regulatory strategies to prevent illness and injury of the public as a result of patronizing Oregon's food, pool and lodging facilities.

The Foodborne Illness Prevention Program works in partnership with local public health authorities, the food service industry, businesses, academia, and state and federal agencies to reduce or eliminate known common causes of foodborne illness.

The Public Pool and Tourist Facility programs work in partnership with local public health authorities, industry and businesses to reduce or eliminate the risk of waterborne illness and accidental injury and death from public use of pools or tourist facilities.

#### **Where service recipients are located**

Services are provided through local health departments to businesses in the hospitality, recreation, and lodging industries statewide.

#### **Who receives services**

Licensing, inspection and outbreak investigation services are provided to nearly 22,000 food service establishments service and temporary restaurants, 3,400 public pools and 2,300 tourist accommodations benefiting Oregonians and visitors.

#### **How services are delivered**

Services are delivered by intergovernmental agreements with 36 local public health authorities. County environmental health staffs are the direct service providers.

## **Why these services are significant to Oregonians**

The foodborne illness prevention and public pool and tourist programs focus their efforts on the prevention of illness and accidental injury. The impacts of foodborne illness are significant.

- From January 2003 through December 2012, more than 1,835 people were sickened in 292 foodborne illness outbreaks in Oregon.
- A foodborne illness outbreak costs an establishment an average of \$75,000.
- When a restaurant is sued and the source of the illness is known, the expected award is \$82,333, according to the National Restaurant Association.
- The economic cost of foodborne illness, related to five pathogens (including E. coli 0157-H7 and salmonella), is estimated at \$6.9 billion annually.
- Foodborne illness in the United States costs between \$10 billion and \$83 billion annually, according to the US Food and Drug Administration.

## **Performance measures**

A significant key performance measure for this program is the reduction in the rate of occurrence of foodborne illness risk factors in restaurants. Often the ability to report these measures is hampered by a fractious licensing and inspection data system. However, the section is in the final phases of completing a rewrite of its integrated licensing and inspection data system. Upon completion of this project (scheduled for a July 1 2012 implementation) the section will have real time access to the inspection and risk factor data.

In addition, the program is responsible for customer satisfaction and time/activity reports. The section also documents inspection reports and conducts performance audits.

## **Quality and efficiency improvements**

In order to improve the quality of services provided to clients, program staff reviewed 11 counties (Umatilla, Harney, Union, Multnomah, Linn, Marion, Benton, Polk, Jackson, Morrow and Douglas). We accompanied 12 inspectors during their routine food service inspections and provided standardization training to 21 additional inspectors. Performance and trends are tracked to create a record of improvement in efforts to eliminate the known causes of foodborne illness.

## **Program Review Summary 2010**

Category	In Compliance
Licensing and fees	98%
Inspection standards	92%
Staffing and training	100%
Food handler training	75%
Record keeping and reporting	100%
Epidemiology and accident investigation and reporting	100%
Enforcement procedures	92%
Minimum standards, program review and penalties	97%

Statewide improvement is still needed in licensing and fees.

- License categories may not be added.
- Fees for additional inspections must be charged properly.

Improvement is also needed in inspection standards.

- Inspection rates for all licensed facilities should be 100 percent.
- Temporary restaurants must receive an inspection or a consultation.
- Problem and correction statements for violations noted on restaurant inspection reports must be clear and distinct.
- OAR references for violations must be included on all hand-written inspection reports.
- If a critical violation has been corrected, it must be clearly stated on the inspection report or a recheck inspection must be conducted.

In addition, ORS 183 must be adopted for administrative hearings and all field staff must comply with minimum requirements of the field review protocol.

**Field review summary 2010: Percent in compliance**

<b>CATEGORY</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>
Introduced self to the operator prior to starting the inspection and provided business card	100%	100%	100%	83%	100%	96%	100%	100%
Washed their hands at the beginning and as needed during the inspection	100%	100%	100%	100%	100%	100%	100%	100%
Checked each hand sink for accessibility, hot and cold water, soap and paper towels	100%	100%	100%	100%	100%	100%	100%	100%
Took temperatures on the cook line, hot holding units, and cold holding units	94%	97%	94%	67%	100%	91%	100%	100%
Asked open-ended questions and listened to the operator	98%	100%	100%	83%	100%	100%	100%	100%
Observed food handlers for handling of raw product, personal hygiene and hand washing	98%	95%	95%	83%	100%	100%	100%	100%
Asked operators about the availability, use, calibration, and cleaning of probe thermometers	96%	93%	93%	83%	95%	96%	86%	100%
Checked for refrigerator thermometers	100%	100%	100%	83%	100%	100%	100%	100%
Checked wipe cloths for sanitizer residual	100%	100%	100%	100%	100%	100%	100%	100%
Asked operators about their use of sanitizer test strips	94%	96%	96%	83%	95%	100%	100%	100%
Asked about cleaning procedures of in-place equipment	84%	100%	94%	83%	100%	100%	100%	100%

<b>CATEGORY</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>
Asked how and where food is prepared	100%	100%	100%	100%	100%	96%	100%	100%
Asked cooks how they know when an item is cooked to proper temperature	100%	100%	100%	83%	95%	96%	100%	100%
Asked cooks how they cool food items prepared in advance and in large quantities	100%	100%	100%	100%	95%	96%	86%	100%
Asked cooks about their procedures on how foods are reheated	100%	100%	100%	100%	95%	96%	86%	100%
Asked operators about their hand washing and ill employee policies	100%	96%	96%	67%	90%	100%	71%	93%
Asked about catering activities	94%	96%	100%	67%	95%	87%	100%	93%
Asked about menu changes	100%	96%	100%	100%	95%	100%	86%	93%
Verified that critical violations were corrected or an approved alternative was in place before leaving the facility	100%	96%	100%	100%	100%	96%	100%	100%
Asked questions regarding food handler cards	100%	96%	94%	67%	100%	96%	86%	100%

Specific areas for field staff improvement statewide are:

- Asking the person in charge if they have access to the Oregon Food Sanitation Rules;
- Asking about cleaning of probe thermometers between uses;
- Asking operators about raw vs. ready-to-eat wiping cloths;
- Asking open-ended questions about cooling and reheating practices;
- Asking about employee illness policies, cuts and burns, double hand-wash policy and glove use;
- Asking about changes in menu and exotic meats; and
- Verifying food handler certification of all food workers.

## **Key budget drivers and issues**

The costs of the state and local restaurant food safety programs (approximately \$5.4 million) are borne by the Oregon restaurant industry.

No General Fund money is used in the prevention of foodborne illness.

## ***Radiation Protection Services (RPS)***

### **Services provided**

Radiation Protection Services (RPS) protects the citizens and workers in Oregon from unnecessary radiation exposure. RPS is responsible for conducting a statewide radiological health and safety program in Oregon. The purpose of the program is to:

- Protect the general public and the environment from exposure to unnecessary radiation levels;
- Reduce the possibility of accidental radiation exposure;
- Train local and state emergency services personnel;
- Keep occupational radiation exposure as low as possible;
- Reduce unnecessary radiation exposure to workers and patients; and
- Revise rules to address health and safety issues related to rapidly emerging technologies in medicine, dentistry, academic, and industrial settings.

On-site facility inspections of registrants and licensees are conducted, samples are collected and analyzed, training is provided, and statutes and administrative rules are enforced.

### **Where service recipients are located**

Service recipients are located throughout Oregon. Approximately 13,800 sources of radiation are licensed or registered, and subsequently inspected in more than 4,400 service-provider facilities located in all Oregon counties (including hospitals, dental and medical clinics, radiation oncology clinics, tanning salons, high tech manufacturing firms, academic and research facilities, paper and pulp processing plants, foundries, and mineral extraction facilities).

### **Who receives services**

Services are provided to an estimated 3.6 million Oregonians through licensing and inspection programs. Radioactive materials are used in more than half of all Oregon counties in hospitals, universities, research labs and mills for wood and paper products. Tanning salons are also registered and inspected in all counties.

### **How services are delivered**

Each year, more than 1,400 statewide on-site safety inspections are facilities licensed to use sources of radiation. Approximately 4,500 X-ray machines, radioactive material, and tanning devices are tested each year to ensure they are being operated safely by authorized users and meet all state and federal requirements. Additionally, trained radiation safety personnel respond to approximately 85 incidents each year involving radiation sources.

### **Why these services are significant to Oregonians**

In approximately 20 percent of all X-ray inspections, radiation exposure has been reduced to lower levels to ensure worker and patient safety, while also preserving or improving diagnostic image quality. In addition, new radiation technology applications are being evaluated and approved by RPS to allow enhanced access to dental and medical care by underserved populations. Patient exposure reduction achieved by the X-ray program 2002-11

<b>Facility Type</b>	<b>Number of facilities inspected</b>	<b>Number of facilities with one or more machines requiring patient exposure reduction</b>	<b>Percent of facilities with one or more machines requiring patient exposure reduction</b>	<b>Average radiation exposure reduction to patient</b>
All	6185	1267	20%	10%
Dental	3189	1012	32%	10%
Other medical types	1308	236	18%	8%
Non-medical types	1688	19	1%	5%

Other medical types = Medical, Hospital, Chiropractor, Osteopath, Radiologist, PA/NP, State Hospital, State Medical, Naturopath  
Dental = Denturist, Dentist, State Dentist  
Non-medical types = academic, industrial and veterinary

Post 9/11 has resulted in increased federal safety and security standards. The radioactive materials licensing program has ensured that Oregon is compliant with these new standards and has improved the possession, transport, safety and security of radioactive materials for medical and non-medical purposes.

Emergency responses to incidents involving radiation sources can also result in joint investigations with Oregon OSHA that improve radiation safety operating conditions for workers and patients.

In response to the 2011 Japan radiation event, RPS has increased environmental monitoring activities to ensure that all Oregonians are safe and do not receive any higher than normal levels of radiation due to tsunami marine debris.

### **Performance measures**

Though there are no OHA key performance measures that focus directly on RPS programs, the section has performance measures that guide management actions.

### **Radioactive Material Licensing program**

The Radioactive Material Licensing program measures performance against a goal of completing all inspections within 25 percent past the specified inspection frequency. Current staffing levels and specialized US Nuclear Regulatory Commission (NRC) core training are critical to performing at this level. Evaluation of the performance of this goal is reviewed periodically by the NRC through Integrated Materials Performance Evaluation Program audits, which have been required as part of the division's federal/state agreement since 1965. Federal program audits are performed every four years.

### **X-ray machine testing and inspection program**

For the X-ray machine testing and inspection program, the RPS management team has set performance goals for completion of all required X-ray facility and machine testing inspections within the time frames specified in administrative rule. Current staffing levels and US FDA and other specialized training are critical to

performing at this level. Due to the current number of X-ray facilities, additional inspection staffing of 1-2 FTE is warranted for this year.

### **Tanning device testing and inspection program**

For the tanning device testing and inspection program, the management team has set performance goals for completion of all required tanning facility and FDA compliance inspections within a two- to three-year period. In 2011, the program inspected 219 facilities and eliminated a backlog of inspections. Current staffing should be adequate until 2015.

### **Quality and efficiency improvements**

X-ray facility inspections are usually scheduled with registrants to decrease business impact. Unannounced inspections are performed as needed to ensure compliance with state and federal standards. Turnaround time for licensing has been improved during the current biennium.

The tanning program enhancements include that all tanning operators are now required to receive formal training before operating tanning devices and new on-line operator training is available to meet this requirement. In addition, tanning beds are now required to be equipped with remote digital timers and a client skin-typing requirement has been instituted.

Enforcement has become more effective because of recent legislation that standardized enforcement authority and penalties for noncompliant licensees and registrants and gave the agency the authority to impose civil penalties. This enforcement tool promotes better regulatory standardization for the future and improves oversight of problematic facilities.

Developmental projects to improve RPS staff efficiencies and licensee service have been initiated, including electronic field reporting and licensing, and online registration payments.

### **Key budget drivers and issues**

Federal regulatory authority over licensed users of radioactive materials has significantly increased during the past decade improving security around materials that are critical for medical imaging, blood irradiation and research, as well as measurement of density of materials, process improvement and cancer therapy. Additional security concerns require more staff time and enforcement activities,

translating into additional program costs. Funding for this increased workload and enforcement activity was included as a fee increase request during the 2011 Legislative Session. Another adjustment will likely be required during the 2015 or 2017 Legislative Session in order to offset increased staffing and related enforcement activity costs.

Environmental health programs generally use fee-for-service funding by licensees who directly benefit from the licensed activities authorized under environmental health programs. Very limited General Fund support is provided in environmental health programs that may have traditionally received GF moneys in prior biennia to fund incident and emergency response activities. Cost of living allowance and workload increases are the primary drivers for requesting additional funding support from fee-based programs to improve public health and safety.

RPS program efficiencies have been affected through travel consolidation, office centralization, cross-training of inspection and compliance staff, and streamlined administrative procedures. Within the constraints of federal mandates, continued efforts to improve processes and streamline licensing and regulatory procedures are ongoing throughout environmental health programs.

### *Drinking Water Services (DWS)*

#### **Services provided**

Drinking Water Services (DWS) assures the safety of drinking water provided by all public water systems in Oregon. The program carries out the mission of the division by reducing the incidence and risk of waterborne disease and exposure of the public to hazardous substances potentially present in drinking water supplies. The program administers and enforces state and federal safe drinking water quality standards; prevents contamination of public drinking water systems by protecting drinking water sources; assures that public water systems meet standards for design, construction, and operation; inspects public water systems and assures that identified deficiencies are corrected; provides technical assistance to public water suppliers to solve operational problems; provides financial assistance to communities to construct safe drinking water infrastructure; and certifies and trains water system operators.

### **Where recipients are located**

More than 3,600 public water systems located throughout Oregon serve drinking water to more than 3.5 million Oregonians and our visitors. Individual public water systems vary widely in type, size and capacity, from very large water systems like the City of Portland to very small federal, state and private campgrounds.

### **Who receives services**

Services provided protect the health of more than 3.5 million Oregonians and visitors who consume water from public drinking water systems.

### **How services are delivered**

Drinking water oversight is delivered by a partnership with county public health departments, and partner state agencies. Staff are located in Portland, Pendleton, Springfield and Medford. Thirty-one county health departments and the Oregon Department of Agriculture deliver drinking water technical and regulatory services locally under contract. Services also are provided under interagency agreements with the Oregon Infrastructure Finance Authority for financing to communities for safe drinking water construction projects, and with the Oregon Department of Environmental Quality for protecting sources of drinking water.

### **Why these services are significant to Oregonians**

Safe drinking water matters to each of us every day. Safe drinking water is essential to our health, the economic development of our communities, and our quality of life.

### **Performance measures**

There are no OHA key performance measures for DWS. EPA has established two national performance measures that the program uses to report on progress: 1) the percentage of population served by community drinking water systems that meet health-based standards, and 2) the percentage of community drinking water systems that meet health-based standards. Recent performance on these two measures is shown below for Oregon and for EPA Region X (Oregon, Idaho, Washington, and Alaska):

**Percentage of population served by community drinking water systems that meet health-based standards**

<b>Year</b>	<b>Oregon</b>	<b>EPA Region X</b>
2005	94%	95%
2006	96%	95%
2007	90%	92%
2008	97%	96%
2009	98%	96%
2010	80%	92%
2011	95%	97%
2012 — EPA Regional Target		91%

<b>Percentage of community drinking water systems that meet health-based standards</b>		
<b>Year</b>	<b>Oregon</b>	<b>EPA Region X</b>
2005	85%	87%
2006	88%	87%
2007	85%	88%
2008	86%	88%
2009	89%	88%
2010	83%	90%
2011	83%	91%
2012 — EPA Regional Target		90%

These data show that Oregon nearly always meets the EPA goal for community population served with safe drinking water. The exception was 2010; the drop to 80% resulted entirely from the Thanksgiving 2009 weekend boil notice in the City of Portland that affected a large population. Oregon has more difficulty meeting the EPA goal for community systems that serve safe drinking water. This is because most instances of unsafe water occur in small water systems. Ninety percent of public water systems in Oregon serve fewer than 500 people. Small

water systems have difficulty meeting safe drinking water standards because providers lack technical, financial and managerial resources that larger water systems have. In 2010, a number of smaller water systems were unable to meet the new lower federal standard for arsenic implemented in recent years, and must now install arsenic removal treatment or develop a new source of drinking water.

### **Quality and efficiency improvements**

In order to improve services, improve results, and meet federal requirements for Primacy, Drinking Water Services implemented federal drinking water standards beginning in 1986. The program has also worked with local communities since then to improve public water systems and dramatically reduce the number of community acute waterborne disease outbreaks. The program has improved access to and use of water supplier drinking water testing data by posting these on a website for water suppliers, the consuming public, and state and local agency partners. The program also improves drinking water safety by training and certifying water system operators, by making loans to communities for safe drinking water construction projects, and by assessing and protecting sources of drinking water to prevent future contamination. Since the beginning of the federal Safe Drinking Water Revolving Fund in 1996, the program in partnership with the Oregon Infrastructure Financing Authority awarded over \$260 million to 130 Oregon communities for safe drinking water construction projects, including \$28 million in American Recovery and Reinvestment Act Funds. EPA recently recognized Oregon for its outstanding utilization rate of SRF funds.

In addition, the program improves the quality and efficiency of services through the use of Lean Management. Lean management has been used to streamline processes for entering and handling the large volume of water quality compliance data, reviewing water system construction plans, and inspecting water systems. Performance measures are in place to track the results of process changes made, keep new processes on track, and to collect data showing when additional changes are needed to meet desired outcomes. Lean management will continue to be used in the future to assure the most efficient use of limited resources within the program while improving the value of the products and services delivered to customers.

### **Key budget drivers and issues**

Changes in federal law require significant revisions to the way Oregon ensures safe drinking water protection. The number of federally regulated drinking water

contaminants rose from 23 in 1986 to 91 in 2006. A dozen federal regulatory initiatives are scheduled during the next two biennia, including several new regulated contaminants and significant revision of existing rules. In addition, EPA is developing a new national drinking water database system which states must implement in late 2014.

During 2011 legislative session, \$4 million in general funds were eliminated for the drinking water program. They were replaced with \$3 million in other funds transfer. At the same time, federal budget cuts reduced federal funds to the program by an additional \$1 million. Program staffing was reduced from 49 to 41 positions for the 2011-13 biennium. The following program services are impacted:

- Elimination of oversight and testing for 900 very small water systems required under state law,
- Reduced consultation and regulatory assistance to communities on how to meet safe drinking water standards,
- Reduced capacity to coordinate with other agencies on policies that may impact drinking water,
- Elimination of planning and exercising for emergency preparedness.

## ***CENTER FOR PREVENTION AND HEALTH PROMOTION***

### ***Key programs***

The Center for Prevention and Health Promotion (CP&HP) administers programs directed at improving the overall health of Oregon's men, women, children and families through preventive health programs, systems, policies, and services. Objectives and activities include collecting and sharing data to assess the health of Oregonians; developing and implementing public health policy based on these data; and ensuring the availability, quality and accessibility of health services, health promotion and health education. CP&HP also provides technical assistance, consultation and resources to local health departments and other community partners. The major program areas within CP&HP include Maternal and Child Health, Health Promotion and Chronic Disease Prevention, Injury and Violence Prevention, Oral Health, Adolescent Health and Genetics, Reproductive Health, and Nutrition and Health Screening (WIC).

Major funding sources for the Center for Prevention and Health Promotion include:

#### Federal Funding:

- Department of Agriculture:
  - Nutrition and Health Screening for Women, Infants and Children (WIC);
  - WIC and Senior Farmers Market Nutrition Programs;
- Department of Health and Human Services (DHHS)
  - DHHS Office of Population Affairs:
    - Family Planning Title X
  - DHHS Maternal and Child Health Bureau:
    - Title V Maternal and Child Health Block Grant;
    - Maternal and Infant Home Visiting
  - DHHS Center for Disease Control and Prevention (CDC)
    - Office of Public Health Genomics;
    - Breast and Cervical Cancer Program;
    - Diabetes, heart disease, stroke, asthma, tobacco prevention, arthritis risk reduction and management
    - Injury prevention and surveillance;
    - Oregon Violent Death Reporting System (OVDRS);
  - DHHS Center for Medicaid and Medicare Services:
    - Oregon ContraceptiveCare (family planning Medicaid waiver)
    - Medicaid administrative match in oral health;

### **State Funds:**

- State General Fund match requirement for Oregon Contraceptive Care;
- State General Fund and provider tax School-Based Health Center program.

### Other funds:

- Suicide prevention;
- Prescription drug monitoring;
- Tobacco Use Reduction Account (Ballot Measure 44);

### ***Injury and Violence Prevention Program (IVP)***

#### **Services provided**

The Injury and Violence Prevention (IVP) section monitors both unintentional and violent injuries in the state, and works to prevent them. Current areas of focus include prevention of injury and violence among adults and children, older adult falls, suicide, prescription drug overdose, child maltreatment, all-terrain vehicle injury data collection and evaluation, prescription drug monitoring, and injury and violence surveillance and epidemiology. Injury and Violence Prevention provides information to the public, the media and policymakers, partners with local non-governmental organizations and government agencies to implement prevention programs, provides training and technical assistance to local communities to support prevention, and works with an Injury Community Planning Workgroup to evaluate progress, leverage resources, and develop new program direction.

#### **Where service recipients are located**

Services are provided to all Oregonians statewide. SAFE KIDS coalitions implement booster seat and car safety seat programs, poisoning prevention and fall prevention programs throughout the state.

The electronic Prescription Drug Monitoring Program (PDMP) provides data on controlled substance prescriptions dispensed to patients. Prescribers can use patient reports to help them assess and provide care for patients.

Data collection, analysis and dissemination guide the efforts of community level coalitions throughout the state. Police departments, hospitals, emergency departments and medical examiners in all counties work with program staff to maintain data systems. Evaluation activities conducted with partners throughout the state monitor the impact of all-terrain vehicle rider education training, suicide

prevention activities and community uptake of prescription drug monitoring data, and uptake of senior falls prevention.

Youth suicide prevention activities are being implemented in high schools in 22 counties, and intervention skills training is being implemented statewide.

Older adult fall prevention is being implemented in eight counties through community centers, senior centers, faith communities, senior housing and hospitals. Health care systems are developing pilot projects to implement four older adult fall prevention interventions. Providence Health Systems, Legacy Health Systems, Kaiser Health Systems, and the Portland Veteran's Administration are implementing four older adult fall prevention interventions in various lines of their businesses.

The program utilizes federal funding to support statewide infrastructure for the older adult fall prevention program. These funds support program materials, technical support and training, evaluation, and long-term financial sustainability efforts. In order for the program to reach large numbers of older Oregonians, benefit reimbursement will be necessary. The program is currently working with health care systems to adopt and integrate fall prevention for seniors into their service package for seniors.

### **Who receives services**

Services are provided to all communities throughout Oregon.

### **How services are delivered**

Services are provided both from the program's central staff as well as through partnerships with local health departments, schools, numerous community-based organizations and governmental agencies.

### **Why these services are significant to Oregonians**

Injury is the second-leading cause of death among Oregonians aged 1 to 44 years and is among the leading causes of hospitalization. Injury affects everyone, regardless of age, sex, or race. More than 2,100 Oregonians die each year as the result of injury; more than 1,400 of these are unintentional injuries. Injuries are preventable, and a public health approach to injury prevention is a process that involves identifying and defining the problem, identifying risk and protective

factors, developing and testing prevention strategies, and assuring widespread adoption of effective strategies.

Four injury outcomes have been identified for priority prevention status:

- Suicide;
- Falls among older adults;
- Unintentional drug overdoses; and
- Motor vehicle traffic injuries.

Priority areas were identified based on the overall impact of these injuries including:

- Number of deaths; premature deaths;
- Number of hospitalizations;
- Trends over time; and
- Potential for reducing the impact through the application of evidence-based prevention efforts.

### **Performance measures**

Injury Prevention and Epidemiology has one OHA key performance measure:

KPM 17: Teen suicide

*Purpose:* The agency strategy is to encourage local organizations and agencies to integrate best practices and evidence-based practices in suicide prevention into existing infrastructure in schools, non-profit organizations and agencies. In addition, the agency is leveraging resources from federal agencies and foundations to support building projects. Projects include public health surveillance, evaluating projects, and disseminating results broadly. The projects also include development of interventions that will reduce risk factors and increase protective factors identified by data in individuals, families, communities and on the societal level. Reducing suicides among youth will require implementation of multiple strategies over time. Teen suicide prevention approaches include:

- Increasing community readiness to adopt suicide prevention strategies.
- Improving screening and assessment that can identify youth at risk in all settings where youth are typically assessed.
- Providing training for professionals in health, behavioral health and social services for youth.

- Teaching young people to take suicide talk seriously and report it to an adult.
- Establishing procedures and policies in schools.
- Reducing the stigma associated with behavioral health care and with suicide.

<b>Teen Suicide:</b> the rate of suicide among youth ages 10-24 years, per 100,000										
<b>DATA</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
<b>Actual</b>	7.6	8.4	8.9	8.2	9.8	7.9	8.7	7.9	7.2	
<b>Target</b>	10.4	10.3	10.2	10.1	9.9	9.8	8.5	8.4	8.4	8.4

*How Oregon compares to other states:* Oregon’s suicide rates are consistently higher than the national rate.

**Quality and efficiency improvements**

The National Violent Death Reporting System is a system the CDC put in place to improve understanding of the causes of violent death in the US. It uses data from death certificates, the Medical Examiner's Office, and the state crime lab to lead to a new understanding of violent death that was not previously possible. Oregon is one of only 18 states that have been funded for this innovative program. Data from this program is used by the state police in training. Recently researchers at the Portland Veteran’s Administration used data to publish a study on health care use among veterans who died by suicide in Oregon.

An alarming trend of prescription drug overdose, misuse and diversion has contributed to a yearly increase in the number of prescription drug related deaths in Oregon in the past five years. In light of this trend, Senate Bill 355 was passed by the Oregon Legislature in 2009 to develop an electronic Prescription Drug Monitoring Program (PDMP) that helps health care providers better treat their patients and prevent some of the problems associated with controlled substances. The system provides round-the-clock electronic access to patient-level data on medications that have been dispensed to patients by licensed pharmacies for authenticated and certified users who are licensed to prescribe and dispense schedule II, III, and IV drugs. Under limited circumstances staff also provides data for consumers, law enforcement, licensing boards and researchers.

The purposes of the Prescription Drug Monitoring Program are to:

- Provide authenticated and certified users round-the-clock electronic access to patient-level data on medications that have been dispensed to the patient by licensed dispensers;
- Monitor drugs that are found to be highly overused;
- Provide information about appropriate methods of disposal;
- Implement programs to assist prescribers to screen and identify patients who might have a drug abuse problem and refer them to appropriate treatment resources;
- Reduce diversion of prescription drugs by providing information to prescribers who are licensed to write prescriptions; and
- Use data to inform, develop and implement population-based prevention approaches to reduce prescription drug poisoning — such as public information campaigns about use of specific medications.

Senate Bill 101 directed the Oregon State Parks and Recreation Department (OSPRD) to establish an all-terrain vehicle (ATV) rider training program in 2009. The department contracted with the program to create a surveillance system through sentinel hospitals to track injuries caused by ATV crashes and to learn how they can be prevented. The system also will be used to contribute information for evaluating the ATV rider education program. Program staff are collecting data that will provide an ATV advisory committee information needed for evaluation and to inform policy.

The Substance Abuse and Mental Health Services Administration funded IVP to implement a new grant to reduce suicide among youth and young adults aged 15-24. The focus of this grant program is to develop critical expertise on the local level in 22 counties during a three year period to create a sustainable effort. High schools in these counties are implementing comprehensive programs and the Veterans Administration suicide prevention program is partnering with these local efforts to target young veterans returning from Iraq and Afghanistan.

Reducing suicide and family violence is one of the priority areas for the division for the 2013-15 biennium. Suicide prevention key activities planned include increasing prevention through Nurse-Family Partnerships and evidence-based parenting programs, increasing classroom programs in elementary and middle schools, partnering with schools to implement a coordinated and comprehensive school health approach that supports the social, emotional and behavioral health of

students in school improvement planning documents, promote and strengthen use of positive youth development and youth engagement policies and practices, and develop a suicide prevention plan that spans all ages.

Family violence prevention key activities planned include expanding the Nurse Family Partnership home visiting program to increase safe and nurturing family relationships and increase opportunities for children to enter kindergarten ready to learn, implementing Positive Youth Development strategies that could help guide effective programs and policies that prevent violence among youth and learn skills for creating safe and nurturing families, assure that family violence primary and secondary prevention strategies are included in Oregon health transformation and Coordinated Care Organizations such as evidence-based screening, counseling, referral, and care coordination, develop a public health communication plan to increase public awareness about family violence, and strengthen the domestic violence prevention advocates program currently placed in the state Department of Human Services offices by linking to public health primary and secondary prevention services.

### **Key budget drivers and issues**

Because this program depends heavily on federal funding, changes in federal appropriations for injury prevention programs and the failure of federal funding to keep up with inflation have a large impact on services.

### ***Maternal and Child Health Section (MCH)***

The Maternal and Child Health (MCH) Section develops, implements and evaluates public health programs and policy that address health priorities of Oregon's pregnant women, infants and children. This section promotes and maintains the health, safety, well-being and appropriate development of children and their families, strengthening the early childhood system. The team of public health nurses, health educators and policy analysts establishes statewide service delivery standards and training for local health departments, state agencies and a broad range of partners and providers, and assists with policy development and technical issues. Epidemiologists, research analysts, program evaluators and informatics staff support comprehensive data systems for surveillance, assessment, and program and systems evaluation at the state and local level.

Recent work includes broader, cross-agency and statewide policy and program initiatives that address system improvements across populations. Women's and maternal health includes preconception and perinatal health (prenatal and postpartum) health. Domestic and sexual violence prevention is a Title V priority. MCH holds the State Rape Prevention and Education grant. MCH facilitated the HB 2666 Maternal Mental Health workgroup that provided eight recommendations for a statewide response to the issue of maternal mental health during and after pregnancy. Recent fulfillment of HB 2235 resulted in a website for providers and patients on maternal mental health. A social marketing radionovella, *Amor y Salud*, promoted young Latinas maintain culturally protective health behaviors pre-conceptually for subsequent improved birth outcomes. The Oregon MothersCare program strives to enroll eligible pregnant women on OHP early in pregnancy and link them to prenatal and dental care and social services during this critical period.

Infant and child health is addressed through several programs. The Early Hearing Detection and Intervention (EHDI) program ensures all children are screened and referred for hearing loss. The Child Health Equity Outreach Program enrolls eligible children with parents of mixed documentation on OHP. The LAUNCH program — Linking Actions for Unmet Needs in Children's Health — supports early childhood systems improvements at the state and local level in a demonstration project implementing evidence-based practices. The Early Childhood Comprehensive Systems grant has been instrumental in supporting the development of the Early Learning Council. Partnerships with the pediatric community resulted in improved developmental screening by providers (ABCD III) and continuous practice improvements (OPIP). MCH provides health consultation for child care providers and partners. In addition, MCH has initiatives in reducing childhood obesity, injury prevention and oral health. MCH surveillance is addressed through the Pregnancy Assessment and Monitoring System (PRAMS, PRAMS 2) and the Birth Anomalies Registry (BAR).

Public Health Home visiting has been a large initiative for the section. In partnership with the Oregon Commission on Children and Families, the Oregon Department of Education and the Department of Human Services, the program created the Statewide Home Visiting Steering Committee (HVSC) in July 2010. The committee, along with a larger stakeholders group, have develop a mission, vision, guiding principles, and a system map that integrates all home visiting programs in Oregon. The system will provide more effective and efficient services to women, children and families through coordination and a continuum of care. In addition, the the program secured Affordable Care Act (ACA) Maternal, Infant,

and Early Childhood Home Visiting (MIECHV) formula and competitive grants to conduct a statewide home visiting needs assessment and expand and establish evidence-based home visiting models in 8 counties. These grants also support the development of a home visiting data system, evaluation and rollout of the system at the local level.

### **Services provided**

Public Health Home Visiting is a core program within Oregon's home visiting system that provides case management, consultations, health and development assessments, and education to at-risk and high-risk families with health problems and other concerns. Public health nurses work with a variety of community and medical resources to ensure good health outcomes.

The Maternity Case Management (MCM) program provides assessments, interventions and referrals during home visits for pregnant women and teens with medical or social risk factors. These visits expand traditional prenatal services with interventions to improve pregnancy outcomes and reduce the incidence of low birth weight infants and prematurity by targeting risk factors such as tobacco and substance use, intimate partner violence, and maternal mental health. The program promotes adequate prenatal care and provides nutrition counseling for pregnant women with nutritional risk factors

The Babies First! (BF!) program identifies infants and children up to age 5 who have medical and social risk factors for chronic health conditions and developmental delays. Public health nurses work with the families to conduct assessments and screening in the home. Growth, physical and emotional health, oral health status, and immunization status all are monitored. Standardized screening for vision and hearing, developmental status, and maternal-infant interaction is undertaken and family assessments are made.

### **Where service recipients are located**

Maternity Case Management services are provided by county health departments, managed care organizations, and private providers through the Oregon Health Plan. Babies First! services are provided by county health departments.

Home Visiting Programs  
July 2009 — June 2010

	<b>MCM Clients</b>	<b>Babies First! Clients</b>
<b>State Totals</b>	<b>3,656</b>	<b>9,311</b>

**Who receives services**

**Maternity Case Management**

In FY 2009-10, maternity case management served 3,700 pregnant women during more than 16,000 visits. More than 70 percent were women with Oregon Health Plan coverage and 10.6 percent with CAWEM coverage.

**Babies First!**

In FY 2009-10 BF! served approximately 9,300 children from birth to age 5 with health and social histories that place the child at-risk for health and development problems. Seventy-two percent of Babies First! clients present with multiple risk factors at initial contact.

**Home Visiting Program Initial Risk Factors**

**July 2009 — June 2010**

<b>Babies First!</b>	<b>% of Total</b>
Parent with limited resources	58%
Concern of parent/provider	56%
Prematurity	13%
At-risk caregiver	12%
Parental alcohol/substance abuse	7%

**How services are delivered**

**Maternity Case Management**

These services are provided through face-to-face contact in the client’s home by county health department public health nurses during the prenatal period and up to two months postpartum.

## **Babies First!**

These services are provided during home visits by public health nurses. They include standardized health and development assessments for the child's growth and nutritional status, developmental screening, hearing, vision and dental screening, growth and immunization monitoring, assessments of parent-child interaction, and education, information and referrals for the parents.

## **Why these services are significant to Oregonians**

Families served by public health home visiting programs benefit from long-term health, social, economic and emotional support early in pregnancy and throughout the early stages of life. Research repeatedly shows that early identification and intervention for chronic conditions will improve the health, functioning and mental health of both the child and parent. These individual family improvements strengthen early learning opportunities and reduce negative long-term societal impacts such as juvenile delinquency. These services are a key part of a greater system of home visiting programs that serve families based on their needs.

## **Performance measures**

KPM 20 (2011-13): Prenatal care for women in the first trimester

*Purpose:* Early prenatal care is an important strategy for preventing early childhood disease and conditions and promoting healthy growth and development. Low-income infants are statistically at higher risk for poor health outcomes. The indicator of early prenatal care reflects how well the health and social systems perform in reaching low-income pregnant women to promote healthy babies.

All women should receive prenatal care in the first four months of pregnancy; our goal is that 88.7 percent of women get this care. However, only 79.9 percent of low-income women in Oregon received prenatal care during the first four months of pregnancy. Trends in early prenatal care reflect challenges qualifying for health care programs, including reductions in Oregon Health Plan (OHP) eligibility. Other barriers include requiring low-income women covered by Medicaid to re-apply to receive OHP-Plus benefits when their pregnancy is confirmed; not knowing pregnancy is an OHP qualifying condition; lack of presumptive eligibility for Medicaid in Oregon; lengthy Medicaid applications; and required asset testing of pregnant women to process OHP applications. The Oregon MothersCare program attempts to address these barriers. To monitor income disparities for access to early prenatal care, a proxy for low-income and non-low income women

is the number of women reporting that they were enrolled in the Supplemental Nutrition Program (WIC) for one or more months during pregnancy, the best available data for estimating low-income status in pregnancy.

*How Oregon compares to other states:* Overall, Oregon ranks in the middle nationally for early prenatal care among all births and Medicaid births. Oregon ranks above Washington and below Idaho. California continues to lead, remaining in the top 10 nationally.

<b>KPM 20: EARLY PRENATAL CARE:</b> The percentage of low-income women who initiated prenatal care in the first 3 months of pregnancy compared to higher income women: a) WIC enrolled, b) non-WIC enrolled:										
ACTUAL										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
<b>WIC enrolled</b>	74.0 %	73.6 %	71.8%	73.0 %	71.1 %	69.7 %	60.5 %	63.3 %		
<b>non-WIC enrolled</b>	86.5 %	86.1 %	86.3%	86.3 %	84.7 %	83.8 %	78.6 %	78.5 %		
TARGET										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
<b>WIC enrolled</b>						70.0 %	71.0 %	73.0 %	74.0 %	76.0%
<b>non-WIC enrolled</b>						84.0 %	85.0 %	86.0 %	86.0 %	87.0%

KPM 21: Tobacco use among a) adults, b) youth, c) pregnant women

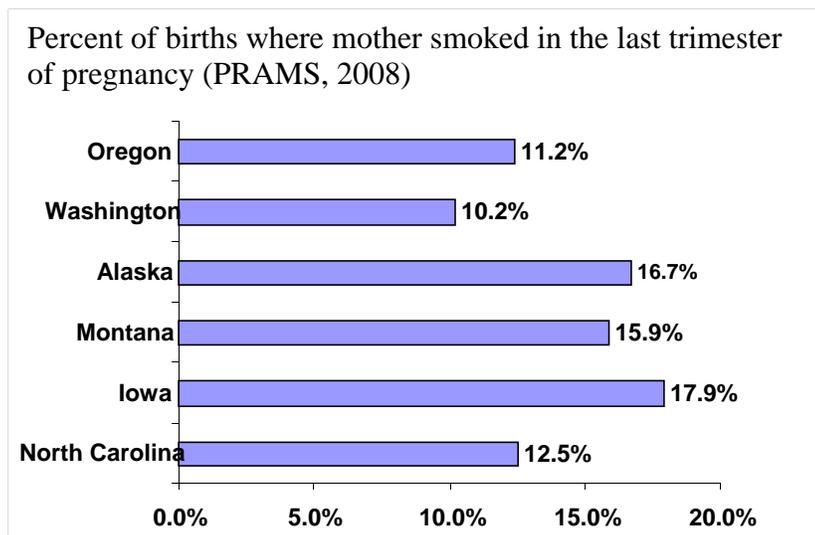
*Purpose:* A woman’s use of tobacco during pregnancy is associated with serious and, at times, fatal health problems for the child, ranging from low birth weight and premature births to stillbirth and Sudden Infant Death Syndrome. Smoking cessation assessment and counseling for pregnant women and parents are delivered through Maternity Case Management and Babies First! programs, as well as private health providers.

TOBACCO USE											
Tobacco use among: a) adults <sup>1</sup> , b) youth <sup>2</sup> , c) pregnant women <sup>3</sup>											
		2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
<b>Actual</b>	<b>Adult</b>	21.4 %	21.1 %	20.1 %	18.8 %	18.6 %	17.0 %	15.7 %	17.5 %		
<b>Target</b>	<b>Adult</b>	20.2 %	19.8 %	19.4 %	19.0 %	18.6 %	18.2 %	17.6 %	17.4 %	15.0 %	15.0 %
<b>Actual</b>	<b>Youth</b>	10.7 %	10.5 %	8.1% %	9.8% %	8.7% %	9.0% %	8.6% %	9.9% %		
<b>Target</b>	<b>Youth</b>	12.2 %	11.8 %	11.4 %	11.0 %	10.0 %	10.0 %	9.0% %	9.0% %	8.0% %	7.5% %
<b>Actual</b>	<b>PW</b>	12.1 %	12.1 %	13.7 %	13.7 %	10.7 %	10.4 %	11.1 %			
<b>Target</b>	<b>PW</b>	13.2 %	13.8 %	13.4 %	12.0 %	11.4 %	10.8 %	10.8 %	10.8 %	10.8 %	10.8 %

1. BRFSS data, Age-adjusted, 18+
2. Oregon Healthy Teens, 8<sup>th</sup> Grade Students
3. PRAMS data, Tobacco use in third trimester

*How Oregon compares to other states:* Oregon ranks in the middle of states in terms of smoking in the last trimester of pregnancy, but trails Washington in reducing smoking rates.

Percent of births where mother smoked in the last trimester of pregnancy:



## **Quality and efficiency improvements**

The Maternal and Child Health section, along with state agency partners are providing leadership and direction in the development of Oregon’s home visiting system. The partnerships at the state and local levels, as well as the current economic context, have galvanized a new commitment and approach to home visiting that will benefit families and align with the early childhood goals stated in the Governor’s Early Learning initiative.

## **Health disparities**

The Maternal and Child Health section provides several programs that reduce disparities for Oregon women and children. The section provides federal MCH block grant funds to five tribal government health clinics for maternal and child health services identified by tribal members. Federal grant funding provides a program allowing enrollment of resident children of parents with mixed documentation into the Healthy Kids health insurance program. Federal MCH block grant funds support the Oregon MothersCare program, which provides Oregon Health Plan application support for women with cultural and geographic disparities. This section assures that education and outreach materials are available in all languages served by the local MCH health services.

## **Public Health Home Visiting programs**

Race and ethnicity data indicate the home visiting programs are reaching out to minority populations who experience health disparities.

Client Race/Ethnicity  
July 2009 — June 2010

<b>Race</b>	<b>MCM</b>	<b>Babies First!</b>	<b>State</b>
White	75%	74%	90%
American Indian/Alaska Native	3%	3%	1.6%
Black/African American	5%	8%	2%
Asian	3%	4%	4%
Hawaiian/Pacific Islander	1%	1%	
Multiple Races	1%	3%	2.4%
Unknown	8%	8%	
Ethnicity			

Non-Hispanic	86%	86%	
Hispanic	12%	12%	11%
Unknown	2%	2%	

**Key budget drivers and issues**

The 2010 Federal Patient Protection and Affordable Care Act included competitive grants to states for assessing need and implementing evidence-based maternal and child health home visitation programs. The federal funds Oregon secured created an exceptional opportunity for establishing and sustaining a comprehensive Oregon home visiting system. A key budget driver for Oregon to leverage home visiting federal funds is the Act’s requirement that states agree to maintain non-federal funding (mostly state general funds) for grant activities at a level not less than those in place on the enactment date of the legislation (March 23, 2010). One of these sources is the state general funds for Babies First! It provides the target case management leverage funding to resource the public health nurse home visiting programs.

***Oral Health Unit***

The Oral Health Unit is responsible for advancing evidence-based strategies to improve the oral health status of all Oregonians. The unit is modeled after the Association of State and Territorial Dental Directors’ (ASTDD) “Guidelines for State and Territorial Oral Health Programs.” The Oral Health Unit takes a comprehensive approach to improving oral health outcomes. The unit is active in policy development, ongoing data collection and maintenance of a surveillance system, and delivery of direct community-based preventive dental services. The Oral Health Unit also is building and enhancing partnerships, providing leadership, and educating the public.

**Services provided**

The Oral Health Unit has three key programs that target children from birth into elementary school since dental disease is the most common chronic condition among children. Preventing decay during this period significantly increases the likelihood that an individual can remain caries free and avoid dental disease in older adulthood.

### **Project “First Tooth”**

First Tooth is an early-childhood cavity prevention program that trains pediatric medical providers to conduct oral health risk assessments, provide education, and apply fluoride varnish during well child visits for children under age 4. First Tooth also trains general dentists on how to serve the very young child and how to coordinate with pediatric medical providers to establish dental homes for children under the age of four.

### **School-based dental sealant program**

This program serves first and second graders, preventing decay in the first permanent (adult) molars where about 85 percent of decay normally occurs. Dental sealants are delivered by registered dental hygienists onsite at participating schools using portable dental equipment.

### **School-based fluoride tablet and rinse program**

This program is administered to K-6 grades in elementary schools with 30 percent or more of the students eligible for the Federal Free and Reduced Lunch Program.

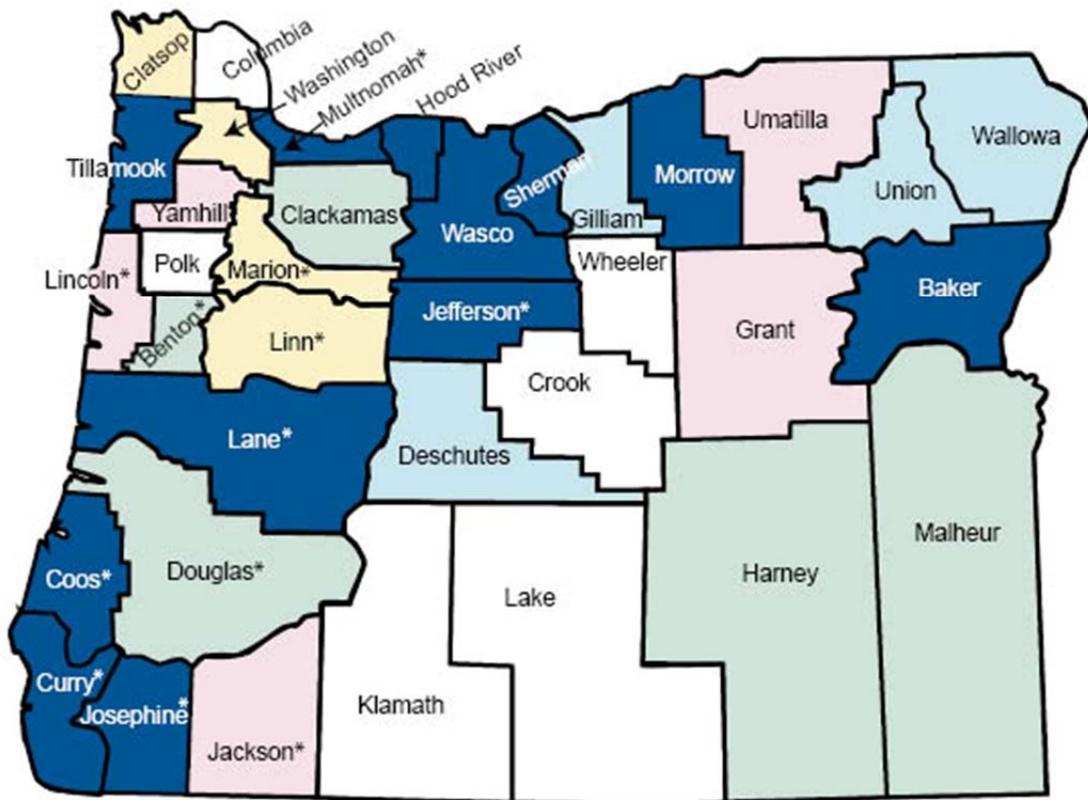
An oral health surveillance system tracks data for populations across the lifespan, measuring disease prevalence, health related behaviors and progress towards meeting Healthy People 2020 goals. A key component of the system is the dental screening survey for oral disease prevalence among first- through third-graders. Called the Smile Survey, it takes place every five years. The 2012 survey includes height and weight assessments and is now referred to as the 2012 Smiles and Healthy Growth Survey.

### **Where service recipients are located**

The Oral Health Unit provides school-based dental sealant services statewide through more than 140 elementary schools. Over 90 elementary schools participate in the school-based fluoride tablet and rinse program. The school-based dental sealant program coordinates with locally-administered programs, such as Multnomah County Health Department, to increase capacity.

School-based dental sealant programs during the 2011-12 school year  
Percent of eligible schools served per county.

Participation of Eligible Schools by County	
100%	Dark Blue
75 - 99%	Light Blue
50 - 74%	Light Green
25-49%	Yellow
0-24%	White
* Counties w/local programs	



**Who receives services**

School-based dental sealants are available to first and second graders in elementary schools with 50 percent or more of the student body eligible for the Federal Free and Reduced Lunch Program.

During the 2010-11 school-year, more than 16,000 dental sealants were placed for students in 142 schools in twenty five counties. Over 2,000 children were referred for dental treatment. Operating at maximum capacity, an estimated 142 schools will be served during the 2011-12 school year; about 18,000 dental sealants will be placed. Statewide, the program reaches 30% percent of all eligible schools. The number of schools eligible increased by almost 10% from the previous school year. Still, when combined with locally-operated dental sealant programs, 66 percent of eligible schools are served.

Dental sealants placed for eligible  
First and Second Graders, Oregon, 2006-2012

Year	Number of Sealants Placed
2006-07	1,200
2007-08	3,700
2008-09	10,700
2009-10	19,000
2010-11	16,000
2011-12	18,000

**How services are delivered**

School-based dental sealants are delivered by registered dental hygienists with the aid of dental assistants. Each year the program utilizes more than 550 volunteer dental hygienists and dental assistants from around the state. Parents and caregivers receive results information, schools receive follow-up information about the children served, and the Oral Health Unit uses the screening and dental sealant data to measure quality assurance. Ninety-nine percent of participating schools report great satisfaction with the program.

School-based fluoride tablets are delivered daily in the classroom by a teacher, aid, or onsite coordinator. Fluoride rinse is delivered once per week in a similar manner. Usage is tracked and reported annually to the Oral Health Unit.

### **Why these services are significant to Oregonians**

In Oregon, only 27 percent of the total population receives the benefit of community water fluoridation. The school-based fluoride tablet and rinse program brings the benefits of fluoride to children. According to the Smile Survey 2007, a survey of first, second, and third graders in Oregon:

- Nearly two out of three first, second and third graders have cavities;
- More than one in three children have untreated decay;
- One in five children has rampant decay — decay in seven or more teeth; and
- On any given day, more than 5,000 children are in need of urgent treatment due to severe pain or infection.

### **Performance measures**

The Oral Health Program has outcome measures based on national benchmarks, but no current OHA key performance measures (KPM).

### **Quality and efficiency improvements**

The school-based dental sealant program administered by the Oral Health Unit addresses quality assurance and efficiency in several ways. The model follows the best practice recommendations from the Association of State and Territorial Dental Directors for school-based dental sealant programs. Screening and sealant services are delivered following a strict protocol for safety and efficacy. Data is collected in a uniform manner and entered into a statewide dental sealant surveillance system, and a sample of children is re-screened to ensure retention of the dental sealants. Currently, the dental sealant retention rate within the program is over 85%.

### **Health disparities**

The school-based dental sealant program targets elementary schools with at least 50 percent of the students eligible for the Federal Free and Reduced Lunch. This ensures that schools with the greatest proportion of low-income children are served. The program also reaches rural and remote schools, often providing the only dental services children may receive due to the disproportionately small number of dentists serving in those areas. First Tooth aims to increase the percentage of Medicaid-eligible children under age four who have a dental home. Historically, children in these groups are not seen by a dentist until they are older and have significant dental disease.

Statewide, the Oral Health Unit provides links to enroll people in dental insurance and with public and private dental health services. Consistent with SB 855, passed during the 2005 Legislative Session, the section awards Maternal and Child Health (MCH) block grant funding to four tribal governments to provide MCH services. Two of the tribal health clinics are providing oral health services to prevent early childhood cavities: the health clinics of the Coquille Indian Tribe and the Cow Creek Band of Umpqua Tribe of Indians. The CP&HP provides technical assistance; consultation and partnerships to assure the tribal clinics have resources to implement programs for their members in collaboration with their communities. SB 738, passed during the 2011 Legislative Session, tasks the Oral Health Unit with overseeing approval and monitoring of statewide pilot projects to test new or expanded dental provider types aimed at increasing access to prevention and early management of dental disease for vulnerable populations.

### **Key budget drivers and issues**

The Centers for Disease Control (CDC) did not re-fund a critical grant for the Oral Health Program, a grant that supported infrastructure to implement key statewide program initiatives. Program funding was stabilized by matching General Fund dollars with a Medicaid match. The funding maintains the statewide school-based dental disease prevention program (dental sealants and fluoride supplement programs). SB 738 requires OHA to establish Oregon Administrative Rules to accept applications for dental workforce pilot projects and monitor approved projects. Recommendations on new workforce strategies are expected.

### ***Adolescent Health program (AH)***

Adolescent Health programs (AH) are public health programs or resources that include School-Based Health Centers (SBHCs), coordinated school health, teen pregnancy, nutrition and physical activity, and adolescent health policy. This program is most closely related or aligned with direct services to the population.

### **Services provided**

The School-Based Health Center (SBHC) program provides access to over 52,000 youth to a comprehensive set of developmentally and age-appropriate preventive health, primary care and mental health services. Services include routine physical exams, including sports physicals; well-child and adolescent exams; diagnosis and treatment of acute and chronic illness; emotional and mental health services; and treatment of minor injuries. The centers also prescribe medications; provide vision,

dental and blood pressure screenings; administer immunizations; perform classroom presentations on relevant health issues; and offer age-appropriate reproductive health services, health education, counseling and wellness promotion.

Oregon is a national leader and has 27 years of experience with these centers. During the 2010-11 service year, 63 certified centers in 21 counties served 22,421 in 68,021 visits. Seven new centers opened as a result of expansion funds provided by the legislature (2009-11) and it is expected that four to six new centers will certify and open in 2011-12 to complete that investment.

Adolescent Health also leads Oregon's coordinated school health program, Healthy Kids Learn Better (HKLB), in collaboration with the division's Health Promotion and Chronic Disease Section. Coordinated School Health (CSH) is an evidence-based model the Centers for Disease Control (CDC) created in the 1990s to support schools in addressing student health. Core to this model is evidence around the link between health and learning. The model has been used to address student health needs related to physical activity, nutrition, tobacco prevention, safety and asthma.

The Healthy Kids Learn Better Coalition, a statewide public/private partnership has worked most recently to encourage education reform efforts to recognize the importance of health in achieving educational outcomes and has made recommendations to the Oregon Education Investment Board related to necessary school capacity to address health issues, state infrastructure supports and the adoption of student health indicators into educational metrics.

Oregon was awarded the Personal Responsibility Education Program (PREP) grant through the Family Youth Services Bureau to implement evidence based programs addressing teen pregnancy and sexually transmitted infections, including HIV prevention in youth. Through the PREP grant, Oregon selected the program ¡Cuídate!, an evidence-based program for Latino youth. This program addresses Oregon's significant disparity in Hispanic teen birth rates and teen pregnancy rates. This 5-year formula grant provides Oregon with approximately \$600,000 annually to implement ¡Cuídate! through 4 Local Public Health Authorities (LPHA) in Oregon. ¡Cuídate! is being implemented with PREP funds in the tri-county area, in Deschutes, Crook, and Jefferson counties, and in Jackson, Marion, and Multnomah counties. Washington LPHA is not supported by PREP funds, but is receiving technical assistance to implement ¡Cuídate! within the county. Implementation of ¡Cuídate! with Oregon youth started in December of 2011.

**Where service recipients are located**

During the 2010-11 service year, services were provided through public-private partnerships and medical sponsorships that develop School-Based Health Centers on school property. The centers are located in elementary schools (ES), middle schools (MS), high schools (HS) and combined (K-8 and K-12) grade campuses.

<b>County</b>	<b>School</b>	<b>Clients</b>	<b>Visits</b>
<b>Baker</b>	<b>Total</b>	<b>284</b>	<b>1149</b>
	Baker HS	284	1149
<b>Benton</b>	<b>Total</b>	<b>1926</b>	<b>5268</b>
	Lincoln ES	1369	3849
	Monroe ES/MS	557	1419
<b>Clackamas</b>	<b>Total</b>	<b>609</b>	<b>1667</b>
	Canby HS	291	752
	Oregon City HS	318	915
<b>Columbia</b>	<b>Total</b>	<b>478</b>	<b>697</b>
	Lewis and Clark ES	318	462
	Rainier MS/HS	160	235
<b>Coos</b>	<b>Total</b>	<b>215</b>	<b>579</b>
	Marshfield HS	215	579
<b>Curry</b>	<b>Total</b>	<b>144</b>	<b>303</b>
	Brookings-Harbor HS	144	303
<b>Deschutes</b>	<b>Total</b>	<b>1547</b>	<b>2174</b>
	Ensworth ES	624	820
	Lynch ES	451	623
	La Pine K-12	272	474
	Redmond HS	52	67
	Sisters HS	148	190
<b>Douglas</b>	<b>Total</b>	<b>455</b>	<b>1185</b>
	Douglas HS	130	277
	Roseburg HS	325	908
<b>Jackson</b>	<b>Total</b>	<b>2263</b>	<b>10837</b>
	Ashland HS	483	1403
	Crater HS	367	913

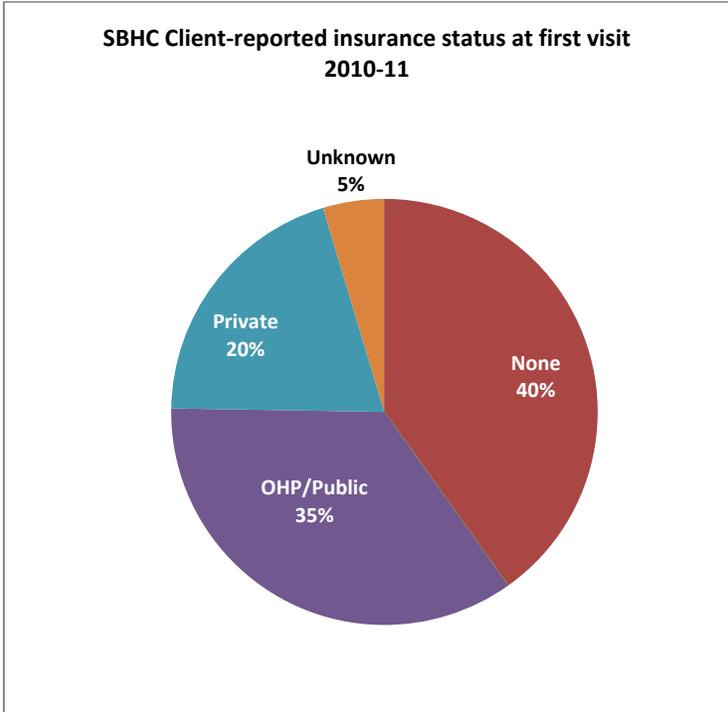
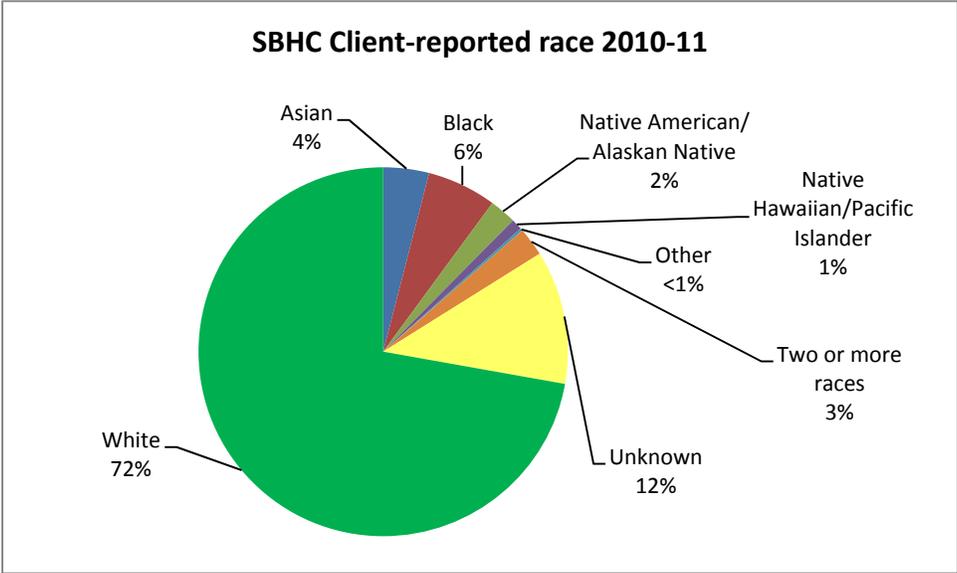
<b>County</b>	<b>School</b>	<b>Clients</b>	<b>Visits</b>
	Jackson ES	328	1978
	Jewett ES	272	823
	Oak Grove ES	347	1852
	Phoenix ES	306	1458
	Washington ES	363	2410
<b>Josephine</b>	<b>Total</b>	<b>952</b>	<b>4571</b>
	Evergreen ES	341	1389
	Illinois Valley HS	294	1489
	Lorna Byrne MS	317	1693
<b>Klamath</b>	<b>Total</b>	<b>115</b>	<b>235</b>
	Gilchrist School	115	235
<b>Lane</b>	<b>Total</b>	<b>2891</b>	<b>10277</b>
	Churchill HS	379	1241
	North Eugene HS	845	3254
	Sheldon HS	628	2195
	South Eugene	720	2199
	Springfield HS	766	1388
<b>Lincoln</b>	<b>Total</b>	<b>732</b>	<b>2744</b>
	Newport HS	246	859
	Taft HS	204	746
	Toledo HS	120	460
	Waldport HS	162	679
<b>Marion</b>	<b>Total</b>	<b>366</b>	<b>573</b>
	Hoover ES	366	573
<b>Multnomah</b>	<b>Total</b>	<b>5679</b>	<b>16896</b>
	Cesar Chavez K-8	210	715
	Cleveland HS	735	2328
	David Douglas HS	682	1687
	George MS	215	819
	Grant HS	717	1857
	Harrison Park K-8	320	649
	Jefferson HS	376	1404
	Lane MS	298	653

County	School	Clients	Visits
	Madison HS	580	1915
	Marshall HS	474	1373
	Parkrose HS	660	1957
	Roosevelt HS	412	1541
<b>Umatilla</b>	<b>Total</b>	<b>876</b>	<b>3163</b>
	Pendleton HS	504	2129
	Sunridge MS	372	1034
<b>Union</b>	<b>Total</b>	<b>327</b>	<b>987</b>
	La Grande HS	327	987
<b>Washington</b>	<b>Total</b>	<b>1261</b>	<b>3019</b>
	Forest Grove HS	467	1033
	Merlo Station HS	205	613
	Tigard HS	601	1373
<b>Wheeler</b>	<b>Total</b>	<b>177</b>	<b>408</b>
	Mitchell K-12	177	408
<b>Yamhill</b>	<b>Total</b>	<b>335</b>	<b>1289</b>
	Willamina HS	293	1010
	Yamhill-Carlton HS	169	279

### **Who receives services**

Services are provided to school-aged youth grades K-12 regardless of insurance status. Some centers offer additional services to school staff or other community members through extended hours and agreements.

During the 2010-11 service year females (57 percent) were more likely to be clients than males (43 percent) and accounted for a larger proportion of all visits (63 percent). In addition, centers are effective in reaching minority populations where health disparities are often identified. The majority of clients served were school aged (age 5-19, 88 percent), the remaining were infants or adults in those centers that are open to other members of the community. Clients reported their insurance status at the time of their first visit as 40 percent uninsured, 35 percent public, 20 percent private and 5 percent unknown.



## **How services are delivered**

Services are provided in centers located on school property by qualified medical and mental health providers. The facility may be integral to the school's main building or in an adjacent modular unit specifically designed as a medical facility. Currently, 60 percent of centers are sponsored by Federally Qualified Health Centers (FQHCs). Local health departments receive funding using a formula based on the number of certified school-based health centers in their county. Currently, counties with only one certified SBHC receive \$60,000 annually and counties with more than one certified SBHC receive \$41,000 annually for each center. The distribution and sharing of funds is determined at a local level after consideration of need, medical sponsorships and local agreements. The program estimates that every state General Fund dollar invested leverages three to five dollars in local investments.

As Coordinated Care Organizations are encouraged to include Patient-Centered Primary Care Home (PCPCH) recognized clinics into their delivery service networks, more SBHCs are moving towards State PCPCH) recognition. Currently, 19 out of 63 certified SBHCs are PCPCH recognized.

## **Why these services are significant to Oregonians**

School-based health centers are an important part of the safety net system, support the educational mission and are a working example of alignment with the goals of health care transformation's triple aim. The centers focus on preventive health services, are an integrated patient-centered access model of care that is cost effective. Nationally, research on the model has been linked to Medicaid savings and reduced emergency department use and hospitalization.

Oregon's children and teens have an increasing number of unmet health care needs while rates of un-insurance typically rise among adolescents and young adults. Many Oregon students are more likely to depend on school-based health centers as a regular source of care. In a recent survey, 81 percent of students surveyed indicated they were unlikely to have received care that day if there was not a SBHC available to them (2010-11 SBHC Patient Satisfaction Survey). The centers reduce barriers to care and improve access to youth regardless of insurance status. The centers keep kids in the classroom, help maximize instructional time, and promote positive health and mental health status, which are linked to school success.

## **Performance measures**

Because preventive and early intervention services provided in SBHCs relate to so many other health indicators for school-aged youth, SBHCs are linked to several performance measures from a wide variety of agencies. These measures include Public Health KPM 28 (teen pregnancy), KPM 27 (teen suicide), KPM 29 (intended pregnancy), and KPM 31 (tobacco use); in DMAP KPM 23 (preventive services for children), KPM 24 (preventive services for OHP youth and adults); in OHPR KPM 35 (safety net clinic use), and; in AMH KMP 5 (8<sup>th</sup> grader use of alcohol), KPM 6 (8<sup>th</sup> grader use of illicit drugs) and KMP 7 (child mental health services).

## **Quality and efficiency improvements**

In order to improve the quality of services, the following quality improvement plan was adopted for implementation.

**Goal:** School-Based Health Centers are committed to high quality, age-appropriate, accessible health care for school-age children. To ensure this goal, centers are targeting key health performance measures.

**Approach:** The first full year of implementation of the key performance measures tied to county contracts was in the 2008-09 service year. Sites unable to meet targeted KPM goals must complete KPM improvement forms to identify and implement an action plan to improve practice. Progress must be demonstrated from year to year and centers must meet statewide target goals within two years, otherwise funding may be reduced. During the past year a review of center KPM's and their alignment with PCPCH/CCO metrics was conducted.

**Measures:**

<b>Sentinel Condition</b>	<b>State Goal</b>	<b>2010-11 Results</b>
1. Risk Assessment	Complete risk assessment done for children seen three or more times in one service year	100% Compliant
2. Comprehensive physical exam	Complete physical exam every two years for children seen three or more times in one service year	100% Compliant
3. Height, weight and BMI	At least one recording of each measure for children seen three or more times in one service year	97% Compliant

**Health disparities**

School-Based Health Centers are a health care access model and are recognized as part of the Oregon Safety Net system. This access model works to reduce health disparities by breaking down traditional barriers to health care faced by children and adolescents. Adolescents represent the highest uninsured age group; their opportunities to receive health care services are limited because of transportation and financial barriers and concerns about stigma and confidentiality.

The centers work to reduce health disparities by providing services to any student regardless of health insurance status and their ability to pay. During 2010-11, 40 percent of clients were uninsured at their first visit, representing the largest insurance category.

In addition, the centers are effective in reaching minority populations where health disparities are often identified. Clients comprise a larger proportion of the minority population than found in typical clinical practice; 22% of clients are Hispanic.

School-Based Health Centers also reduce health disparities by the nature of their locations. In some of the more remote communities, the health services provided in the center are the only health care services available for many miles.

## **Key budget drivers and issues**

In 2010, Congress passed the Federal Patient Protection and Affordable Care Act (P.L. 111-148), which lends strong support to the future of School-Based Health Centers, with its emphasis on evidence-based preventive care and safety net clinics as part of the larger solution to increasing the number of Americans who have affordable and comprehensive health insurance.

In particular, the Act includes two important provisions for school-based health centers: language authorizing a federal SBHC grant program include;

**Section 4101(a)** of the Affordable Care Act allowed school-based health centers across the nation to access \$200 million in competitive federal funds over the next four years. The grants are limited to facilities expenditures –such as the acquisition or improvement of land, construction costs, or equipment. To date, \$4.8 million of the \$100 million released has been awarded to 14 Oregon communities.

**Section 4101(b)** of the Affordable Care Act provides language authorizing a federal school-based health center grant program. At this time, appropriations have not yet been directed toward this program.

The availability of local matching and operational funds comprise the primary budgetary challenges. The current funding formula is a public health investment model that requires a three to five local match for every state dollar. Sustainability planning at the local level is influenced by factors including insurance coverage, service mix, reimbursement rates, billing capacity, business infrastructure, medical sponsorship and strength of community partnerships. The most significant new driver for the school-based health center system is their ability to become PCPCH recognized, adoption of electronic health records and practice management tools, as well as negotiating with Coordinated Care Organizations to be an integral part of their delivery system network.

## ***Reproductive Health (RH) and Breast and Cervical Cancer programs***

### **Services provided**

The Reproductive Health program (RH) and Breast and Cervical Cancer Program (BCCP), which includes WISEWOMAN (Well-Integrated Screening and Evaluation of Woman Across the Nation), are now part of the Adolescent, Genetics, and Reproductive Health Section in the CP&HP.

The Reproductive Health (RH) program provides a range of health services, counseling, and education to help Oregonians plan the timing and spacing of their children. Client services are supported by OregonContraceptiveCare (CCare), formerly known as the Family Planning Expansion Project (FPEP), and a federal grant, Title X

Services provided through the BCCP include clinical breast examinations, mammograms, Pap tests, diagnostic testing after an abnormal screening result, surgical consultations, and referrals to treatment. Clients also are provided screening for heart disease, stroke, tobacco use, obesity and diabetes through a grant called WISEWOMAN.

### **Where service recipients are located**

Both RH and BCCP/WISEWOMAN provide services through a network of local providers across the state. RH services are provided at 177 clinic locations.

The Breast and Cervical Cancer Program works with about 109 enrolling providers, who provide primary screening and case management services, and 184 ancillary providers such as labs, radiology facilities, surgeons and hospitals. WISEWOMAN services are provided by 9 of the 90 enrolling providers.

### **Who receives services**

Priority for RH services is given to individuals under 250 percent of the Federal Poverty Level (FPL). Local clinics served 113,415 people during calendar year 2011, including 108,743 women and 4,672 men, and 83,848 clients below 100 percent FPL.

BCCP/WISEWOMAN services are offered to women ages 40-64 who are at or below 250 percent FPL and do not have insurance or are underinsured. During the 2010-2011 fiscal year, the BCCP program enrolled 7,929 clients.

### **How services are delivered**

There is a significant overlap between RH providers and BCCP/WISEWOMAN enrolling or primary screening sites. County health departments, Federally Qualified Health Centers, rural health centers, Planned Parenthood clinics, School-Based Health Centers and private medical professionals all deliver reproductive health services.

In addition to the providers listed for RH above, Breast and Cervical Cancer Program/WISEWOMAN providers include Rural Health Centers, laboratories, imaging facilities, hospital systems, outpatient radiology and ambulatory surgery centers, surgeons, primary care providers, radiologists, pathologists, medical and radiation oncologists, and radiation therapy facilities. These providers offer breast and cervical cancer screening and diagnostic services to eligible clients throughout the state.

### **Why these services are significant to Oregonians**

RH services protect and promote Oregonians' health by helping families have children only when they are ready for them. The program benefits all Oregonians by reducing public spending on maternal and infant health services through the reduction of unintended pregnancies.

The BCCP helps reduce cancer mortality and morbidity by screening medically underserved women for breast and cervical cancer at no cost to them and by making referrals to treatment for clients with a cancer diagnosis.

The WISEWOMAN program helps to identify and reduce heart disease and stroke risk in women and uses lifestyle interventions designed to assist women to identify their risk and develop an action plan for change.

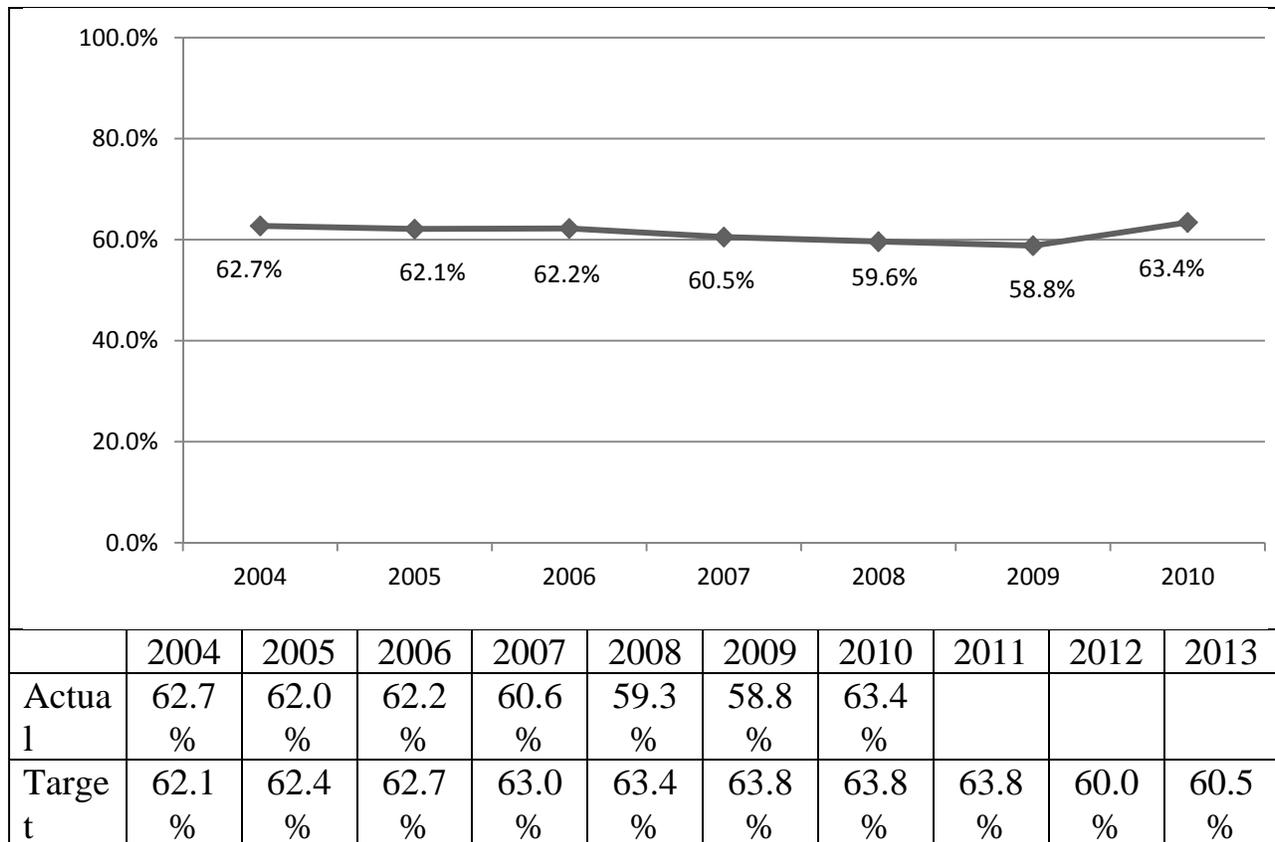
### **Performance measures (RH)**

The Reproductive Health program has one OHA key performance measure (KPM).

KPM 29: Percentage of births where mothers report that the pregnancy was intended.

*Purpose:* This measure provides an indication of how effective RH is in helping women prevent unintended pregnancies before they occur. Pregnancy intent involves more than one person and often is influenced by complex feelings and attitudes. However, this measure is directly linked to national goals, most notably the Healthy People 2020 objective FP-1 to increase the proportion of pregnancies that are intended.

% of Pregnancies in Oregon That Were Intended



*How Oregon compares to other states:* Healthy People 2020 Objective FP-1 sets a goal of increasing the proportion of U.S. pregnancies that are intended to 56 percent. Oregon currently falls above this goal, as do many other states. Oregon remains slightly above this average. The Alan Guttmacher Institute ranks Oregon ninth in the nation for its efforts to help women avoid unintended pregnancy.

**Quality and efficiency improvements (RH)**

The RH, BCCP and WISEWOMAN programs engage in varied quality improvement (QI) activities, not only to assure regulatory compliance, but also to continually improve program performance and provider and client satisfaction.

RH designs and implements various screening and audit procedures used to assure program integrity and reduce risk of overpayment. Other QI activities include a biennial client satisfaction survey and an annual staff training needs assessment. The program also provides local staff training events (clinical, fiscal, administrative, management, QI, counseling, marketing, and more).

BCCP/WISEWOMAN conducts an annual provider satisfaction survey to assess training and technical assistance needs and identify areas for improvement. In addition, annual site visits are conducted to offer training and support for providers having difficulty meeting performance measures.

**Health disparities (RH)**

The Reproductive Health program works with its provider agencies to meet the Culturally and Linguistically Appropriate Services (CLAS) guidelines for health care. All provider agencies, as well as the RH program itself, have conducted CLAS self-assessments and are developing strategies for improving performance. During calendar year 2011, RH provided services to the following populations:

<b>Race/Ethnicity</b>	<b>Clients Served CY 2011</b>
White	92,982
African American	2,585
American Indian/Alaska Native	1,512
Asian	3,069
Hawaiian/Pacific Islander	1,131
Other/Unknown	8,354
Hispanic	21,824
Non-Hispanic	91,591

**Key budget drivers and issues (RH)**

The program began a social marketing campaign late in 2009 to increase enrollment after citizenship verification became required and client participation severely declined for OregonContraceptiveCare (CCare). Significant budget cuts in late 2010 curtailed outreach efforts and client enrollment numbers remain somewhat static.

The key issue for the is limited funding for breast and cervical cancer screening and diagnostic services. BCCP is funded by a grant from the CDC. These funds are used largely for direct services. BCCP leverages these federal dollars with matching funds from the Susan G. Komen for the Cure (Komen) SW Washington and Oregon Affiliate. The CDC provides \$3 for every \$1 Komen provides. At the

current funding level, approximately 7,000 medically underserved women receive screening services for early detection of breast and cervical cancer each year through BCCP.

***Nutrition and Health Screening Program (WIC)***

**Services provided**

The Nutrition and Health Screening Program (WIC) provides leadership in development of and planning for health and nutrition policies; promotes the use of quality nutrition standards in the community; and ensures healthy WIC-approved foods are available in local grocery stores. In addition, the program collects and analyzes health and nutrition status data of pregnant women, infants and young children and supports state and local breastfeeding and nutrition coalitions.

In local communities, WIC clinics provide individual assessment of growth, and health and education and counseling on nutrition and physical activity, including promotion of a healthy lifestyle and prevention of chronic diseases including obesity. Local programs also provide breastfeeding education and support and referrals to other preventive health services and social services.

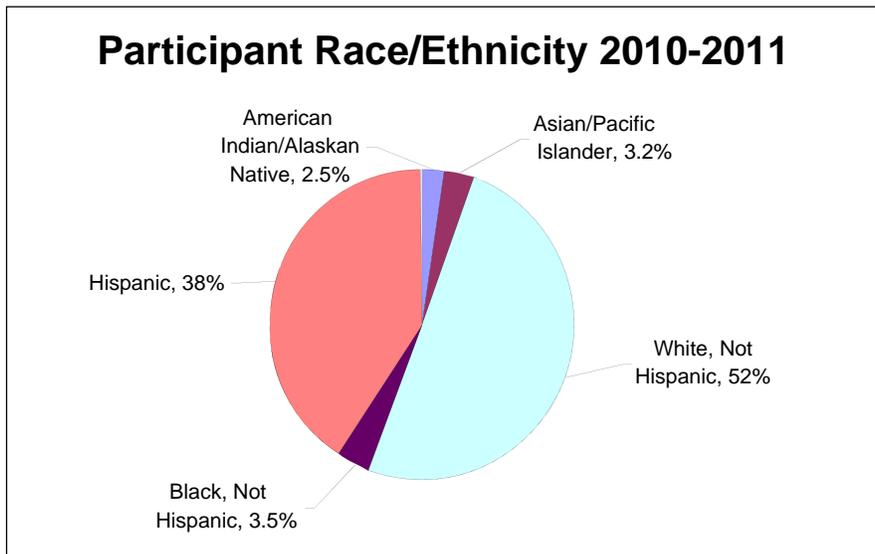
**Where service recipients are located**

Services are provided to recipients in all areas of the state.

De-duplicated count of WIC Participants (2011)

<b>County</b>	<b>Clients Served</b>	<b>County</b>	<b>Clients Served</b>
Baker	806	Josephine	4,528
Benton	2,434	Klamath	4,331
Clackamas	10,089	Lake	363
Clatsop	2,058	Lane	13,385
Columbia	2,202	Lincoln	2,362
Coos	3,058	Linn	6,105
Crook	969	Malheur	2,658
CT Umatilla	184	Marion	14,543
CT Warm	782	Multnomah	21,818

County	Clients Served	County	Clients Served
Springs			
Curry	963	Polk	2,191
Deschutes	6,944	Salud	14,775
Douglas	5,517	Tillamook	1,120
Grant	296	Umatilla/Morrow	6,984
Harney	347	Union	1,381
Hood River	1,439	Wallowa	256
Jackson	10,601	Wasco/Sherman	1,787
Jefferson	1,213	Washington	20,224
State Total:		177,827	



**Who receives services**

Services are provided to lower-income pregnant, postpartum and breastfeeding women, and children under the age of 5 who have a health or nutrition risk. During 2011 local programs served 177,827 women, infants and children. This includes 46 percent of all infants born in the state, 61 percent of all infants born in rural counties, and one in three Oregon children under the age of 5. More than two-thirds of those served are in working families.

## **How services are delivered**

The services are provided through partnerships with 29 local health departments, two tribal organizations and two nonprofit organizations.

## **Why these services are significant to Oregonians**

WIC services provide a unique set of targeted services to help families give their children a healthy start. These services may include nutrition and health assessments, nutrition education, breastfeeding support and education, a prescribed monthly food benefit, and referrals to relevant public health, community and medical resources.

WIC families purchase \$67.6 million of nutritious foods at more than 610 stores statewide. The WIC Farm Direct Nutrition Program helps lower-income families purchase about \$424,000 in local fresh fruits and vegetables, supporting local farmers and communities throughout the state.

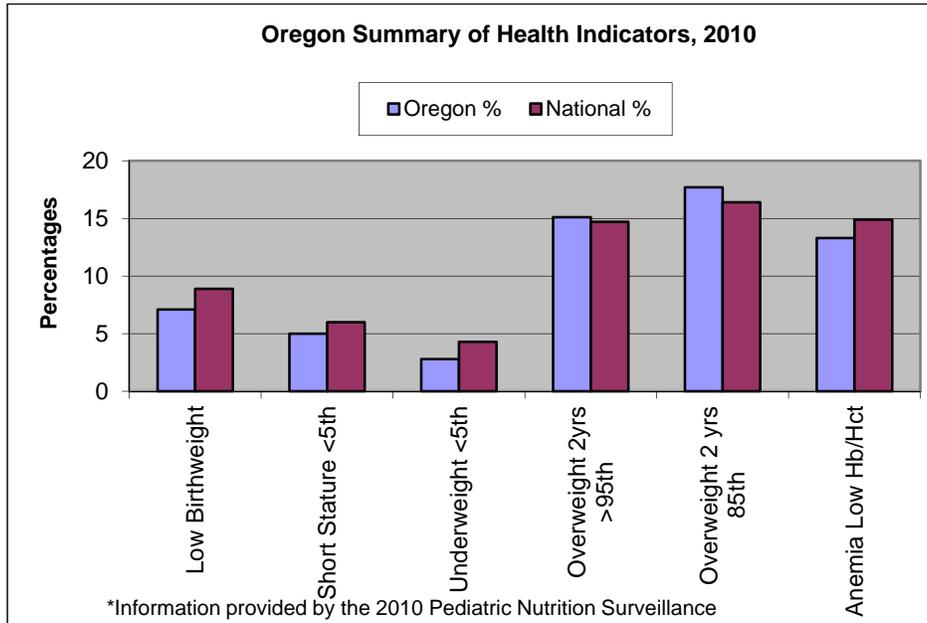
## **Performance measures**

The WIC program is an important provider of preventive health services and economic security for lower-income young Oregon families. The program most strongly relates to key performance measures 11 (Food Stamp Utilization) and 20 (Early Prenatal Care) which are reported elsewhere.

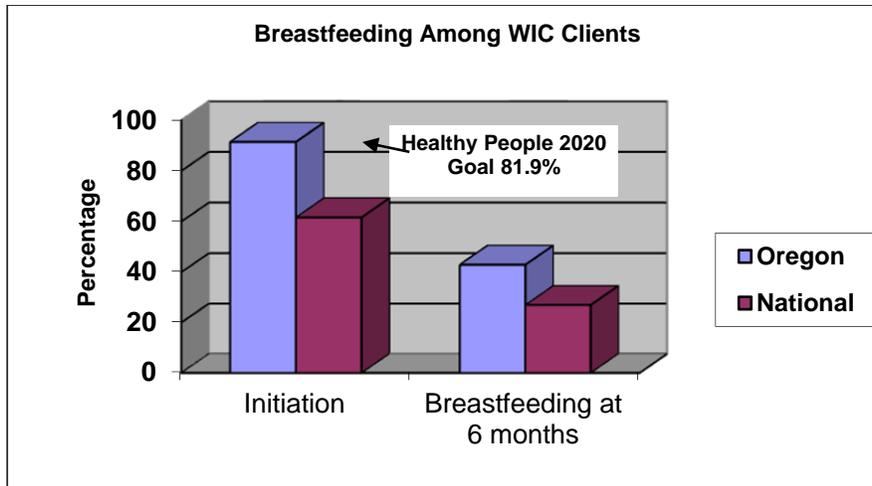
The program implements activities to meet the outcomes of national performance measures required by the federal Title V-Maternal and Child Health block grant. NPM 11 measures the percent of mothers who breastfeed their infants at six months of age and NPM 14, measures the body mass index levels of WIC children between 2 and 5 years of age. The program implements activities that support the public health goals of obesity and overweight prevention among pregnant women and young children. These activities include nutrition screening and education, promoting fresh fruits and vegetables as an important part of everyday eating, and increasing food security and physical activity for children and their families.

*How Oregon compares to other states:* Oregon scores better than the national average on most health indicators for the WIC child population, according to data from the 2010 Pediatric Nutrition Surveillance Survey. In particular, Oregon's rate of low birth weight, underweight, and low iron are better than the national rates.

One area of concern is that Oregon’s percentage of two to five-year-olds classified as overweight exceeds the national average. However, Oregon is not among the states with the highest rates of overweight preschoolers. WIC education focuses on the influencers of overweight, such as healthy eating habits, increased physical activity and community resources.



Oregon leads the nation in the number of mothers who begin breastfeeding and continue to nurse at six months and beyond. Oregon also enjoys the smallest disparity between WIC mothers and non-WIC mothers in relation to breastfeeding. Nationally, the difference in breastfeeding initiation is about 20 percent, while in Oregon it is less than 10 percent. Breastfeeding is associated with a reduced risk of many negative health conditions for both mother and infant (including ear infections, diabetes and breast cancer).



**Quality and efficiency improvements**

Training support is provided for all local WIC staff to improve the quality of services provided to WIC clients. The training plan includes training support for new staff, for existing staff, for breastfeeding expertise, for new initiatives, quarterly in-services, and a statewide meeting every other year.

More than 90 percent of Oregon women start out breastfeeding in the hospital after delivery, one of the highest rates in the nation. Lack of breastfeeding support and barriers when returning to work make it difficult for most women to continue breastfeeding for the 12 months recommended by the American Academy of Pediatrics. To address the disparity in access to breastfeeding support and consultation, the program has targeted local non-English-speaking WIC staff for in-depth breastfeeding training and certification. In 2010 WIC expanded its Breastfeeding Peer Counselor program from four to eleven agencies, which has the potential to provide peer support to approximately 60 percent of the prenatal participants in WIC.

**Health disparities**

WIC is assisting in the effort to decrease health disparities through its outreach, research and health promotion efforts. For example, WIC has targeted outreach strategies and materials to effectively reach traditionally underserved communities.

Nationally, breastfeeding rates are significantly lower among lower-income women and particularly African Americans. Oregon however, exceeds national rates including its African American population.

The WIC program works with its statewide network of authorized grocery stores to improve access to healthy foods in all Oregon communities by establishing minimum required stock levels for key healthy foods such as whole grain breads and fresh fruits and vegetables.

### **Key budget drivers and issues**

Uncertainty around FFY 2013 funding levels could impact the program, as all funding is from the federal government. Reduced funding during a time of potentially increased demand, high food inflation and increased county budget deficits will be problematic.

### ***Health Promotion and Chronic Disease Prevention Section (HPCDP)***

#### **Services provided**

The Health Promotion and Chronic Disease Prevention section (HPCDP) monitors chronic diseases and their risk factors in the state, and promotes policies, systems and environments to prevent these diseases. The program also promotes screening for these diseases when appropriate, and improves care and self-management support for people with chronic diseases. The program addresses issues including asthma, arthritis, cancer, diabetes, heart disease and stroke. Programs work to address the leading underlying risk factors for these diseases — tobacco use, physical inactivity and poor nutrition. The program provides information to the public, the media and policymakers about chronic diseases and their risk factors in Oregon.

The programs provide services at both the state and local level. Statewide activities include data collection, analysis and reporting; purchase of statewide media promoting tobacco prevention and healthy behaviors; operation of the Oregon Tobacco Quitline; and enforcement of the Indoor Clean Air Act. The program also develops model policies and programs for tobacco, nutrition, physical activity and chronic disease self-management and implements these policies and programs at the state level. Additionally the program provides training and technical assistance for county and tribal public health agencies, community-based organizations, employers, schools and health systems.

The program provides funding to county and regional public health agencies, tribes and community-based organizations to implement evidence-based policies and programs for tobacco prevention, nutrition, physical activity, and chronic disease self-management in local settings including communities, schools, worksites, and health care settings.

The Tobacco Prevention and Education Program (TPEP), funded by a portion of state tobacco taxes, works to prevent tobacco use and exposure by educating the public about the dangers of tobacco, providing support to quit tobacco through the Quit Line, creating tobacco-free environments in communities, workplaces, and public places, and eliminating tobacco disparities in vulnerable population groups. The program collects and analyzes tobacco-related data and information from state and national surveys and research studies to monitor and improve prevention and education efforts. Since the program started in 1997, Oregon has experienced significant declines in tobacco consumption and youth smoking (52% and 54%, respectively.).

While prevention of chronic diseases is a high priority, about 45 percent of Oregon adults already have at least one chronic disease. They need tools to help them self-manage their conditions and successfully implement their health care providers' recommendations. To that end the program works at the state and local level to build a statewide infrastructure for chronic disease self-management through the evidence-based Living Well Programs (Stanford Chronic Disease Self-Management Program). Living Well is a six-week peer-led workshop for people with one or more chronic conditions and their support people. The program is available in a culturally adapted Spanish language version, as well as a seven-week version designed specifically for people living with HIV/AIDS and their support people. The program covers topics such as healthy eating, depression management, communication, managing fatigue, and working with health care professionals. Participants learn about and practice problem solving and action planning techniques.

### **Where service recipients are located**

HPCDP services such as publication of chronic disease data, tobacco prevention media outreach and the Oregon Tobacco Quitline are provided to Oregonians statewide. All county and regional public health agencies and tribes provide local tobacco prevention programs and some are funded for local healthy communities

programs to improve population health through nutrition, physical activity and chronic disease self-management.

Living Well has been offered in 32 of Oregon's 36 counties. To improve availability in those areas currently without programs, the program continues to work through its local partners to develop infrastructure in all areas of the state.

### **Who receives services**

These services and programs are provided to all Oregonians in all counties and tribal areas. By July 1, 2013, 14,000 Oregonians will have accessed the Oregon Tobacco QuitLine and received support and counseling for quitting tobacco use.

As of December 31, 2011, 7,753 Oregonians with a chronic condition or their caregivers have participated in the Living Well program. Participants reported an average of more than three chronic conditions, with most participants reporting arthritis, high blood pressure, chronic pain, depression, high cholesterol or diabetes.

### **How services are delivered**

These programs and services are provided both from the program's central office and in partnership with all 34 local health departments, health systems, all nine federally-recognized tribes, and numerous community-based organizations.

### **Why these services are significant to Oregonians**

Chronic diseases continue to take a huge toll on Oregonians. In 2009, almost half of Oregon adults (45 percent) had at least one of the following chronic diseases: arthritis, asthma, cancer, cardiovascular disease, or diabetes. In the same year, chronic diseases such as heart disease and stroke, cancer, chronic lower respiratory disease, and diabetes, caused two-thirds of the deaths in Oregon, with cancer and heart disease being the leading causes of death. Chronic diseases are enormous drivers of health care costs. Nationally, 83 cents and 96 cents of Medicaid and Medicare dollars, respectively, are spent treating chronic diseases. Hospitalization costs for chronic diseases in Oregon exceeded \$2.22 billion a year in 2009. Many of these diseases are preventable by decreasing tobacco use and improving nutrition, physical activity and disease self-management.

For people living with a chronic disease, self-management is critical to improving quality of life and decreasing health care costs. Oregon State University completed a Living Well Program Impact Report based on data from August 2005 through December 2009. Living Well is estimated to have resulted in 107 quality adjusted life years gained, 557 avoided emergency department visits, and 2,783 avoided hospital stays among participants during that time period. The estimated savings is more than \$7 million.

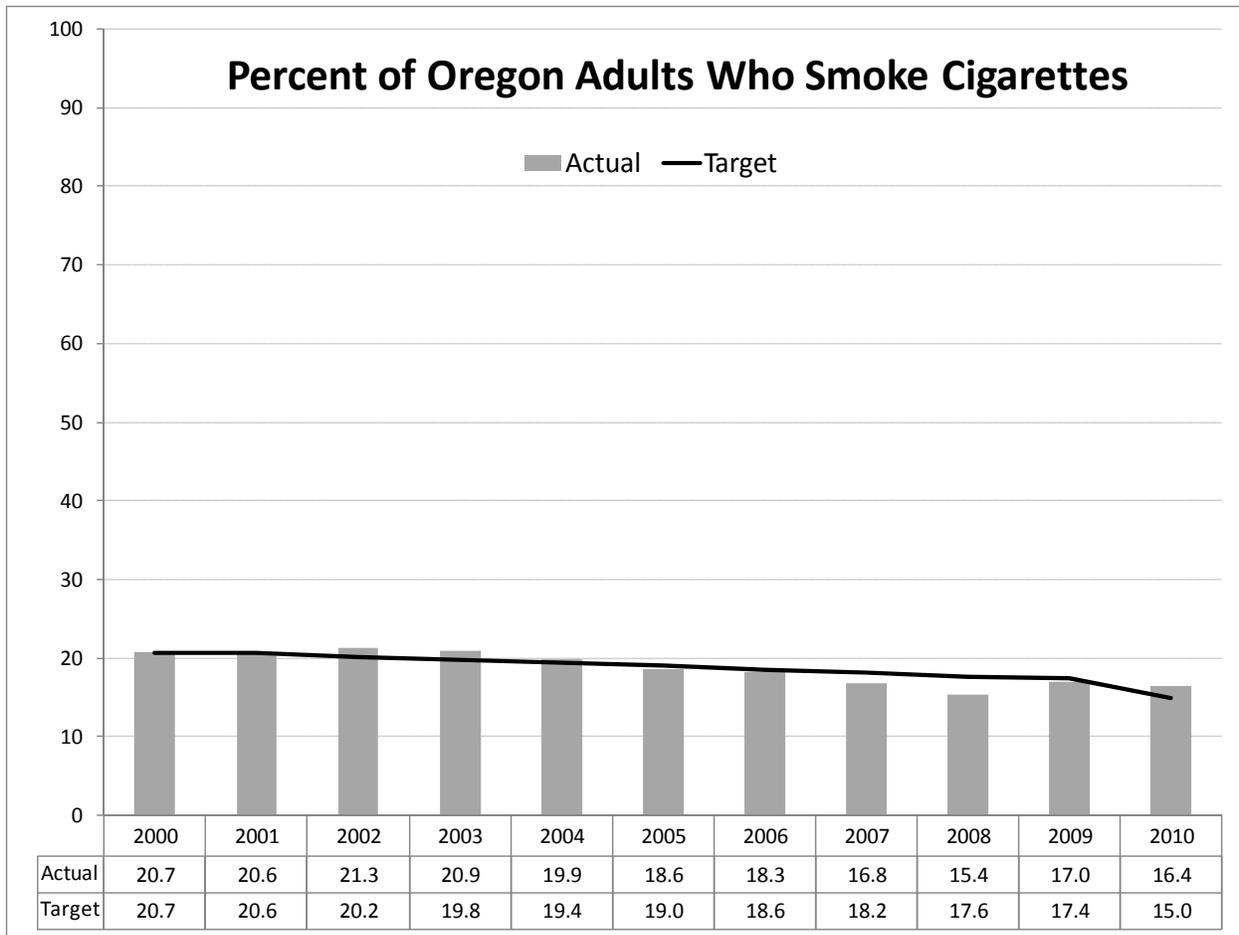
If the program enrolled only 5 percent (78,300) of Oregonians with a chronic disease, its estimated five year effects could result in \$142 million saved through avoidance of emergency department visits and hospital stays.

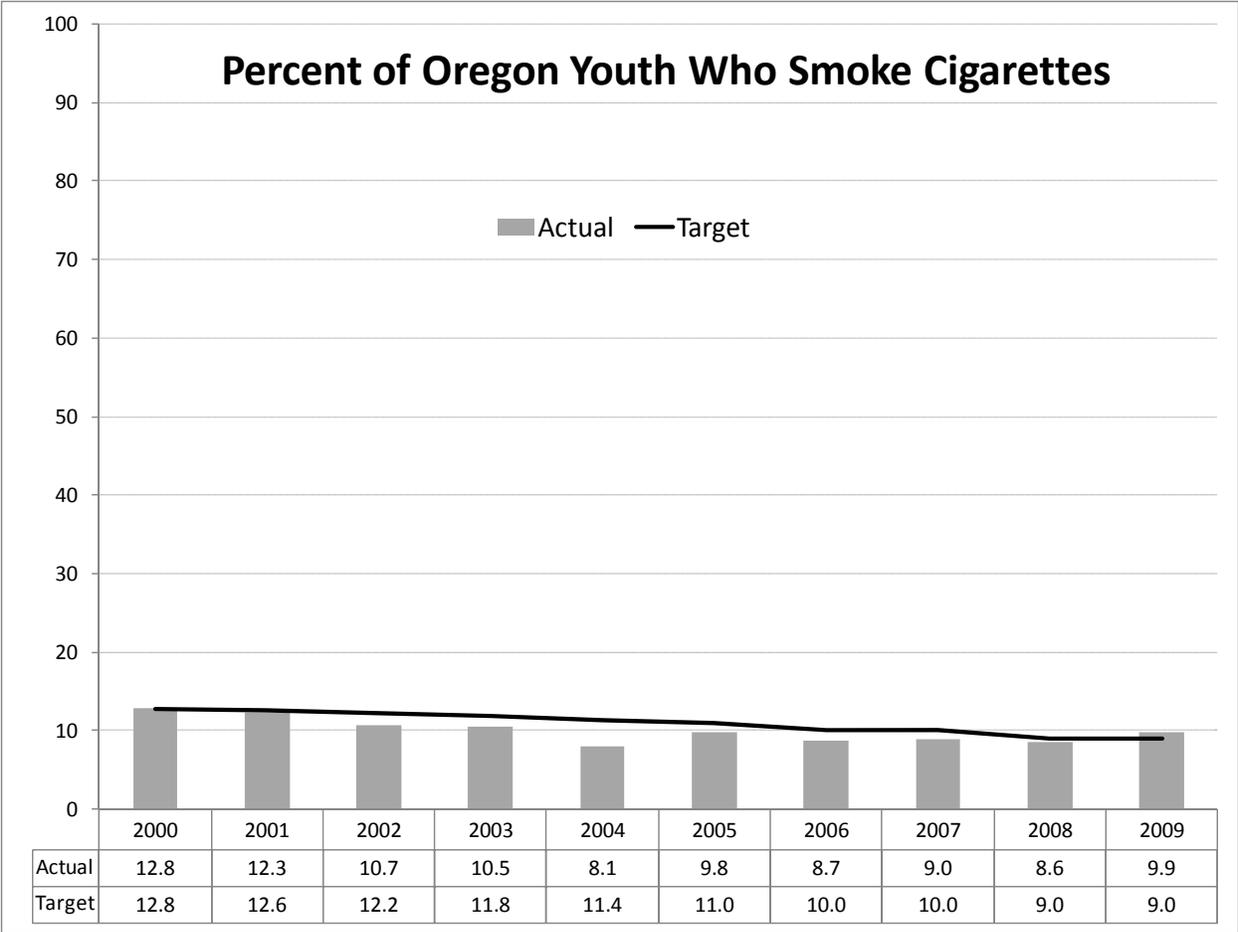
### **Performance measures**

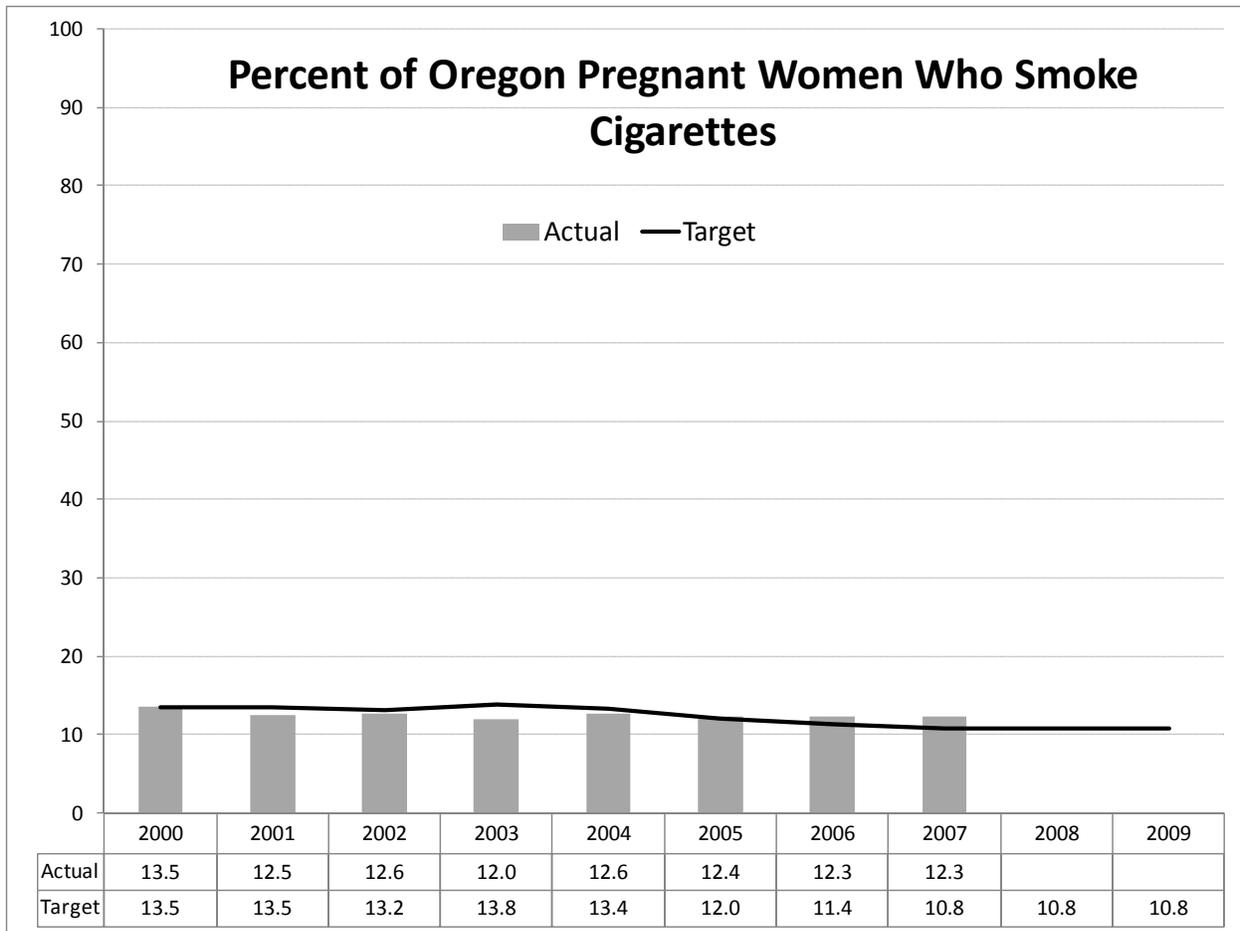
HPCDP has three OHA key performance measures.

KPM 21: Tobacco use

*Purpose:* The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco at any age has significant health benefits. Studies show that 90 percent of adult smokers started smoking before they were 18 years old. Preventing youth from starting to smoke will lead to lower smoking rates among adults in the years ahead. A woman's use of tobacco during pregnancy is associated with serious, and at times fatal, health problems for the child, ranging from low birth weight and premature births to stillbirth and Sudden Infant Death Syndrome (SIDS). Successful efforts by TPEP to decrease the prevalence of tobacco use among youth, adults and pregnant women will lead to reduced morbidity and mortality, contributing substantially to the OHA vision of a healthy Oregon in both the short-term and long-term.

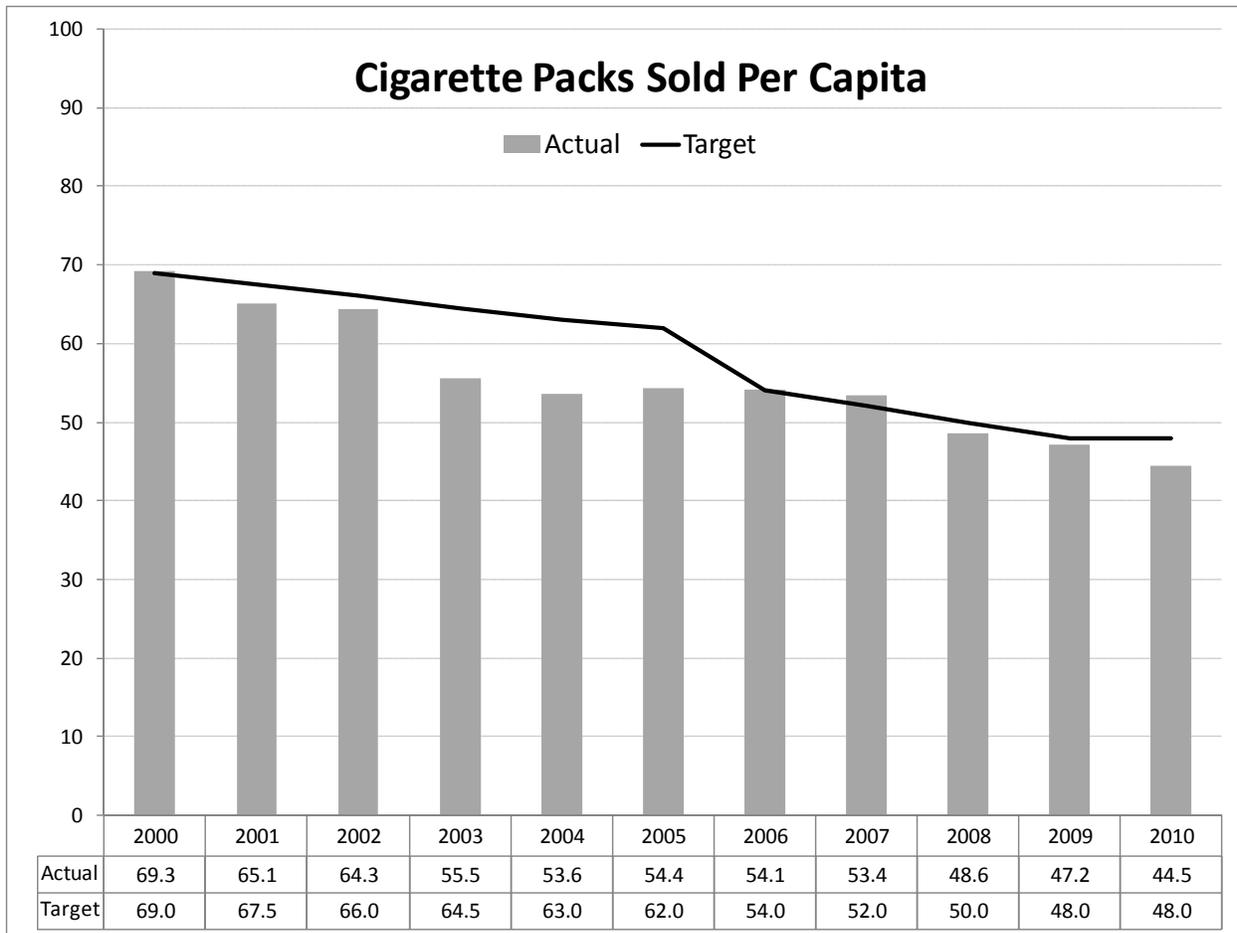






#### KPM 22: Cigarette packs sold

*Purpose:* The main goal of TPEP is to reduce tobacco use by youth, adults and pregnant women. Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco or reducing the amount smoked has significant health benefits. Reductions in the number of cigarette packs sold per capita results from two distinct phenomena — a decrease in the number of current smokers and a decrease in the quantity of cigarettes smoked among continuing smokers. It is clear that reducing the per capita packs of cigarettes sold will lead to substantial improvement in people’s health, both in the short-term and long-term.



*How Oregon compares to other states:* Prior to TPEP’s inception in 1997, Oregon had greater per capita sales of cigarette packs than the rest of the country (92.1 in Oregon vs. 87.2 in the US). In 2010, conversely, per capita sales of cigarette packs was lower in Oregon than in the rest of the country (44.5 in Oregon vs. 47.3 in the US). The current difference between Oregon and the U.S. represents a much steeper decline in per capita cigarette sales in Oregon, on average, than in the rest of the country.

**KPM 32: Overweight and Obese Prevalence**

*Purpose:* The prevalence of overweight and obesity constitute an urgent public health issue in the U.S. and in Oregon. While Oregon does not have a state program to address this epidemic, it is critical to monitor these trends so that the scope and growth of the epidemic is understood. This performance measure was legislatively approved for addition during the 2011-2013 biennia, and thus data have not yet been reported.

## **Quality and efficiency improvements**

Risk behaviors for many chronic diseases overlap and include tobacco use, physical inactivity and poor nutrition. To leverage the multiple disease-specific federal funding streams, HPCDP provides funding to county and regional public health agencies and tribes to create local partnerships that address all three of these risk factors and promote self-management of chronic diseases and timely screening for chronic diseases. This “healthy communities” program continues to be very well received. Funding counties and tribes to implement local plans developed with partners depends on availability of federal and funds.

Living Well has been selected as a self-management intervention due to its ability to address the needs of people with various chronic conditions. Because Oregon has large rural and frontier areas, promoting statewide infrastructure for Living Well is more efficient than focusing on disease-specific self-management programs. Living Well complements disease-specific education available through the health care system and does not duplicate services.

Preventing tobacco use, decreasing obesity/overweight, and preventing or reducing heart disease and stroke are priority areas for the division for the 2013-15 biennium. Key activities planned include creating environments that put health within reach by providing more options for healthy eating, physical activity and tobacco-free living; collecting, analyzing and disseminating data on tobacco, obesity and heart disease; and providing educational messages about the dangers of tobacco use, physical inactivity and poor nutrition.

## **Key budget drivers and issues**

Because HPCDP depends heavily on federal funding, changes in federal appropriations for chronic disease programs and the lack of increases in federal funding for these programs to keep up with inflation have a large impact on services.

During the past few decades Oregonians’ weight has increased to the point that currently an estimated two-thirds of all adult Oregonians are either overweight or obese. The health consequences of this are serious and include diabetes and heart disease. Recent studies demonstrate that increases in obesity account for at least a third of the inflation in health care spending in Oregon, and this number will continue to climb if the root causes are not addressed. There is currently no funding for a statewide obesity prevention and education program in Oregon. If

funding were available, it would fund state and local activities (such as) to create healthy school, work, home and community environments that support people making healthful choices about eating and physical activity. Communities around the state would receive funding to address local issues, with overall support and technical assistance from the state.

The Health Promotion and Chronic Disease Prevention program utilizes federal funding from multiple grants to support statewide infrastructure for the Living Well program. These funds support program materials, statewide marketing efforts, technical support and training for local partners, and long-term financial sustainability efforts. Local programs use community benefit dollars, grant funds, and minimal participant fees to provide workshops. In order for the program to reach large numbers of Oregonians with chronic conditions, benefit reimbursement will be necessary. The program is currently developing a business plan to guide strategy for increasing long term program reach and financial sustainability.

## ***CENTER FOR PUBLIC HEALTH PRACTICE***

### ***Key programs***

The Center for Public Health Practice (CPHP) prevents and controls communicable diseases, operates the state vital records system, assures the quality of services in local health departments, and screens all newborns for preventable genetic disorders. Programs collect and analyze data, investigate and stop disease outbreaks, disseminate information, and implement evidence-based practices and policies to improve the health of Oregonians. Operational areas include Acute and Communicable Disease Prevention, Community Liaison, Immunization, HIV/STD/TB, Health Statistics, and the Oregon State Public Health Laboratory.

The major sources of funding for CPHP include various federal grants, primarily from the CDC (46%), other funds (35%), and State general funds (19 %).

#### Federal funds:

- HIV prevention, and disease monitoring;
- Sexually transmitted disease control and prevention;
- Tuberculosis control and prevention;
- Emerging infections;
- Epidemiology and laboratory capacity;
- DHHS Center for Disease Control and Prevention (CDC)
  - Immunization and Vaccines for Children;
- Behavior Risk Factor Surveillance System (BRFSS);
- Preventive Health Block Grant;
- Clinical laboratory certification (CLIA/CMS);
- Social Security Administration (SSA) Vital Events;
- National Center for Health Statistics (NCHS)

#### Other funds:

- Ryan White base;
- Laboratory Testing Fees;
- Vital Event Fees;
- Council of State and Territorial Epidemiologists (CSTE)

State Funds:

- Support activities at Local Health Departments; and
- Portions of 7 key positions at the State level

### ***Acute and Communicable Disease Prevention (ACDP)***

#### **Services provided**

The Acute and Communicable Disease Prevention (ACDP) section monitors communicable disease occurrence in the state; guides local public health department staff in investigating and controlling communicable diseases; investigates communicable disease outbreaks; and helps ensure that communicable disease threats, including bioterrorist threats, are responded to appropriately. In addition, ACDP provides information to the public, the media and policy makers about communicable diseases in Oregon.

#### **Where service recipients are located**

These services are provided to Oregonians statewide.

#### **Who receives services**

Services are provided to all Oregonians.

#### **How services are delivered**

Services are provided both from the program's central office and in partnership with 34 local health departments.

#### **Why these services are significant to Oregonians**

Every year ACDP logs more than 200 disease outbreaks, such as the recent outbreak of *E. coli* O157 infections from strawberries, and helps to ensure that the outbreaks are investigated appropriately and brought under control. Local health departments, health care providers and consumers rely upon the expertise in this program to protect health and safety.

#### **Performance measures**

ACDP has no OHA key performance measures.

### **Quality and efficiency improvements**

None are identified for this program.

### **Key budget drivers and issues**

ACDP depends heavily on federal funding, so Oregon has limited ability to set priorities for communicable disease control. A >30% reduction in Oregon general funds for ACDP during 2011 left ACDP with little infrastructure with which to compete for federal funds.

### ***Community Liaison (CL)***

#### **Services provided**

The Community Liaison (CL) unit provides services that support the 34 county local health departments. These services include ensuring compliance with the local public health portion of ORS 431, site visits to local health department's to ensure compliance with contract and minimum standards, and public health nursing workforce development. The CL unit also serves as the state's resource for the Conference of Local Health Officials (CLHO).

#### **Where service recipients are located**

The services are provided statewide through the 34 local health departments.

#### **Who receives services**

Services are provided to the 34 local health departments and state program staff who lack expertise in local public health issues.

#### **How services are delivered**

Compliance, workforce development and technical assistance are provided to local health departments by three CL staff. Site visits to each county local health department occur at least once during the year, and staff has frequent contacts with the departments on a regional or state basis.

#### **Why these services are significant to Oregonians**

The services provided by the CL unit ensure a state-local partnership and a state-local public health system. The services help ensure compliance with federal and

state statutes and rules, state-local contracts, and minimum standards for local public health.

### **Performance measures**

While the Community Liaison unit does not have an OHA key performance measure, its state and local partnerships help further the OHA mission that people are healthy.

### **Quality and efficiency improvements**

In order to improve the quality of services provided by local health departments, the CL unit participates in all state-county public health workgroups; visits each county at least once during the year; and has created a Community Liaison website that provides local health departments with review tools, contract information, treatment protocols and a job announcement site.

### **Key budget drivers and issues**

The CL unit is presently funded 100 percent by the federal Preventive Health and Health Services block grant.

### ***Immunization***

#### **Services provided**

The Immunization Program (IP) provided services in 2011 that included purchasing and distributing \$40 million in vaccines to both the public and private sectors. Epidemiologists partner with local health department staff to provide disease surveillance and outbreak control. Health educators and public health nurses provide model vaccine standing orders, health education materials, and training and technical assistance on vaccines to providers, while also providing consumer vaccine education to ensure the public understands the benefits and risks of vaccinations and vaccine preventable diseases. The school law team coordinates the efforts of schools and child care centers to protect children from vaccine preventable diseases.

An Immunization Program priority is working with community partners to improve lifespan immunization rates. The ALERT immunization information system (ALERT IIS) receives immunization records from vaccine providers statewide, maintaining accurate, timely and complete immunization records for clinical, school and community use. The program merged the statewide

immunization information system and the immunization electronic medical record system for local health departments into a comprehensive Immunization Information System (IIS) in 2010. The new IIS was rolled out throughout 2011, and is continuing to increase participation among adult immunization providers. Finally, the program assesses immunization rates across the lifespan to measure progress, evaluate interventions and identify vulnerable populations.

### **Where service recipients are located**

Immunization services are provided throughout the state in partnership with county health departments, tribal health centers, state residential facilities and private providers. The Immunization Program also partners with public and private schools and child care facilities across the state to ensure student compliance with school immunization requirements.

### **Who receives services**

Immunization services are a high priority for all children, with special emphasis on children from birth through two years of age, at school entry and seventh grade. Adult immunizations generally target high risk populations, including those with diabetes, liver disease, immunodeficiencies, kidney failure, asplenia (the absence of normal spleen functioning), and HIV, as well as health care workers, and those age 65 and older.

### **How services are delivered**

Immunization services are delivered by both public and private providers, including pediatricians, family practice doctors, local health departments, federally qualified health centers, tribal health centers, and rural health clinics. One out of two children in Oregon is eligible for no-cost vaccine provided by the state, and more than half of those get their vaccines in private clinics. Of all children in Oregon — including those eligible for state programs and those who receive immunization services from their private health plans — an estimated 80 percent of all children in Oregon will receive their immunizations in the private sector and 20 percent in the public sector.

During 2011, Oregon's local health departments were responsible for administering 20% of state and federally supplied doses of vaccine to people of all ages in their communities — providing a critical safety-net service toward keeping people healthy and safe.

**Doses of Vaccine Administered, by County, 2011 (as reported by VFC enrolled providers to ALERT IIS)**

County	Immunization Doses Given by Local Health Departments and other public safety-net providers	Immunization Doses Given by Private Providers	Total Doses	% Public	% Private
Baker	6,257	0	6,257	100%	0%
Benton	4,170	29,004	33,174	13%	87%
Clackamas	10,309	124,005	134,314	8%	92%
Clatsop	3,897	11,564	15,461	25%	75%
Columbia	891	6,745	7,636	12%	88%
Coos	3,431	23,881	27,312	13%	87%
Crook	1,915	2,856	4,771	40%	60%
Curry	1,761	1,027	2,788	63%	37%
Deschutes	14,089	46,747	60,836	23%	77%
Douglas	13,656	19,291	32,947	41%	59%
Grant	1,029	1,219	2,248	46%	54%
Harney	908	1,001	1,909	48%	52%
Hood River	3,913	9,896	13,809	28%	72%
Jackson	18,398	57,695	76,093	24%	76%
Jefferson	7,994	3,050	11,044	72%	28%
Josephine	7,666	16,805	24,471	31%	69%
Klamath	3,000	23,184	26,184	11%	89%
Lake	2,439	0	2,439	100%	0%
Lane	15,665	86,461	102,126	15%	85%
Lincoln	5,888	6,679	12,567	47%	53%
Linn	2,713	29,506	32,219	8%	92%
Malheur	2,647	18,060	20,707	13%	87%

<b>Doses of Vaccine Administered, by County, 2011 (as reported by VFC enrolled providers to ALERT IIS)</b>					
Marion	46,195	113,226	159,421	29%	71%
Morrow	4,071	0	4,071	100%	0%
Multnomah	88,158	441,086	529,244	17%	83%
North Central Health Dist	13,792	9,591	23,383	59%	41%
Polk	2,579	619	3,198	81%	19%
Tillamook	3,861	6,003	9,864	39%	61%
Umatilla	12,206	16,394	28,600	43%	57%
Union	2,751	6,748	9,499	29%	71%
Wallowa	811	2,358	3,169	26%	74%
Washington	22,313	239,786	262,099	9%	91%
Wheeler	415	0	415	100%	0%
Yamhill	8,776	28,708	37,484	23%	77%
	338,564	1,383,195	1,721,759	20%	80%

Children in Oregon must have certain immunizations for school and children's facility attendance or obtain a religious or medical exemption:

- Diphtheria
- Tetanus
- Pertussis
- Polio
- Measles
- Mumps
- Rubella
- Hepatitis B
- Hepatitis A
- Varicella 1
- Hib (*Haemophilus influenzae* type b)

Tdap vaccine was required for seventh graders for the first time in school year 2008-09, and for seventh, eighth and ninth graders in school year 2010-11,

marking the beginning of the phase-in through 12th grade to be completed in school year 2013-14. Hepatitis A vaccine was required for children in preschool, childcare, Head Start, kindergarten, 1st and 2nd grades. The third year of the phase-in through 12th grade is to be completed in school year 2014-15.

In 2009, the Immunization Program began the process of collecting more detailed information about religious exemptions to school immunization requirements. During the past 10 years, the number of parents claiming religious exemptions has been steadily increasing. Beginning in school year 2010-11, with full implementation anticipated by 2011-12, the Immunization Program will collect data about the number of children in preschool, childcare, Head Start and kindergarten with religious exemptions for individual vaccines.

### **Why these services are significant to Oregonians**

The Immunization Program is committed to ensuring that Oregonians need not suffer the consequences of vaccine-preventable diseases. Immunizations protect all Oregonians from vaccine preventable diseases. The Vaccine for Children (VFC) program allows access to vaccine by populations who may not otherwise have the means to purchase vaccine, ensuring individual and community protection. The program also allows private pediatricians and other providers to continue to serve eligible children with vaccine provided through the program. Epidemiologic data shows that when 75 percent to 90 percent of the population is vaccinated, all the population is protected from disease transmission.

### **Performance measures**

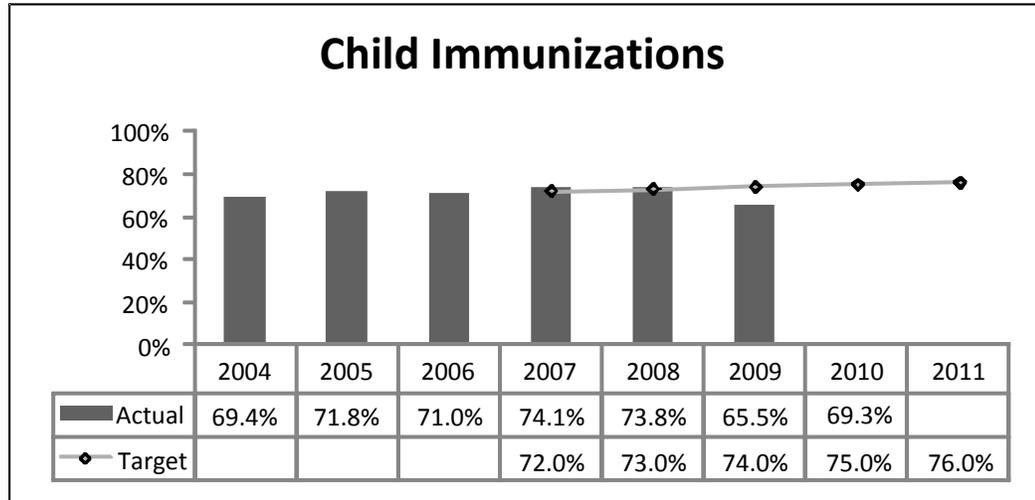
The Immunization Program has two key performance measures, and one new outcome measure.

KPM 23: The percentage of 24 to 35-month-old children who are adequately immunized.

*Purpose:* This performance measure is the percent of children 24 to 35 months of age immunized with four or more doses of diphtheria, tetanus and pertussis vaccine (DTaP); three or more doses of polio vaccine; one or more doses of measles, mumps and rubella vaccine (MMR); three or more doses of *Haemophilus influenzae* type b (Hib) vaccine; three or more doses of hepatitis B vaccine; and at least one dose of varicella vaccine (4:3:1:3:3:1). The goal is

to increase immunization rates to meet the Healthy People 2010 objective of 90 percent.

During 2010, 72.9 percent of two year old children were fully immunized, up from 65.5% in 2009. A national shortage of Hib vaccine drove the decline in 2009 vaccination rates; the increase in 2010 rates is indicative of a recovery from that period of Hib vaccine shortage.



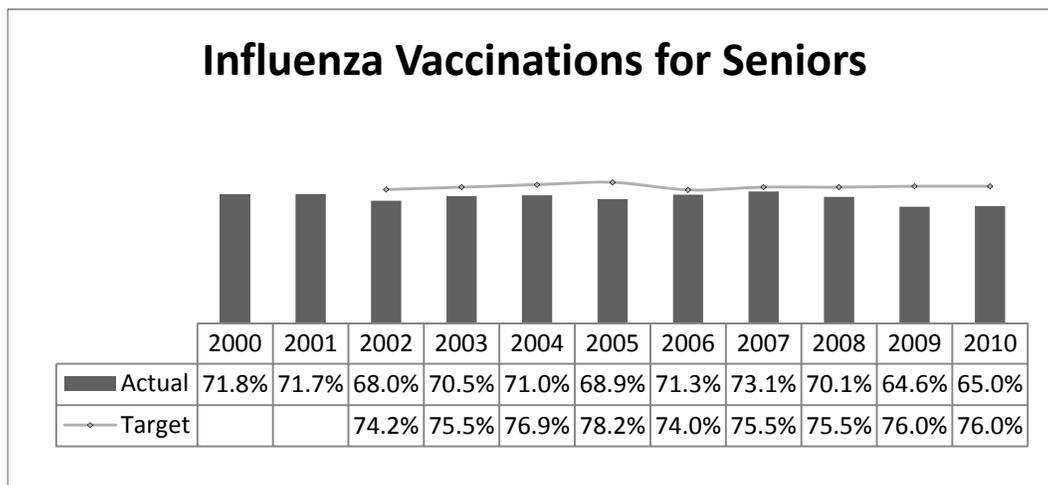
*How Oregon compares to other states:* The best comparison available to other states is the National Immunization Survey, a phone survey of residents in each state used to assess coverage among children 19-35 months of age. The approximate national rate for 4:3:1:3:3:1 during 2010 based on the National Immunization Survey was 74.9 ( $\pm 1.2$ ) percent nationally, and 69.3 ( $\pm 6.3$ ) percent for Oregon. Oregon's rates fall below the national average, but not statistically significantly. However, Oregon does continue to have higher rates of vaccine exemption among Kindergarten-aged children, compared to the national average, which may play a role in lower rates at the time of these assessments.

<b>National Immunization Survey, 2010</b>	
<b>State</b>	<b>Immunization Rate 4:3:1:3:3:1</b>
Florida (ranked 1 <sup>st</sup> )	85.8% ± 5.1
Washington	73.7% ± 5.4
Oregon	69.3% ± 6.3
Nevada	66.6% ± 6.9
Idaho	61.2% ± 6.7
National	74.9% ± 1.2

KPM 24: The percentage of adults aged 65 and over who receive an influenza vaccine.

*Purpose:* This performance measure is the percent of adults, ages 65 and older and living independently, who received an influenza immunization in the past 12 months. The goal is to continue to increase immunization rates to meet the Healthy People 2010 objective of 90 percent.

The percentage of older adults immunized annually against influenza has remained relatively flat during the past several years and below the targets. Following the pandemic influenza during the 2009-10 season, a survey of Oregon residents found that the top reason for not getting a H1N1 flu shot was that Oregonians did not believe shots were necessary and they had concerns about vaccine safety.



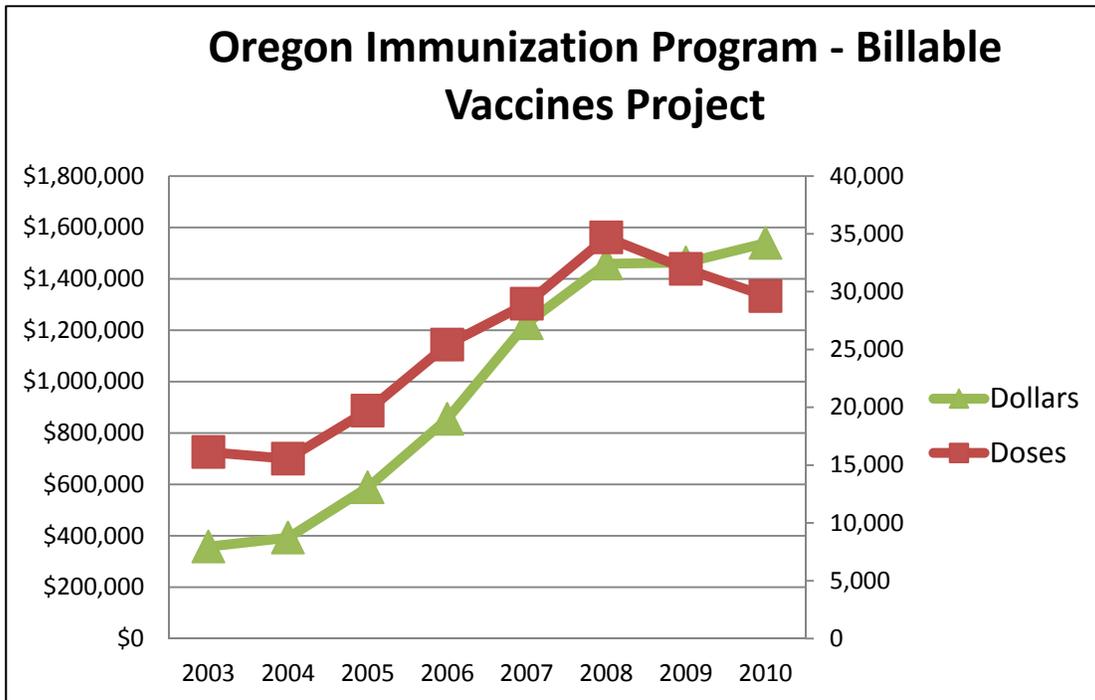
*How Oregon compares to other states:* During 2010, the national immunization rate for persons 65 and older was 67.5 percent, with state rates ranging from 73.4 percent in Colorado to 59.3 percent in Nevada. Oregon ranked 46th, with 65.0 percent of the 65-plus population immunized.

<b>Behavioral Risk Factor Surveillance System, 2010</b>	
<b>State</b>	<b>Influenza Immunization Rate</b>
Colorado (ranked 1st)	73.4%
California	63.0%
Idaho	60.7%
Nevada	59.3%
Oregon (46th)	65.0%
Washington	69.3%
National	67.5%

**Quality and efficiency improvements**

During recent years the Immunization Program worked with Oregon’s local Health Departments to implement a new process and culture for billing insured clients and their health plans for the cost of vaccines provided in public clinics. The program stopped using taxpayer-funded vaccine to immunize the well-insured. Oregon’s public clinics administered 29,619 doses of vaccine to fully insured clients, valued at \$1.5 million in CY 2010. Revenue from this project is used to purchase additional vaccine for the well-insured clients being served in public clinics, and to fund special outreach projects to increase access to immunization services. The CDC has adopted this as a best practice nationally.

Oregon Immunization Program — Billable Project History



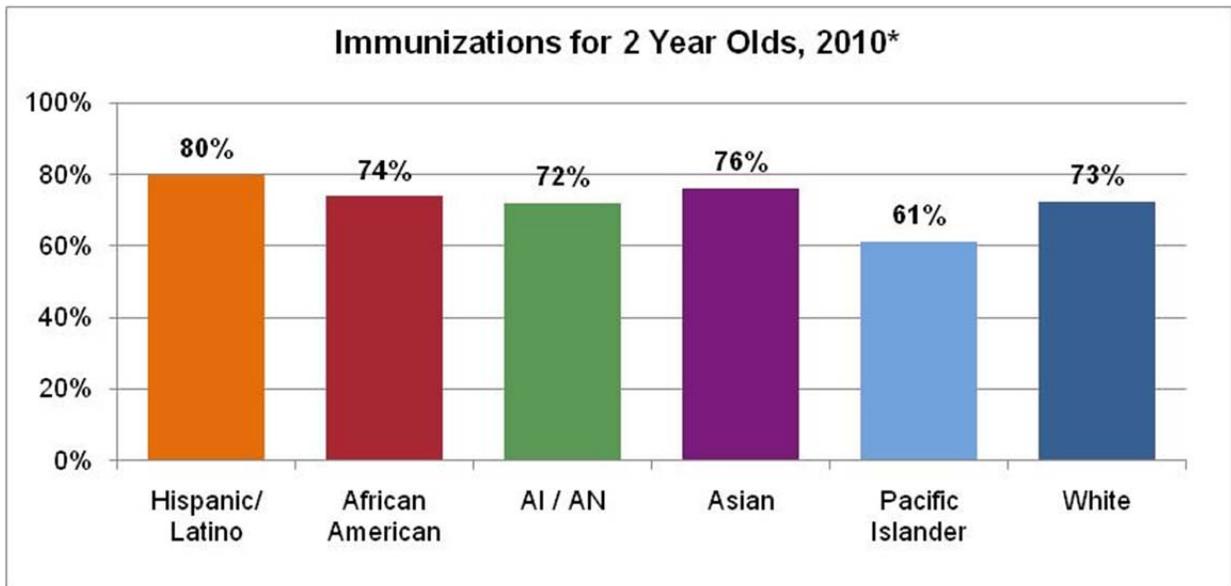
With the advocacy and leadership of Representative Nancy Nathanson, the Oregon legislature passed the “Vaccine Stewardship” legislation in 2011 (ORS 433.103), requiring all providers who receive vaccine from the program to account for the doses in Oregon’s award winning ALERT IIS. In addition, providers are now required to assure their staff are trained in the storage, handling and clinical administration of vaccines.

The ALERT Immunization Registry is converting to a new platform, becoming the ALERT Immunization Information System, or IIS. The new IIS will allow clinics to submit, correct and extract their patients' data through a broader variety of methods, thus improving the quality, timeliness and completeness of IIS data. In addition, the IIS will offer more tools to clinic sites allowing them to run their own benchmarking reports, reminder or recall notices and immunization rates. The robust new platform should also allow the IIS to function far more efficiently and effectively.

## **Health disparities and immunization rates**

The Oregon Immunization Program houses two statewide coalitions, the Oregon Partnership to Immunize Children (OPIC) and the Oregon Adult Immunization Coalition (OAIC), and partners with local health departments, community based organizations, tribal health centers, non-profit organizations and local providers to monitor immunization uptake and access in vulnerable populations.

Development of community-specific immunization rates helps the Immunization Program target interventions and coalition outreach activities. In a 2010 analysis, Oregon's Hispanic community (80 percent) had higher immunization rates than non-Hispanics (71 percent). Oregon's Asian (76 percent) and African American (74 percent) populations had immunization rates higher than those of the white population (72 percent) and at or above the state average (72 percent). The Hawaiian/Pacific Islander (61 percent) and American Indian/Alaskan Native (72 percent) populations had lower rates than the state average, however only the Hawaiian/Pacific Islander population had rates significantly lower. 2010 is the first year when the Immunization Program has reported a rate specific to the Hawaiian/Pacific Islander population; this population was previously grouped with the Asian population and lower rates would have been masked by the higher rates associated with the much larger Asian population. The Hawaiian/PI population represents the smallest race group, including only 310 children, however, the disparity is documented and it is a population that will receive increased attention from the immunization program.



## **Key budget drivers and issues**

Oregon has three primary sources of vaccine funding. In 2011, funds from all three sources totaled \$40,000,000.

- Vaccines for Children (VFC) is a federal entitlement program that covers children who are uninsured, on OHP/Medicaid, American Indian/Alaskan Native, and underinsured (insured but not for immunization) if served in a federally qualified health center. VFC covers all ACIP-recommended pediatric vaccines for children from birth through 18 years.
- Federal 317 funds are limited and have not increased significantly since late 1990. Currently, 317 funds support lifespan vaccine delivered in public clinics. Approximately fifty percent of 317 funding supports adult immunizations.
- Billable funds are collected by the Oregon Immunization Program from public providers for insured clients served in public clinics.

Beyond VFC, Oregon's vaccine funding is inadequate to assure ongoing access for all childhood ACIP-recommended vaccines. Fully insured children have access in both the public and private sectors, just like VFC eligible children. It is the children who are insured, but by a plan that does not cover vaccine or that includes an unaffordable co-pay or deductible, who often do not have access to immunizations. In the public sector, we use limited Section 317 funds to cover most routine vaccines for these children. Prior to launching Oregon's unique billables project, these children did not have equal access. Since the billables project, underinsured children have been eligible for all routinely recommended vaccines (except males for HPV vaccine) and for the adolescent booster dose of meningococcal vaccine.

## ***Human Immunodeficiency Virus (HIV), Sexually Transmitted Disease (STD) and Tuberculosis (TB)***

### **Services provided**

The HIV, STD and TB Program monitors the occurrence of these diseases in the state, works to prevent their spread and provides direct services to low income HIV positive persons, and people with tuberculosis and sexually transmitted diseases. Important tools for preventing the spread of these diseases include:

- Providing information systems for public health surveillance of HIV, STDs and TB;
- Providing medicines for treatment of TB and STDs;
- Interviewing and counseling patients with reportable STDs and identifying others at risk of infection;
- Tracing and ensuring treatment of contacts of patients with tuberculosis and sexually transmitted diseases;
- Sponsoring and monitoring statewide HIV prevention efforts;
- Counseling and testing for HIV;
- Providing HIV medical case management directly or through local contracted agencies; and
- Directly providing rental assistance and other housing-related assistance for persons with HIV.

This program also provides information to the public, the media, health care professionals and policymakers about HIV, STDs and TB in Oregon.

### **Where service recipients are located**

The services are provided to Oregonians statewide.

### **Who receives services**

Services are provided to all Oregonians affected by or at risk of acquiring HIV, other sexually transmitted diseases or tuberculosis. Targeted services are provided directly or through contracts to local health departments, to HIV-infected persons and their families.

### **How services are delivered**

Services are provided both from the program's central office and in partnership with local health departments and numerous community-based organizations.

### **Why these services are significant to Oregonians**

HIV is a life-threatening infection. Each year approximately 300 Oregonians are infected with HIV. Appropriate treatment of HIV infection not only extends life, but also reduces the risk of spreading HIV. Other STDs such as *Chlamydia* and gonorrhea are the most commonly reported communicable diseases in Oregon. They can facilitate HIV infection and also cause infertility. TB also is a life-threatening infection. Drug-resistant TB is a particularly serious problem that is

increasing worldwide. Though still uncommon in Oregon, ensuring prompt identification and appropriate treatment of individuals infected with drug-resistant TB is critical to helping prevent the problem from growing.

The HIV care and treatment program provides HIV medical case management and support services, targeted housing assistance, HIV prescription drugs and medical insurance to people with low incomes. Continuous, uninterrupted access to medical therapies improves health outcomes, slows or halts disease progression, and reduces the likelihood of disease transmission. This results in a lowered financial burden for both public and private medical and social services providers.

**Performance measures (HIV, STD, TB)**

This program has one OHA key performance measure.

KPM 36: The proportion of reported HIV/AIDS cases interviewed by a local or state public health professional and offered assistance with partner notification and referral to HIV treatment

*Purpose:* The aim of the HIV programs is to reduce new HIV infections. One important way to accomplish this is by finding and testing sex and needle partners of patients with newly reported cases, treating and counseling the partners if infected and counseling about HIV avoidance if not infected. Governmental partners include the Centers for Disease Control and Prevention and local health authorities. Non-governmental partners include clinical laboratories, health practitioners and health care facilities that report cases, and non-governmental HIV prevention agencies.

**Table.** Percentage of people with newly diagnosed HIV infection interviewed for purposes of partner notification and referral, Oregon HIV/STD/TB Program, 2002 — 2011.

<b>DATA</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
<b>Actual</b>	6%	13%	10%	17%	21%	43%	74%	70%	87%	87%
<b>Target</b>						40%	50%	90%	90%	90%

*How Oregon compares to other states:* Rates of HIV, STDs and TB in Oregon tend to be lower than the national rate.

## **Quality and efficiency improvements (HIV, STD, TB)**

### **The HIV Care and Treatment Programs**

The HIV community based medical case management program completed a two year pilot project June 30, 2011. This new model for case management and support services (in 22 counties outside of the Portland metropolitan area) provides medical case management by certified AIDS care nurses and a centralized care coordination center. Some local county health departments continue to provide case management and support services in areas outside of the regional service area.

The STD, HIV surveillance and TB programs have collaborated with the Acute and Communicable Disease Prevention section and all 34 local health authorities to develop an integrated disease reporting database that has replaced several obsolete information systems. The new system facilitates efficiency in investigation of diseases of public health importance, reduces time required to investigate and improves the quality of reportable disease investigation for local public health officials, and improve timeliness and quality of federal reporting.

The TB program collaborates with Oregon State Public Health Laboratory to use two new tests that improve the timeliness and accuracy of diagnosis of tuberculosis in Oregon: the Quantiferon-Gold<sup>®</sup> assay for the diagnosis of TB infection; and nucleic acid amplification testing for making identification of tuberculosis as a cause of pneumonia more timely.

Similarly, the STD program continued work with the Oregon Public Health Laboratory to implement a modern nucleic acid amplification test for diagnosis of *Chlamydia* and gonorrhea.

### **Key budget drivers and issues**

Collectively the HIV/Sexually Transmitted Disease/Tuberculosis (HST) program depends predominantly on federal funding. Reductions in federal appropriations for HIV, STD and TB programs during the past half-decade and the lack of increases in federal funding for these programs continue to substantially limit services.

HST General Fund dollars comprise a minority of the overall HST budget.

## *Health Statistics (HS)*

### **Services provided**

Health Statistics (HS) is responsible for registering, certifying, amending, and issuing Oregon vital records Oregon law requires that all vital events such as births, marriages, divorces, registered domestic partnerships, dissolution of registered domestic partnerships, fetal deaths, and deaths be permanently recorded and registered. These are the legal records documenting a vital event and, in the case of birth certificates, are the primary documents used to establish identity. During 2011, HS registered 113,000 vital events and issued 177,000 certificates. In addition to playing a critical role as legal documents, these documents make it possible to collect statistics related to these events. Vital records data are used throughout the state and nation for program planning and policy development and are the primary data sources used for measuring key health indicators found in the Healthy People 2020 Objectives, Public Health Accreditation Board state health assessments, Key Performance Measures, and many other health indicators projects. The center also administers the Oregon Healthy Teens Survey and the Behavioral Risk Factor Surveillance Survey, two important sources of data about risk behaviors and provides information to the public, the media and policymakers about health behaviors in Oregon.

The work HS does supports the vision, mission and values of the Public Health Division in three primary ways:

- Providing quality customer service to Oregonians who experience vital events to ensure those events are legally registered in the state vital records system in perpetuity so they, or any eligible family member, can get certified copies of their vital records.
- Promoting good partnership with a variety of different stakeholders who are responsible for producing the vital records.
- Providing accurate and timely vital statistics data that are used for measuring lifelong health.

### **Where service recipients are located**

The services are provided to Oregonians statewide.

### **Who receives services**

Services are provided to all Oregonians.

### **How services are delivered**

Services are provided both from the program's central office and in partnership with local health departments.

### **Why these services are significant to Oregonians**

Vital records are key legal documents required for a variety of purposes. Data collected by HS are critical for informed policymaking.

### **Performance measures**

This program has no OHA key performance measures.

### **Quality and efficiency improvements**

During the 2011-13 biennium the program continues improving the Oregon Vital Event Registration System (OVERS) which includes the Electronic Death Registration System, Electronic Birth Registration and Fetal Death System. The Oregon Vital Event Registration System is a fully electronic secure web-based vital records system. This system allows all aspects of the vital records process, from registration at the data source to issuance of certified copies in the counties and state, to be electronic rather than paper-based. The implementation of this system provides for more timely, accurate and secure processing of these important documents for Oregonians. The center also expanded implementation of the nationally-based electronic systems for electronic verification of birth certificates by agencies. Other efficiency improvements include installing Kiosk for vital records orders; converting all vital records data from the mainframe to OVERS; and streamlining errors processing on birth records to reduce work at the hospital and in HS. As funding permits in the future, there are plans to add Induced Termination of Pregnancy to the electronic system, to convert older birth and death records on the mainframe to OVERS, and to electronically image older paper records.

### **Key budget drivers and issues**

This work is event driven, not revenue driven. The section is legally required to process and register all vital events regardless of the revenue we get through the

sale of vital records. No matter how many births, deaths, marriages, divorces or other vital events occur in Oregon, HS must process and register those events as part of the state's vital records system. Fees received from the purchase of vital records are the primary source of revenue for the section. The fee revenue funds 90% of our work. The remaining 10% of our work is funded from federal contracts and grants, primarily from the Social Security Administration and the National Center for Health Statistics through both the Vital Statistics Cooperative Program and the National Death Index. During the past few years the number of vital records sold has declined so the Center is getting less fee revenue. Fees support a wide range of vital records functions beyond just selling birth certificates and other vital records. Despite the decline in sales of vital records, workload has increased because more records need to be amended; more users are added to OVERS; security and fraud prevention improvement are made; data quality improvement are made, and more requests for data access are received and processed. These changes have a budgetary impact on the section.

### ***Oregon State Public Health Laboratory***

The Oregon State Public Health Laboratory (OSPHL) supports state and local public health programs in controlling communicable diseases, identifying metabolic disorders in newborn infants, and ensuring the quality of testing in clinical and environmental laboratories statewide.

During the 2013-15 biennium, the laboratory will perform approximately 26.5 million tests on 803,000 samples submitted by local health departments, community clinics, hospitals, physicians and others for communicable disease testing and newborn screening.

Communicable disease testing is performed to identify and prevent infections that can be transmitted in the community. These include tuberculosis, influenza, sexually transmissible infections (gonorrhea, *Chlamydia*, syphilis), *Salmonella*, *E. coli*, HIV, hepatitis, norovirus, pertussis (whooping cough), rabies, parasites, and many others. Samples are submitted by local health departments, community clinics, hospitals, and other health care providers. This testing benefits individual patients and supports public health efforts to prevent and control outbreaks.

The laboratory's Northwest Regional Newborn Screening Program tests all infants born in Alaska, Hawaii, Idaho, Nevada, New Mexico and Oregon for 46 different disorders of body chemistry that can cause serious disability or death unless

detected and treated soon after birth. During 2013-15 SPHL will screen 321,140 infants and refer to treatment approximately 800 children with these disorders.

As an essential part of Oregon's emergency preparedness system, the laboratory provides and coordinates rapid laboratory response to emergencies and threats ranging from pandemic influenza to bioterrorism by testing unknown samples and operating the Laboratory Response Network (LRN). The network consists of 91 laboratories that can package and ship biological and chemical specimens for testing. Of these, 47 are microbiology labs whose staff can quickly identify microbes in human samples that represent an emergent threat and refer them to SPHL for confirmation and typing.

The OSPHL certifies 2,480 clinical laboratories in Oregon under the federal Clinical Laboratory Improvement Amendments and accredits 38 Oregon environmental labs in collaboration with the Oregon Department of Environmental Quality and the Oregon Department of Agriculture.

The major funding sources include:

State:

General Fund to support communicable disease testing for local health departments and epidemiology

Federal:

- Office of the State Public Health Director;
- Center for Public Health Practice; and
- Center for Health Protection.

Fees:

- Newborn screening and other testing fees;
- Laboratory licensing and accreditation fees

### **Services provided**

OSPHL provides:

- Communicable disease testing (virology/immunology and microbiology);
- Newborn metabolic screening;
- Rapid response to threats and emergencies;
- Environmental testing (food and water);

- Laboratory compliance monitoring and accreditation; and
- Technical assistance to local health departments.

### **Where service recipients are located**

The hospitals, practitioners, local health departments, clinics and patients who receive OSPHL services are located throughout the state of Oregon. The newborn screening program serves hospitals and patients throughout Alaska, Hawaii, Idaho, Nevada, New Mexico and Oregon. Samples are collected at these sites and transported to OSPHL for testing.

### **Who receives services**

Communicable disease testing and rapid response services are provided to state and local public health programs and their clients throughout Oregon as part of clinic visits, disease surveillance and outbreak investigations. Newborn screening is provided to all infants born in Alaska, Hawaii, Idaho, Nevada, New Mexico and Oregon. Laboratory compliance activities are provided to all clinical laboratories and many environmental laboratories in Oregon.

### **How services are delivered**

All staff are located at OSPHL in Hillsboro, where testing is performed in a centralized facility. Laboratory compliance staff travels throughout the state to conduct on-site inspections and to provide technical assistance and training for local health departments.

### **Why these services are significant to Oregonians**

Disease control programs, including local health department clinics, rely heavily upon laboratory testing by OSPHL to identify and prevent the spread of infections in the community. The OSPHL provides tests that are highly specialized, necessary for epidemiologic activities and unavailable elsewhere in Oregon. Newborn screening prevents severe disability and death of infants through early diagnosis and treatment. Laboratory compliance activities protect the public by ensuring that medical and environmental laboratories meet the necessary federal and state standards for accurate testing.

### **Performance measures**

The State Public Health Laboratories does not have primary responsibility for any OHA key performance measures, but does support several KPMs. KPM 30 - early

prenatal care for low income women - is supported by the provision of prenatal testing for hepatitis B, syphilis, *Chlamydia*, and rubella. KPM 35 - safety net clinic use - is supported by the provision of testing for local health departments, community and migrant clinics and other safety net providers.

### **Quality and efficiency improvements**

During the current biennium OSPHL has modernized and automated several of its testing methods. This has resulted in more analytical output per staff position and greater accuracy of test results. Examples include the automated processing and testing of blood specimens for tuberculosis (Quantiferon); automated testing of HIV and hepatitis samples onto one test platform for greater efficiency; and acquisition of a liquid handling system that automates the pooling of *Chlamydia* specimens for testing.

In 2012, a new Laboratory Information Management System (LIMS) was implemented that improves the tracking and reporting of samples and results, and enhances quality assurance monitoring. It changed workflow processes for increased efficiency and less paperwork. The new LIMS also improves data sharing and interoperability with other PHD programs and CDC, as well as Web-based access to test results by OSPHL clients. The newborn screening information system was upgraded to provide better customer service through remote data entry, remote result viewing and remote case management.

Newborn Screening is involved with the Laboratory Efficiencies Initiative (LEI) through CDC and the Association of Public Health Laboratories (APHL). It is aimed at helping state and local public health laboratories improve their operating efficiency and thus their ongoing capacity to conduct testing services. By adopting high-efficiency management practices and system-wide savings through procurement discounts through point purchasing; generation of new revenue streams; contractual services; regionalization of testing; and adoption of cost-saving technologies and testing platforms. SPHL is being used as an example of a successful regional program.

The OSPHL has a comprehensive quality management system in place and continues to maintain external accreditation by the College of American Pathologists (CAP). This requires continuous, ongoing evaluation and improvement of all aspects of quality. In April 2012, the SPHL was inspected and reaccredited by CAP through May 2014.

### **Key budget drivers and issues**

Because the OSPHL budget depends heavily on federal funds from several sources for its core services, fluctuations in federal funding can impact OSPHL's ability to provide basic support for disease control programs. The impact of the Oregon health system transformation is unknown; the insurance mandate and Coordinated Care Organizations may have a significant impact on the test volume and funding of the OSPHL.