

Public Health

The Oregon Public Health Division is part of the Oregon Health Authority, which was created in 2009 with a clear direction to innovate, improve, and rework the state health care system for three goals: 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.

Goals

The Public Health Division (PHD) helps fulfill those goals by protecting the health of all the people of Oregon by preventing avoidable illness, death and disability, improving the health status of Oregon's communities, and reducing the need for costly illness care for all Oregonians

History

In 1903, because of concern about infectious disease outbreaks – smallpox, bubonic plague and tuberculosis – the Legislature created a State Board of Health with a \$5,000 budget. This legislation also provided for a public health laboratory, a vital statistics registry and county boards of health.

During the next 70 years the scope of Oregon's public health services reached out to more Oregonians. The 1971 Legislature created the Oregon Department of Human Resources (DHR) as an umbrella agency for public health, mental health, social services, corrections and employment. In this new agency, the State Board of Health became the Oregon Health Division.

During the next 30 years the division grew in response to a variety of challenges, including growing refugee populations in the 1970s, the AIDS epidemic of the 1980s and increasing concern with radiation exposure following the Chernobyl disaster in the Soviet Union. The nation's first bioterrorist event occurred in Wasco County when people associated with the Rajneeshpuram community intentionally contaminated a salad bar in The Dalles with salmonella. Epidemiologic and laboratory investigation by the division identified and documented the extent of this episode. The terror attacks of 2001, including anthrax exposure, led to the

perception of public health as a key element of public safety and significant new investment in federal public health preparedness funding.

More recently, during 2009 and 2010 public health responded to the H1N1 threat. The state Health and Medical Agency Operations Center, whose goal was to protect the health of the people of Oregon, was activated for 86 days. Through extensive planning, public health through its local partners delivered 810,000 doses of H1N1 vaccine to 750,000 individuals.

One of the new challenges facing the public health system is the increasing impact of chronic disease and injuries in Oregon's communities. Heart disease, cancer and stroke are the major causes of death and disability. Injury is the third leading cause of death nationally and the leading cause of death for children and young adults. The improvements in life expectancy and health have stalled – largely through an increase in obesity – and the route to improvement includes community-based public health prevention and early intervention activities. The system created by the 1903 legislation – including local service delivery, a state laboratory and a strong reliance on data – provides the foundation for better public health today.

Services

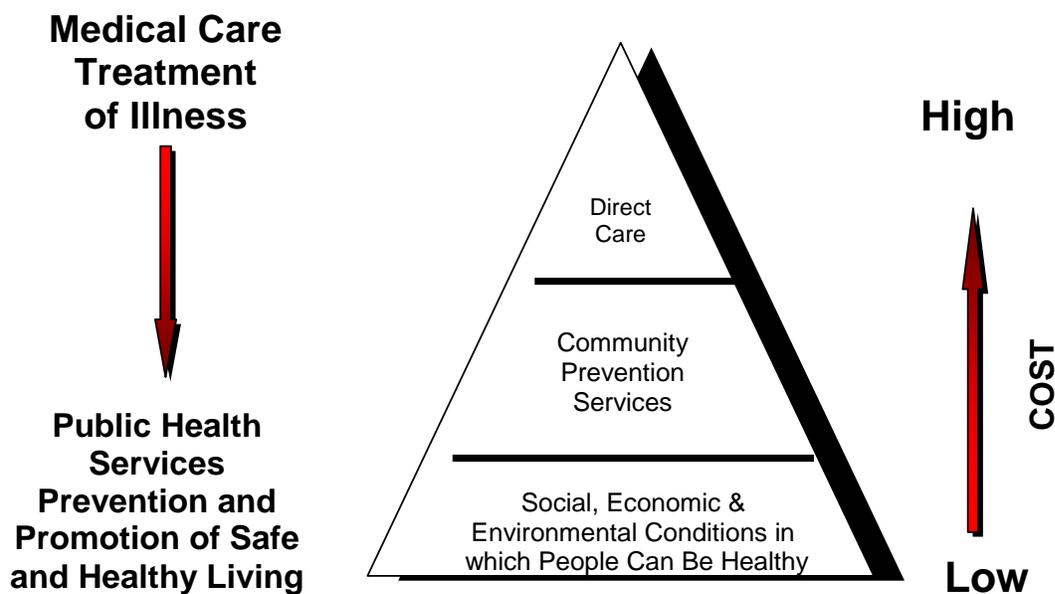
Public health is fundamentally about prevention and working with communities to create conditions that support health, in contrast to the medical care system, which primarily treats illnesses in individuals. Since 1900 life expectancy in the United States has increased by more than 30 years, most of which is attributable to advances in public health – safe drinking water, improved nutrition, sewage disposal and broad-scale immunizations.

Although public health has been the most significant factor in improving health and longevity, only 1.5 percent of OHA General Fund resources are spent on these preventive and community-based public health services. While Oregonians should never be denied the medical care they need, efforts to prevent illness and promote healthy living can greatly reduce the burden and cost of disease, and ultimately of medical care.

The health services pyramid below illustrates a public policy dilemma. Currently, society invests most health dollars in direct medical care for those who can gain access. It invests relatively little in low-cost, preventive population-based services.

Investment in ensuring the health of Oregon’s communities could significantly reduce overall medical care costs.

Investments in community preventive services can often go unseen by the general public because of their effectiveness in preventing outbreaks or chronic conditions from happening in the first place. These investments include working with health professionals to improve health screening; organizing community efforts to address the causes of diseases such as diabetes, asthma and stroke; conducting media campaigns to encourage healthy and responsible behaviors; and gathering and distributing health data and vital records.



As the state component of the public health system, the OHA Public Health Division oversees the system as a whole, and tries to ensure that major causes of death, illness and injury are addressed to the extent resources allow. Some programs are operated directly by PHD, while others are delivered in collaboration with the 34 local health departments in counties across the state, which have the statutory authority to protect the public’s health in their counties. While a small amount of the state investment in public health remains at the state level, most of it is either transferred to local health departments for their work, or pays for state staff to provide services in direct support of local health department activities, such as laboratory services for infectious disease testing.

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

services include programs for communicable diseases, immunizations, preventive services for children and women, and inspections of food and water systems. Other programs and services primarily are delivered at the state level, including statewide regulation of some services and potential hazards, scientific analysis and the development of statewide plans to prevent epidemics, control disease, reduce exposure to health hazards, ensure safe food and water, and promote healthy behaviors. Public health programs frequently collaborate with a range of health care providers and other organizations and agencies.

Recent years have brought recognition of new risks to the health of the public. These risks include new or potential diseases such as SARS, West Nile virus, and avian and pandemic flu, and “old” diseases that are returning with epidemic potential such as whooping cough, tuberculosis and E. coli. This has increased the need for disease surveillance, public education and preparedness. The public also is increasingly concerned about the need to prevent injuries, suicide and exposure to environmental hazards. In addition, there is 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. For example, extended periods of extreme heat can cause an increase in heat-related illnesses, especially in the older, very young and those with chronic conditions.

Because terrorist attacks and natural disasters have serious health consequences, the public health system has an important role to play in emergency preparedness. Federal funding for public health emergency preparedness activities has directed many of the activities of state and local public health programs in this area, but federal requirements have not always matched up well with the preparedness needs of Oregon’s communities.

Public health programs that regulate and investigate health care facilities are expected to ensure that health care practices are evidence-based and that patient safety is safeguarded.

With reduced or static funding for state and local public health programs in recent years, the gap between expectations and actual capacity to protect people has widened. Chronic underfunding and increasingly fragmented and narrow financial support for public health have eroded many previously strong programs and have limited the ability of Oregon’s state and local public health system to appropriately protect Oregonians.

Programs

PHD serves Oregonians through the following major programs:

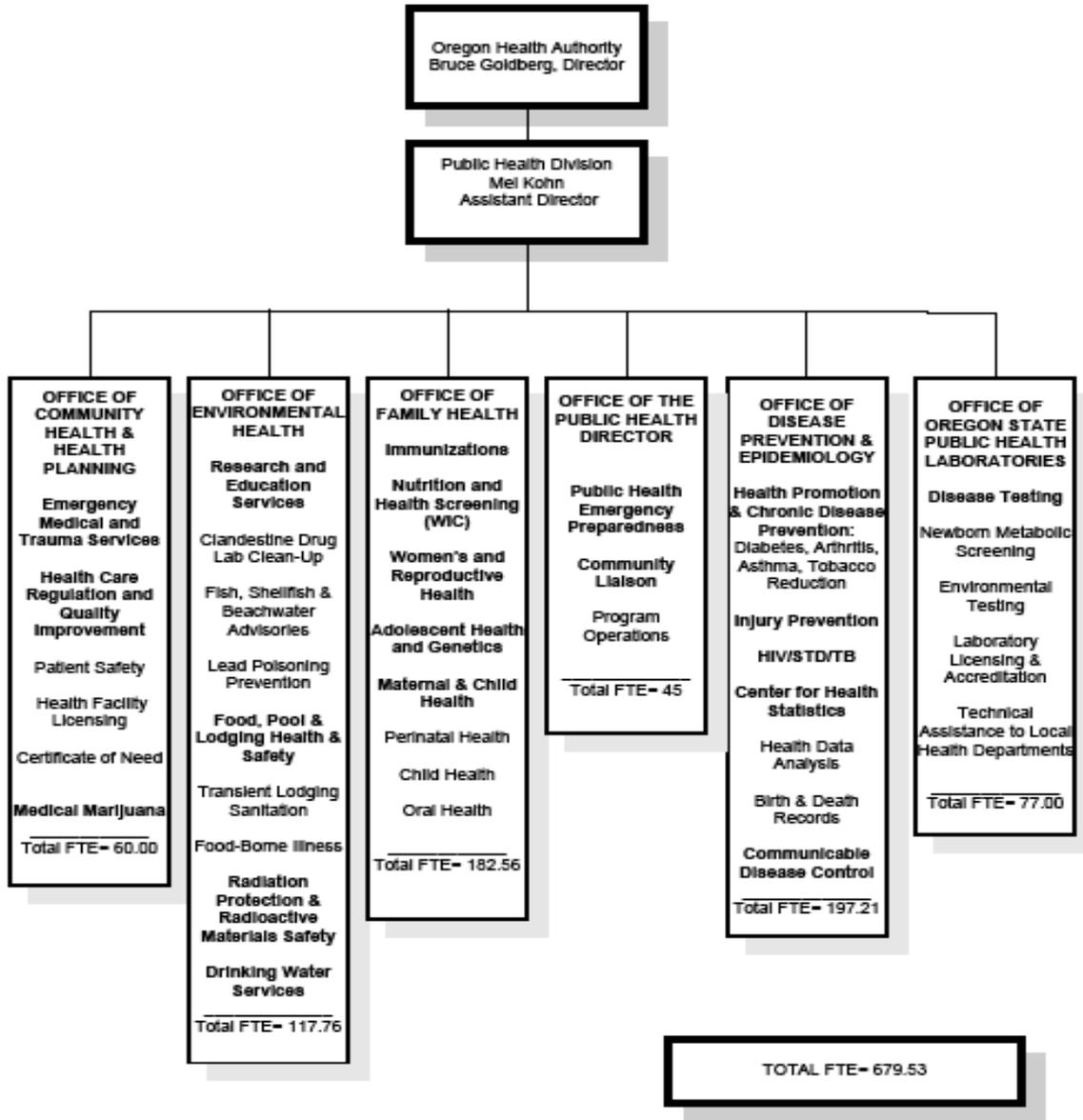
- Office of the State Public Health Director
- Office of Community Health and Health Planning
- Office of Environmental Public Health
- Office of Family Health
- Office of Disease Prevention and Epidemiology
- Office of State Public Health Laboratories

These programs provide a foundation for Oregon's health system that ultimately results in disease prevention, improved individual and community health, and lower health costs. Taken together, these programs help ensure the health and safety of all Oregonians, especially children and other vulnerable citizens, as well as visitors to the state.

The following chart outlines the Public Health Division's major program areas and the OHA principles they support.

| PUBLIC HEALTH PROGRAM AREA | Child Health | Prevention | Comm. Disease | Access to Care | Environmental Health | Licensing and Regulation |
|--|---------------------|-------------------|----------------------|-----------------------|-----------------------------|---------------------------------|
| Office of State Public Health Director | | | | | | |
| Public Health Officer | | | | | | X |
| PH Emergency Preparedness | | X | X | | X | |
| Community Liaison | X | X | X | X | X | X |
| Office of Community Health and Health Planning | | | | | | |
| Emergency Medical Services | | | | X | | X |
| Health Care Regulation and Quality Improvement | | | | | | X |
| Medical Marijuana Program | | | | | | X |
| Office of Environmental Public Health | | | | | | |
| Research and Education Services | X | X | X | X | X | X |
| Drinking Water Services | | X | | | X | X |
| Food, Pools, and Lodging Safety | | X | | | | X |
| Radiation Protection Services | | X | | | X | X |
| Office of Family Health | | | | | | |
| Immunization | X | X | X | X | | X |
| Nutrition and Health Screening (WIC) | X | X | | X | | |
| Women's and Reproductive Health | X | X | X | X | | |
| Adolescent Health and Genetics | | X | | X | | |
| Maternal and Child Health (MCH) | X | X | | X | | |
| Office of Disease Prevention & Epidemiology | | | | | | |
| Health Promotion, Chronic Disease Prevention | | X | | | | |
| Injury Prevention and Epidemiology | | X | | | | |
| HIV/STD/TB | | | X | | | |
| Health Statistics (Vital Records) | | | | | | X |
| Acute and Communicable Disease | | | X | | | |
| Office of the State Public Health Laboratories | | | | | | |
| Newborn Screening | X | X | | X | | |
| Lab compliance and quality assurance | | | | | X | X |
| Virology/Immunology | X | | X | X | | |
| Microbiology | X | | X | X | X | |

Organizational structure



Office of the State Public Health Director (OSPHD)

Key programs

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

OSPHD manages the Public Health Emergency Preparedness Program (PHEP), 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. PHEP has been a part of state leadership in advancing the state's plans for pandemic influenza and the development of a state Crisis Communication Plan. Through the ongoing planning, training, activities and coordination of this program the communities of Oregon and the state overall are far better prepared to detect and respond to a public health emergency.

The Community Liaison unit provides support and oversight to local health departments. While PHD programs interact with the local health departments, the unit serves to coordinate the various activities and serves as the primary resource for the local public health systems overall. This is accomplished through technical assistance, coordinating statutory required agency reviews, overseeing the disbursement of state support for public health funds to local health departments, directing the annual plan process and related budget revisions, and identifying grants and assisting with their preparation.

The Program Operations unit is responsible for providing division-wide administrative services to PHD in the areas of rulemaking, legislative support and coordination, risk management and safety, Web technology and support, volunteer coordination, business continuity planning, informatics, travel, and video-conferencing. This unit also functions as the liaison between PHD and the DHS/OHA Administrative Services Division programs representing the PHD on department-wide initiatives and workgroups.

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;
- Centers for Disease Control and Prevention Preventive Health Block Grant; and
- State Support for Local Public Health (General Fund per capita).

Public Health Emergency Preparedness Program (PHEP)

Services provided

The Public Health Emergency Preparedness Program (PHEP) has three primary roles.

PHEP's first role is to develop emergency-ready state and local public health programs by upgrading, integrating and evaluating state and local public health preparedness for and response to terrorism, pandemic influenza, natural disasters, chemical releases and other public health emergencies. These activities include federal, state, local and tribal governments, the private sector, and non-governmental organizations.

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

PHEP's second role is to improve the ability of hospitals and health care systems to prepare for and respond to pandemics, bioterrorism, natural disasters 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).

PHEP's third role is to prepare and respond to the health and medical aspects of a potential or actual chemical release associated with the U.S. Department of Defense, Umatilla Military Chemical Depot storage or destruction of chemical munitions.

Funding for these activities is provided through the Federal Emergency Management Agency's Chemical Stockpile Emergency Preparedness Program.

Where service recipients are located

Anyone, anywhere within Oregon's borders, including tribal lands – or potentially 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, PHEP activities are located across program offices in:

- Public Health Preparedness Operations, Planning, Liaison, Risk Communications, Information Technology and Training programs (PHEP)
- Acute and Communicable Disease Program (ACDP)
- Oregon State Public Health Laboratories (OSPHL)
- Radiation Protection Services (RPS)
- Research and Education Services (R&E)
- Emergency Medical Services and Trauma Systems (EMS/TS)
- Maternal and Child Health (MCH)
- Immunization Program (IP)

Funding is provided to 36 counties and eight tribes to perform the activities that support the CDC grant guidance. The Oregon Association of Hospital and Healthcare Systems (OAHHS) provides technical assistance and consultation on healthcare and hospital preparedness. Seven Regional Lead Agencies (RLAs) are partners that contract with PHD to coordinate the work activities of the Healthcare Preparedness Program.

Who receives services

The services are provided statewide through two contracting sources. For the CDC activities, PHEP contracts with 36 counties and eight tribes for the work activities that support the grant guidance. For the healthcare preparedness activities, PHEP contracts with seven regional lead agencies.

How services are delivered

Services are provided by PHD staff and employees of public health departments, hospitals, health care facilities and tribes.

Why these services are significant to Oregonians

One of the fundamental responsibilities of state government is to provide for the safety of the people of the state. While the activities of PHEP are constrained by the guidance that accompanies the federal grants, PHEP endeavors to integrate 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 using the CDC Preparedness Goals and associated measures to monitor performance.

The goal of the Healthcare Preparedness agreement is to prepare hospitals and supporting health care systems, in collaboration with other partners, to deliver coordinated and effective care to victims of terrorism and other public health emergencies. Activities include improving hospital bed and personnel surge capacity, decontamination capabilities, isolation capacity, pharmaceutical supplies, and supporting training, education, drills and exercises. The Healthcare Preparedness Program has been reviewed by an independent contractor in 2010 and is undergoing programming and structural adjustments to ensure accountability, efficiency and effectiveness as part of the program's commitment to continuous quality improvement.

The Chemical Stockpile Emergency Preparedness Program's (CSEPP) goal is to protect communities near the chemical weapons stockpile depot. This federal /state /local partnership has helped these communities by enhancing emergency plans

and providing chemical accident response equipment and warning systems. Annual chemical stockpile emergency preparedness exercises are held in communities surrounding the depot each year. The program and its partners practice keeping the public safe in the unlikely event of a chemical stockpile accident.

Performance measures

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

Quality and efficiency improvements

In order to improve the quality of preparedness activities, PHEP works with its key partners to:

- Demonstrate the capability to notify and assemble a health and medical incident response team within 60 minutes (at the state level).
- Increase the use and development of interventions known to prevent human illness from chemical, biological and radiological agents as well as naturally occurring health threats.
- Decrease the time needed to classify health events as terrorism or naturally occurring.
- Decrease the time needed to detect and respond to chemical, biological and radiological agents in tissue, food or environmental samples that cause threats to the public's health.
- Improve the timeliness and accuracy of communications to health care providers and the general public regarding threats to the public's health.
- Decrease the time to identify causes, risk factors and appropriate interventions for those affected by threats to the public's health.
- Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.
- Decrease the time needed to restore operations to provide general public health services.

- Increase the long-term follow-up provided to those affected by threats to the public's health.
- Decrease the time needed to implement recommendations from after-action reports following threats to the public's health.
- Increase the number of public health and medical service staff in Oregon's emergency volunteer program.
- Increase the number of health care partners that provide alternate care sites.
- Increase the capability of tracking the hospital bed availability system.
- Increase interoperable communication systems within the public health and medical services areas.
- Increase state, local and tribal public health and medical service personnel who receive training to support the National Response Plan.
- Increase all-hazard planning, training, exercise, evaluation and corrective actions for state, local and tribal public health and medical service personnel.
- Maintain and improve capability to report available hospital beds for at least 75 percent of participating hospitals within four hours of a request.
- Maintain and improve capability to query the state health care volunteer registration system to generate a list of potential volunteer health professionals within two hours of a request.
- Conduct exercises that incorporate National Incident Management System concepts and principles.

During 2009-2010 PHEP and our preparedness system partners responded to the H1N1 threat. The state Health and Medical Agency Operations Center was activated for 86 days and staffed by PHEP and Health Division staff. Incident Command System principles were used to organize and implement the response. Actions taken to protect the health of the people of Oregon included:

- Within 26 days, planned and implemented the Governor's Pandemic Influenza Summit attended by over 900 community leaders and viewed by thousands of additional people via live video streaming. This event raised awareness of the potential impact of pandemic influenza on the public and private sectors and was a call for accelerated business continuity and preparedness efforts.

- As of April 29, 2010, 810,000 doses of H1N1 vaccine were delivered to 750,000 individuals.
- Development of a system-wide coordinated Communications Plan. Messages emphasizing the importance of immunizing children and people at highest risk of serious illness or death, as well as prevention messages regarding hand washing, covering your cough and staying at home when sick were delivered via television, radio, and print outlets as well as social media such as Facebook and Twitter.
- Established a statewide H1N1 hotline and nurse triage service that provided information about H1N1, vaccine availability and safety to 14,503 callers from every county in the state.
- Within 17 days, developed and launched the flu.oregon.gov website to provide timely, accurate, centralized information on H1N1, vaccine, epidemiology and response activities.
- Conducted 12,000 laboratory tests for H1N1 influenza in four months. Volume peaked in October when 6,000 tests were conducted.
- Distributed 5,228 courses of antiviral medication to 93 local health departments, tribes and state institutions. Additionally, personal protective equipment (PPE) received from the federal Strategic National Stockpile was distributed.
- Conducted epidemiologic studies to identify and track disease prevalence and groups at highest risk for illness and death.
- Provided regular situational assessments and conference calls to response partners and key stakeholders.
- Requested and received special authorities from the Governor to expedite contracting and procurement. This was the first time these authorities were used in an Oregon emergency response.
- Conducted 12 system-wide “hotwashes” to collect feedback on system performance to improve future response efforts. The formal H1N1 After Action Report was published Aug. 1, 2010.

Key budget drivers and issues

Historically, the PHEP program has been 100 percent federally funded. However, beginning August 2009, the state is required to provide a 5 percent match in order to continue federal grant funding, with the match increasing to 10 percent beginning in August 2010 for both the CDC and HPP grants. Additionally during the past several years, the base funds have been reduced at a rate of 10 to 15 percent annually. These reductions in turn have a significant impact on local health departments' and health care systems' abilities to sustain and improve preparedness efforts at the community and hospital levels.

Community Liaison (CL)

Services provided

The Community Liaison (CL) unit provides services that support the 34 county local health departments (LHDs). These services include ensuring compliance with the local public health portion of ORS 431, site visits to LHDs 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 LHDs.

Who receives services

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

How services are delivered

The compliance, workforce development and technical assistance to LHDs are provided by three CL staff. Site visits to each county LHD occur at least once during the year, and staff has frequent contacts with LHDs 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 CL unit does not have an OHA key performance measure, its state and local partnerships help further the OHA mission that people are healthy.

How Oregon compares to other states

No comparable data are available.

Quality and efficiency improvements

In order to improve the quality of services provided by LHDs, 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 LHDs 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.

Office of Community Health and Health Planning (OCHHP)

Key programs

The Office of Community Health and Health Planning (OCHHP) 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, OCHHP also ensures that established standards are met by hospitals, other health care facilities and agencies, emergency medical technicians, ambulance services, and hospital trauma systems. OCHHP also administers several special programs, including the Oregon Medical Marijuana Program.

Through its three major program areas, OCHHP:

- 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.
- Administers a registration system for patients, caregivers and growers eligible to participate in the Oregon Medical Marijuana Program.
- Manages other special programs such as the Institutional Review Board for protecting human subjects involved in public health research.

Major funding sources for OCHHP include:

- Fees through regulatory licensure, certifications and inspections,
- Other fees for OMMP cardholders, and
- Grant from DHHS Centers for Medicare and Medicaid Services.

Emergency Medical Services and Trauma Systems (EMS/TS)

Key services

The Emergency Medical Services and Trauma Systems (EMS/TS) program certifies and regulates emergency medical care providers and emergency medical services agencies throughout Oregon. 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 standards for emergency vehicles.
- Ensures that emergency 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 mass casualty incidents, epidemics and catastrophic events.
- Inspects and licenses ambulances and ambulance services, including approximately 600 ambulances, 25 air ambulances and 137 emergency medical service agencies.
- Enforces professional standards for emergency medical technicians, first responders and ambulance services including issuing certifications to approximately 11,200 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.
- Develops, implements and provides ongoing monitoring of Oregon's trauma system including establishing system standards, designation of trauma hospitals to care for critically injured patients and collection of trauma registry data.

- 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.
- Ensures trauma system standards are followed, which has resulted in a decrease in mortality from 25 percent preventable deaths pre-trauma system to a current 4 percent death rate.

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 technical 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, may become patients of EMS and trauma providers. The quality and effectiveness of care is critical to successful outcomes of this 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, and the designation of facilities to provide definitive care to specific patients; to monitor the quality and effectiveness of trauma systems, the emergency medical services system and the care provided by designated specialty care facilities. Additionally, 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. Additionally, research has demonstrated that establishing similar designation systems for heart attack, stroke and pediatric patients can significantly improve the outcomes of these patients. Finally, 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. The plan is contained in Legislative Concept 683.

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 specifically serve the rural and frontier regions of the state. Additionally, Oregon was one of the beta-test states for Computer Adaptive Testing and is using this new technology and methodology to improve availability, accuracy and timeliness of the exam process. 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 study the situation and 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 has bought 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 the 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

In order to balance the 2009-2011 Legislatively Approved Budget, a Mobile Training Unit (MTU) position was eliminated which resulted in a decrease in the amount of training that can be provided. This will ultimately lead to a decrease in providers because rural areas cannot afford the training that is required for the providers to be certified and recertify biannually.

The mission of the MTU is to keep rural volunteer emergency response agencies operational through the provision of continuing education that is mandatory for certified EMS personnel. The MTU is designed to help prevent the volunteer ambulance, economically challenged service area providers, and first response systems from the inability to provide 9-1-1 services due to the lack of adequately trained and certified volunteer EMTs and first responders.

Health Care Regulation and Quality Improvement (HCRQI)

Services provided

The Health Care Regulation and Quality Improvement (HCRQI) program ensures that Oregonians have wide access to the health care they need and that it will be safe and of high quality. This is accomplished through two main activities: 1) regulatory: state licensure and federal Medicare certification of health facilities, providers and suppliers; and 2) consultative: quality and patient safety improvement support and tools.

HCRQI:

- Sets standards for high-quality, safe health care through administrative rule promulgation.
- Conducts onsite surveys to evaluate compliance with state licensure rules and federal Medicare conditions of participation and coverage.
- Investigates complaints and allegations of poor medical care.
- Performs onsite building inspections for health care facility construction projects to ensure that newly constructed facilities provide safe and adequate care and lodging for persons receiving services.
- Promotes cost containment through better programming, design, and construction.
- Provides information and education for staff in health care facilities and agencies.
- Completes initial licensure and certification surveys of new providers in a timely manner.
- Provides oversight for the Institutional Review Board.
- Provides information and education for staff in health care facilities and agencies.

HCRQI also works with consumers, health care providers, health care organizations and other state partners to improve the quality of health care. The program:

- Develops, encourages, coordinates and supports efforts to improve patient safety and reduce medical errors through statutory responsibilities related to the Oregon Patient Safety Commission and other venues.

- Develops, encourages and supports efforts by physicians, nurses, and other practitioners to provide leadership in improving the quality of health care.

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

Services are provided at the facility level, except for certification of hemodialysis technicians. These facilities and providers include:

- Ambulatory surgical clinics,
- Birthing centers,
- Caregiver registries,
- 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 in-patient care facilities, and
- Oregon Patient Safety Commission, including the certification of its reporting system.

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. During the 2009 Legislative Session, passage of SB 158 required that all facilities be inspected at least once every three years.

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

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 HCRQI program has one measure.

Measure: Annual State Performance Audit by Federal Grant Partner (Medicare). Includes onsite review by federal government, including review of records and staff interviews and ongoing review of data submitted by the state in mandatory federal data system.

Purpose: The purpose of this measure is to ensure that 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

HCRQI recently reorganized its management structure:

- redefining the role of the section manager 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;
- assigning a survey manager to oversee the routine regulatory work and ensure excellent customer service for our licensees;
- assigning a complaints coordinator as lead worker to improve the efficiency and effectiveness of this regulatory activity;
- adding two operations and policy analysts for health care improvement and patient safety and for operations improvement using Lean tools; and
- adding three nurse surveyors to meet the increasing regulatory work.

HCRQI participates in the Lean Daily Management system. The purpose is to make our processes more efficient and effective.

Key budget drivers and issues

For FFY 2009, 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 2009 should allow HCRQI to survey all facility and provider types at least once every three years. Furthermore, HCRQI received approximately \$150,000 in ARRA funds to increase surveys in ambulatory surgery centers in Oregon in 2009-2010.

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

Hiring difficulties due to competition from salaries offered by private employers is an issue resulting in hiring delays and consequently inspection delays.

Oregon Medical Marijuana Program (OMMP)

Services provided

The Oregon Medical Marijuana Program (OMMP) administers the registration program of the Oregon Medical Marijuana Act (OMMA) that 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.
- 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 41,407 as of July 2010.

Who receives services

A patient who has one of the following qualifying debilitating medical conditions, or a medical condition or treatment for a medical condition that produces one of the following, may become a registered identification cardholder:

- Agitation due to Alzheimer's disease,
- Cancer,
- Glaucoma,
- HIV positive status,
- AIDS,
- Cachexia,
- Severe pain,
- Severe nausea,
- Seizures, and/or
- 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 OMMP processes applications from Oregonians suffering from qualifying debilitating medical conditions when a physician advises that such use may provide a medical benefit.

Why these services are significant to Oregonians

Since the inception of the OMMA in 1998 the program has shown continued growth. To date, there are more than 41,407 patients in the program and more than 61,500 registered OMMP cardholders, including caregivers and growers. This includes patients, caregivers and persons responsible for a medical marijuana growing 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 one measure.

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.

How Oregon compares to other states: No comparable data are available.

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 a location is an authorized marijuana grow site.

How Oregon compared to other states: No comparable data are available.

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 will reduce processing time, improve search capabilities for providing information to cardholders, and enhance report capabilities.

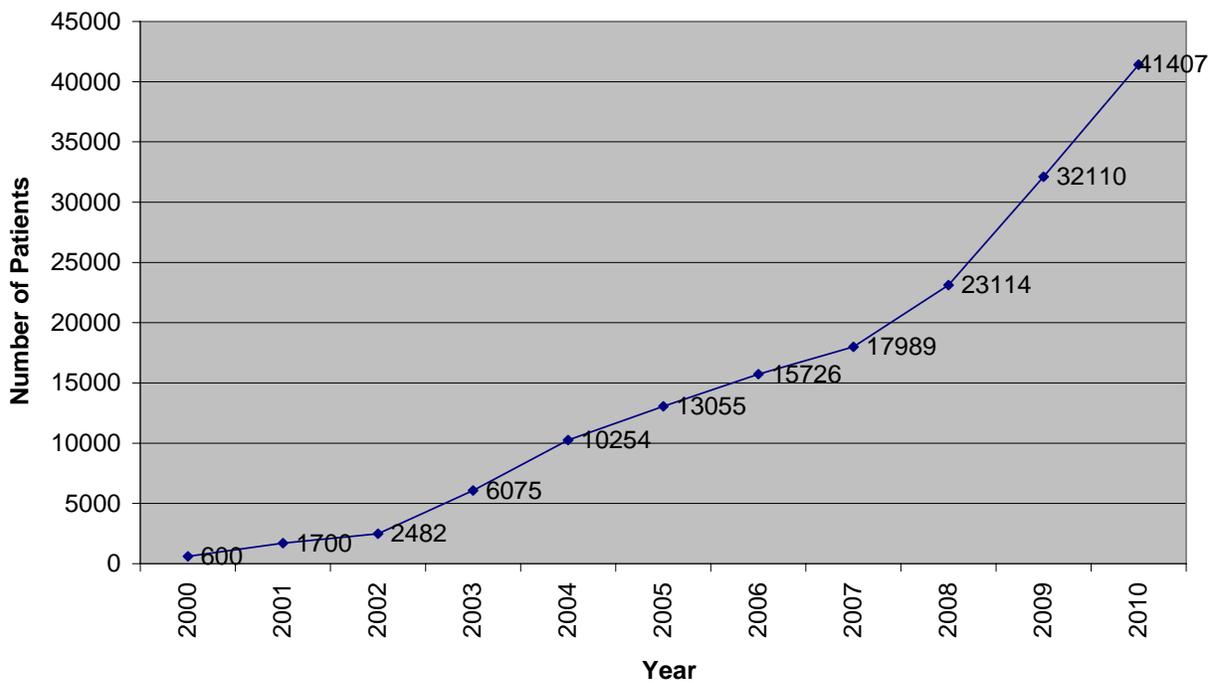
The OMMP participates in the Lean Daily Management system, the purpose of which is to make processes more efficient and effective. Through the review and implementation of two process improvement suggestions, the program is projected to save \$47,444 by eliminating a portion of the patient verification letters to selected physicians and “application OK” letters for patients connected to these physicians.

Key budget drivers and issues

OMMP 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.

The November 2010 ballot will include a measure to establish a regulated medical marijuana supply system by licensing dispensaries that will be authorized to dispense medical marijuana to cardholders and licensing producers that will be authorized to provide medical marijuana to the licensed dispensaries. If this initiative passes, considerable workload and revenue will increase the scope of the program.

OMMP Trends Over Time 2000-2009



Office of Environmental Public Health (OEPH)

OEPH leads 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. OEPH partners 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 office is organized into four programmatic sections:

- The Research & 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 18,000 food facilities, 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.
- The 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.

Major funding sources for OEPH include:

Federal funds

Environmental Protection Agency (EPA)

- Drinking Water Primacy
- State Revolving Loan Fund
- Water System Operator Certification

- Beach Safety
- Indoor Radon Outreach & 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

**Department of Health and Human Services
Centers for Disease Control and Prevention (CDC)**

- Environmental Health Network
- Childhood Lead Poisoning
- Environmental Public Health Tracking Program
- Elevated Blood Lead Surveillance for Adults
- Worker Illness and Injury Prevention Program
- Hazardous Substances Emergency Event Surveillance
- Environmental Health Assessment Program
- Harmful Algal Blooms Surveillance

Fees and other funds

- 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
- Clandestine Drug Laboratory Program
- Pesticide Analysis and Response Center

Research & Education Services (R&E)

Services provided

Research & Education Services (R&E) is the state’s primary point of scientific and technical expertise on diverse health concerns in the built and natural environments. The toxicologists, epidemiologists, program coordinators, research analysts, health educators and support staff in R&E conduct environmental and occupational public health studies to identify and prevent occupational and environmental 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 OBMP Monitoring and blue-green algae oversight, also provide an important service to out-of-state visitors.

- R&E is home to many statewide programs located in four management groups. These include:
 - Health Assessment & Consultation
 - Occupational Public Health
 - Environmental and Hazardous Incident Tracking, and
 - Healthy Homes

Health Assessment & Consultation

- Oregon Beach Monitoring program (OBMP) monitors Oregon’s coastal recreational waters for bacterial contamination.

- Clandestine Drug Lab program (CDL) oversees the clean-up of properties used to manufacture illegal drugs.
- Environmental Health Assessment Program (EHAP) works with communities affected by hazardous waste sites.
- Environmental Public Health Tracking program (EPHT) brings together environmental and human health data to allow for the analysis of the relationship between the two.
- Harmful Algal Bloom Surveillance program (HABS) tracks the occurrence, type and duration of algae blooms in Oregon's waters, and any reported health affects in humans and/or animals.
- Hazardous Substances Event Surveillance System (HSEES) tracks and reports on non-petroleum based releases of hazardous substances.
- Lead Poisoning Prevention Program (LEAD) monitors lead exposures in children and adults and works to reduce exposures from lead-based paint.
- Oregon Worker Injury and Illness Protection Program (OWIIPP) monitors and reports on work place injuries and illnesses.
- Pesticide Exposure Safety and Tracking program (PEST) investigates pesticide exposure cases and educates the public on ways to reduce the risk of exposure.
- Toxicology Consulting Services (TOCS) provides technical assistance on all environmental toxicological issues to programs within PHD, state agencies, tribes, elected officials and citizens.

Who receives services

All Oregonians benefit from the scientific knowledge, skill and expertise of R&E staff. From Oregon's coastal waters to communities large and small affected by hazardous waste sites, our staff are working to help Oregonians understand the risks they may encounter from environmental hazards and the steps they can take to reduce or eliminate those risks.

R&E scientists and professional staff work with all levels of community members including local, state and federal elected officials; concerned citizens; academic scientists; private industry; environmental regulatory agencies; other state agencies (e.g., OR-OSHA, Agriculture, ODFW, Forestry and DCBS), and environmental and community advocacy groups

How services are delivered

All programs and services in R&E are data-driven. They use data to investigate and assess the relationship between human health and the environment. Some data are collected directly, such as the Oregon Beach Monitoring Program, which collects samples from Oregon's coastal waters; some are recipients of data from medical providers submitting mandatory reports on specific conditions such as the Child and Adult Lead Program, which monitors and investigates elevated blood lead levels, and the Pesticide Exposure Safety and Tracking program, which monitors, classifies and follows up on adults and children exposed to pesticides.

Many of R&E's programs use data collected by other local, state and federal agencies. The Hazardous Substances Emergency Event Surveillance program collected data from a variety of sources that have a role in identifying, responding to and/or reporting on incidents. The Environmental Health Assessment Program relies on data collected by state and federal environmental quality agencies to determine if people have been exposed to harmful chemicals from hazardous releases. The Oregon Worker Injury and Illness Protection Program uses data from a variety of public and private sources to determine the types, frequency, causes and severity of occupational injuries. Finally, the Environmental Public Health Tracking program, currently under development, is designed to seek out data from a variety of sources and make it available to citizens, researchers and policy makers in order to increase accessibility and use of environmental and human health data.

Several of R&E's programs place an emphasis on community education and outreach. EHAP, HABS, OWIIPP, PEST, LEAD and OBMP have specific initiatives to work directly with individuals, groups and communities affected by environmental issues. The TOCS (Toxicology Consulting Services) team routinely responds to more than 200 calls each month on dozens of topics. In addition to providing individual services to Oregon residents, the program also provides technical assistance and expertise, impacting statewide environmental policy.

Why these services are significant to Oregonians

OBMP services protect the health of Oregon's beach water users. Exposure to recreational marine waters contaminated with bacteria, viruses or other disease-causing organisms can result in a variety of illnesses (e.g., gastrointestinal problems) in people using these waters. Clandestine Drug Lab services help

Oregonians keep themselves and their families safe by working to ensure that they aren't exposed to contamination due to the manufacturing of illegal drugs (primarily methamphetamine).

The services provided by EHAP help citizens make informed decisions about reducing or preventing exposures to environmental contaminants. For example, EHAP has worked at sites where there was exposure, or suspected exposure, to such carcinogens as asbestos, arsenic, mercury and/or chlorinated solvents. The EPHT network will help strengthen Oregon's ability to track and prevent health problems linked to the environment. More specifically, communities may learn about health and the environment in their area, scientists may get information to help their research, and officials may get information to set policy and promote activities to protect and improve health in communities.

The goal of the HSEES system is to prevent morbidity and mortality among the citizens of Oregon associated with acute releases of hazardous substances. Due to increasing awareness of the dangers of lead exposure provided by education and outreach activities, blood lead testing of at-risk children in Oregon continues to increase each year.

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

Schools, day care centers, businesses, tribes, local governments, natural resource organizations, state agencies, the medical community and the general public are served by Toxicology Consulting Services. Services include consultation, risk assessment and expert advice from the TOCS team 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 Paint programs, which are partially funded by fees. 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.

Since late 2005 the number of new properties with which CDL deals has dropped considerably, due in part to August 2005 legislation limiting the availability of materials required to manufacture methamphetamine. This has resulted in an 84 percent drop in cases from the busiest year of the program – from 327 new cases in 2001 to 52 in 2006, 22 in 2007 and 20 in 2008 – the lowest since the program began in 1990. CDL is fee-based, and receives money only when property owners submit information for each step in the assessment and decontamination process. Although new cases are declining, the program continues to work with property owners of older cases to help them bring their properties through the program.

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 of the public from using public pools or tourist facilities.

Where service recipients are located

Services are provided through local health departments to businesses and facilities statewide.

Who receives services

Licensing, inspection and outbreak investigation services are provided to nearly 18,000 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 staff 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 2004 through July 2006, more than 1,835 people were sickened in 103 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 U.S. Food and Drug Administration.

Performance measures

A significant key performance measure for FPLHSS 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 its second risk factor assessment. FPLHSS will be able to start plotting some data, both changes that are positive and negative. In addition, FPLHSS is responsible for customer satisfaction and time/activity reports. The section also documents inspection reports and conducts audits of performance by county.

Quality and efficiency improvements

In order to improve the quality of services provided to clients, program staff reviewed 11 counties and accompanied inspectors during their routine food service inspections. Performance and trends are tracked to create a record of improvement in efforts to eliminate the known causes of foodborne illness.

Field review summary: Percent in compliance

| CATEGORY | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Introduced self to the operator prior to starting the inspection and provided business card | 100% | 97% | 100% | 100% | 100% | 83% | 100% | 96% |
| Washed their hands at the beginning and as needed during the inspection | 100% | 97% | 100% | 100% | 100% | 100% | 100% | 100% |
| Checked each hand sink for accessibility, hot and cold water, soap and paper towels | 96% | 97% | 100% | 100% | 100% | 100% | 100% | 100% |
| Took temperatures on the cook line, hot holding units, and cold holding units | 96% | 90% | 94% | 97% | 94% | 67% | 100% | 91% |
| Asked open-ended questions and listened to the operator | 96% | 100% | 98% | 100% | 100% | 83% | 100% | 100% |
| Observed food handlers for handling of raw product, personal hygiene and hand washing | 79% | 93% | 98% | 95% | 95% | 83% | 83% | 100% |

| CATEGORY | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|--|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Asked operators about the availability, use, calibration, and cleaning of probe thermometers | 88% | 80% | 96% | 93% | 93% | 83% | 95% | 96% |
| Checked for refrigerator thermometers | 100% | 100% | 100% | 100% | 100% | 83% | 100% | 100% |
| Checked wipe cloths for sanitizer residual | 100% | 87% | 100% | 100% | 100% | 100% | 100% | 100% |
| Asked operators about their use of sanitizer test strips | 100% | 97% | 94% | 96% | 96% | 83% | 95% | 100% |
| Asked about cleaning procedures of in-place equipment | 96% | 97% | 84% | 100% | 94% | 83% | 83% | 100% |
| Asked how and where food is prepared | 92% | 97% | 100% | 100% | 100% | 100% | 100% | 96% |
| Asked cooks how they know when an item is cooked to proper temperature | 92% | 90% | 100% | 100% | 100% | 83% | 95% | 96% |
| Asked cooks how they cool food items prepared in advance and in large quantities | 100% | 97% | 100% | 100% | 100% | 100% | 95% | 96% |
| Asked cooks about their procedures on how foods are reheated | 92% | 97% | 100% | 100% | 100% | 100% | 95% | 96% |
| Asked operators about their hand washing and ill employee policies | 92% | 86% | 100% | 96% | 96% | 67% | 90% | 100% |
| Asked about catering activities | 88% | 78% | 94% | 96% | 100% | 67% | 95% | 87% |
| Asked about menu changes | 88% | 87% | 100% | 96% | 100% | 100% | 95% | 100% |
| Verified that critical violations were corrected or an approved alternative was in place before leaving the facility | 100% | 100% | 100% | 96% | 100% | 100% | 100% | 96% |
| Asked questions regarding food handler cards | 100% | 100% | 100% | 96% | 94% | 67% | 100% | 96% |

Specific areas for improvement statewide are:

- Asking about the availability, use, calibration and cleaning of probe thermometers.
- Taking temperatures of food products in hot and cold holding units.
- Asking about procedures for cleaning in-place equipment such as slicers, cutting boards and culinary sinks.
- Taking final cooking temperatures of food.
- Observing food handlers during the inspection to ensure they are washing their hands and handling foods appropriately.
- Asking about glove use, employee illness policies and watching for proper habits.
- Asking the manager if he or she has access to the Oregon Food Sanitation Rules.
- Asking about exotic meats, shellfish and parasite destruction in the facility.
- Asking about catering activities in the facility.

Key budget drivers and issues

The costs of the state and local restaurant food safety programs – \$5.4 million – are borne by the Oregon restaurant industry. No General Fund money is used.

Radiation Protection Services (RPS)

Services provided

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

- Protect the general public and the environment from exposure to unnecessary radiation levels.
- Reduce the possibilities of accidental radiation exposures.
- Train local and state emergency services personnel.
- Keep occupational radiation exposure as low as possible.

- Reduce unnecessary radiation exposure to workers and patients.
- Revise rules to address health and safety issues related to rapidly emerging technologies in medicine, dentistry and academic settings.
- On-site reviews of registrants and licensees are conducted, samples are collected and analyzed, training is provided, and statutes and administrative rules are enforced. Every Oregonian is potentially affected via medical, dental or environmental avenues.

Where service recipients are located

Service recipients are located throughout Oregon. Approximately 13,800 sources of radiation are licensed and inspected in more than 4,350 facilities located in all Oregon counties (including hospitals, dental 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 to test all X-ray equipment in dental offices, medical clinics, hospitals, veterinary clinics, chiropractic, and podiatry clinics, and industrial locations. 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 also are licensed and inspected in all counties.

How services are delivered

More than 1,400 on-site safety inspections are completed each year for facilities licensed to use sources of radiation in every county in Oregon. More than 3,500 X-ray machines and tanning devices are tested each year to ensure they are operating safely 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 21 percent of all X-ray inspections, radiation exposure is able to be reduced to lower levels with diagnostic image quality preserved or improved in each case to help ensure worker and patient safety. Emergency responses to

incidents involving radiation sources also result in some investigations done in cooperation with Oregon OSHA that improve radiation safety operating conditions for workers and patients.

Patient exposure reduction achieved by the X-ray program
01/01/2002 – 12/31/2009

| Facility Type | Number of facilities inspected | Number of facilities with one or more machines requiring patient exposure reduction | Percent of facilities with one or more machines requiring patient exposure reduction | Average radiation exposure reduction to patient |
|---------------------|--------------------------------|---|--|---|
| All | 4448 | 933 | 21% | 9% |
| Dental | 2173 | 731 | 34% | 10% |
| Other medical types | 1036 | 185 | 18% | 7% |
| Non-medical types | 1239 | 17 | 1% | 4% |

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

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 Materials Licensing Program

RPS’s 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 NRC core training are critical to performing at this level. Evaluation of the performance of this goal is periodically reviewed by the U.S. Nuclear Regulatory Commission through Integrated Materials Performance Evaluation Program (IMPEP) audits, which are required as part of PHD’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 goals for performance in completion of all required X-ray facility and machine testing inspections within due dates specified in administrative rule. Current staffing levels and U.S. FDA and other specialized training are critical to performing at this level. At the current growth rate for X-ray facilities, additional inspection staffing of 1-2 FTE will be required by 2011.

Tanning Device Testing and Inspection Program

For the tanning device testing and inspection program, the RPS management team has set goals for performance in completion of all required tanning facility and FDA compliance testing inspections within a two- to three-year period. Current staffing levels and U.S. FDA and other specialized training are critical to performing at this level. At the current growth rate for tanning facilities, current staffing should be adequate until 2015.

2009 Data: 201 Facilities inspected; 758 tanning devices tested; Backlog = 107 vs. 61 facilities.

Quality and efficiency improvements

X-ray inspections are scheduled with registrants to lessen business impact during inspections. Unannounced inspections are performed at problematic facilities to ensure compliance with state and federal standards. Turnaround time for licensing has been greatly improved during the current biennium.

Enforcement has become more effective with authority to impose civil penalties through recent legislation to standardize enforcement authority and penalties for noncompliant licensees and registrants. This enforcement tool promotes better regulatory standardization in the future and improves oversight of problematic facilities.

Key budget drivers and issues

Federal regulatory authority over licensed users of radioactive materials has significantly increased during the past decade to improve security of this critical material used for medical imaging, blood irradiation, research, measurement of density of materials, process improvement and cancer therapy. These additional security concerns require more staff time and enforcement activities, translating into additional program costs. Funding for this increased workload and enforcement activity will be included as a fee increase request during the 2011 Legislative Session in order to offset increased staffing and related enforcement activity costs. Another adjustment will likely be required during the 2015 or 2017 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. COLA and workload increases are the primary drivers for requesting additional funding support from fee-based programs to improve public health and safety.

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

The Drinking Water Services helps reduce the risk of disease for people who consume drinking water at public water systems in Oregon. The program is carried out through partnership with local public health agencies and other state departments, as well as direct service by DWS. The program helps carry out the mission of the department by reducing the risk of waterborne disease and reducing exposure to hazardous substances potentially present in drinking water supplies.

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 Oregon's 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 are provided to protect the health of more than three and a half million Oregonians and Oregon visitors who consume water from public drinking water systems.

How services are delivered

Drinking water oversight is delivered by a partnership of PHD, local county public health departments and other state agencies. PHD staff is located in Portland, Pendleton, Springfield and Medford. Twenty-nine county health departments and the Oregon Department of Agriculture deliver local drinking water protection services under contract. Services also are provided under contract with the Oregon Development (drinking water loan fund) and the Oregon Department of Environmental Quality (protect drinking water sources).

Why these services are significant to Oregonians

Safe tap water from every public water system in the state is essential to protect people's health, support local economies, and sustain Oregon's quality of life.

Performance measures

There are no OHA key performance measures for DWS. However DWS has lead responsibility for Oregon Benchmark 69, "percentage of Oregonians served by community drinking water systems that meet health-based standards" and "percentage of community drinking water systems that meet health-based standards." Recent performance on these measures is shown below:

| Percentage of Oregonians served by community drinking water systems that meet health-based standards | | |
|---|---------------|-------------|
| Year | Oregon | U.S. |
| 2005 | 94% | 89% |
| 2006 | 96% | 89% |
| 2007 | 90% | 92% |
| 2009 | 98% | 92% |
| 2011 – EPA Goal | 91% | 91% |

| Percentage of community drinking water systems that meet health-based standards | | |
|--|---------------|-------------|
| Year | Oregon | U.S. |
| 2005 | 85% | 90% |
| 2006 | 88% | 90% |
| 2007 | 85% | 89% |
| 2009 | 90% | 90% |
| 2011 – EPA Goal | 90% | 90% |

These data show that Oregon meets the EPA goal for community population served with safe drinking water, but Oregon has only just met 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 water systems in Oregon serve fewer than 500 people. Small water systems have difficulty meeting safe drinking water standards because of lack of financial and managerial resources.

Quality and efficiency improvements

In order to improve services provided to clients, Drinking Water Services implemented federal drinking water standards beginning in 1986, and has worked with local communities since then to improve local water systems and dramatically reduce the number of community acute waterborne disease outbreaks. The program

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 improved 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. In 2009, the Department and OBDD applied for, received and awarded \$28 million in ARRA funds to 17 Oregon communities for drinking water construction projects.

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. During 2007 the program received \$2.5 million in additional General Fund resources from the Legislature to 1) fully implement all current federal drinking water standards at all 2,600 public water systems subject to federal requirements; 2) implement three new federal drinking water standards specified by the 1996 Safe Drinking Water Amendments; and 3) oversee the estimated 900 very small public water systems (4-14 connections) subject to state law.

Oregon completed initial implementation by hiring 11 new staff, expanding county contacts, expanding the Drinking Water Advisory Committee, improving water system inspections and implementing a new inspection fee. The program adopted the new EPA rules in June 2009. Implementation and enforcement of the new rules began in 2009-2011, and will continue in 2011-2013.

The Legislature reduced the drinking water program general funds by \$418,393 in 2009-2011. The impact was a 50 percent reduction in the new effort to oversee the 900 known very small water systems subject to state law. These systems serve an estimated population of 16,000 people. The program focused the reduced effort on those systems with contaminated drinking water, and will extend water system inspection frequency from every five years to every 10 years. This means small water systems subject to state law still receive more public health oversight and protection than in the years prior to 2007, but receive less than larger water systems subject to federal requirements.

Office of Family Health (OFH)

Key programs

The Office of Family Health (OFH) administers programs directed at improving the overall health of Oregon's women, children and families through preventive health programs and services. Objectives and activities include collecting and sharing data through the FamilyNet data system to assess the health of women, children and families; 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. The Office of Family Health also reduces and eliminates disparities and provides technical assistance, consultation and resources to local health departments and other community partners. The major program areas within OFH include Maternal and Child Health (MCH) programs that encompass Perinatal, Child and Oral Health, Adolescent Health and Genetics, Women's and Reproductive Health, Nutrition and Health Screening (WIC), and Immunization.

Major funding sources for the Office of Family Health include:

- U.S. Department of Agriculture – Nutrition and Health Screening for Women, Infants and Children (WIC);
- U.S. Department of Agriculture – WIC and Senior Farmers Market Nutrition Programs;
- U.S. Department of Health and Human Services (DHHS) – Family Planning Title X and Oregon ContraceptiveCare (CCare), formerly known as the Family Planning Expansion Project (FPEP), a Title XIX waiver;
- DHHS Center for Disease Control and Prevention (CDC) Immunization and Vaccines for Children (VFC);
- DHHS – Title V Maternal and Child Health Block Grant (MCH);
- DHHS Substance Abuse and Mental Health Services Administration (SAMHSA) for Linking Actions for Unmet Needs in Children's Health (LAUNCH) Cooperative Agreement;
- Medicaid Administrative Match in Immunization and Oral Health;

- State General Fund match requirement for Oregon Contraceptive Care (CCare), formerly known as the Family Planning Expansion Project (FPEP);
- State General Fund and Provider Tax School-Based Health Center Program (SBHC);
- CDC Office of Public Health Genomics; and
- CDC Breast and Cervical Cancer Program (BCCP)

Maternal and Child Health (MCH) Program

The Maternal and Child Health (MCH) Program is responsible for developing, implementing and evaluating public health programs that address the health priorities of Oregon’s pregnant women, infants and children. The focus of MCH is to promote and maintain the health, safety, well-being and appropriate development of children and their families. Program areas focus on perinatal health (prenatal and post-partum), infant and child health, oral health, and newborn hearing screening.

The multidisciplinary staff of public health nurses, dental hygienists, health educators and policy analysts establishes statewide standards and provides training, policy development and technical assistance to local health departments and a wide range of providers. MCH epidemiologists, research analysts and program evaluation staff work with the informatics staff to support comprehensive data systems for surveillance, assessment and system evaluation at the state and local level.

Services provided

Two key MCH program areas are the public health home visiting services and oral health services.

Public health home visiting services provide 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.

Perinatal Home Visiting Services are provided through the Maternity Case Management program. Public health nurses provide 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 by targeting risk factors such as tobacco and substance use, intimate partner violence, maternal mental health, and risk of prematurity. The program promotes adequate prenatal care and provides nutrition counseling for pregnant women with nutritional risk factors

During July through December of 2009, a pilot project occurred to develop and test an environmental hazard tool to identify hazards, promote prevention strategies, and remediate environmental exposures in the home that pose a risk for pregnant women and their babies.

Infant and Child Home Visiting Services are provided through the Babies First! program. This home visiting 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 that includes monitoring growth, physical and emotional health, oral health status, immunization status, standardized screening for vision and hearing, developmental status, maternal-infant interaction, and family assessment.

The Oral Health program delivers two school-based services to elementary school children: dental sealants and fluoride tablets. School-based dental sealant programs serve first and second graders, preventing decay in the first primary molars where about 85 percent of decay normally occurs. School-based dental sealants are delivered by registered dental hygienists and are an evidence-based best practice. Participating schools must have a 50 percent or greater eligibility rate for the Federal Free and Reduced Lunch Program. All first- and second-graders in an eligible school may receive services. Eligible elementary schools with fewer than 100 students total receive services for all grades, K-5/6.

An oral health surveillance system tracks data for populations across the lifespan measuring disease prevalence and progress towards meeting Healthy People 2020 goals. A dental screening survey of oral disease prevalence among first- through third-graders is implemented every five years, and in 2012, the survey will include

collaborative planning to capture BMI data to support prevention planning efforts around childhood obesity.

Project “First Tooth” is an early childhood cavities 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 3. 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 three. The project follows national guidelines on preventive dental care and services for infants and children. Program staff provide ongoing technical assistance to local county health departments to aid them in incorporating early childhood cavities prevention activities into home visits.

Where service recipients are located

The public health home visiting programs are provided throughout the state. The Maternity Case Management program is provided by county health departments, managed care organizations, and private providers through the Oregon Health Plan. The Babies First! program is provided by county health departments.

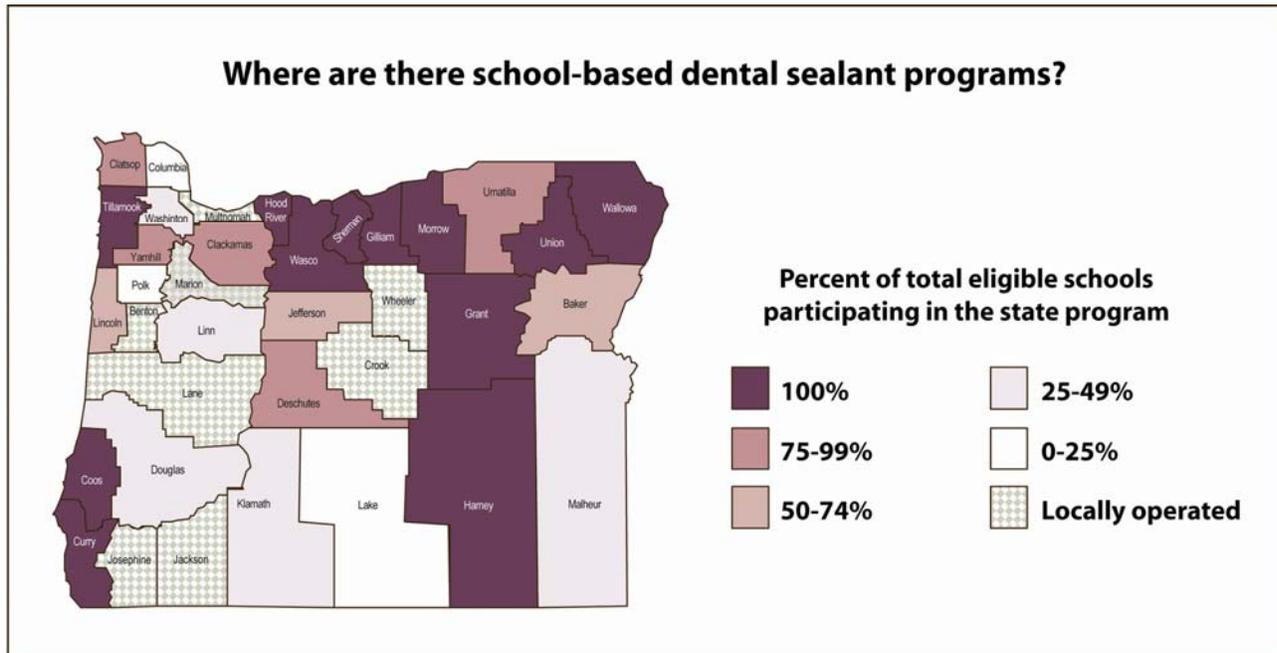
**Home Visiting Programs
July 2008 – June 2009**

| County | MCM Clients | Babies First! Clients |
|---------------|--------------------|------------------------------|
| Baker | 0 | 114 |
| Benton | 6 | 33 |
| Clackamas | 100 | 177 |
| Clatsop | 76 | 96 |
| Columbia | 47 | 32 |
| Coos | 10 | 140 |
| Crook | 10 | 32 |
| Curry | 0 | 14 |
| Deschutes | 196 | 276 |
| Douglas | 117 | 297 |

| County | MCM Clients | Babies First! Clients |
|---------------------|--------------------|------------------------------|
| Gilliam | 0 | 1 |
| Grant | 8 | 10 |
| Harney | 1 | 7 |
| Hood River | 20 | 141 |
| Jackson | 176 | 255 |
| Jefferson | 11 | 61 |
| Josephine | 172 | 161 |
| Klamath | 0 | 125 |
| Lake | 1 | 13 |
| Lane | 360 | 250 |
| Lincoln | 292 | 360 |
| Linn | 17 | 137 |
| Malheur | 5 | 65 |
| Marion | 97 | 533 |
| Morrow | 2 | 9 |
| Multnomah | 1,653 | 4,628 |
| Polk | 33 | 107 |
| Tillamook | 16 | 103 |
| Umatilla | 5 | 46 |
| Union | 41 | 165 |
| Wallowa | 1 | 2 |
| Wasco/Sherman | 40 | 97 |
| Washington | 237 | 634 |
| Wheeler | 0 | 6 |
| Yamhill | 23 | 157 |
| State Totals | 3,773 | 9,284 |

The Oral Health Program provides school-based dental sealant services statewide directly through more than 150 elementary schools.

School-Based Dental Sealant Programs during the 2010-2011 School Year Percent of Eligible Schools Served Per County



Who receives services

Perinatal Home Visiting: Approximately 6,200 pregnant women received Maternity Case Management (MCM) services over 16,000 visits during FY 2007-2008 through 27 county health departments. MCM services are provided for pregnant women regardless of insurance coverage, but 63 percent were women with Oregon Health Plan coverage and 9 percent with CAWEM coverage.

A typical pregnant woman in Oregon receiving services in the MCM program is in her 20s; is white, non-Hispanic and unmarried; has a high school education; and has OHP Plus Insurance coverage benefits. She and her family struggle with being low-income and can be dealing with multiple risk factors. Examples include mental health issues such as depression, nutritional inadequacy, substance abuse including alcohol, smoking, and possibly medical risk factors such as diabetes and/or obesity. She probably has inadequate dental care with poor oral health and did not plan to become pregnant.

Infant and Child Home Visiting: More than 32,000 Babies First! services are provided to 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.

A typical Babies First! client is a newborn infant who was born into poverty, white and non-Hispanic, with Oregon Health Plan insurance coverage. The infant lives in a family where the parents struggle to pay rent and purchase essentials such as food and diapers. The parents have limited knowledge of basic infant care and need help accessing services and learning to care for their fragile infant. A typical family is referred to Babies First! by the hospital, and enters the program with multiple concerns such as poor parent-child interaction and a worried parent and/or doctor.

Clients who are served by the home visiting programs present with a variety of social and medical risk factors at initial contact. Fully 57 percent of Babies First! clients present with multiple risk factors at initial contact. The table below identifies the most common risk factors noted at initial contact with home visiting program clients.

**Home Visiting Program Initial Risk Factors
July 2008 – June 2009**

| Babies First! | % of Total |
|----------------------------------|-------------------|
| Parent with limited resources | 55% |
| Concern of parent/provider | 64% |
| Prematurity | 14% |
| At-risk caregiver | 13% |
| Parental alcohol/substance abuse | 8% |

Oral Health Program: 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. In schools with less than 100 students total, the service is available to all grades in the elementary school.

During the 2009-2010 school year, over 20,000 dental sealants were placed in students from schools in twenty nine counties that participated. In 11 counties, 100

percent of the eligible schools participate in the program. Statewide the program served 73.7 percent of eligible schools (not including eligible schools that are served by a locally operated program).

How services are delivered

Maternity Case Management: Pregnant women are referred to MCM services from programs and providers including Oregon Mother's Care, WIC and social services. The Maternity Case Manager assists the client in the management of health, economic, social and nutrition factors through the prenatal period and up to two months postpartum, including linkage and referrals to other services as needed. This is provided through face-to-face contact, ideally in the client's home and generally by county health department public health nurses.

Babies First!: During home visits the public health nurses conduct standardized health and development assessments for the child's growth and nutritional status. Infants receive developmental screening, monitoring of growth, hearing, vision and dental screening, assessments of parent child interaction, and immunization status. Parents receive information and have learning opportunities regarding safety in the home, Sudden Infant Death Syndrome (SIDS) prevention and support services, and overall child health. Referrals are made for medical care and social services as needed.

Oral Health Program: School-based dental sealants are delivered by registered dental hygienists with the aid of dental assistants using complete portable dental sealant equipment units. The program has utilized over 550 volunteer dental hygienists and dental assistants. Units are brought to the school at an agreed-upon schedule and set up in the cafeteria, a portable building, and even a corner in a hallway. An entire classroom is screened in about 15 minutes. Children who are determined to receive the dental sealant are brought out individually. Placing the dental sealants takes about 30 minutes. Ninety-nine percent of participating schools reported great satisfaction with the program. Oral health screening-surveillance is conducted by registered dental hygienists who are specially trained and on contract with OFH. Early childhood cavities prevention services are delivered by public health nurses, dental hygienists and other health care professionals in local county health departments, Head Start sites, WIC, and now through First Tooth in medical offices.

Why these services are significant to Oregonians

Families served by public health nursing home visiting programs benefit from long-term health, social, economic and emotional support early in pregnancy and throughout the early stages of life. Research has repeatedly shown 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.

Basic oral health prevention services that are identified as best practices ensure overall health of children and adults. Underserved children suffer oral disease disproportionately and these services create a system for access and ultimately reduce dental decay and disease significantly, thereby reducing overall lifetime treatment costs. According to the Smile Survey 2007, a screening 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 has decay that has not been treated.
- One in five children has rampant decay that is decay in seven or more teeth.
- On any given day, more than 5,000 children are in need of urgent treatment due to severe pain or infection.

Performance measures

The Maternal and Child Health (MCH) Program has the following OHA key performance measures (KPM) and Healthy People 2010 outcome measures.

Measure: KPM 18, Prenatal care for women in the first trimester

Purpose: Early prenatal care is an important strategy for preventing early childhood diseases and conditions, and promotion of healthy growth and development. Low-income infants are statistically at higher risk for poor health outcomes, and DHS programs and services are focused on this population. The indicator of early prenatal care reflects how well the health and social system performs in reaching the low-income pregnant women to promote healthy babies.

Only 79.9 percent of low-income women in Oregon received prenatal care during the first four months of pregnancy, while the goal for this measure is 88.7 percent. Trends in early prenatal care reflect the reductions in Oregon Health Plan (OHP) eligibility. Low-income women who are already covered by Medicaid when they become pregnant must re-apply after they find out they are pregnant to receive OHP-Plus benefits. For those not previously eligible, it is possible that some of them do not know they now qualify because they are pregnant, especially if they recently were told they were ineligible for OHP due to income. While other states are decreasing barriers for pregnant women through presumptive eligibility for Medicaid (29 states), or with a shortened Medicaid application (25 states), Oregon is not among these states. Additionally, only seven states require asset testing of pregnant women (including bank accounts, vehicles, etc.). While Oregon is not listed, Oregon still requires documentation of assets to process the OHP application.

OFH uses birth certificates record information reported by the mother about her pregnancy collected into a dataset used nationally to monitor trends in birth outcomes. For monitoring trends for disparity in access to early prenatal care from this data source, a proxy for low-income and non-low income women is the number of women reporting that they were enrolled, and not enrolled, in the Supplemental Nutrition Program (WIC) for one or more months during pregnancy. Eligibility for enrollment requires a family income of \leq 185 percent Federal Poverty Level (FPL) and is the best available data for estimating low-income status in pregnancy.

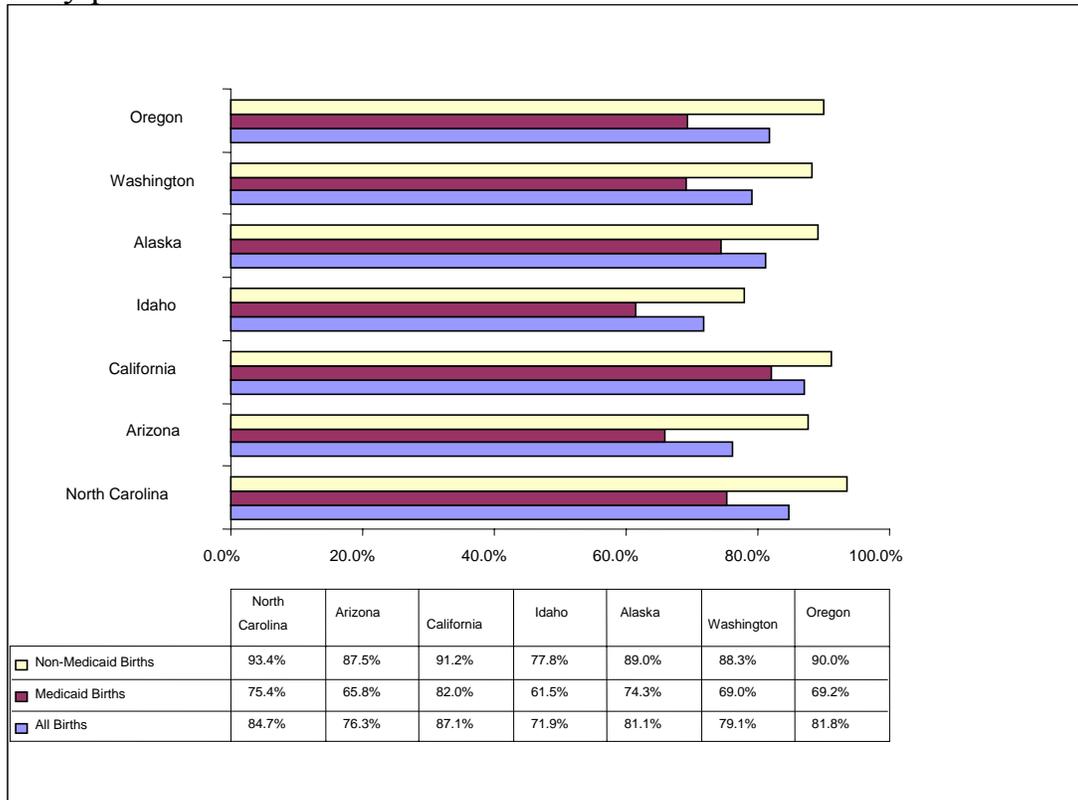
EARLY PRENATAL CARE

The percentage of low-income women who initiated prenatal care in the first 3 months of pregnancy compared to non low-income women: a) WIC enrolled, b) non-WIC enrolled

| | | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---------------|-------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Actual | WIC enrolled | 74.0% | 73.6% | 71.8% | 73.0% | 71.1% | 69.7% | 60.5% | 63.3% | | |
| | non-WIC enrolled | 86.5% | 86.1% | 86.3% | 86.3% | 84.7% | 83.8% | 78.6% | 78.5% | | |
| Target | WIC enrolled | | | | | | 70.0% | 71.0% | 73.0% | 74.0% | 76.0% |
| | non-WIC enrolled | | | | | | 84.0% | 85.0% | 86.0% | 86.0% | 87.0% |

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 in the 10 top ranks across the nation.

Comparison of Medicaid versus non-Medicaid births whose mothers had early prenatal care:



Measure: KPM 24, 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 (SIDS). 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.

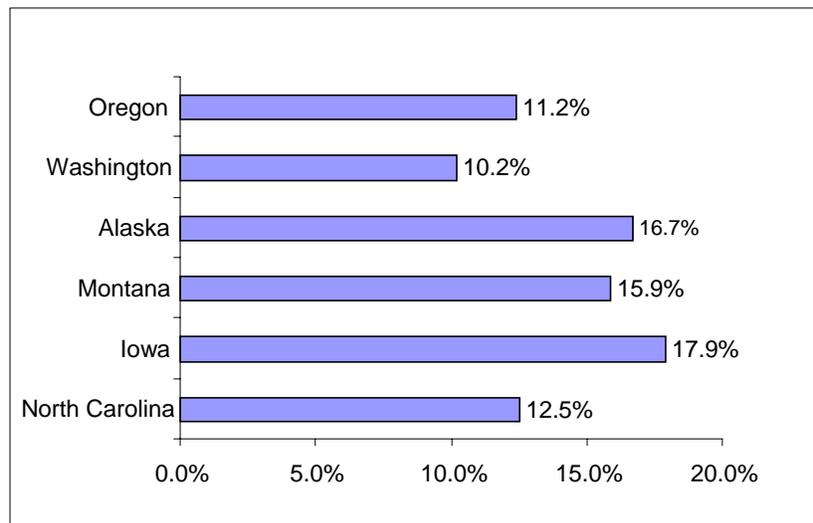
TOBACCO USE

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

| | | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|---------------|--------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Actual | Adult | 21.3% | 20.9% | 19.9% | 18.6% | 18.3% | 17.0% | 15.4% | | | |
| Target | Adult | 20.2% | 19.8% | 19.4% | 19.0% | 18.6% | 18.2% | 17.6% | 17.4% | 15.0% | 15.0% |
| Actual | Youth | 10.7% | 10.5% | 8.1% | 9.8% | 8.7% | 9.0% | 8.6% | 9.9% | | |
| Target | Youth | 12.2% | 11.8% | 11.4% | 11.0% | 10.0% | 10.0% | 9.0% | 9.0% | 8.0% | 7.5% |
| Actual | PW | 12.6% | 12.0% | 12.6% | 12.4% | 12.3% | 12.3% | 11.2% | | | |
| Target | PW | 13.2% | 13.8% | 13.4% | 12.0% | 11.4% | 10.8% | 10.8% | 10.8% | 10.8% | 10.8% |

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 whose mothers smoked in the last trimester of pregnancy.

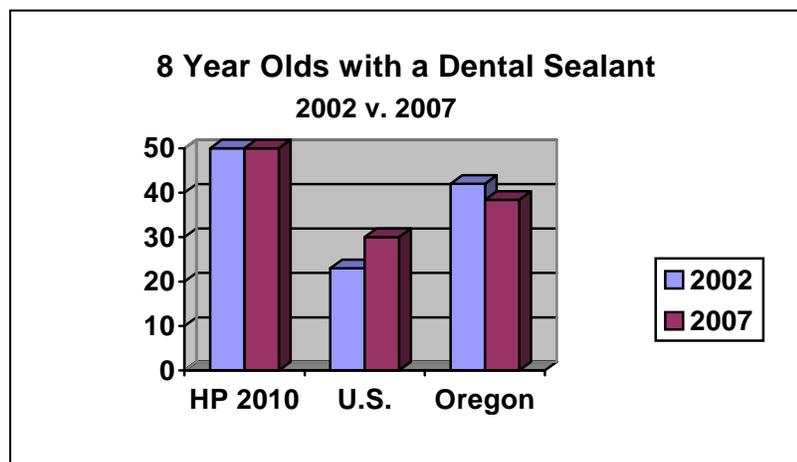


Oral Health Program: The Oral Health Program has three outcome measures based on national benchmarks, but no current OHA KPMs.

Measure: Healthy People 2020 Objective OH HP2020-10, Proportion of 6- to 9-year-olds with dental sealants as collected in the Smile Survey.

Purpose: Dental sealants are considered a best practice in preventing dental decay and disease in the first set of permanent molars (where most decay usually occurs). This measure is an indicator of potential lifetime disease and treatment costs averted.

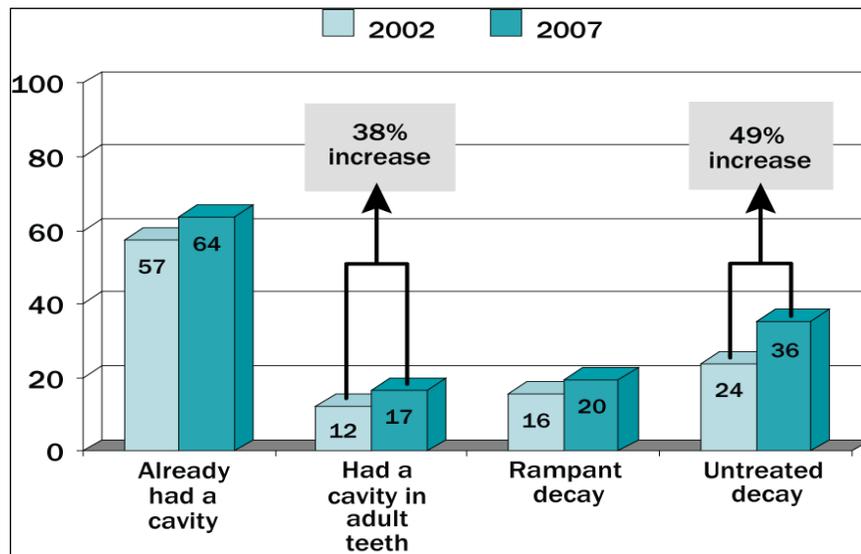
How Oregon compares to other states: According to the 2007 Oregon Smile Survey, 38.4 percent of 8-year-olds had dental sealants, compared with a national average of 30 percent. The Oregon rate is influenced by the success of the Multnomah County Health Department Dental Sealant Program. In 2007, 62.7 percent of third graders in Region 1 (Multnomah County) had a dental sealant, compared to the state average of 43 percent of third graders. Regional data was analyzed by grade, not age. The Oregon Smile Survey will be implemented again in 2012, and it is expected that the proportion of 6- to 9-year-olds with dental sealants will have increased due to the increase in number of schools served by the OHA school-based dental sealant program between 2007 and 2011 (11 schools vs. over 140).



Measure: Healthy People 2020 Objective OH HP 2020-6, proportion of 6- to 9-year-olds with dental caries experience as collected in the Smile Survey.

Purpose: Children who experience decay tend to continue to experience decay at a greater rate as they grow older. Dental decay is a chronic condition.

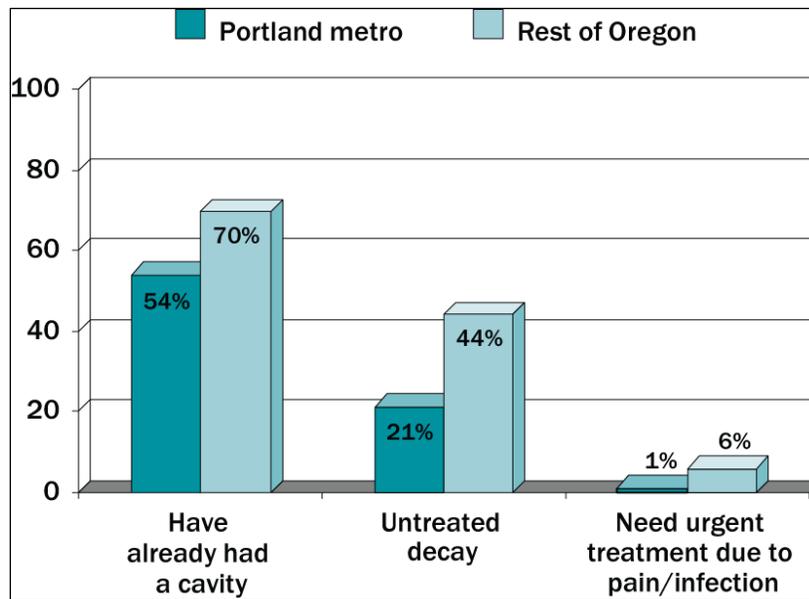
How Oregon compares to other states: According to the 2007 Oregon Smile Survey, 62.7 percent of 6-8-year-olds have dental decay experience in primary or permanent teeth. Additionally, 34.6 percent of 6- to 8-year-olds have untreated decay. This represents an increase of 49 percent since 2002. Oregon ranks 26th out of 32 states with comparable data.



Measure: *Healthy People 2020 Objective OH HP2020-4, increase the proportion of low-income children who receive preventive dental services as collected in the Smile Survey.*

Purpose: Poor children suffer decay disproportionately and have less access to preventive services.

How Oregon compares to other states: According to the 2007 Oregon Smile Survey, 74 percent of poor children have dental decay experience in primary or permanent teeth compared with 46.6 percent of their more affluent peers. Furthermore, children who live outside the Portland metro area have greater dental decay experience (70 percent vs. 54 percent) and greater untreated decay (44 percent vs. 21 percent). National and state comparisons are not available.



Quality and efficiency improvements

The Office of Family Health (OFH), Maternal Child Health (MCH) utilized data gathered in the new ORCHIDS data system to inform an analysis reviewing program strengths, weaknesses, opportunities and threats (SWOT). This analysis was preceded by presentations of current program data as well as information on the state of current home visitation science. Information gathered from our local program providers (line staff) was synthesized and used to create a strategic planning agenda for program decision makers. Staff from OFH and the Oregon Center for Children and Youth with Special Health Care Needs (OCCYSHCN) drafted a proposed new public health home visiting framework. The proposal took into account the following factors: a) current evidence base; b) data that reflects Oregon’s needs; and c) known opportunities. The framework has been agreed upon and assures alignment with evidence-based practice and the development of a home visiting system that includes the Commission on Children and Families (OCCF), DHS Children, Adults and Families (CAF), and the Healthy Start Program. Strategic planning between cross agency early childhood service providers is underway.

The school-based dental sealant program administered by the Oral Health Program 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; and schools have been

identified as an ideal setting for delivering sealants because they ensure access to all children, cause minimal disruption to class time, do not require children miss a school day to see a dentist, and remove travel barriers. Data are collected in a uniform manner and entered into a statewide dental sealant surveillance system.

Health disparities

The Office of Family Health (OFH) created a mechanism for tribal governments to access Federal Funds for maternal and child health services. During January 2007 tribes were able to apply for mini-grants of \$5,000 for six months to develop triennial plans and population data to be used in the state's funding formula for equitable distribution of the MCH Title V Block Grant (pursuant to SB 855, 2005 Legislative Session).

Currently, two tribes have developed proposals around MCH oral health and received mini-grants – the Health Clinics of the Coquille Indian Tribe and the Cow Creek Band of Umpqua Tribe of Indians. The Office of Family Health staff provide technical assistance and consultation in the implementation of their programs. Staff also are in the process of working with the Warm Springs tribe on a proposal to assist with funding a public health nurse. Interested tribes may apply for these MCH planning mini-grants at any time.

Public Health Home Visiting Programs: The U.S. Census Bureau reported Oregon's population in 2009 as being composed of 11 percent Hispanics; 90 percent white, non-Hispanic; and 2 percent African American. Race and ethnicity data indicate the home visiting programs are reaching out to minority populations who experience health disparities. A key component of Babies First! services includes case management services to ensure all children enrolled in the program have access to needed medical and social services. Similarly, MCM ensures all pregnant women have access to the medical and social services they need.

**Client Race/Ethnicity
July 2008 – June 2009**

| | MCM | Babies First! | 2009 Oregon Census Estimates |
|-------------------------------|-----|---------------|------------------------------------|
| Race | | | |
| White | 70% | 71% | 90% |
| American Indian/Alaska Native | 4% | 4% | 1% |
| Black/African American | 9% | 7% | 2% |
| Asian | 3% | 4% | 4% |
| Hawaiian/Pacific Islander | 1% | 2% | 0% |
| Multiple Races | 13% | 4% | 3% |
| Unknown | 0% | 9% | 0% |
| Ethnicity | | | |
| Non-Hispanic | 62% | 63% | 80% |
| Hispanic | 29% | 30% | 11% |
| Unknown | 9% | 7% | 9% |

Key budget drivers and issues

The Title V Block Grant has been expanded to include competitive grants to states based on need for evidence-based maternal child health home visitation programs under the Affordable Care Act. This federal legislation and funding opportunity requires states to demonstrate maintenance of effort for evidence-based home visitation programs. To be eligible for these funds, states must maintain investments in evidence-based home visitation that were in effect on March 23, 2010. The Office of Family Health will be working in close partnership with other state home visitation providers to strengthen Oregon’s home visitation system by leveraging these federal funds. Funds provided to an eligible entity receiving a grant shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives. The grantee must agree to maintain non-federal funding (state general funds) for grant activities at a level which is not less than expenditures for such activities as of the date of enactment of the legislation, March 23, 2010.

The match rate of 27 percent General Fund to 73 percent Federal Funds for Targeted Case Management, which supports the Babies First! and other nurse home visiting services, is at risk of reductions at the federal level. This is a new match rate, effective July 1, 2010, that was approved under ARRA funding.

In addition, the CDC did not re-fund a critical grant for OFH's Oral Health Program, a grant that supported state-level infrastructure to implement key statewide program initiatives. Program funding was stabilized by matching General Fund dollars with a Medicaid match. The funding:

- Expands the statewide school-based dental disease prevention program (dental sealants and fluoride supplement programs)

Adolescent Health Program (AH)

Adolescent Health (AH) includes 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. The SBHC program is described here as a program that is most closely related or aligned with direct services to the population.

Services provided

The School-Based Health Center (SBHC) program provides access to a comprehensive set of developmentally and age-appropriate preventive health, primary care and mental health services for school-aged youth. Services include performing routine physical exams including sports physicals; well-child and adolescent exams; diagnosis and treatment of acute and chronic illness; prescribing medications; treatment of minor injuries; vision, dental and blood pressure screenings; administration of immunizations; emotional and mental health services; age-appropriate reproductive health services; health education, counseling and wellness promotion; and presenting in classrooms on relevant health issues.

Oregon has more than a 20-year history of supporting SBHCs. During the 2008-2009 service year, 54 certified SBHCs in 20 counties served nearly 25,000 clients through more than 72,000 visits. Fourteen communities in 11 counties were awarded planning grants. Three of those counties currently have no certified

SBHCs. One center was certified in spring 2010, and the remaining 13 planning sites are expected to complete final certification review in spring 2011.

Adolescent Health also is leading Oregon’s Coordinated School Health Program, Healthy Kids Learn Better (HKLB), in collaboration with the Health Promotion and Chronic Disease Program in the Office of Disease Prevention and Epidemiology. Coordinated School Health (CSH) is an evidence-based model the CDC created in the 1990s to support schools in addressing student health. Core to this model is the evidence around the link between health and learning. The CSH model has been used to address student health needs related to physical activity, nutrition, tobacco prevention, safety and asthma.

Healthy Kids Learn Better is the first CSH program in the nation to use the CSH model to address mental health. The goal of this project is to improve access for children and youth to a full continuum of mental health services and create environments that promote optimal social and emotional development on school campuses. HKLB has worked to develop this focus area since 2006. Eleven schools and one district program have received intensive training and support related to this school-based mental health approach. These schools have participated in a series of training institutes, pilot tested new assessment tools, and received tailored technical assistance to assess campus mental health needs and develop and implement an action plan to address a priority mental health issue. Oregon is working with the CDC and the National Assembly of School-Based Health Care to further develop the use of CSH to support school mental health.

Where service recipients are located

The services are provided at the local level through public-private partnerships and medical sponsorships that develop SBHCs on school property. SBHCs are found in elementary schools (ES), middle schools (MS), high schools (HS) and combined (K-18 and K-12) grade campuses.

| County | School | Clients | Visits |
|---------------|---------------|----------------|---------------|
| Baker | Total | 401 | 2611 |
| | Baker HS | 401 | 2611 |
| Benton | Total | 1868 | 4003 |
| | Lincoln ES | 1426 | 2977 |
| | Monroe ES/MS | 442 | 1026 |

| | | | |
|------------------|---------------------|-------------|--------------|
| Clackamas | Total | 182 | 445 |
| | Canby HS | 31 | 43 |
| | Oregon City HS | 151 | 402 |
| Columbia | Total | 394 | 670 |
| | Lewis and Clark ES | 394 | 670 |
| | Rainier MS/HS | N/A | N/A |
| Coos | Total | 300 | 866 |
| | Marshfield HS | 300 | 866 |
| Curry | Total | 166 | 297 |
| | Brookings-Harbor HS | 166 | 297 |
| Deschutes | Total | 1171 | 1738 |
| | Ensworth ES | 370 | 514 |
| | Lynch ES | 422 | 563 |
| | La Pine K-12 | 379 | 661 |
| Douglas | Total | 310 | 810 |
| | Douglas HS | N/A | N/A |
| | Roseburg HS | 310 | 810 |
| Jackson | Total | 2035 | 7801 |
| | Ashland HS | 446 | 1375 |
| | Crater HS | 425 | 975 |
| | Jackson ES | 71 | 571 |
| | Jewett ES | 206 | 455 |
| | Oak Grove ES | 309 | 1456 |
| | Phoenix ES | 282 | 1542 |
| | Washington ES | 296 | 1427 |
| Jefferson | Total | 100 | 230 |
| | Madras HS | 100 | 230 |
| Josephine | Total | 1206 | 3653 |
| | Evergreen ES | 429 | 1024 |
| | Illinois Valley HS | 428 | 1348 |
| | Lorna Byrne MS | 349 | 1281 |
| Klamath | Total | 44 | 71 |
| | Gilchrist School | 44 | 71 |
| Lane | Total | 5875 | 14302 |
| | Churchill HS | 1163 | 2491 |
| | North Eugene HS | 1073 | 3520 |
| | Sheldon HS | 1067 | 2923 |

| | | | |
|-------------------|--------------------------|-------------|--------------|
| | South Eugene | 1064 | 2812 |
| | Springfield HS | 1508 | 2556 |
| Lincoln | Total | 908 | 3604 |
| | Newport HS | 259 | 1078 |
| | Taft HS | 267 | 967 |
| | Toledo HS | 186 | 756 |
| | Waldport HS | 196 | 803 |
| Marion | Total | 274 | 464 |
| | Hoover ES | 274 | 464 |
| Multnomah | Total | 6741 | 19881 |
| | Clarendon-Portsmouth K-8 | 297 | 1013 |
| | Cleveland HS | 823 | 2466 |
| | George MS | 220 | 830 |
| | Grant HS | 843 | 2264 |
| | Harrison Park K-8 | 373 | 787 |
| | Jefferson HS | 553 | 1874 |
| | Lane MS | 429 | 880 |
| | Lincoln Park ES | 546 | 1024 |
| | Madison HS | 557 | 2331 |
| | Marshall HS | 826 | 2249 |
| | Parkrose HS | 754 | 2348 |
| | Roosevelt HS | 520 | 1835 |
| Umatilla | Total | 1216 | 6112 |
| | Pendleton HS | 666 | 3793 |
| | Sunridge MS | 550 | 2319 |
| Union | Total | 465 | 1736 |
| | La Grande HS | 465 | 1736 |
| Washington | Total | 846 | 1672 |
| | Forest Grove HS | 77 | 103 |
| | Merlo Station HS | 111 | 219 |
| | Tigard HS | 658 | 1350 |
| Wheeler | Total | 172 | 474 |
| | Mitchell K-12 | 172 | 474 |
| Yamhill | Total | 321 | 640 |
| | Willamina HS | 321 | 640 |

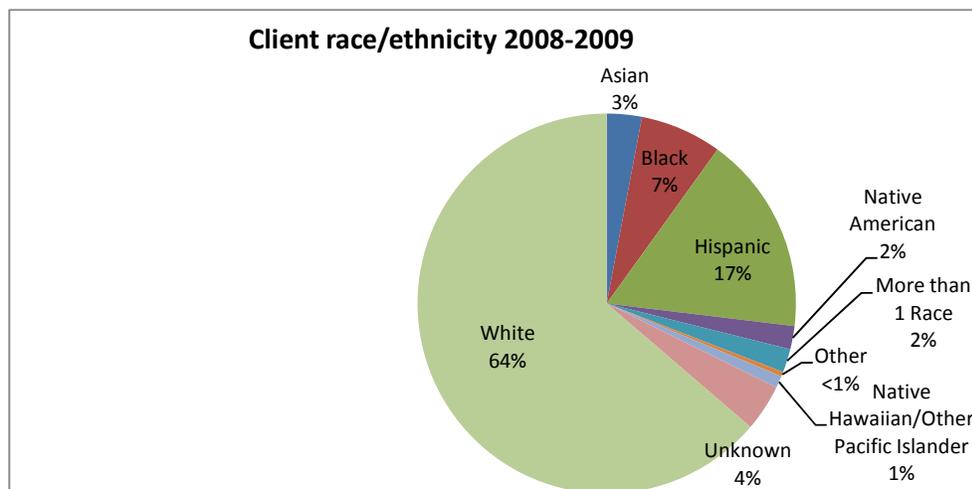
Who receives services

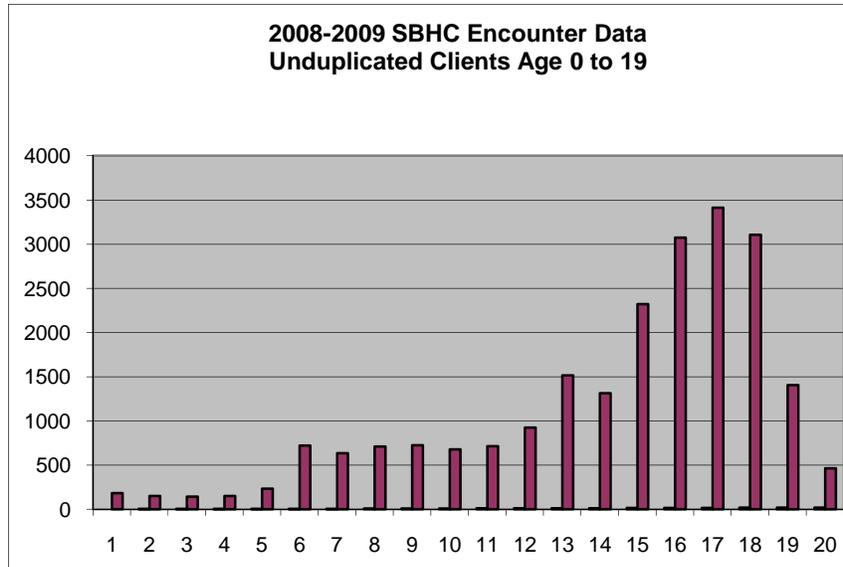
Services are provided to school-aged youth grades K-12 regardless of insurance status. Some SBHCs offer additional services to school staff or other community members through extended hours and agreements.

During the 2008-2009 service year there were 72,080 visits made by 24,995 clients. Females (58 percent) were more likely to be an SBHC client than males (42 percent) and accounted for a larger proportion of all visits (64 percent). Clients reported their insurance status at the time of their first visit as 47 percent uninsured, 25.5 percent public, 24 percent private and 3.5 percent unknown.

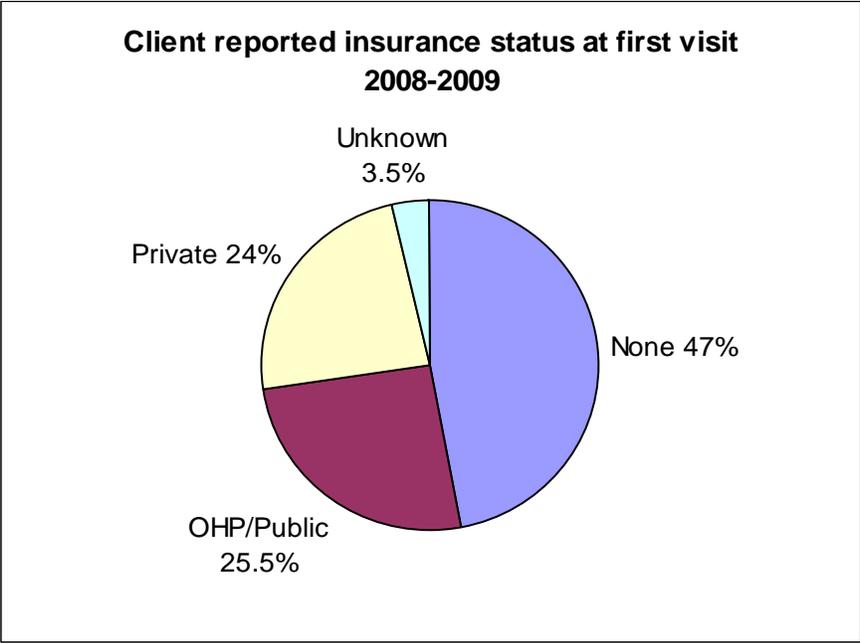
| | |
|------------------|-----|
| Asian | 3% |
| Black | 7% |
| Hispanic | 17% |
| Native American | 2% |
| More than 1 Race | 2% |
| Other | <1% |

| | |
|--|-----|
| Native Hawaiian/Other Pacific Islander | 1% |
| Unknown | 4% |
| White | 64% |





| County | Clients | Visits |
|------------|---------|--------|
| Baker | 401 | 2611 |
| Benton | 1868 | 4003 |
| Clackamas | 182 | 445 |
| Columbia | 394 | 670 |
| Coos | 300 | 866 |
| Curry | 166 | 297 |
| Deschutes | 1171 | 1738 |
| Douglas | 310 | 810 |
| Jackson | 2035 | 7801 |
| Jefferson | 100 | 230 |
| Josephine | 1206 | 3653 |
| Klamath | 44 | 71 |
| Lane | 5875 | 14302 |
| Lincoln | 908 | 3604 |
| Marion | 274 | 464 |
| Multnomah | 6741 | 19881 |
| Umatilla | 1216 | 6112 |
| Union | 465 | 1736 |
| Washington | 846 | 1672 |
| Wheeler | 172 | 474 |
| Yamhill | 321 | 640 |



How services are delivered

Services are provided in the SBHCs by qualified medical and/or mental health providers located on school property. The facility may be integral to the school’s main building or in an adjacent modular unit specifically designed as a medical facility. Currently 63 percent of SBHCs are sponsored by Federally Qualified Health Centers (FQHCs). Local health departments receive funding using a formula based on the number of certified SBHCs in their county. Currently, counties with only one certified SBHC receive \$60,000/yr and counties with more than one certified SBHC receive \$41,000/yr for each center. The distribution and sharing of those dollars is determined at a local level in consideration of need, medical sponsorships and local agreements. It is estimated that every state General Fund dollar invested leverages three to five local dollars in local investments.

Why these services are significant to Oregonians

School-based health centers are an important part of the safety net system, support the educational mission, are overwhelmingly embraced by Oregonians across the state and are cost efficient. Health care needs are trending upwards for Oregon's children and teens, and rates of uninsured among newborns to 18-year-olds are rising and are highest for adolescents. Many Oregon students report unmet health care needs and are more likely to depend on school-based health centers as a regular source of care. SBHCs have demonstrated their ability to reduce barriers to care and improve access to all youth regardless of insurance status. SBHCs keep kids in the classroom, help youth maximize instructional time, and promote positive health and mental health status, which are linked to academic achievement. Nationally, the SBHC model has been linked to Medicaid savings and reduced emergency department and hospitalization use.

Performance measures

The Adolescent Health program has one main OHA key performance measure. The program most strongly relates to Key Performance Measure 35, Safety Net Clinic Use.

Because preventive and early intervention services provided in SBHCs relate to so many other health indicators for school-aged youth, SBHCs are secondarily linked (but not reported on here) to several other performance measures including KPM 8 (teen pregnancy), KPM 13 (teen suicide), KPM 17 (intended pregnancy), KPM 22 (8th grade risk for alcohol and drug use), KPM 24 (tobacco use), KPM 28 (HIV rate), and KPM 29 (OHP clients receiving routine health care).

Measure: KPM 35, Safety Net Clinic Use

Purpose: SBHCs are an important part of the safety net system of care. Because SBHCs are designed as an access model, and data suggest up to 70 percent of students seen in an SBHC likely would not have received services regardless of insurance status, the performance measure focuses on the number of students who have access and the number of clients (users) of SBHC services rather than on insurance status of students within this safety net component.

Other performance measures related to safety net clinic use

| Measure: <i>Number of students who had access to a School-Based Health Center in a Service Year (SY)</i> | | | | | | | |
|---|--------|--------|----------|--------|--------|--------|--------|
| Identify whether the measures is an: Existing Internal Measure <input checked="" type="checkbox"/> New Measure for POP Existing Internal Measures <input type="checkbox"/> | | | | | | | |
| DATA: | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
| Actual | 38,306 | 38,863 | 47,511 | NA | NA | NA | NA |
| Target | | | [41,000] | 50,000 | 53,000 | 56,000 | 59,000 |
| Target Impact: Increase students with access to a SBHC by 3,000 to 7,000; (est. due to school size selection variable) | | | | | | | |

| Measure: <i>Number of unduplicated clients served in a School-Based Health Center in a Service Year (SY)</i> | | | | | | | |
|---|--------|--------|----------|--------|--------|--------|--------|
| Identify whether the measures is an: Existing Internal Measure <input checked="" type="checkbox"/> New Measure for POP Existing Internal Measures <input type="checkbox"/> | | | | | | | |
| DATA: | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
| Actual | 20,831 | 20,971 | 24,995 | NA | NA | NA | NA |
| Target | | | [23,000] | 28,000 | 31,000 | 34,000 | 37,000 |
| Target Impact: Increase number of clients served in a SBHC by 3,000; (est. due to school size selection variable) | | | | | | | |

How Oregon compares to other states: Nationally, there were 1,909 SBHCs in 48 states according to the 2007-2008 National Assembly on School-Based Health Care Census Survey. Oregon reported on 44 SBHCs in that survey while Washington state reported on 20 SBHCs. Oregon was ranked 15th overall in the total number of SBHCs. Some of the more populous states have a large number of centers, such as New York (206) and California (160), while less populous states had relatively few centers, such as Alaska (3) and New Hampshire (1).

The chart below compares Oregon’s answers to the overall national response to questions on operations, funding sources, and whether selected services were offered at the time of the 2007-2008 survey.

| | Oregon SBHCs | Nationwide |
|---|-------------------|-------------------|
| Selected Services | % | % |
| Comprehensive Health Assessments | 98 | 97 |
| General Dental Care | 2 | 10 |
| On-Site STD Diagnosis and Treatment for Adolescents | 81 | 68 |
| Asthma Treatment | 95 | 95 |
| Nutrition/ fitness/ weight management | 98 | 86 |
| Immunizations | 100 | 85 |
| Mental Health Assessment | 93 | 84 |
| Tobacco Prevention | 91 | 80 |
| Grief and Loss Therapy | 86 | 80 |
| Conflict Resolution/ Mediation | 86 | 78 |
| | | |
| Operations | % | % |
| Bill Medicaid | 88 | 81 |
| Prearranged After Hours Care | 79 | 67 |
| Sees Patients Other Than Those in School They Serve | 90 | 64 |
| | | |
| Hours | Hours/Week | Hours/Week |
| Average Operating Hours | 32 | 31 |
| | | |
| Funding Received From | % | % |
| Federal government | 73 | 39 |
| State government | 83 | 76 |
| County and city government | 83 | 37 |
| Private Foundations | 36 | 50 |
| Corporation/ businesses | 31 | 28 |

Source: National Census of School-Based Health Centers, SY 2007-08, National Assembly on School-Based Health Care, 2009, www.nasbhc.org Note that National Census data is only collected and available every 3-4 years.

Quality and efficiency improvements

In order to improve the quality of services provided to SBHCs, the following quality improvement plan was adopted for implementation during the next biennium:

Goal: SBHCs are committed to high quality, age-appropriate, accessible health care for school-age children. To ensure this goal, SBHCs are targeting key health performance measures.

Approach: Year 1 of implementation (SY 2006-2007) was an introduction to the tool and allowed time for sites to identify local system issues that may challenge completion and/or accurate data collection. Year 2 (SY 2007-2008) was used to identify baseline targets for sites and statewide goals were set accordingly. Year 3 (2008-2009) was full implementation of the key performance measures and are now tied to county contracts. Because many services are included within the KPMs, they will remain ongoing. Additional KPMs may be added based on emerging adolescent health issues. Sites unable to meet targeted KPM goals will need to complete KPM improvement forms to identify and implement an action plan to improve practice. Progress must be demonstrated from year to year and meet statewide target goals within two years, otherwise funding may be reduced.

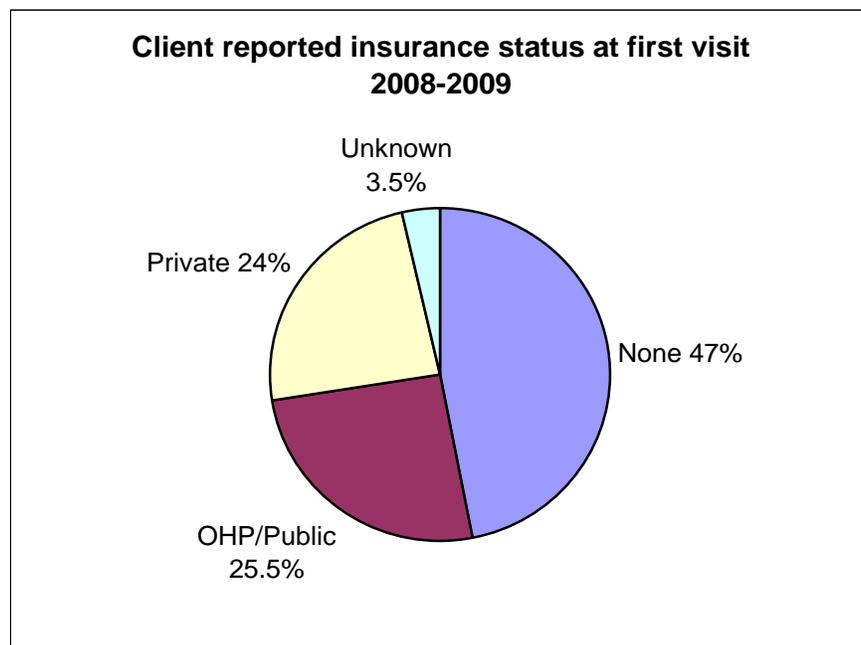
Measures:

| Sentinel Condition | State Goal |
|---|--|
| 1. Risk Assessment ¹ | Complete risk assessment done every service year after three visits (2010-2011 Target 60%) |
| 2. Comprehensive physical exam ² | Complete physical exam every two years after child has been seen three times in one service year (2010-2011 Target 65%) |
| 3. Height, weight and BMI | At least one recording of each measure for children seen at least three times in the SBHC in one service year (2010-2011 Target 90%) |

Health disparities

SBHCs are a health care access model, 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; they are limited to receiving health care services due to transportation and financial barriers, along with concerns of stigma and confidentiality. SBHCs provide physical, mental and preventive health services to any student, regardless of their ability to pay, in a safe, youth-friendly and confidential setting on school grounds.

SBHCs work to reduce health disparities by providing services to any student regardless of health insurance status and their ability to pay. During 2008-2009, 47 percent of SBHC clients were uninsured, representing the largest insurance category.



The U.S. Census data from 2008 report that 2 percent of the Oregon population identified as Black and 11 percent of Oregon citizens are of Hispanic or Latino origin. In contrast, during the 2008-2009 service year, 7 percent of Oregon School-Based Health Center clients reported as Black and a full 17 percent are of Hispanic origin.

SBHCs also reduce health disparities by the nature of their locations. Oregon's 54 SBHCs are located in both rural and urban communities. Two centers are frontier, 24 are rural and 28 are urban, 12 of which are located in the Portland metropolitan area. In some of the more remote communities the health services provided in the SBHC are the only health care services for many miles.

Key budget drivers and issues

In 2010, Congress passed the Federal Patient Protection and Affordable Care Act (P.L. 111-148), a comprehensive overhaul of the health care system that endeavors to rein in costs while expanding affordable health care coverage to every American. Conceptually, the Affordable Care Act lends strong support to the future of School-Based Health Centers, with its emphasis on evidence-based preventive care and welcoming safety net clinics as part of the larger solution to increasing the percentage of Americans who have affordable and comprehensive health insurance.

In particular, the Act includes two important provisions for school-based health centers (SBHCs): language authorizing a federal SBHC grant program (Sec. 4101(b)), and an emergency appropriation that would provide \$200 million for SBHCs over four years (Sec. 4101(a)).

Section 4101(a) of the Affordable Care Act allows for SBHCs 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, equipment, and similar expenditures. Guidance for the first \$50 million in funding was issued by the Bureau of Primary Health Care (BPHC) in the Department of Health and Human Services on June 30, 2010. HRSA expects to award approximately \$50 million for an estimated 1,000 SBHC equipment grants in FY 2010.

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

The passage of the Children's Health Insurance Program Reauthorization Act (CHIP) was signed by President Obama in February 2009 and included the first-ever specific reference to and inclusion of SBHCs within a federal health insurance

reimbursement program, which lays the groundwork for further policy opportunities.

At the local level, the availability of local matching and/or operational funds comprises the primary SBHC budgetary challenges. The current funding formula requires a 3-5 local dollar match for every state dollar. Sustainability planning at the local level is influenced by numerous factors including insurance coverage, service mix, reimbursement rates, billing capacity, business infrastructure, medical sponsorship and strength of community partnerships. The current SBHC funding model is an investment model that does not pay for the full cost or ongoing operations of an SBHC. The ability of a school community to develop a financial model to sustain such local investments continues to be the major challenge of SBHCs.

Women's and Reproductive Health (WRH) Program

Services provided

The Women's and Reproductive Health section (WRH) consists of three main program areas: Reproductive Health (RH), the Breast and Cervical Cancer Program (BCCP), and Women's Health (WH). BCCP was previously a part of the Office of Disease Prevention and Epidemiology, but transferred to OFH in 2007. WRH develops and supports statewide programs and policies to promote the health of individuals, families and communities with a specific emphasis on improving women's health throughout the lifespan.

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 and to remain free of disease. Specific services provided through Reproductive Health include birth control counseling and supplies, annual gynecological exams including cancer screenings, vasectomies, and STD/HIV prevention counseling. Abortions are not provided. Referrals are made for primary care and many other health and social services. 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. The Breast and Cervical Cancer Program is part of the National Breast and Cervical Cancer Early Detection Program. Our clients are also provided screening for heart disease, stroke, tobacco use, obesity and diabetes through a

grant called WISEWOMAN which also makes referrals to classes and other support for chronic disease management.

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 approximately 172 clinic locations. The table below shows the number of RH clients served during 2009 by county of service:

| County | Clients Served 2009 | County | Clients Served 2009 |
|------------|---------------------|------------|---------------------|
| Baker | 390 | Lake | 247 |
| Benton | 3,491 | Lane | 12,911 |
| Clackamas | 3,178 | Lincoln | 1,310 |
| Clatsop | 963 | Linn | 2,300 |
| Columbia | 749 | Malheur | 976 |
| Coos | 1,835 | Marion | 6,453 |
| Crook | 522 | Morrow | 366 |
| Curry | 543 | Multnomah | 23,396 |
| Deschutes | 6,256 | Polk | 1,074 |
| Douglas | 2,391 | Sherman | 2 |
| Gilliam | 2 | Tillamook | 1,020 |
| Grant | 214 | Umatilla | 1,816 |
| Harney | 233 | Union | 767 |
| Hood River | 1,129 | Wallowa | 154 |
| Jackson | 9,387 | Wasco | 1,156 |
| Jefferson | 669 | Washington | 13,484 |
| Josephine | 3,925 | Wheeler | 20 |
| Klamath | 1,820 | Yamhill | 969 |

The Breast and Cervical Cancer Program works with 96 enrolling providers, who provide primary screening and case management services, and 170 ancillary providers such as labs, radiology facilities, surgeons and hospitals. WISEWOMAN services are provided by 30 of the 96 enrolling providers. The table below shows the number of clients served by BCCP during 2008-09 by county of service:

| County | Clients Enrolled FY 08-09 | County | Clients Enrolled FY 08-09 |
|------------|------------------------------|------------|------------------------------|
| Baker | 11 | Lake | 14 |
| Benton | 120 | Lane | 455 |
| Clackamas | 240 | Lincoln | 131 |
| Clatsop | 134 | Linn | 158 |
| Columbia | 36 | Malheur | 47 |
| Coos | 218 | Marion | 532 |
| Crook | 76 | Morrow | 15 |
| Curry | 67 | Multnomah | 865 |
| Deschutes | 314 | Polk | 24 |
| Douglas | 327 | Sherman | 6 |
| Gilliam | 3 | Tillamook | 95 |
| Grant | 43 | Umatilla | 31 |
| Harney | 34 | Union | 12 |
| Hood River | 147 | Wallowa | 2 |
| Jackson | 838 | Wasco | 146 |
| Jefferson | 82 | Washington | 800 |
| Josephine | 198 | Wheeler | 27 |
| Klamath | 14 | Yamhill | 227 |

BCCP clients enrolled 07/01/2008 – 06/30/2009

Who receives services

Priority for RH services is given to individuals under 250 percent of the federal poverty level (FPL). Women, men and teens are all eligible. Local clinics served 108,195 people during 2009; this number includes 104,088 women and 4,107 men, and 82,563 clients below 100 percent FPL.

Breast and Cervical Cancer Program services are offered to women ages 40-64 who are at or below 250 percent FPL and do not have insurance or are underinsured. Priority populations include women ages 50-64, women living in rural areas, women of color, women with disabilities and lesbian women. Women under 40 and men of any age who are symptomatic for breast cancer are eligible for breast diagnostic services.

How services are delivered

There is a significant overlap between RH providers and BCCP/WISEWOMAN enrolling or primary screening sites. Clinics through which RH services are delivered include county health departments, Federally Qualified Health Centers, Rural Health Centers, Planned Parenthood clinics, school-based health centers and private medical professionals.

The Breast and Cervical Cancer Program / WISEWOMAN providers include county health departments, Federally Qualified Health Centers, Rural Health Centers, laboratories, imaging facilities, hospital systems, outpatient radiology centers, surgeons, family physicians and other primary care providers, radiologists, pathologists, medical oncologists, radiation oncologists, ambulatory surgery centers, and radiation therapy facilities.

Why these services are significant to Oregonians

Reproductive Health services protect and promote Oregonians' health by helping families have children only when they are ready for them. Almost 110,000 Oregon women and men count on publicly funded family planning clinics for reproductive health care they would be unable to afford otherwise. The program benefits all Oregonians by reducing public spending on maternal and infant health services whenever an unintended pregnancy is prevented.

The Breast and Cervical Cancer Program 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 program's clients would be unlikely to access cancer screening without the BCCP and its provider network. BCCP also provides a point of entry into the Oregon Health Plan (OHP) for breast and/or cervical cancer treatment. At present, only women screened through BCCP can enroll in OHP's breast and cervical cancer medical program (BCCM).

The leading causes of death for women in Oregon are cancer, heart disease and stroke. With the WISEWOMAN Program, the WRH section will offer screening services in all three areas.

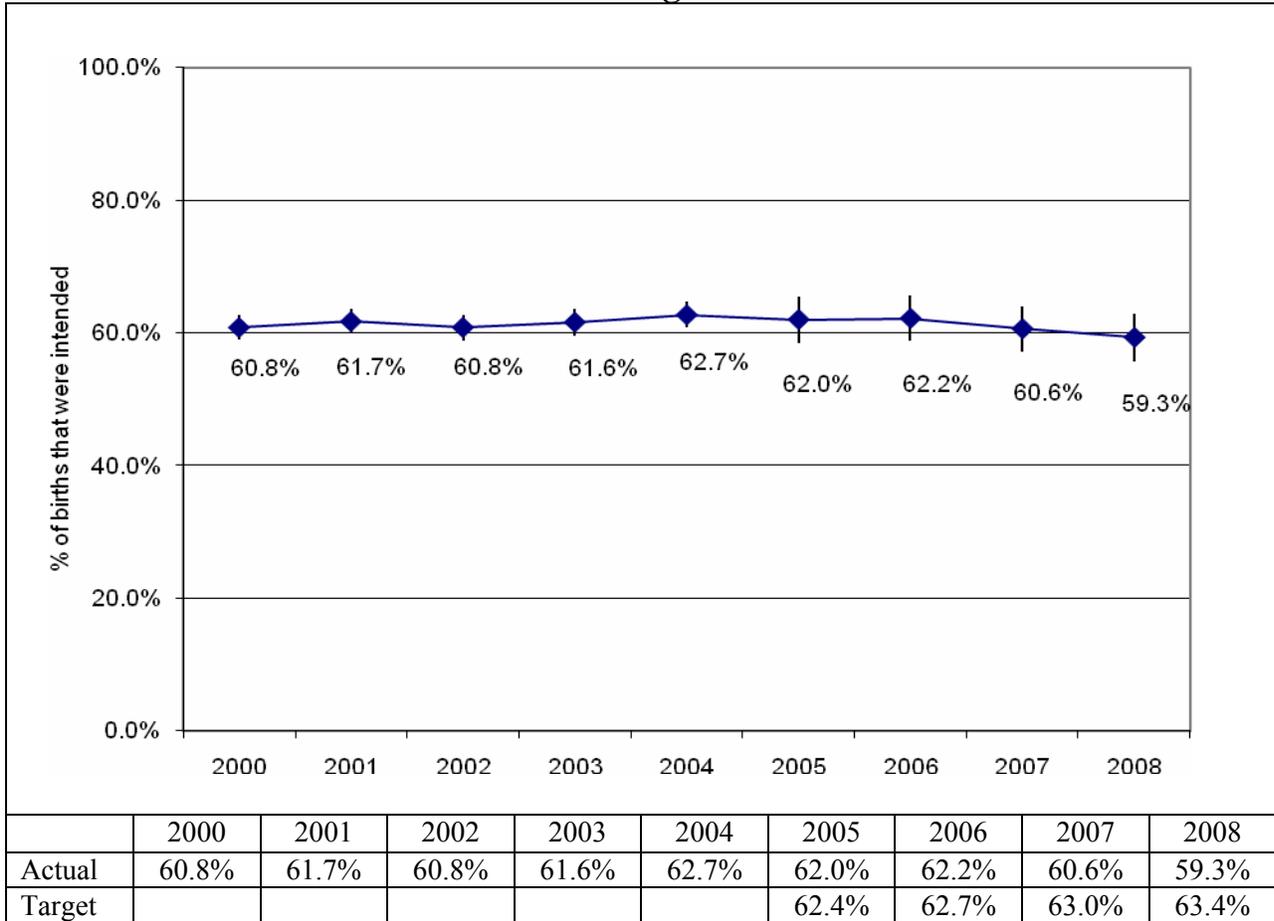
Performance measures (RH)

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

Measure: KPM 12, 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. Clearly, 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 2010 Objective 9-1: Increase the proportion of pregnancies that are intended.

Intended Pregnancies



How Oregon compares to other states: Healthy People 2010 Objective 9-1 sets an ambitious goal of increasing the proportion of U.S. pregnancies that are intended to 70 percent. Oregon currently falls a little short of this goal, as do many other states. The table below shows the proportion of pregnancies that were intended among a few of the 27 states participating in PRAMS, the Pregnancy Risk Assessment Monitoring System, in 2007. This is the most recent year of data available.

| State | Percent of Pregnancies Intended (2007) |
|------------------------------------|---|
| New York (excluding New York City) | 62.6% |
| Rhode Island | 62.2% |
| Oregon | 60.6% |
| Washington | 63.9% |
| Oklahoma | 52.0% |
| Louisiana | 47.5% |
| | |
| 29 state average | 59.2% |

Nationally, the percentage of pregnancies that were intended increased by 2 percent between 2002 and 2007 (the most recent year for which data are available); 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.

Performance measures (BCCP and WISEWOMAN)

Measure: *The Breast and Cervical Cancer Program has 11 data quality indicators by which program performance is measured on a biannual basis. The indicators primarily measure timeliness and appropriateness of care for BCCP clients from initial screening to additional diagnostic procedures (if needed) and final diagnosis and treatment (if required). At the latest CDC review, BCCP met or exceeded the CDC standards for most of the indicators.*

Purpose: These indicators measure quality and timeliness of care and are mandated by the federal grants supporting BCCP. The measures are reviewed on a biannual basis to ensure high quality service delivery and

adherence to clinical guidelines by providers, as well as to evaluate the quality of the two programs.

How Oregon compares to other states: 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. Approximately 57,000 additional women in Oregon are in need of these lifesaving screening services and are unable to access them due to program funding limitations. Nationwide state Breast and Cervical Cancer Programs reach approximately 14 percent of the eligible population; Oregon is currently reaching close to 16 percent of the eligible population. However, Oregon also has a greater need for services. According to the CDC, Oregon and Washington have higher breast cancer incidence rates than most other states, often ranking in the top one and two for breast cancer incidence. For every 100,000 people in the Pacific Northwest, approximately 130 develop breast cancer, as compared to approximately 114 in California and 106 in Nevada. This variance in incidence rates has not been explained.

Quality and efficiency improvements (WRH)

Reproductive Health engages in many activities designed to improve the quality and effectiveness of the services it supports. Continuing education on a range of topics (e.g., new contraceptive methods, cost analysis, program integrity, and culturally and linguistically appropriate services) is offered to local clinic staff at biannual meetings and periodic training events. Agencies' performance and compliance with program standards are monitored by triennial reviews that encompass clinical, fiscal and administrative operations, as well as by regular audits.

During FY 2009-2010, the BCCP/WISEWOMAN team designed and completed significant program transitions implementing improved systems to better serve low- income women in need of chronic disease and breast and cervical cancer screenings in Oregon. In 2009, the program worked with providers and partners to develop and implement more equitable access across Oregon for women seeking screenings; completed the first year implementation of Web Data System – designed to increase payment turnaround for providers and improve data collection; improved BCCP client access to additional chronic disease screenings through an 88 percent increase in the number of WISEWOMAN providers participating in the program; and increased provider and client education through

the implementation of over 20 training supporting providers in data entry and billing. In FY 2010-2011, BCCP/WISEWOMAN will focus on revising the BCCP and WISEWOMAN Oregon Administrative Rules, updating breast and cervical cancer clinical guidelines and program manual, and implement a quality assurance plan to ensure accurate and timely data collection and patient care.

Health disparities (WRH)

The Reproductive Health program works with its provider agencies to meet the Culturally and Linguistically Appropriate Services (CLAS) guidelines for health care. The 14 CLAS standards address culturally competent delivery of health care, language access services and organizational supports for cultural competence, with the goal of delivering the highest quality of care to every patient regardless of race, ethnicity, cultural background or English proficiency. All provider agencies, and the RH program itself, have conducted CLAS self-assessments and are developing strategies for improving performance.

The BCCP and WISEWOMAN priority populations include women living in rural areas, women of color, lesbian women and women with disabilities. A key program goal is to eliminate health disparities through outreach to these populations and the provision of breast and cervical cancer early detection and prevention messages and services. To achieve this goal, BCCP:

- Collaborates with organizations such as the Native American Rehabilitation Association, Inc. (NARA) Indian Health Clinic, Salud Medical Center, Virginia Garcia Memorial Health Center, and Yakima Valley Farm Workers to reach Native American and Latina women.
- Is exploring partnerships with Oregon Health & Science University (OHSU) Center for Women's Health, OHSU Knight Cancer Institute, and Susan G. Komen, which share resources and helps to expand screening services in Oregon.

Key budget drivers and issues (WRH)

The effects of citizenship verification as required in the Deficit Reduction Act of 2006 continue to impact Oregon ContraceptiveCare (CCare), formerly known as FPEP. The program began a significant outreach and social marketing campaign in late 2009. These efforts have resulted in slight increases in enrollment, but

numbers remain low. Significant budget cuts in 2010 have curtailed all outreach efforts.

The key issue for the Breast and Cervical Cancer Program is limited funding for breast and cervical cancer screening and diagnostic services. The Breast and Cervical Cancer Program is funded by a grant from the CDC. These funds are used largely for direct services. The Breast and Cervical Cancer Program 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. Approximately 57,000 additional women in need of these lifesaving screening services are unable to access them due to program funding limitations. Thus, the program is only able to serve approximately 10 percent of the eligible population in Oregon.

Nutrition and Health Screening (WIC) Program

Services provided

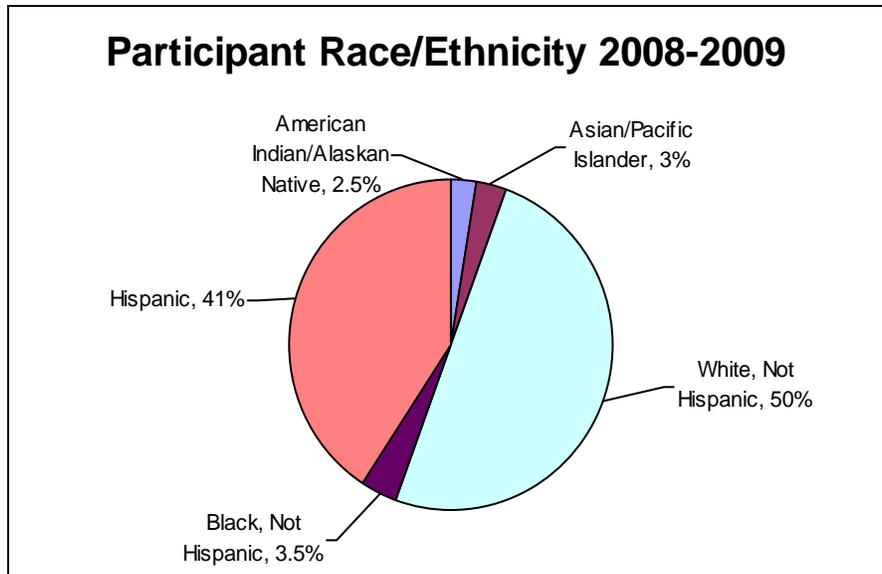
The Nutrition and Health Screening (WIC) Program provides individual assessment of growth and health; education and counseling on nutrition and physical activity, including promotion of a healthy lifestyle and prevention of chronic diseases including obesity; breastfeeding education and support; and 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.

Mothers and children served by local agencies during June 2010

| County | Clients Served | County | Clients Served |
|---------------------|-----------------------|-----------------|-----------------------|
| Baker | 501 | Josephine | 2,912 |
| Benton | 1,409 | Klamath | 2,647 |
| Clackamas | 6,372 | Lake | 200 |
| Clatsop | 1,312 | Lane | 8,195 |
| Columbia | 1,393 | Lincoln | 1,481 |
| Coos | 1,877 | Linn | 3,876 |
| Crook | 643 | Malheur | 1,780 |
| CT Umatilla | 111 | Marion | 9,753 |
| CT Warm Springs | 496 | Multnomah | 19,590 |
| Curry | 627 | Polk | 1,424 |
| Deschutes | 4,424 | Salud | 10,255 |
| Douglas | 3,447 | Tillamook | 729 |
| Grant | 169 | Umatilla/Morrow | 4,474 |
| Harney | 212 | Union | 892 |
| Hood River | 980 | Wallowa | 138 |
| Jackson | 6,724 | Wasco/Sherman | 1,196 |
| Jefferson | 824 | Washington | 13,109 |
| State Total: | | 114,142 | |



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 2009 local programs served 179,127 women, infants and children. This includes 38 percent of all infants born in the state, 51 percent of all infants born in rural counties, and one in three Oregon children under the age of 5. Slightly less than three-quarters of those served are working families.

How services are delivered

The services are provided by staff located in communities across Oregon through a partnership with 29 local health departments, two tribal organizations and two nonprofit organizations.

Why these services are significant to Oregonians

The services provided by the WIC Program are designed to reach families most in need of preventive health services at a critical time in their lives. The program provides a unique set of targeted services to help families give their children a healthy start.

The WIC Program is the primary promoter of breastfeeding for low-income women. Promoting breastfeeding and supporting women who breastfeed is a

proven public health intervention. Breastfeeding protects both mother and child from immediate and future health problems, including maternal and childhood obesity, with corresponding reductions in health care costs.

WIC families purchase \$66.4 million of nutritious foods at more than 630 stores statewide. The WIC Farm Direct Nutrition Program helps lower-income young families purchase \$397,840 in local fresh fruits and vegetables. This supports local farmers by infusing moneys into local communities statewide.

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 measure 11, Food Stamp Utilization.

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 6 months of age and NPM # 14, measuring the Body Mass Index levels of WIC children between 2 and 5 years of age. The program implements activities that support statewide public health goals to prevent obesity and overweight among pregnant women and young children though nutrition screening and education, promoting eating fresh fruits and vegetables, and increasing food security and physical activity for healthier weights for children and their families.

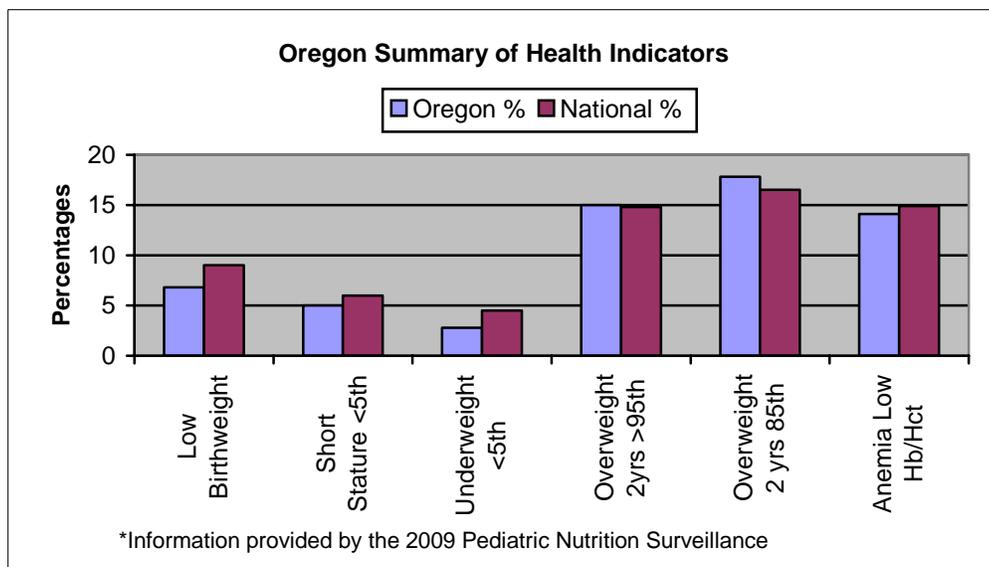
Measure: KPM 11, Food Stamp Utilization

Purpose: WIC staff routinely screen WIC participants for eligibility for food stamps, and refer eligible participants to that program. Fully 60 percent of WIC participants also participate in the food stamp program, which is a significant increase from last year's 48 percent. Many farmers' markets accept the food stamp benefit. The WIC Farm Direct Nutrition Program frees food stamp dollars that would have been spent at farmers' markets.

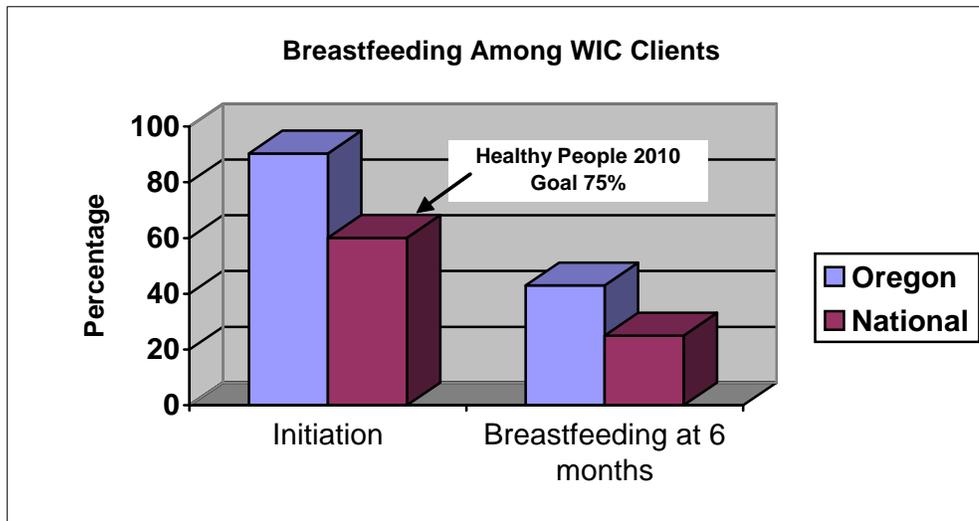
How Oregon compares to other states: Oregon scores better than the national average on most health indicators for the WIC child population, according to data from the 2009 Pediatric Nutrition Surveillance Survey, which collects data primarily from state WIC programs and includes most of the states and territories in the U.S. In particular, Oregon's rate of low birth

weight, underweight, and low iron (hematocrit, or hct) are significantly better -lower) than the national rates.

One area of concern is that Oregon’s percentage of two to five-year-olds-classified as at-risk for being overweight exceeds the national average, although Oregon is not among the states with the highest rates of overweight preschoolers. However, Oregon’s lower ranking does help to reinforce that programs targeting underlying influencers of being overweight, such as healthy eating habits, increased physical activity and community resources are vital to helping families stay healthy. The Nutrition and Health Screening Program focuses education on those influencers of overweight.



Oregon leads the nation in the number of mothers who begin breastfeeding (92.4 percent in Oregon vs. 62.0 percent nationally) and continue to nurse at six months and beyond (43 percent in Oregon vs. 26 percent nationally). 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. As breastfeeding is associated with a reduced risk of many negative health conditions for both mother and infant (e.g., ear infections, diabetes and breast cancer), Oregon is focused on making breast milk the foundation of a baby's early preventive care.



Quality and efficiency improvements

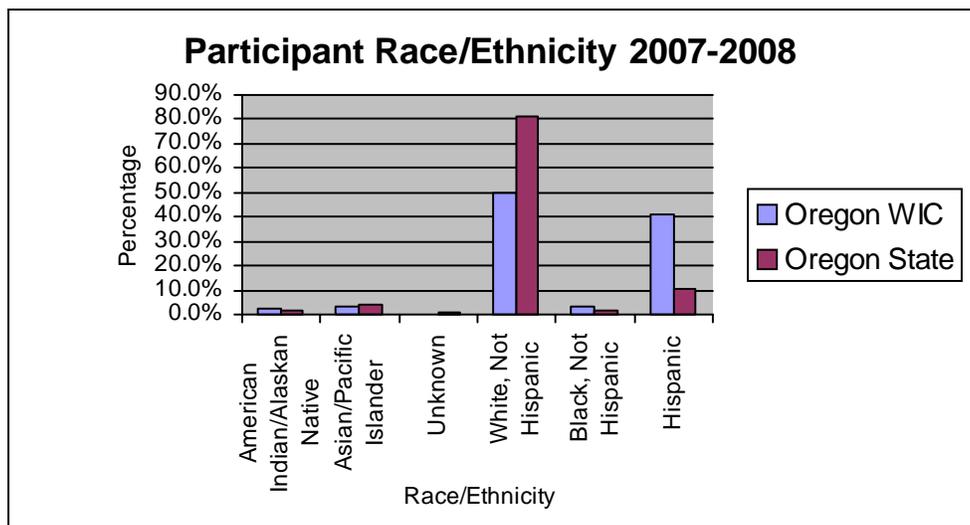
Training support is provided for all local agency WIC staff to improve the quality of services provided to WIC clients. The training plan includes training support for new staff, for existing staff, for breastfeeding expertise, for new initiatives, and in-services and a statewide meeting every other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

More than 90 percent of Oregon women start out breastfeeding in the hospital after delivery, the highest rate 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. For many lower income women, the Nutrition and Health Screening (WIC) Program provides their only breastfeeding support. The program has a no-cost breast pump loaner program for women returning to work, school or jobs training. To address the disparity in access to breastfeeding support and consultation, the program has targeted non-English-speaking local WIC staff for in-depth breastfeeding training and certification.

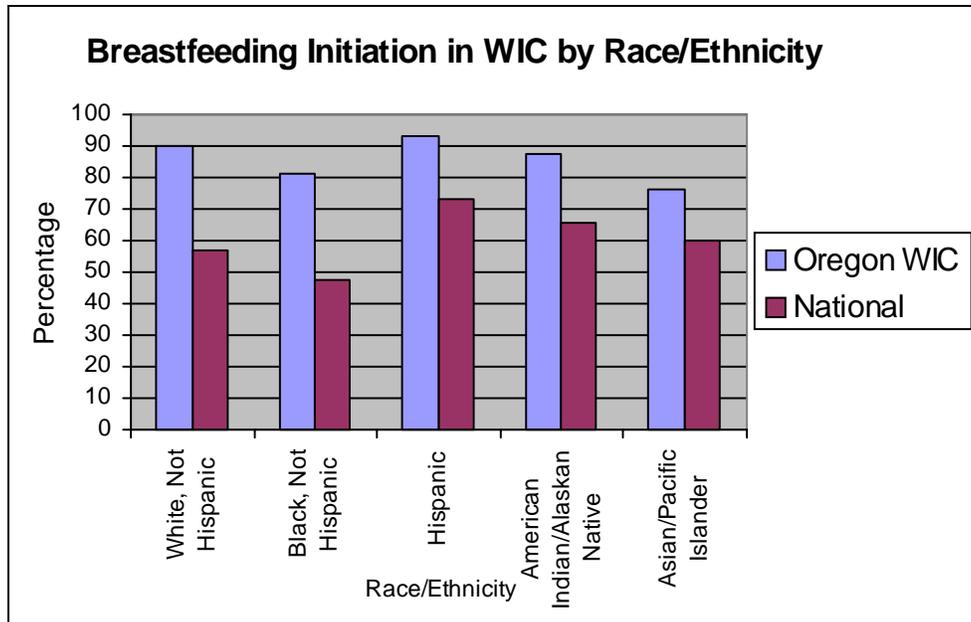
In order to shift costs and administrative effort from over-burdened local offices, the state WIC office has purchased laptop computers for satellite clinics, has voucher stock printed and shipped to clinics, purchases lab equipment for local use, purchases breast pumps, provides printer maintenance for voucher printers, and contracts with a company to calibrate scales at all clinics.

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. In addition, WIC has done a research study on the different reasons why English- and Spanish-speaking women limit exclusive breastfeeding and how peer support may uniquely impact both populations. WIC has changed nutrition education counseling techniques to better engage participants and lead to improved health outcomes. These both contribute to WIC's ability to increase the cultural competency of how services are delivered and help more mothers to breastfeed.



Nationally, breastfeeding rates are significantly lower among lower-income women and particularly African Americans. Oregon however, exceeds national rates including its African American population. To explore the unique factors that make breastfeeding successfully in a population that nationally experiences substantial disparities, Oregon WIC conducted key informant interviews with Black women who successfully initiated breastfeeding. Findings from this study will be used to increase cultural competency in the breastfeeding support services WIC provides.



With the implementation of the new WIC food package in August 2009, WIC was able to improve access to fresh fruits and vegetables for all Oregonians. All WIC authorized grocery stores are now required to stock at least four types of fresh fruit and four types of fresh vegetables at all times. The WIC program continues to work with its authorized grocery stores to improve access to healthy foods in all Oregon communities.

Key budget drivers and issues

Uncertainty around Child Nutrition Act reauthorization and the final funding level of FFY 2011 could impact the program, as all funding is from the federal government. Reduced funding during a time of potential major federally mandated changes and increased county budget deficits could be very problematic. In addition, WIC caseloads have increased by 18 percent during the past 10 years to the current level of 114,142 participants in June 2010.

Immunization Program (IP)

Services provided

The Immunization Program (IP) provided services in 2009 that included purchasing and distributing \$30 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 team receives immunization records from vaccine providers statewide; maintaining accurate, timely and complete immunization records for clinical, school and community use. The program is merging the statewide immunization information system and the immunization electronic medical record system for local health departments into a comprehensive immunization information system in 2010. This is part of the FamilyNet data system for the Office of Family Health. Lastly, 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/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 to 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, congenital immunodeficiencies, kidney failure, asplenia, (the absence of normal spleen functioning), HIV, health care workers, and those 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, and rural health clinics. An estimated 71 percent of childhood immunizations are delivered in the private sector and 29 percent in the public sector.

School and children’s facility immunization administrative rules

Children in Oregon must have these immunizations for school and children’s facility attendance (or a religious or medical exemption):

| | |
|------------|--|
| Diphtheria | Rubella |
| Tetanus | Hepatitis B |
| Pertussis | Hepatitis A |
| Polio | Varicella 1 |
| Measles | Hib (<i>haemophilus influenza</i> type B) |
| Mumps | |

Tdap vaccine was required for seventh graders for the first time in school year 2008-2009, and for seventh and eighth graders in school year 2009-2010, marking the beginning of the phase in through 12th grade to be completed in school year 2013-2014. Hepatitis A vaccine was required for children in preschool, childcare, Head Start, kindergarten, and 1st grade, the second year of the phase-in through 12th grade to be completed in school year 2014-2015.

In 2008, the Immunization Program worked with the School/Children’s Facility/College Law Advisory Committee to develop a set of twelve criteria to evaluate vaccines for potential inclusion in school immunization law. In 2009-2010, the Committee reviewed all of the vaccines currently not required for school attendance against these criteria, and recommended that the Immunization Program not add any of these vaccines as requirements at this time.

In 2009, the Immunization Program began the process of collecting more detailed information about religious exemptions to school immunization requirements.

Over the past 10 years, the number of parents claiming religious exemptions has been steadily increasing. Beginning in school year 2010-2011, with full implementation anticipated by 2012, 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 entitles access to vaccine by populations who may not otherwise have the means to purchase vaccine, ensuring individual and community protection. Epidemiologic data shows that when 75 percent to 90 percent of the population is vaccinated, all the population is protected from disease transmission.

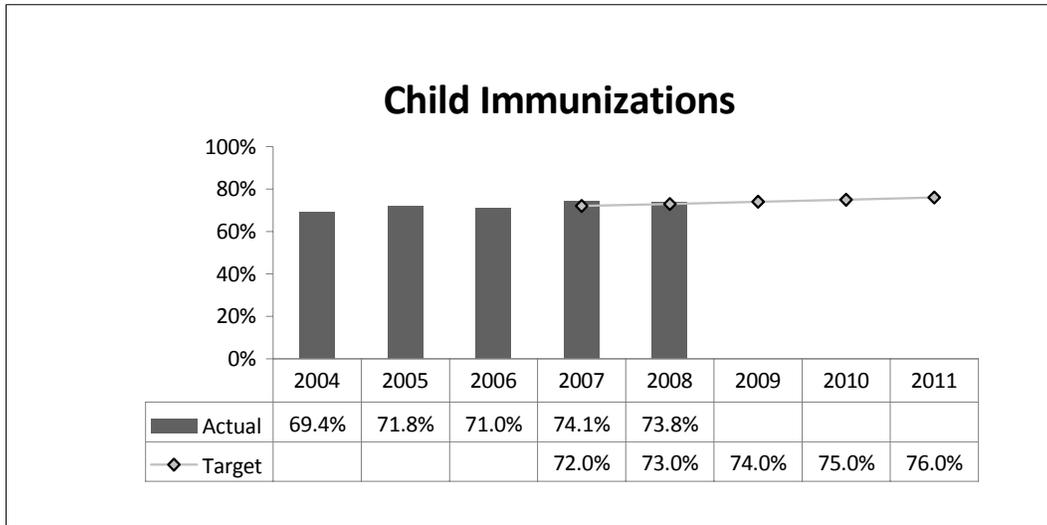
Performance measures

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

Measure: 2009-2011 KPM 33, The percentage of 24-35-month-old children who are adequately immunized

Purpose: This performance measure is the percent of children 24-35 months of age immunized with four or more doses of diphtheria, tetanus and pertussis (DTaP); three or more doses of polio; one or more doses of measles, mumps and rubella (MMR); three or more doses of Haemophilus Influenzae type b; three or more doses of hepatitis B; and at least one dose of varicella (4:3:1:3:3:1). Periodically, the Advisory Committee on Immunization Practice (ACIP) adds new vaccine recommendations to the schedule. The goal is to increase immunization rates to meet the Healthy People 2010 objective of 90 percent.

During 2008, 73.8 percent of two year old children were fully immunized. This rate continues to incrementally increase.



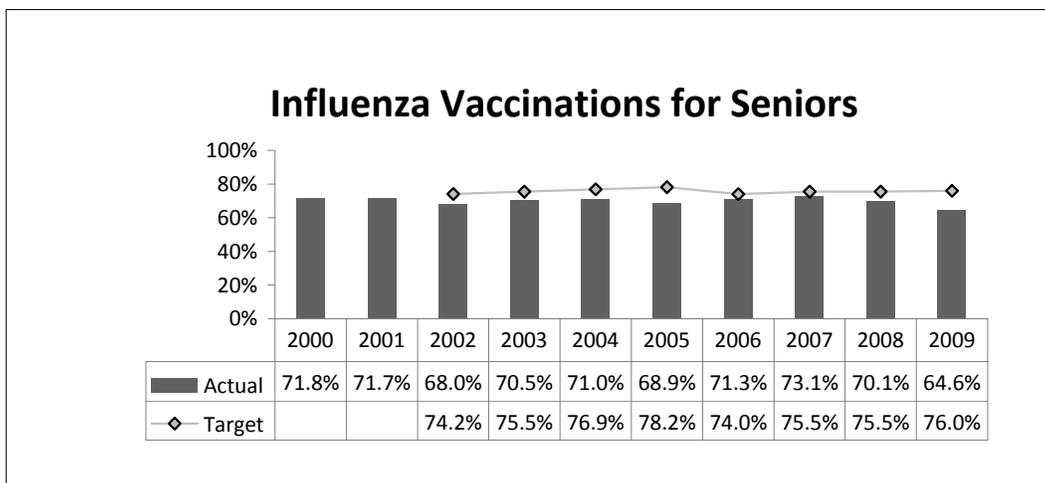
How Oregon compares to other states: The best comparison available to other states is the National Immunization Survey, a phone survey of residents in each state. The national rate for 4:3:1:3:3:1 during 2008 based on the National Immunization Survey was 71.3 (+/-1.2) percent and 67.5 (+/-7.5) percent for Oregon. Oregon’s rates have been below the national average for several years. Infants starting shots at a later age, a complicated immunization schedule making it difficult for parents and providers to ensure that all shots are given when they are due, and a persistent concern about vaccine safety influence these lower rates.

| National Immunization Survey, 2008 | |
|---|--|
| State | Immunization Rate 4:3:1:3:3:1 |
| Maryland (ranked 1 st) | 78.2% ± 5.0 |
| Idaho | 58.5% ± 6.8 |
| Nevada | 61.9% ± 6.8 |
| Oregon (37th) | 67.5% ± 7.5 |
| Washington | 67.4% ± 8.6 |
| National | 71.3% ± 1.2 |

Measure: KPM #34 - 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 2009-2010 season, a survey of Oregon residents found that the top reason for not getting a H1N1 flu shot was because they did not believe it was necessary and they had concerns about vaccine safety.



How Oregon compares to other states: During 2009, the national immunization rate for persons 65 and older was 70.1 percent, with state rates ranging from 76.7 percent in Minnesota to 62.0 percent in Nevada. Oregon ranked 48th, with 64.6 percent of the 65-plus population immunized.

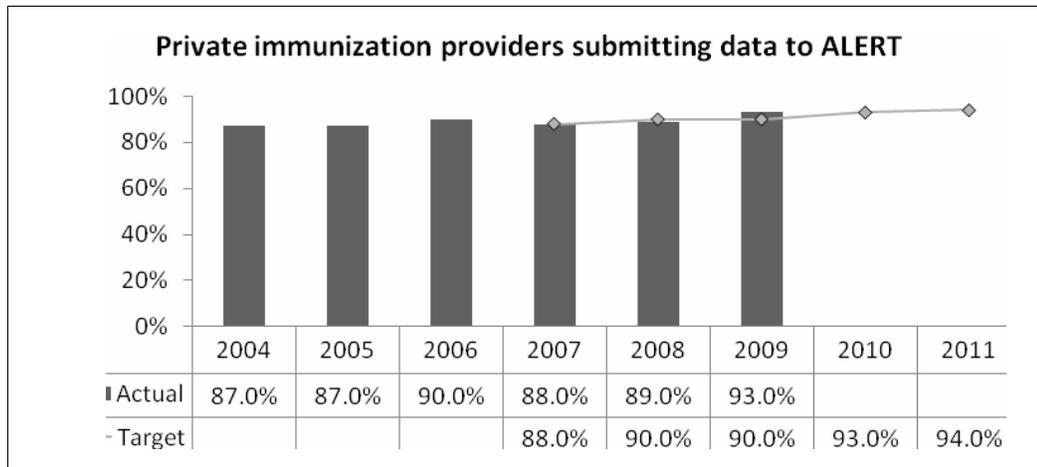
| Behavioral Risk Factor Surveillance System, 2009 | |
|---|------------------------------------|
| State | Influenza Immunization Rate |
| Minnesota (ranked 1st) | 76.7% |
| California | 65.1% |
| Idaho | 64.1% |
| Nevada | 63.5% |
| Oregon (19th) | 64.6% |
| Washington | 70.1% |
| National | 69.8% |

Proposed outcome measures

Measure: Percent of private immunization providers submitting data on 0-6-year-olds to the ALERT registry.

Purpose: This measure tracks the number of private providers in Oregon who immunize children ages 0-6 years and who submitted at least one shot in the previous six months. Public providers are not included in this measure, as they are all required by contract to submit data to ALERT. However, participation by the private sector is voluntary.

Increasing provider reporting to ALERT is a key step in increasing immunization rates and decreasing over-immunization of children. With a well-populated registry, Oregon is now testing different reminder and recall mailings to parents to help them navigate the complex immunization schedule. Additionally, the registry is a tool relied on statewide by providers to assess immunization status of clients, providing current information for clinical decision-making.



How Oregon compares to other states: This measure is interesting to compare nationally, as each state has promoted registry participation differently. Some, like Oregon, promote voluntary participation. Some, like Washington, require mandatory reporting. Even with Oregon’s voluntary private provider reporting, 93 percent of those providers do report, far exceeding participation in neighboring states.

| Private Provider Participation in Immunization Information Systems, 2008 | |
|---|------------|
| United States | 37% |
| California | 33% |
| Idaho | 70% |
| Nevada | 27% |
| Oregon | 89% |
| Washington | 78% |

Source: <http://www.cdc.gov/vaccines/programs/iis/rates/2008-private-map.htm>

Quality and efficiency improvements

During the past few years the Immunization Program and the local health departments have implemented new billing requirements that help Oregon extend vaccines to more people. The program worked with public clinics to implement a new process and culture for billing well-insured clients and their health plans for the cost of vaccines provided in public clinics. The program stopped using taxpayer-funded vaccine to underwrite health plan coverage for immunization. Oregon has collected a total of \$1.4 million in 2009, which was used to buy more vaccine for those who were not well insured, including the purchase of hepatitis A vaccine for children and hepatitis A and B for adults. The CDC has adopted this as a best practice nationally.

The Vaccines for Children team has adopted the use of LEAN tools to improve routine processes and provider services. Previously, VFC relied upon a six-month, paper-based process for annual re-enrollment of providers. Through LEAN, an electronic process was developed to save an estimated \$30,000 in annual staff time and substantially ease provider burden.

In an effort to improve vaccine ordering practices among Oregon providers, the Immunization Program has implemented the Enhanced Ordering Cycle (EOC) initiative. EOC uses clinical data to forecast each clinic's vaccine needs. Use of EOC tools reduces clinic financial risks for stocking vaccine, reduces Immunization Program staffing for processing vaccine orders, and ensures a steady supply of vaccine to Oregonians.

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/recall notices, and immunization rates. The robust new platform should also allow the IIS to function far more efficiently and effectively.

Health disparities

Along with our DHS and OHA associates, the Immunization Program 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.

The Oregon Partnership to Immunize Children (OPIC), a statewide coalition housed in the Immunization Program, works with partners to provide vision and leadership in efforts to eliminate health disparities and promote health equity. OPIC provides timely, culturally appropriate and relevant communications to vaccine decision-makers. The coalition provides a forum for discussion of systemic barriers to immunizations and for collaborative problem solving. Through the OPIC Prevention Project, OPIC builds community capacity to collect, synthesize and identify gaps in Oregon data and supports implementation of strategic immunization interventions.

The Oregon Adult Immunization Coalition (OAIC), a statewide coalition to support immunizations across the lifespan, works with clinical schools to train clinical students in vaccine administration, record keeping and storage and handling. Clinical schools, OAIC and local partners then offer offsite vaccination clinics to underserved adults.

Immunization rates

Development of community-specific immunization rates helps the Immunization Program target interventions and coalition outreach activities. In a 2008 analysis, Oregon's Hispanic community (77.5 percent) had higher immunization rates than non-Hispanics (73.0 percent). Oregon's African American (73.0 percent) and Native American (73.1 percent) rates were lower than the state average (74 percent) in 2007. In order to monitor immunization disparities across racial and ethnic communities, population-based immunization rates are calculated annually for African Americans, American Indian/Alaskan Natives, Asian Americans and the Hispanic community.

Population-based Immunization Rates

4:3:1:3:3:1 Immunization Rate

by Race and Ethnicity

Oregon, 2008

| Race | % Up-To-Date |
|----------------------------|---------------------|
| Asian and Pacific Islander | 75.2 |
| White | 73.8 |
| American Indian | 72.2 |
| African American | 71.4 |
| Ethnicity | |
| Hispanic | 76.5 |
| Non-Hispanic | 72.9 |

Source: Oregon Immunization Program, DHS

Notes: Other and unknown race and ethnicity are not included in this table. Each child reports a single race and single ethnicity.

Engaging the tribes

The Immunization Program works closely with the nine confederated tribes, Chemawa Tribal School, Northwest Portland Area Indian Health Board, and urban tribal health centers to serve the needs of Oregon's tribal population. In 2008, the Immunization Program launched the Tribal Health Initiative, which involved field visits to all tribal health centers. These visits reinforced our commitment to partnership with tribal clinics, helped the Immunization Program understand each clinic's unique opportunities and needs, and to promote the use of Immunization Program technical support and vaccine. The Immunization Program regularly attends SB 770 meetings to update tribal officials.

Key budget drivers and issues

Oregon has three primary sources of vaccine funding:

- Vaccines for Children (VFC) Program 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. Seventy 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. This innovation is unique to Oregon.

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 provide our 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).

Office of Disease Prevention and Epidemiology (ODPE)

Key programs

The Office of Disease Prevention and Epidemiology (ODPE) collects and analyzes data on health behaviors, diseases and injuries, disseminates findings, and designs and promotes evidence-based programs and policies to improve the health and safety of all Oregonians. Areas covered by ODPE include communicable diseases, chronic diseases and injuries. ODPE also is responsible for the vital statistics system (birth and death certificates).

The major sources of funding for ODPE include:

- Various federal categorical grants, primarily from the CDC, including:
 - HIV prevention, and disease monitoring,
 - Sexually transmitted disease control and prevention,
 - Tuberculosis control and prevention,
 - Violent death reporting,
 - Injury prevention and surveillance
 - Suicide prevention
 - Prescription Drug Monitoring
 - Tobacco prevention,
 - Diabetes risk reduction,
 - Cancer surveillance and risk reduction
 - Ryan White / AIDS Drug Assistance Program,
 - Emerging infections, and
 - Epidemiology and laboratory capacity;
- Tobacco Use Reduction Account (Ballot Measure 44); and
- Fees (vital records).

Acute and Communicable Disease Program (ACDP)

Services provided

The Acute and Communicable Disease Program (ACDP) monitors communicable disease occurrence in the state, guides local public health nurses in investigation and control of 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 policymakers 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 salmonellosis outbreak from peanut butter, and helps ensure the outbreaks are investigated and controlled. 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

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

Health Promotion and Chronic Disease Prevention Program (HPCDP)

Services provided

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

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 34 local health departments, tribes, health systems, and numerous community-based organizations.

Why these services are significant to Oregonians

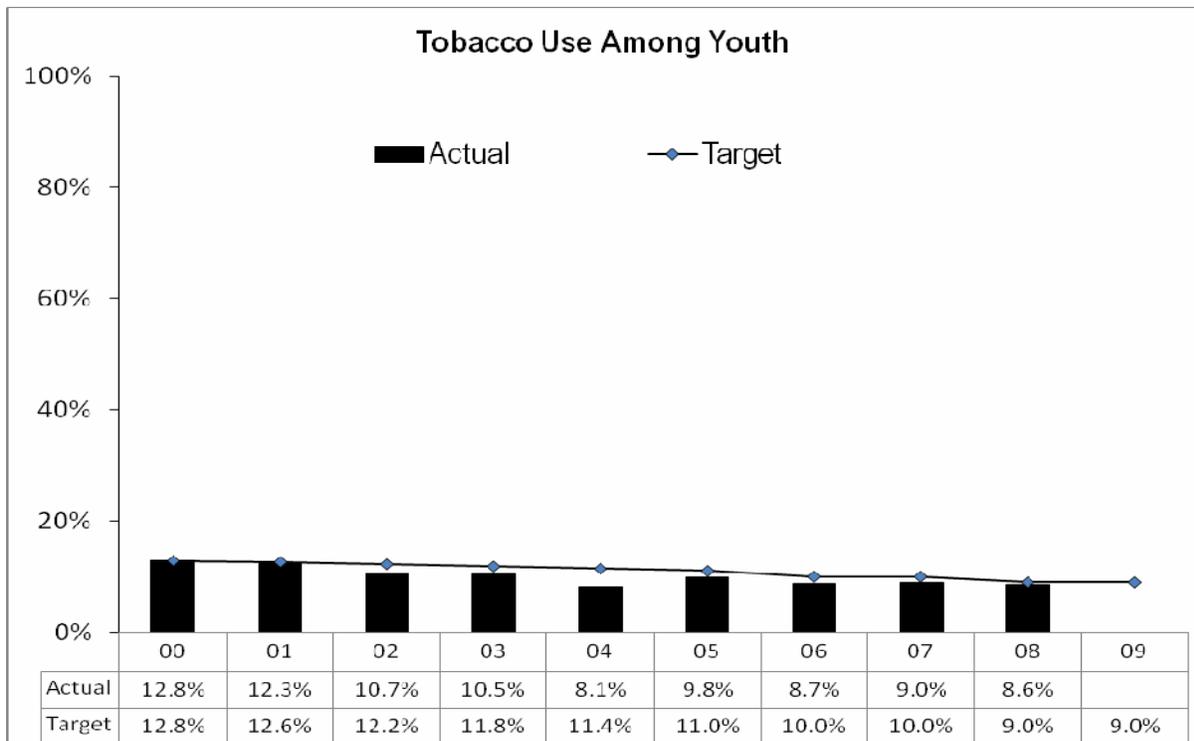
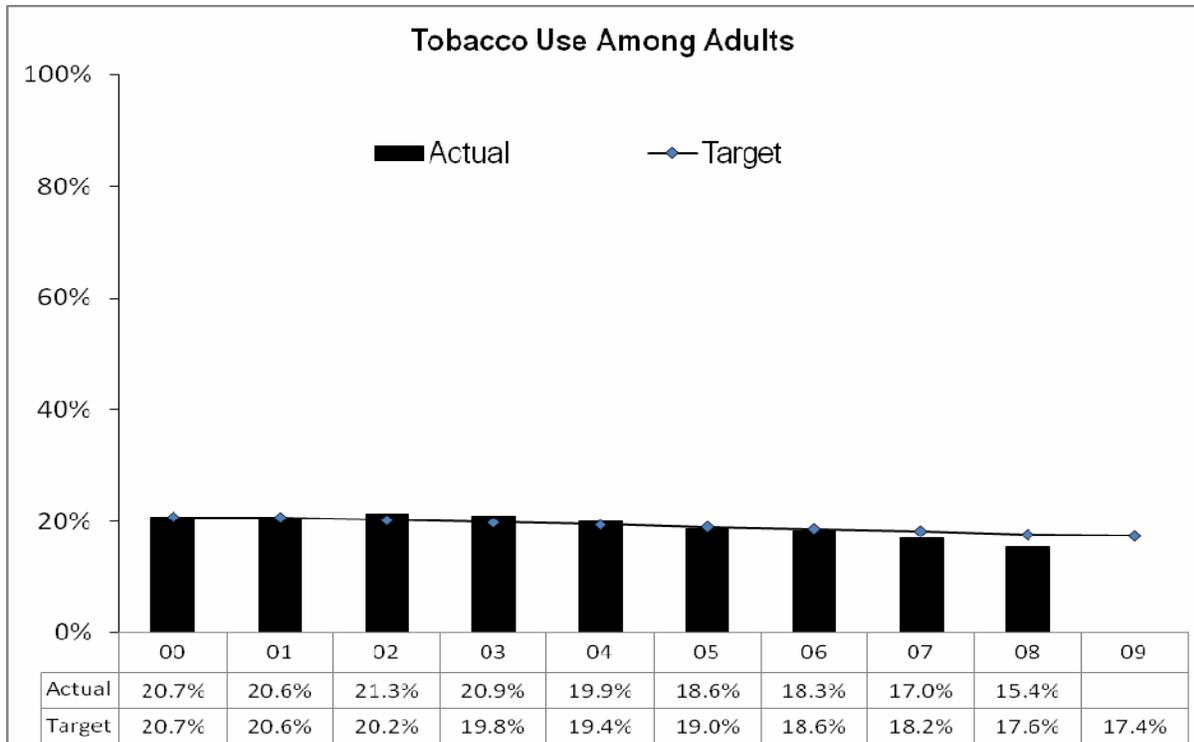
Chronic diseases continue to take a huge toll on Oregonians. Heart disease and cancer, for example, are the leading causes of death for Oregonians. In addition, these diseases are enormous drivers of health care costs. Many of these diseases and their effects are preventable.

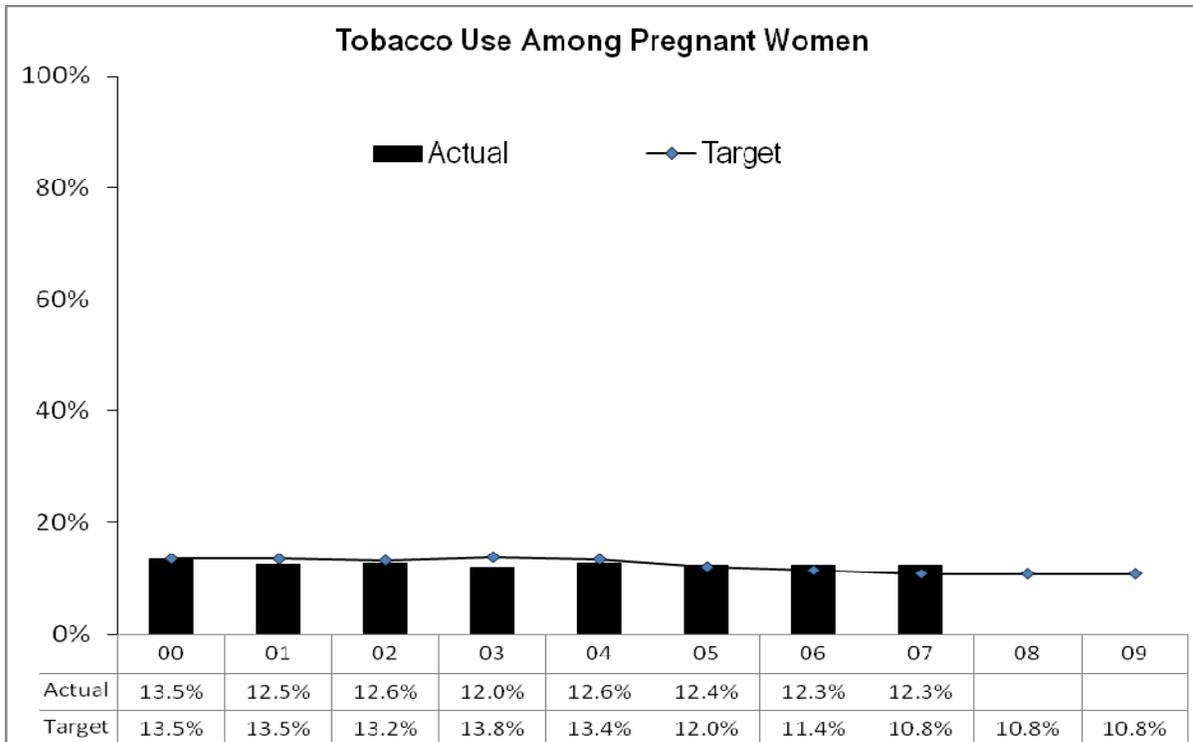
Performance measures

HPCDP has two OHA key performance measures.

Measure: KPM 21, Tobacco Use

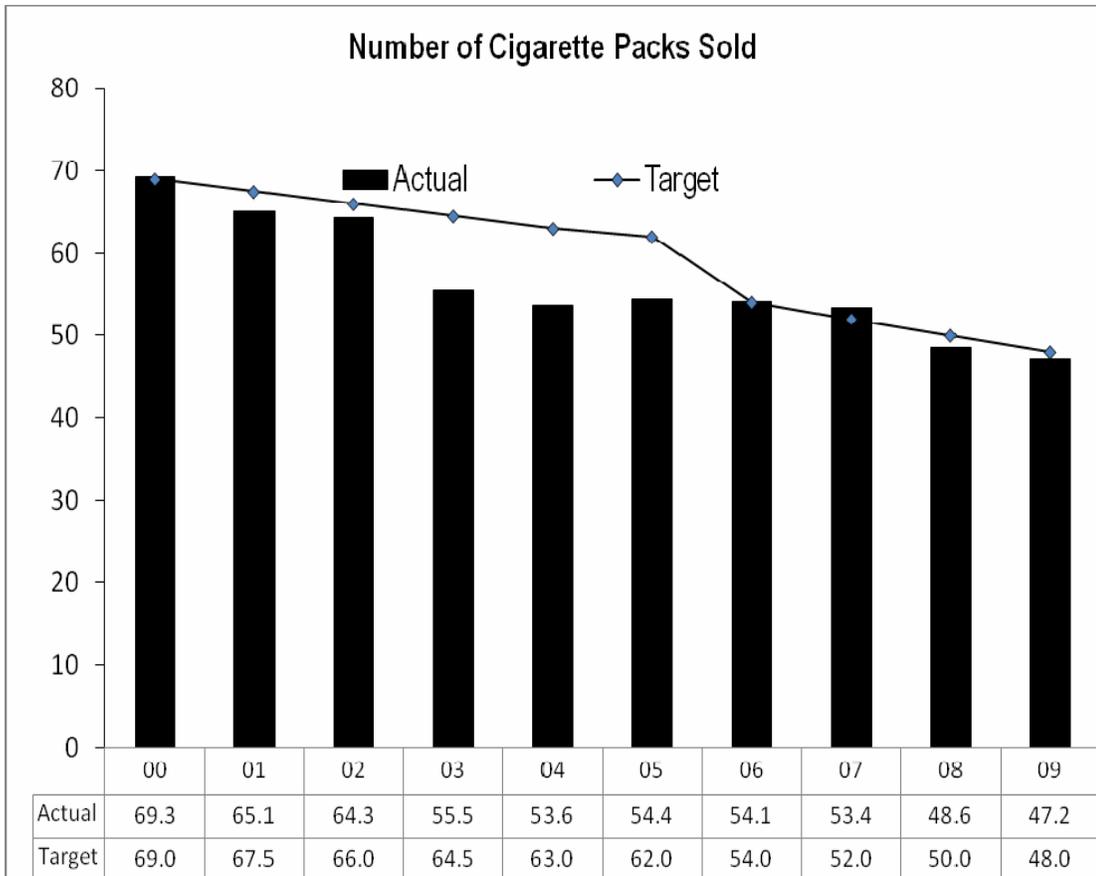
Purpose: The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco at any 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 toward the OHA goal that "people are healthy" in both the short-term and long-term.





Measure: KPM 22, Cigarette Packs Sold

Purpose: One of the main goals of TPEP is to reduce tobacco use by adults. 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 – an increase in former 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 the 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 U.S.). In 2005 U.S. per capita sales of cigarette packs was 61.6, and for Oregon was 54.4. This represents a much steeper decline in per capita cigarette sales in Oregon than in the rest of the country. Nonetheless, Oregon’s per capita pack sales in 2005 were nearly double those of Washington (35.8) and California (33.1), both of which have continued to dedicate significant resources to tobacco prevention activities.

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 that HPCDP receives, HPCDP provides funding to create local coalitions that address all three of these risk factors and also promote self-management of chronic diseases and timely screening for chronic diseases. This

program has been very well received; expansion to include other communities for implementing local coalition plans is planned as funds permit.

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 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 quarter of the inflation in health care spending, and this number will continue to climb if the root causes are not addressed. The Agency Requested Budget includes a Sugar-Sweetened Beverage tax policy option package with a portion of the revenue dedicated to funding an Obesity Prevention and Education program. The package would fund activities 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 opportunities, with overall support and technical assistance from the state.

The Agency Requested Budget also includes two policy option packages with funding dedicated to the expansion of the Tobacco Prevention and Education Program. The first dedicates \$40 million of the Master Settlement Agreement to the Tobacco Prevention and Education Program. The second increases the Tobacco Tax by \$1 per pack of cigarettes and a proportionate amount on other tobacco products, with a portion of the revenue dedicated to fund the Tobacco Prevention and Education Program at the level recommended by the Centers for Disease Control and Prevention. Tobacco is the leading preventable cause of death and disability in Oregon, killing roughly 7,000 Oregonians each year.

Injury Prevention and Epidemiology Program (IPE)

Services provided

Injury Prevention and Epidemiology (IPE) monitors both unintentional and violent injuries in the state, and works to prevent them. Current areas of focus for IPE

include childhood injury prevention, suicide prevention, prescription opiate non-medical use prevention, all terrain vehicle injury data collection and evaluation, prescription drug monitoring, and injury and violence surveillance and epidemiology. Injury Prevention and Epidemiology also provides information to the public, the media and policymakers about injuries in Oregon.

Where service recipients are located

The services are provided to all Oregonians statewide. SAFE KIDS coalitions implement booster seat and car safety seat programs throughout the state.

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

Data collection, analysis and dissemination guide the efforts of community level coalitions throughout the state.

Who receives services

Services are provided to all communities throughout Oregon.

How services are delivered

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

Why these services are significant to Oregonians

Injury is the third leading cause of death in Oregon, and is also among the leading causes of hospitalization. Injury affects everyone, regardless of age, sex, or race. In fact, injury is the leading cause of death among Oregonians one to 44 years of age. 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.

Through analysis of state data, four injury outcomes have been identified for priority prevention status:

- Suicide
- Falls among older adults
- Unintentional Poisonings
- Motor vehicle traffic injuries

These priority areas have been identified based on the overall impact of these injuries by

- their relative rank of mortality;
- number of hospitalizations;
- years of potential life lost (YPLL);
- trend (concerning trend of increase);
- 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:

Measure: KPM 8, Teen Suicide

Purpose: The agency strategy is to encourage local organizations and agencies to integrate best practices and evidence based practices in suicide prevention practices 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, development of interventions that will reduce risk factors and increase protective factors identified by data in individuals, families, communities and on the societal level, evaluate projects, and disseminate results broadly. Reducing suicides among youths will require implementation of multiple strategies over time including:

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

- Teaching youths 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.

Teen Suicide: the rate of suicide among adolescents per 100,000

| DATA | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|--------|------|------|------|------|------|------|------|------|------|------|
| Actual | 7.6 | 8.4 | 8.9 | 8.2 | 9.8 | 7.9 | 8.7 | | | |
| Target | 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 has put in place to improve understanding of the causes of violent death in the U.S. 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 possible before. Oregon is one of only 18 states that have been funded for this innovative program that will help prevent violent death 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 last 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 will help health care providers better treat their patients and prevent some of the problems associated with controlled substances. The system is to provide authenticated and certified users who are licensed to prescribe and dispense schedule II, III, and IV drugs electronic 24/7 access to patient-level data on drugs that have been dispensed to their patients by licensed pharmacies. Under limited circumstances staff are also to provide data for consumers, law enforcement, licensing boards, and researchers.

The purposes of the Prescription Drug Monitoring Program are:

- Provide authenticated and certified users who are licensed to prescribe and dispense schedule II, III, and IV drugs electronic 24/7 access to patient-level data on drugs that have been dispensed to the patient by licensed dispensers,
- 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 drugs that are found to be highly overused and information about appropriate methods of disposal.

The legislature mandated the creation of a Prescription Drug Monitoring Program in June of 2009.

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

The Substance Abuse and Mental Health Services Administration funded IPE to implement a new grant to reduce suicide among youth and young adults aged 15-24. The focus of this activity is to develop critical expertise on the local level in 22 counties over a three year period in order 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.

Key budget drivers and issues

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

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

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 spread include:

- Providing information systems for public health surveillance of HIV, STDs and TB;
- Providing medicines for treatment of TB and STDs;
- Interviewing /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;
- Directly providing rental assistance and other housing-related assistance for persons with HIV; and
- Providing access to prescription drugs and medical services to HIV-infected Oregonians who lack the means to pay for this treatment.

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 affected 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 supportive services, targeted housing assistance and 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 the following OHA key performance measure:

Measure: KPM 26, 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 HIV Programs of Oregon's HIV/STD/TB (HST) Program in the Public Health Division aim to reduce new HIV infections. One important way to accomplish this is by finding and testing sex and needle partners of newly reported cases, treating and counseling them 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.

Goal: People are healthy
Oregon context: HIV diagnosis, Communicable disease
Data source: Public Health Division, Office of Disease Prevention And Epidemiology, HIV/AIDS Reporting Systems (HARS) database and PSU Census
Owner: Public Health Division, Office of Disease Prevention and Epidemiology, HIV/STD/TB Program, OHA

Table. Percentage of people with newly diagnosed HIV infection that is interviewed for purposes of partner notification and referral, Oregon HIV/STD/TB Program, 2002 – 2008.

| DATA | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 |
|--------|------|------|------|------|------|------|------|------|------|------|
| Actual | 6% | 13% | 10% | 17% | 21% | 43% | 74% | | | |
| Target | | | | | | 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 Program’s AIDS Drug Assistance Program’s (ADAP) status as a State Pharmaceutical Assistance Program (SPAP) continues to provide cost savings to the program and facilitates access to HIV medications for Medicare eligible clients. This is primarily by allowing expenditures made on behalf of the client by the state program to count toward meeting the client’s out-of-pocket expenses of the coverage gap each year. In addition, the program is in the final stages of implementing a change in the ADAP model for delivery of prescription drugs to its clients. This new model includes a voluntary mail order

service and a contracted network of walk-in pharmacies. This change will produce significant cost savings, increase convenience for clients, and will allow for a reduced likelihood of program reductions or closure to new enrollment, and will be implemented in phases. The ADAP has a required general fund match as a condition of receiving federal funding.

In addition, the community based medical case management program will complete its pilot project phase in 2011. This new model for case management services and support services (in six counties outside of the Portland metropolitan area) provides medical case management by certified AIDS care nurses, and a centralized care coordination center. This pilot model will be expanded to other areas of the state at a later time. Some local county health departments and a community based organization continue to provide case management and support services in areas outside of the pilot project area.

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

The TB program has collaborated with Oregon Public Health Laboratory to commence use of two new tests that improve the timeliness and accuracy of diagnosis of tuberculosis disease in Oregon – the Quantiferon-Gold® 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 has worked with the Oregon Public Health Laboratory to implement a modern nucleic acid amplification test for diagnosis of chlamydia and gonorrhea, which began in mid-2009.

Key budget drivers and issues

Collectively the 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 have substantially limited services.

HST General Fund dollars comprise a minority of the overall HST budget. Nevertheless, a 10 percent annual reduction in state funding likely would affect all 36 Oregon counties. Such a reduction would:

- Reduce by 20 the number of people each year with tuberculosis who will not receive directly observed therapy, the current standard of care for tuberculosis.
- Require 40 people with tuberculosis each year to purchase their own medicine, imperiling their treatment adherence.
- Reduce by 420 people each year the number of people who are notified of an exposure to a sexually transmitted infection.
- Reduce by 70 people each year the number of people who are not notified that they have a confirmed sexually transmitted infection.
- Reduce by 3,000 people each year the number of people who are tested for HIV, meaning that 20 infected people will not discover their HIV infection early.
- Reduce by 350 people each year the number of HIV-infected people who receive medical case management services.

Center for Health Statistics (CHS)

Services provided

The Center for Health Statistics (CHS) provides vital records including birth, death and marriage certificates, for Oregonians. During 2009 CHS registered 133,000 vital events and issued 200,000 certificates. In addition to playing a critical role as legal documents, these documents make it possible to collect statistics related to these events. The center 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 vital events in Oregon.

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 CHS are critical for informed policymaking.

Performance measures

This program has no OHA key performance measures.

Quality and efficiency improvements

During the 2009-2011 biennium CHS continued improving the Oregon Vital Event Registration System (OVERS) which includes the Electronic Death Registration System and the 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 at the counties and state, to be electronic-based, rather than paper-based. The implementation of this system provides more timely, accurate and secure processing of these important documents for Oregonians. The center also implemented two nationally-based electronic systems. One provides electronic verification of birth certificates by agencies, such as DMV and Medicaid offices in other states. The second provides electronic exchange of vital records among states in a standard secure format. As funding permits in the future CHS plans to add other components to the system to cover Induced Termination of Pregnancy, Electronic Marriage Registration System and an Electronic Divorce Registration System.

Key budget drivers and issues

In the context of increased concern about homeland security, there is a special need to ensure that vital records, which can be used for identification purposes, are protected from theft and fraud. Changes in federal requirements related to the security of these records along with changes in identity documentation required by other agencies can have a large budgetary impact on this program.

Office of State Public Health Laboratories (OSPHL)

The Office of State Public Health Laboratories (OSPHL) supports state and local public health programs to control communicable diseases, identifies metabolic disorders in newborn infants, and ensures the quality of testing in clinical and environmental laboratories statewide.

During the 2011-2013 biennium OSPHL will perform approximately 25.9 million tests on 817,000 samples submitted by local health departments, community clinics, hospitals, physicians and others for communicable disease testing and newborn screening.

The Office of State Public Health Laboratories' Northwest Regional Newborn Screening Program tests all infants born in Alaska, Hawaii, Idaho, Nevada, New Mexico and Oregon for 43 different disorders of body chemistry that can cause serious disability or death unless detected and treated soon after birth. During 2011-2013 OSPHL will screen 337,250 infants and refer to treatment approximately 506 children with these disorders.

As an essential part of Oregon's emergency preparedness system, OSPHL 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 LRN consists of 88 laboratories that can package and ship biological and chemical specimens for testing, and of those 54 are advanced microbiology labs whose staff can quickly identify microbes in human samples that represent an emergent threat and refer them to OSPHL for confirmation and typing.

The Office of State Public Health Laboratories certifies 2,361 clinical laboratories in Oregon under the federal Clinical Laboratory Improvement Amendments and accredits 33 Oregon environmental labs in collaboration with the Oregon Department of Environmental Quality and the Oregon Department of Agriculture.

The major funding sources for OSPHL include:

- Various federal grant funding from OSPHD, ODPE and OEPH,
- Newborn metabolic screening and other testing fees,

- Laboratory licensing and accreditation fees, and
- Oregon Environmental Laboratory Accreditation Program.

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 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 to 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 travel 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 Office of State Public Health Laboratories also 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 Office of State Public Health Laboratories does not have primary responsibility for any OHA key performance measures, but does support the following KPMs:

KPM 18, Early Prenatal Care for Low Income Women, by providing prenatal testing for hepatitis B, syphilis, Chlamydia, and rubella;

KPM 28, HIV Rate, by performing HIV testing; and

KPM 31, Safety Net Clinic Use, by providing 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.

The Office of State Public Health Laboratories has improved the quality of its services by adding new tests, including gonorrhea testing, using molecular methods for pandemic H1N1 influenza and several other respiratory agents, norovirus sequencing, *Mycobacterium* direct test for tuberculosis, and microcystin toxin in cyanobacteria. A new statewide courier service has resulted in faster delivery of specimens and improved specimen integrity. A Transformation Initiative rapid process improvement on laboratory specimen tracking led to site-specific specimen tracking, reduced errors, faster turn-around time for test results to the submitters, and improved customer satisfaction.

In June 2010 a request for proposals was issued for a new Laboratory Information Management System (LIMS) to improve the tracking and reporting of samples and results, and to enhance quality assurance monitoring is in process. The new LIMS also will improve 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.

The Office of State Public Health Laboratories has a comprehensive Quality Assurance 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 2010 the OSPHL was inspected and reaccredited by CAP through May 2012. In June 2010 the OSPHL hosted 47 partners from a wide variety of organizations to assess the strengths and gaps in the statewide laboratory system that supports public health, as part of the Laboratory System Improvement Program (LSIP) developed by the Association of Public Health Laboratories (APHL). The work will continue with characterizing the public health laboratory system in Oregon, defining roles and responsibilities and developing strategic directions followed by specific action plans.

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.