

PUBLIC HEALTH

The Oregon Public Health Division is part of the Oregon Health Authority. The OHA was created in 2009 with a clear direction to innovate, improve, and rework the state health care system for the achievement of 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 OHA goals by protecting the health of all the people in Oregon — 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. The enacting 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 expanded to reach 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 with the assistance of 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 because of an increase in obesity; 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

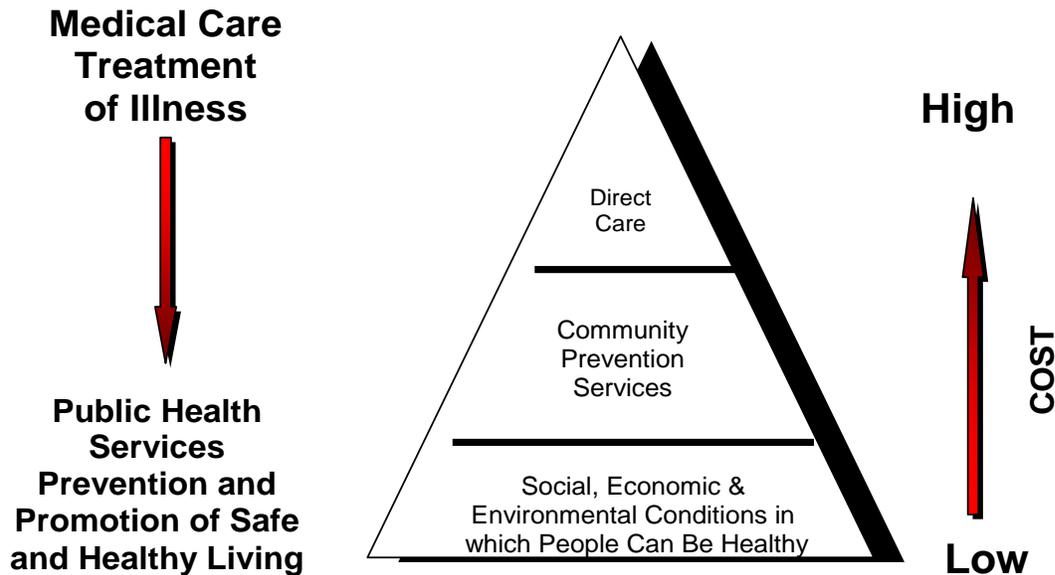
In contrast to the medical care system, which primarily treats illnesses in individuals, public health is fundamentally about prevention: working with communities to create conditions that support health. Since 1900 life expectancy in the United States has increased by more than 30 years, mostly because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

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 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 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 ensures 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, 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 the dollars either transfer to local health departments for their work or pay 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, health promotion, and inspections of food and water systems. Other programs and services primarily are delivered at the state level, including statewide regulation of 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 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. These risks increase 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. 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 directs many of the activities of state and local public health programs in this area, but federal requirements do not always match up well with the preparedness needs of Oregon’s communities.

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

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 limit the ability of Oregon’s state and local public health systems 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; and
- 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	

OFFICE OF THE STATE PUBLIC HEALTH DIRECTOR (OSPHD)

Key programs

The Office of the State Public Health Director (OSPHD) provides policy and direction to the public health programs within the division, and ensures that the 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 to combat pandemic influenza and the development of a state crisis communication plan. Through the ongoing planning, training, 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 other PHD programs interact with the local health departments, this unit serves to coordinate the various activities and serves as the primary resource for the local public health systems overall. This unit provides technical assistance, coordinates statutorily required agency reviews, oversees the disbursement of state support for public health funds to local health departments, directs the annual plan process and related budget revisions, and identifies grants and assists with their preparation.

The Program Operations unit is responsible for providing division-wide administrative services to PHD in areas including rulemaking, legislative support and coordination, risk management and safety, Web technology, volunteer coordination, business continuity planning, 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. The program upgrades, integrates and evaluates state and local public health preparedness for response to terrorism, pandemic influenza, natural disasters, chemical releases and other public health emergencies. These activities include interaction with federal, state, local and tribal governments, the private sector, and non-governmental organizations.

Funding for these activities comes 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 US 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 — and potentially those in neighboring states — could be a recipient of services should a public health emergency event occur in the state or region. Within the Public Health Division, 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 & Education Services (R&E);
- Emergency Medical Services and Trauma Systems (EMS/TS);
- Maternal and Child Health (MCH); and
- 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

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 was 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 goal of the Chemical Stockpile Emergency Preparedness Program (CSEPP) 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 hospital bed availability.
- 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 2009-10 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. The system partners took numerous actions to protect the health of the people of Oregon, including:

- Planning and implementing within 26 days, the Governor's Pandemic Influenza Summit attended by more than 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.
- Delivering, as of April 29, 2010, 810,000 doses of H1N1 vaccine to 750,000 individuals.
- Developing 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.
- Establishing 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, developing and launching the flu.oregon.gov website to provide timely, accurate, centralized information on H1N1, vaccine, epidemiology and response activities.
- Conducting 12,000 laboratory tests for H1N1 influenza in four months. Volume peaked in October when 6,000 tests were conducted.
- Distributing 5,228 courses of antiviral medication to 93 local health departments, tribes and state institutions. Additionally, personal protective equipment received from the federal Strategic National Stockpile was distributed.

- Conducting epidemiologic studies to identify and track disease prevalence and groups at highest risk for illness and death.
- Providing regular situational assessments and conference calls to response partners and key stakeholders.
- Requesting and receiving special authorities from the Governor to expedite contracting and procurement. This was the first time these authorities were used in an Oregon emergency response.
- Conducting 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. The match increased 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 significant impact on the ability of local health departments and health care systems 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. These services include ensuring compliance with the local public health portion of ORS 431, site visits to local health department’s to ensure compliance with contract and minimum standards, and public health nursing workforce development. The CL unit also serves as the state’s resource for the Conference of Local Health Officials (CLHO).

Where service recipients are located

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

Who receives services

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

How services are delivered

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

Why these services are significant to Oregonians

The services provided by the CL unit ensure a state-local partnership and a state-local public health system. The services help ensure compliance with federal and state statutes and rules, state-local contracts, and minimum standards for local public health.

Performance measures

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

Quality and efficiency improvements

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

Key budget drivers and issues

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

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 hospitals, other health care facilities and agencies, emergency medical technicians, ambulance services, and hospital trauma systems meet established standards. OCHHP also administers several special programs, including the Oregon Medical Marijuana Program (OMMP).

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; and
- 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
- Grants from DHHS Centers for Medicare and Medicaid Services.

Emergency Medical Services and Trauma Systems (EMS/TS)

Services provided

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 in 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, designating trauma hospitals to care for critically injured patients and collecting 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; and
- Ensures trauma system standards are followed, resulting 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 assistance directly to providers. Services provided locally include education, consultation, technical assistance, and verification of compliance with state statutes and rules. EMS/TS staffs also provide oversight of EMS and trauma providers to ensure and document compliance with standards.

Why these services are significant to Oregonians

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

Performance measures

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

Measure: Continue implementation and evaluation of the Oregon Trauma System, the emergency medical services system, and the designation of facilities to provide definitive care to specific patients; 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 SB 106.

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 US Department of Transportation National Standard Curriculum for first responders, EMT-basics and paramedics. Staff have developed and implemented an Oregon-specific curriculum for EMT-intermediates to serve the rural and frontier regions of the state. 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 US Department of Transportation National Standard Curriculum no longer will be available after 2012, so the EMS/TS program and the Oregon Medical Board's EMS Committee have established a workgroup to propose a plan for Oregon to follow when this change occurs.

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

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

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

Quality and efficiency improvements

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

Additionally, by increasing emphasis on providing technical and educational assistance to EMS agencies and pre-hospital providers, EMS/TS expects to improve overall compliance with standards and therefore improve quality of services by community providers. The EMS/TS is now conducting criminal background reviews on all initial and renewal applicants. While this will increase

the resources needed to issue certifications, it will provide additional assurance that Oregon EMS providers are trustworthy.

Key budget drivers and issues

In order to balance the 2009-11 legislatively approved budget, a mobile training unit (MTU) position was eliminated, resulting in a decrease in the amount of available training. This ultimately will lead to a decrease in providers because rural areas cannot afford the training required for providers to be certified and recertified biannually.

The mission of the MTU is to keep rural volunteer emergency response agencies operational through the provision of continuing education mandatory for certified EMS personnel. The MTU is designed to increase the ability of volunteer ambulances, economically challenged service area providers, and first response systems to provide 9-1-1 services that might be lost through 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 access to the safe, high-quality health care they need. This is accomplished through two main activities: regulation of health facilities, providers and suppliers through state licensure and federal Medicare certification; and consultation that provides support and tools to ensure quality and patient safety improvement. The Health Care Regulation and Quality Improvement program:

- 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; and
- 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
- 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. The facilities and providers who receive services from this program 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
- The 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.

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 reviews by the federal government, including review of records and ongoing reviews of data submitted by the state to the mandatory federal data system, as well as staff interviews.

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

How Oregon compares to other states: According to federal data, Oregon operates near the mean of other states in enforcement actions, number of

surveys completed, and the percentage of complaint investigations substantiated.

Quality and efficiency improvements

HCRQI recently reorganized its management structure.

- The role of the section manager was redefined to coordinate regulatory and consultative activities for health facilities; improve oversight by surveying all providers at least once every three years; and proactively ensure compliance among acute care and community-based providers.
- A survey manager was assigned to oversee the routine regulatory work and ensure excellent customer service for licensees.
- A complaints coordinator was assigned as lead worker to improve the efficiency and effectiveness of this regulatory activity.
- Two operations and policy analysts were added to improve health care, patient safety and operations using Lean tools.
- Three nurse surveyors were added 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 2009-10.

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

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). The act provides legal protection from state civil and criminal prosecution for qualified patients who comply with program requirements to grow and use marijuana as an alternative medicine.

The OMMP:

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

Where service recipients are located

OMMP serves patients statewide. The number of patients registered with the program has increased from approximately 600 in May 2000 to more than 41,407 as of July 2010.

Who receives services

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

side effects are:

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

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

How services are delivered

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

Why these services are significant to Oregonians

Since the inception of the 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 grow site. This program allows Oregonians suffering from debilitating medical conditions to use medical marijuana without fear of civil or criminal penalties.

Performance measures

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

Measure: Percentage of time Verification System is available to authorized law enforcement personnel.

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

Quality and efficiency improvements

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

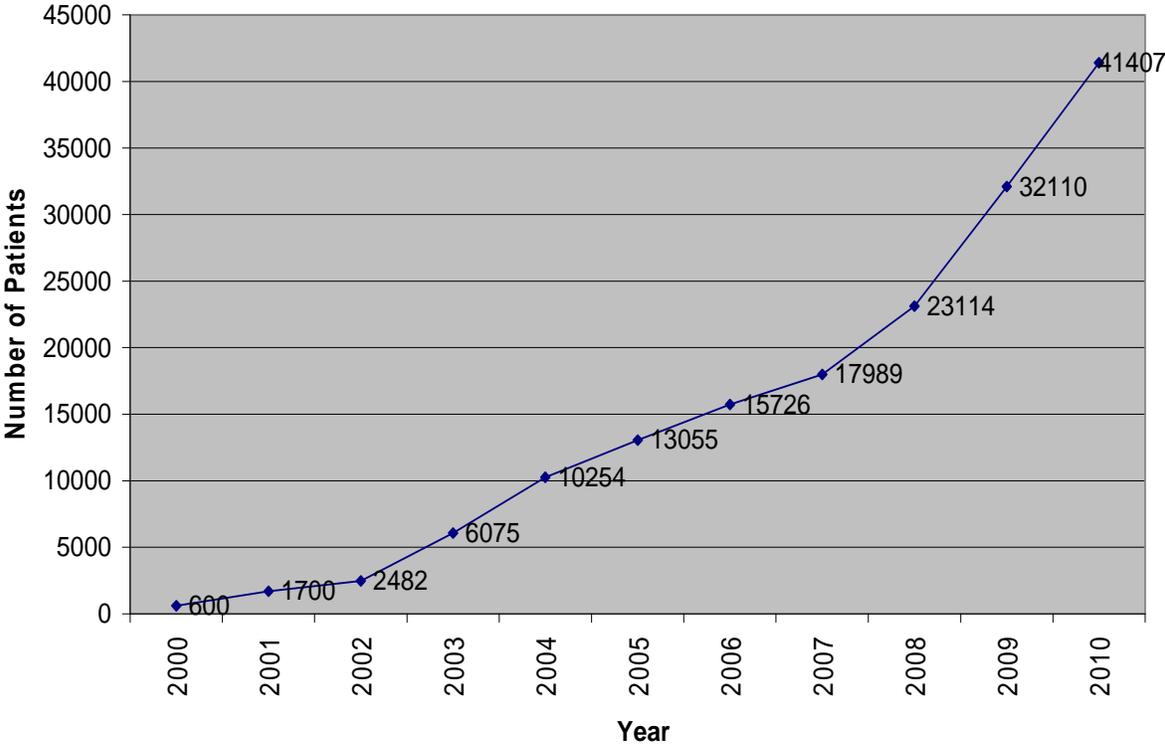
The program currently is in the process of implementing a new database system for its registry. Replacing an outdated system developed for relatively small numbers of individuals, the new database system will reduce processing time, improve search capabilities for providing information to cardholders, 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 projects it will 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.

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 program sections.

- The Research and Education Services section prevents or minimizes human health effects from hazardous working conditions, injuries and exposure to hazardous waste and other environmental dangers.
- The Food, Pool and Lodging Health and Safety section is home to Oregon's food-borne illness protection program and provides leadership for local health departments to ensure safety in Oregon's 23,000 full service and temporary restaurants, 3,400 public pools and 2,300 tourist accommodations.
- The Radiation Protection Services section protects both workers and the public from unnecessary and unhealthy radiation exposure, and provides Oregon's sole public resource for radiation-related incidents, whether accidental or intentional.
- Drinking Water Services works to ensure safe drinking water by reducing the risk of waterborne disease and exposure to chemical contaminants in Oregon's 3,600 public drinking water systems.

Funding for OEPH comes from a wide range of sources.

Federal funds

Environmental Protection Agency (EPA)

- Drinking water primacy
- Drinking Water State Revolving Loan Fund
- Water system operator certification
- Beach safety
- Indoor radon outreach and education

- Lead abatement training and certification
- Drinking water source protection coordination

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

- Mammography facilities inspection

Centers for Disease Control and Prevention (CDC)

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

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
- Renovation, repair and painting program
- Clandestine drug laboratory program
- Pesticide analysis and response center

Research and Education Services (R&E)

Services provided

Research and Education Services (R&E) is the state's primary point of scientific and technical expertise on 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 Oregon Beach Monitoring Program 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 five management groups: Health Assessment and Consultation; Occupational Public Health; Environmental and Hazardous Incident Tracking; Healthy Waters; and Healthy Homes and Schools.

Health Assessment and Consultation

- The Environmental Health Assessment Program (EHAP) works with communities affected by hazardous waste sites.
- The Climate Change and Preparedness Program works with communities, non-governmental organizations and other state and local agencies to identify and address potential risks to Oregonians from climate-related and other events.
- Health Impact Assessment (HIA) and Brownfields work with communities, non-governmental organizations and other state and local agencies to assess the possible impacts of proposed developments and policies on the health of Oregonians.

Environmental and Hazardous Incident Tracking

- Environmental Public Health Tracking program (EPHT) brings together environmental and human health data to allow for the analysis of the relationship between the two.
- Hazardous Substances Incident Surveillance Program (HSIS) tracks and reports on non-petroleum based releases of hazardous substances.
- Toxicology Consulting Services (TOCS) provides technical assistance on all environmental toxicological issues to programs within public health, state agencies, tribes, elected officials and citizens.

Healthy Waters

- Oregon Beach Monitoring Program (OBMP) monitors Oregon's coastal recreational waters for bacterial contamination.
- Harmful Algae Bloom Surveillance program (HABS) tracks the occurrence, type and duration of algae blooms on Oregon's waters, and any reported health effects in humans and animals.
- Fish Advisory Program monitors Oregon's fisheries and advises when contamination levels of toxins exceed safe limits.
- Unregulated Drinking Water program (UDWI) identifies and evaluates sources of information on drinking water sources that aren't regulated by EPA or the State Drinking Water Program.

Healthy Homes and Schools

- Clandestine Drug Lab program (CDL) oversees the clean-up of properties used to manufacture illegal drugs.
- Pesticide Exposure Safety and Tracking program (PEST) investigates pesticide exposure cases and educates the public on ways to reduce the risk of exposure.
- Radon program provides education and outreach to Oregonians to assist with the identification of homes and schools with radon contamination.

Occupational Public Health Program

- 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 Program (OWIIPP) monitors and reports on work place injuries and illnesses.

Who receives services

All Oregonians benefit from the scientific knowledge, skill and expertise of R&E staff. From Oregon's coastal waters to communities affected by hazardous waste sites, staff work 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; 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 is collected directly. The Oregon Beach Monitoring Program collects samples from Oregon's coastal waters. Some programs 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 collects data from a variety of sources that have a role in identifying, responding to and 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 and have specific initiatives to work directly with individuals, groups and communities affected by environmental issues. R&E's technical staff of toxicologists, epidemiologists, industrial hygienists and health educators routinely responds to more than 200 calls each month on dozens of topics. In addition to providing individual services to Oregon residents, 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 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 chlorinated solvents. The EPHT network will 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 HSIS system is to prevent morbidity and mortality 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 increases 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 decreased 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 from public use of 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 23,000 full service and temporary restaurants, 3,400 public pools and 2,300 tourist accommodations benefiting Oregonians and visitors.

How services are delivered

Services are delivered by intergovernmental agreements with 36 local public health authorities. County environmental health 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 US 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 and will be able to plot data more effectively. 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 (Benton, Columbia, Crook, Douglas, Grant, Jackson, Jefferson, Marion, Morrow, Polk and Wallowa) and accompanied 7 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.

Program Review Summary 2009

<i>Category</i>	<i>In Compliance</i>
Licensing and fees	98%
Inspection standards	87%
Staffing and training	100%
Food handler training	88%
Record keeping and reporting	100%
Epidemiology and accident investigation and reporting	100%
Enforcement procedures	94%
Minimum standards, program review and penalties	97%

Statewide improvement is still needed in licensing and fees.

- Pro-ration of fees must be applied properly.
- Fees for additional inspections must be charged properly.

Improvement is also needed in inspection standards.

- Inspection rates for all licensed facilities should be 100 percent.

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

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

Field review summary 2009: Percent in compliance

CATEGORY	2003	2003	2004	2005	2006	2007	2008	2009
Introduced self to the operator prior to starting the inspection and provided business card	97%	100%	100%	100%	83%	100%	96%	100%
Washed their hands at the beginning and as needed during the inspection	97%	100%	100%	100%	100%	100%	100%	100%
Checked each hand sink for accessibility, hot and cold water, soap and paper towels	97%	100%	100%	100%	100%	100%	100%	100%
Took temperatures on the cook line, hot holding units, and cold holding units	90%	94%	97%	94%	67%	100%	91%	100%
Asked open-ended questions and listened to the operator	100%	98%	100%	100%	83%	100%	100%	100%
Observed food handlers for handling of raw product, personal hygiene and hand washing	93%	98%	95%	95%	83%	100%	100%	100%
Asked operators about the availability, use, calibration, and cleaning of probe thermometers	80%	96%	93%	93%	83%	95%	96%	86%
Checked for refrigerator thermometers	100%	100%	100%	100%	83%	100%	100%	100%

Checked wipe cloths for sanitizer residual	87%	100%	100%	100%	100%	100%	100%	100%
Asked operators about their use of sanitizer test strips	97%	94%	96%	96%	83%	95%	100%	100%
Asked about cleaning procedures of in-place equipment	97%	84%	100%	94%	83%	100%	100%	100%
CATEGORY	2002	2003	2004	2005	2006	2007	2008	2009
Asked how and where food is prepared	97%	100%	100%	100%	100%	100%	96%	100%
Asked cooks how they know when an item is cooked to proper temperature	90%	100%	100%	100%	83%	95%	96%	100%
Asked cooks how they cool food items prepared in advance and in large quantities	97%	100%	100%	100%	100%	95%	96%	86%
Asked cooks about their procedures on how foods are reheated	97%	100%	100%	100%	100%	95%	96%	86%
Asked operators about their hand washing and ill employee policies	86%	100%	96%	96%	67%	90%	100%	71%
Asked about catering activities	78%	94%	96%	100%	67%	95%	87%	100%
Asked about menu changes	87%	100%	96%	100%	100%	95%	100%	86%
Verified that critical violations were corrected or an approved alternative was in place before leaving the facility	100%	100%	96%	100%	100%	100%	96%	100%
Asked questions regarding food handler cards	100%	100%	96%	94%	67%	100%	96%	86%

Specific areas for field staff improvement statewide are:

- Asking the person in charge if they have access to the Oregon Food Sanitation Rules;
- Asking about cleaning of probe thermometers between uses;
- Asking operators about raw vs. ready-to-eat wiping cloths;
- Asking open-ended questions about cooling and reheating practices;

- Asking about employee illness policies, cuts and burns, double hand-wash policy and glove use;
- Asking about changes in menu and exotic meats; and
- Verifying food handler certification of all food workers.

Key budget drivers and issues

The costs of the state and local restaurant food safety programs — \$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 citizens and workers in Oregon from unnecessary radiation exposure. RPS is responsible for conducting a statewide radiological health and safety program in Oregon. The purpose of the program is to:

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

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 that 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 can be reduced to lower levels with diagnostic image quality preserved or improved to help ensure worker and patient safety. Emergency responses to incidents involving radiation sources also result in 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 2002-09

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 Material Licensing program

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

X-ray machine testing and inspection program

For the X-ray machine testing and inspection program, the RPS management team has set performance goals for completion of all required X-ray facility and machine testing inspections within the time frames specified in administrative rule. Current staffing levels and US FDA and other specialized training are critical to performing at this level. At the current growth rate for X-ray facilities, additional inspection staffing of 1-2 FTE will be required this year.

Tanning device testing and inspection program

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

In 2009, the program inspected 202 facilities and had a backlog of 107 inspections. In 2010, the program inspected 214 facilities and decreased the backlog to 42 inspections.

Quality and efficiency improvements

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

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

The RPS tanning program enhancements include that all tanning operators are now required to receive formal training before operating tanning devices and new on-line operator training is also available to meet this requirement.

Key budget drivers and issues

Federal regulatory authority over licensed users of radioactive materials has significantly increased during the past decade improving security around materials that are critical for medical imaging, blood irradiation and research, as well as measurement of density of materials, process improvement and cancer therapy. Additional security concerns require more staff time and enforcement activities, translating into additional program costs. Funding for this increased workload and enforcement activity will be included as a fee increase request during the 2011 Legislative Session. 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. Cost of living allowance and workload increases are the primary drivers for requesting additional funding support from fee-based programs to improve public health and safety.

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 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 carries 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 our visitors. Individual public water systems vary widely in type, size and capacity, from very large water systems like the City of Portland to very small federal, state and private campgrounds.

Who receives services

Services are provided to protect the health of more than 3.5 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 the Public Health Division, local and county public health departments and other state agencies. The 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 Oregon Business Development Department and the Oregon Department of Environmental Quality.

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%
2008	97%	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%	89%
2006	88%	89%
2007	85%	89%
2008	86%	89%
2009	89%	89%
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 providers lack technical, 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 improves drinking water safety by training and certifying water system operators, by making loans to communities for safe drinking water construction projects, and by assessing and protecting sources of drinking water to prevent future contamination. In 2010, the Department and Oregon Business Development Department awarded more than \$73 million to seven Oregon communities for safe drinking water construction projects, including \$28 million in American Recovery and Reinvestment Act Funds.

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. These funds were directed at full implementation of all current federal drinking water standards at all 2,600 public water systems subject to federal requirements; implementation of three new federal drinking water standards specified by the 1996 Safe Drinking Water Amendments; and overseeing 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 and will continue through 2013.

The Legislature reduced the drinking water program general funds by \$418,393 in 2009-11. 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 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, 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);
- WIC and Senior Farmers Market Nutrition Programs;
- U.S. Department of Health and Human Services (DHHS)
- Family Planning Title X and Oregon Contraceptive Care formerly known as the Family Planning Expansion Project (FPEP);
- Title V Maternal and Child Health block grant;
- DHHS Center for Disease Control and Prevention (CDC)
- Immunization and Vaccines for Children;
- Office of Public Health Genomics;
- Breast and Cervical Cancer Program;
- DHHS Substance Abuse and Mental Health Services Administration
- Linking Actions for Unmet Needs in Children's Health cooperative agreement;
- Medicaid administrative match in immunization and oral health;
- State General Fund match requirement for Oregon Contraceptive Care;
- State General Fund and provider tax School-Based Health Center program.

Maternal and Child Health (MCH) program

The Maternal and Child Health (MCH) program is responsible for developing, implementing and evaluating public health programs and policy 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 and to strengthen the early childhood system. This includes perinatal health (prenatal and post-partum), infant and child health, newborn hearing screening, program and population surveillance, evaluation and assessment.

The multidisciplinary staff of public health nurses, health educators and policy analysts establishes statewide service delivery standards and training for local health departments, other agencies and a wide range of partners and providers as well as assisting with policy development and technical issues. MCH epidemiologists, research analysts and program evaluation staff work with the informatics staff to support comprehensive data systems for surveillance, assessment, and program and system evaluation at the state and local level.

Recent work has included broader, cross-agency and statewide policy and program initiatives that address system improvements. Examples include facilitating the HB 2666 Maternal Mental Health workgroup that provided eight recommendations for a statewide response to the issue of maternal mental health during and after pregnancy. Work initiated with the LAUNCH grant — Linking Actions for Unmet Needs in Children's Health — supports early childhood systems improvements at the state and local level in a demonstration project implementing evidence-based practices. Public Health Home Visiting is a core program within Oregon's home visiting system. Staff has been working with cross-agency and local partners to develop a home visiting system that will provide more effective and efficient services to women, children and families through coordination and a continuum of care.

Services provided

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 and prematurity by targeting risk factors such as tobacco and substance use, intimate partner violence, and maternal mental health. The program promotes adequate prenatal care and provides nutrition counseling for pregnant women with nutritional risk factors

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

Where service recipients are located

The public health home visiting programs are provided throughout the state. County health departments, managed care organizations, and private providers make the maternity case management program available through the Oregon Health Plan. The Babies First! program is provided by county health departments.

**Home Visiting Programs
July 2009 — June 2010**

County	MCM Clients	Babies First! Clients
Baker	0	84
Benton	5	42
Clackamas	238	178
Clatsop	63	87
Columbia	42	22
Coos	3	146

Crook	19	40
Curry	0	28
Deschutes	160	378
Douglas	90	293
Gilliam	0	0
Grant	7	12
Harney	0	9
Hood River	23	137
Jackson	177	236
Jefferson	6	41
Josephine	132	126
Klamath	0	291
Lake	3	10
Lane	395	304
Lincoln	316	364
Linn	48	120
Malheur	38	52
Marion	109	507
Morrow	0	3
Multnomah	1,540	4,537
Polk	32	87
Tillamook	10	83
Umatilla	4	24
Union	24	175
Wallowa	1	1
Wasco/Sherman	6	86
Washington	174	610
Wheeler	0	4
Yamhill	27	194
State Totals	3,656	9,311

Who receives services

Perinatal Home Visiting

In FY 2009-10, 28 county health departments provided approximately 3,700 pregnant women with maternity case management services (MCM) during more than 16,000 visits. MCM services are provided for pregnant women regardless of insurance coverage, but 70.4 percent of those served were women with Oregon Health Plan coverage and 10.6 percent with CAWEM coverage.

A typical pregnant woman receiving services in Oregon in the MCM program is in her 20s; is white, non-Hispanic and unmarried; has a high school education; and has OHP Plus insurance benefits. She and her family struggle with being low-income and she may face multiple risk factors. Mental health issues such as depression, poor oral health, nutritional inadequacy, substance abuse (including abuse of alcohol and tobacco), and medical risk factors such as diabetes and obesity put both mother and child at risk for short and long-term complications. She probably did not plan to become pregnant.

Infant and Child Home Visiting

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 or doctor.

Clients served by the home visiting programs present with a variety of social and medical risk factors at initial contact. Fully 72 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 2009 — June 2010**

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

How services are delivered

Maternity Case Management

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. Case management 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, public health nurses conduct standardized health and development assessments for the child’s growth and nutritional status. Infants receive developmental screening, hearing, vision and dental screening, growth and immunization monitoring, and assessments of parent-child interaction. Parents receive information and have learning opportunities regarding overall child health, safety in the home, prevention of Sudden Infant Death Syndrome and support services. Referrals are made for medical care and social services as needed.

Why these services are significant to Oregonians

Families served by public health home visiting programs benefit from long-term health, social, economic and emotional support early in pregnancy and throughout the early stages of life. Research repeatedly has 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. These services are a key part of a greater system of home visiting programs that serve families based on their needs.

Performance measures

The Maternal and Child Health program has two OHA key performance measures (KPM) and Healthy People 2010 outcome measures.

KPM 20: Prenatal care for women in the first trimester

Purpose: Early prenatal care is an important strategy for preventing early childhood disease and conditions and promoting healthy growth and development. Low-income infants are statistically at higher risk for poor health outcomes 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 low-income pregnant women to promote healthy babies.

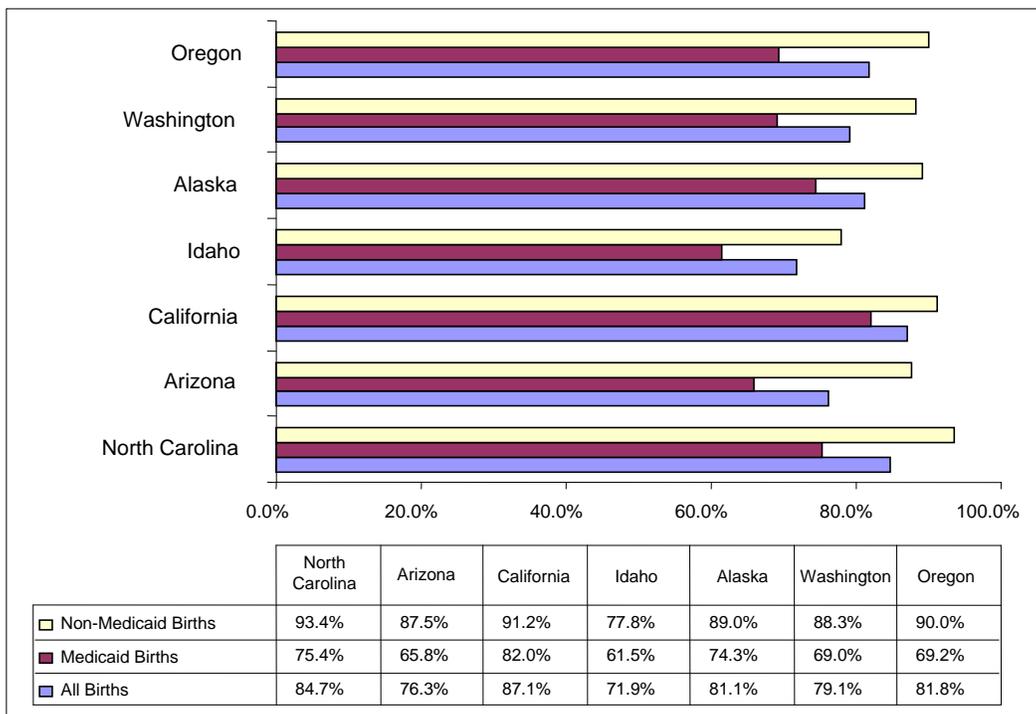
Only 79.9 percent of low-income women in Oregon received prenatal care during the first four months of pregnancy, while the goal for this measure is 88.7 percent. Trends in early prenatal care reflect the reductions in Oregon Health Plan (OHP) eligibility. Low-income women covered by Medicaid when they become pregnant must re-apply to receive OHP-Plus benefits after they find out they are pregnant. For those not previously eligible, some do not know they 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.). Oregon still requires documentation of assets to process the OHP application. OFH uses data mothers report about their pregnancy on birth records to create a nationally used dataset for monitoring trends in birth outcomes.

For monitoring trends of 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 in the Supplemental Nutrition Program (WIC) for one or more months during pregnancy. Eligibility for enrollment requires a family income of less than or equal to 185 percent of the federal poverty level (FPL) and is the best available data for estimating low-income status in pregnancy.

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

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:										
ACTUAL										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
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										
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
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%

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



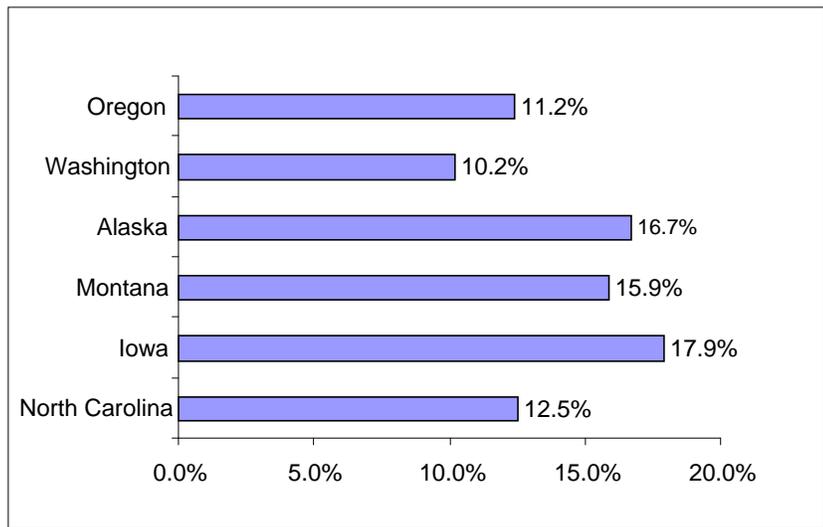
KPM 21: Tobacco use among a) adults, b) youth, c) pregnant women

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

TOBACCO USE											
Tobacco use among: a) adults, 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 where mother smoked in the last trimester of pregnancy:



Quality and efficiency improvements

The Office of Family Health (OFH), Maternal and Child Health section, along with state agency partners are providing leadership and direction in the development of Oregon's home visiting system. Beginning in 2010, partners from the Commission on Children and Families (OCCF), DHS Children, Adults and Families (CAF), Oregon Center for Children and Youth with Special Health Needs (OCCYSHN), OHA Addictions and Mental Health, the Oregon Department of Education Head Start program, and the Governor's Office created the Home Visiting steering committee. This committee is responding to federal funding opportunities that have resourced a statewide home visiting needs assessment. Based on this needs assessment the steering committee, along with state and local stakeholders and family representatives, will frame a home visiting system that is accessible, universal, timely, evidence-based, effective, efficient, culturally appropriate and sustainable. This framework will be taken to local partners for input and refinement. The partnerships at the state and local level as well as the current economic context have galvanized a new commitment and approach to home visiting that will benefit families and align with the early childhood goals stated in the incoming Governor's Early Childhood Charge.

Health disparities

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

Public Health Home Visiting programs

The U.S. Census Bureau reported Oregon's racial makeup in 2009 as 90 percent white, 2 percent African American, 4 percent Asian/Pacific Islander, 1.6 percent American Indian, and 2.4 percent identifying as more than one race. Eleven percent of the total population reports Hispanic ethnicity. 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 include 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 2009 — June 2010**

Race	MCM	Babies First!
White	75%	74%
American Indian/Alaska Native	3%	3%
Black/African American	5%	8%
Asian	3%	4%
Hawaiian/Pacific Islander	1%	1%
Multiple Races	1%	3%
Unknown	8%	8%
Ethnicity		
Non-Hispanic	86%	86%
Hispanic	12%	12%
Unknown	2%	2%

Key budget drivers and issues

The Federal Patient Protection and Affordable Care Act passed in 2010 includes competitive grants to states for assessing need and implementing evidence-based maternal and child health home visitation programs. Federal funds will be increasingly available during the next five years, creating an exceptional opportunity for establishing and sustaining a comprehensive Oregon home visiting system.

A key budget driver for Oregon to leverage home visiting federal funds is the Act’s requirement that states agree to maintain non-federal funding (mostly state general funds) for grant activities at a level not less than those in place on the enactment date of the legislation (March 23, 2010). Home visiting partners are working to establish availability of state funds necessary to satisfy the maintenance of effort clause.

Another budget driver is the change in the federal match rate for targeted case management (TCM), which currently supports Babies First! and other nurse home visiting services. Effective July 1, 2010, and approved under ARRA, the TCM required local match was reduced from approximately 40 percent to 26-27 percent depending upon Medicaid or SCHIP coverage.

Oral Health Unit

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

Services provided

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

Project "First Tooth"

This project is an early childhood cavity prevention program that trains pediatric medical providers to conduct oral health risk assessments, provide education, and apply fluoride varnish during well child visits for children under age 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.

School-based dental sealant program

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

School-based fluoride tablet and rinse program

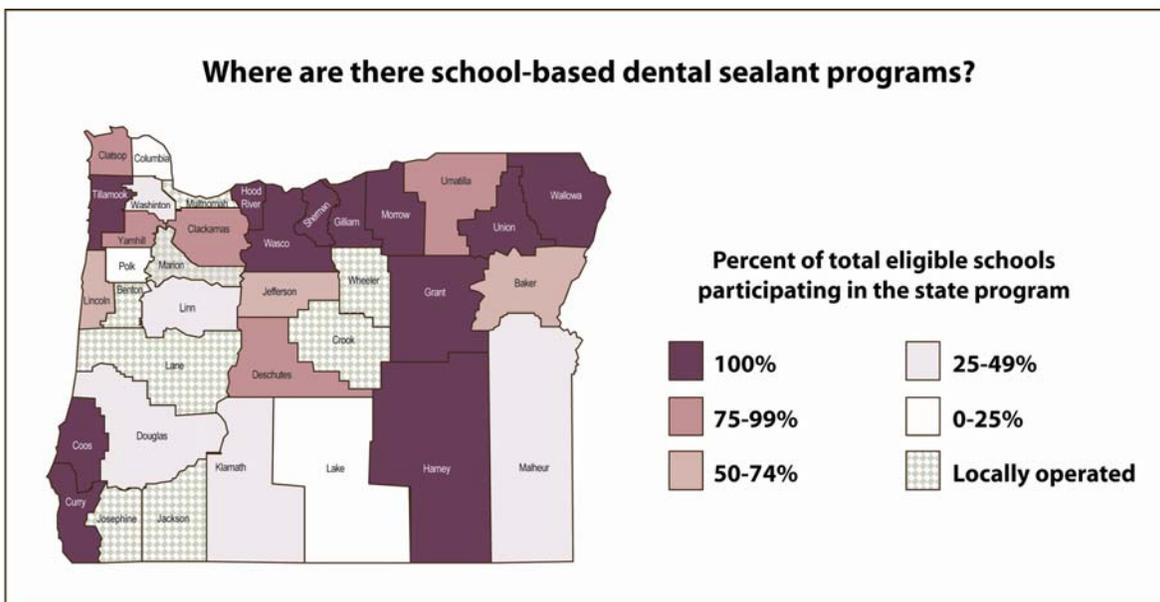
This program is administered to K-6 grades in elementary schools with 30 percent or more of the students eligible for the Federal Free and Reduced Lunch Program.

An oral health surveillance system tracks data for populations across the lifespan, measuring disease prevalence, health related behaviors and progress towards meeting Healthy People 2020 goals. A key component of the system is the dental screening survey for oral disease prevalence among first- through third-graders. Called Smile Survey it takes place every five years; the next survey is scheduled for 2012.

Where service recipients are located

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

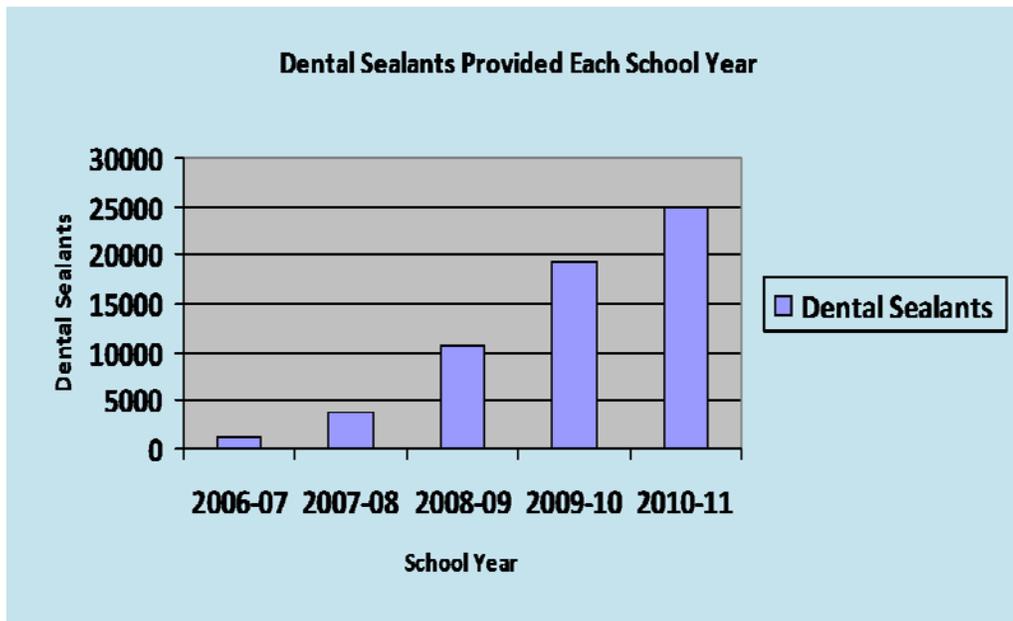
School-based dental sealant programs during the 2010-11 school year Percent of eligible schools served per county



Who receives services

School-based dental sealants are available to first and second graders in elementary schools with 50 percent or more of the student body eligible for the Federal Free and Reduced Lunch Program. In schools with less than 100 total students, the service is available to all grades in the elementary school. All children in the targeted grades in an eligible school may receive services, which include a thorough oral health screening and placement of dental sealants if clinically indicated.

During the 2009-10 school year, more than 19,000 dental sealants were provided for students in 140 schools in twenty nine counties. Operating at maximum capacity, an estimated 143 schools will be served during the 2010-11 school year; providing more than 25,000 dental sealants. Statewide the program reaches 35 percent of all eligible schools. When combined with locally-operated dental sealant programs, more than 70 percent of eligible schools are served.



How services are delivered

School-based dental sealants are delivered by registered dental hygienists with the aid of certified dental assistants. Each year the program utilizes more than 550 volunteer dental hygienists and dental assistants from around the state. Parents and caregivers receive results information, schools receive follow-up information about

the children served, and the Oral Health Unit uses the screening and dental sealant data to measure quality assurance. Ninety-nine percent of participating schools report great satisfaction with the program.

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

Why these services are significant to Oregonians

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

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

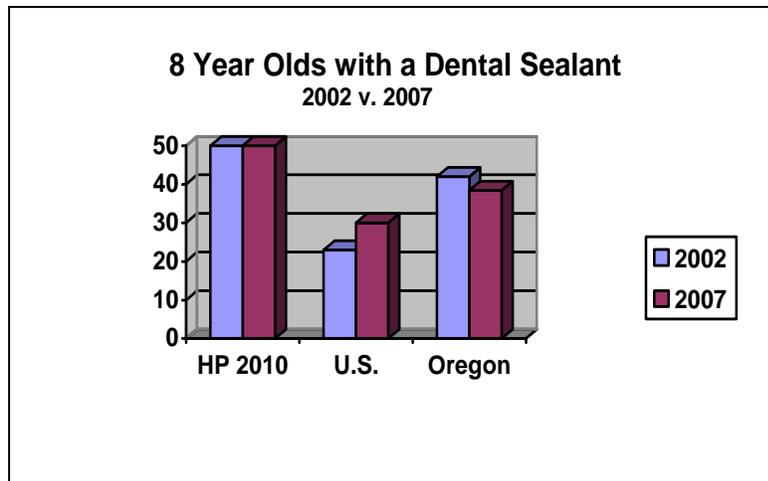
Performance measures

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

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: 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 eight-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.



Measure: Title V key performance measure, percent of children ages 0-36 months with a preventive dental visit.

Purpose: This measure is considered an indicator of access to care, in particular, a dental home.

How Oregon Compares to Other States: Based on the most recent available data, Oregon children under age three seem to rank lowest in getting preventive dental visits when compared to three other nearby states (6.8 percent vs. Alaska’s 8.2 percent, Idaho’s 19.5 percent, Washington’s 20.5 percent and 10.6 percent in the U.S. overall).

Quality and efficiency improvements

The school-based dental sealant program administered by the Oral Health Unit addresses quality assurance and efficiency in several ways. The model follows the best practice recommendations from the Association of State and Territorial Dental Directors for school-based dental sealant programs. 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 to miss a school day to see a dentist, and remove travel barriers. Screening and sealant services are delivered following a strict protocol for safety and efficacy. Data is collected in a uniform manner and entered into a statewide dental sealant surveillance system. Parents and caregivers receive results information, children with identified urgent treatment needs are case-managed by the school nurse, and a sample of children are re-screened to ensure retention of the dental sealants.

Health disparities

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

Statewide, the Oral Health Unit provides links to enroll people in dental insurance and with public and private dental health services. Consistent with SB 855, passed during the 2005 Legislative Session, the Office of Family Health awards Maternal and Child Health (MCH) block grant funding to four tribal governments to provide MCH services. Two of the tribal health clinics are providing oral health services to prevent early childhood cavities: the health clinics of the Coquille Indian Tribe and the Cow Creek Band of Umpqua Tribe of Indians. The Office of Family Health provides technical assistance, consultation and partnerships to assure the tribal clinics have resources to implement programs for their members in collaboration with their communities.

Key budget drivers and issues

The Centers for Disease Control (CDC) did not re-fund a critical grant for the OFH Oral Health Program, a grant that supported infrastructure to implement key statewide program initiatives. Program funding was stabilized by matching General Fund dollars with a Medicaid match. The funding maintains the statewide school-based dental disease prevention program (dental sealants and fluoride supplement programs).

Adolescent Health program (AH)

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

Services provided

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

Oregon has a 25-year history of supporting SBHCs. During the 2009-10 service year, 55 certified SBHCs in 20 counties served nearly 24,000 clients in more than 69,000 visits. Eleven communities in eight counties were awarded planning grants. Two of those counties currently have no certified SBHCs. One center was certified in spring 2010, seven sites are expected to complete final certification review in spring 2011, and two sites will open in fall or winter 2011. The remaining site plans to open in 2012.

Adolescent Health also leads 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 Centers for Disease Control (CDC) created in the 1990s to support schools in addressing student health. Core to this model is evidence around the link between health and learning. The 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 coordinated school health 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. Healthy Kids Learn Better has worked to develop this focus area since 2006. Staff from eleven schools and one district program received intensive training and support related to the school-based mental health approach. The staff of these schools participated in a series of training institutes; pilot tested new assessment tools; and received tailored technical assistance in assessing

campus mental health needs and developing and implementing an action plan to address priority mental health issues. 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

During the 2009-10 service year, services were provided through public-private partnerships and medical sponsorships that develop School-Based Health Centers on school property. The centers are located in elementary schools (ES), middle schools (MS), high schools (HS) and combined (K-8 and K-12) grade campuses.

County	School	Clients	Visits
Baker	Total	436	1595
	Baker HS	436	1595
Benton	Total	1811	4479
	Lincoln ES	1305	3244
	Monroe ES/MS	506	1235
Clackamas	Total	291	630
	Canby HS	128	202
	Oregon City HS	163	428
Columbia	Total	673	1131
	Lewis and Clark ES	559	962
	Rainier MS/HS	114	N/169
Coos	Total	236	530
	Marshfield HS	236	530
Curry	Total	114	226
	Brookings-Harbor HS	114	226
Deschutes	Total	1591	2281
	Ensworth ES	734	1008
	Lynch ES	502	692
	La Pine K-12	355	581
Douglas	Total	557	1541
	Douglas HS	98	228
	Roseburg HS	459	1313
Jackson	Total	2058	7918
	Ashland HS	468	1425

	Crater HS	371	898
	Jewett ES	242	641
	Oak Grove ES	357	1697
	Phoenix ES	332	1506
	Washington ES	288	1751
Josephine	Total	1041	5505
	Evergreen ES	371	1782
	Illinois Valley HS	353	1967
	Lorna Byrne MS	317	1756
Klamath	Total	78	143
	Gilchrist School	78	143
Lane	Total	4395	11707
	Churchill HS	727	1407
	North Eugene HS	908	2972
	Sheldon HS	805	3141
	South Eugene	744	2108
	Springfield HS	1211	2079
Lincoln	Total	720	2935
	Newport HS	221	843
	Taft HS	226	766
	Toledo HS	146	966
	Waldport HS	127	627
Marion	Total	301	479
	Hoover ES	301	479
Multnomah	Total	5837	17919
	Cesar Chavez K-8	245	798
	Cleveland HS	675	2337
	George MS	227	890
	Grant HS	708	2020
	Harrison Park K-8	346	642
	Jefferson HS	442	1506
	Lane MS	359	733
	Lincoln Park ES	500	888
	Madison HS	572	2229
	Marshall HS	702	1992
	Parkrose HS	582	2025
	Roosevelt HS	479	1859

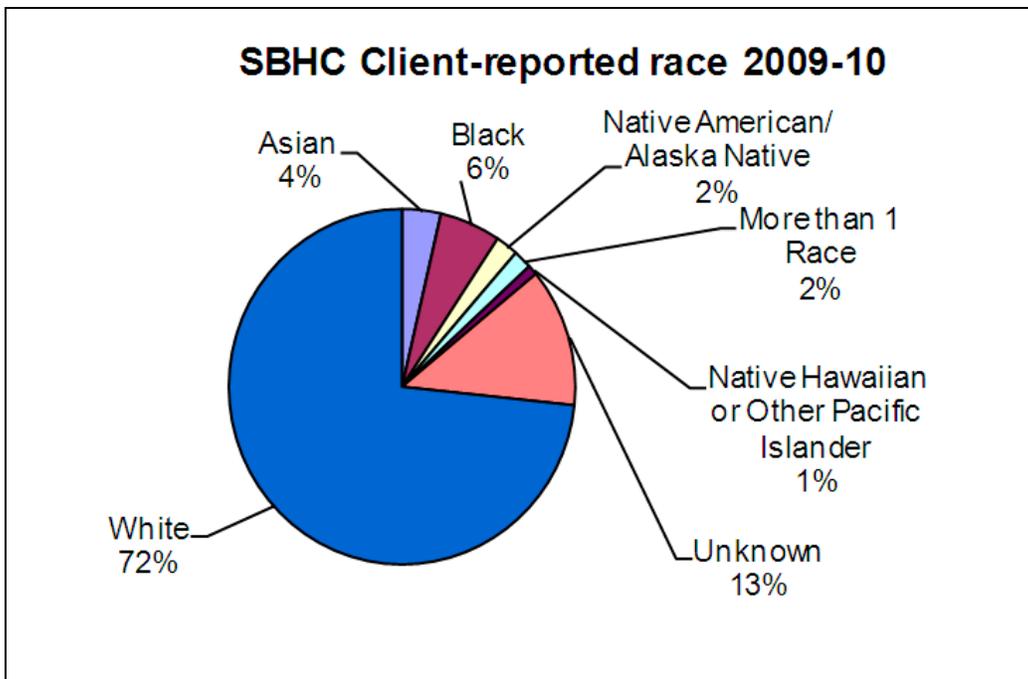
Umatilla	Total	1195	4885
	Pendleton HS	666	3018
	Sunridge MS	529	1867
Union	Total	351	1050
	La Grande HS	351	1050
Washington	Total	1605	2966
	Forest Grove HS	620	934
	Merlo Station HS	171	406
	Tigard HS	814	1626
Wheeler	Total	184	479
	Mitchell K-12	184	479
Yamhill	Total	407	1069
	Willamina HS	407	1069
	Yamhill-Carlton HS	NA	NA

Who receives services

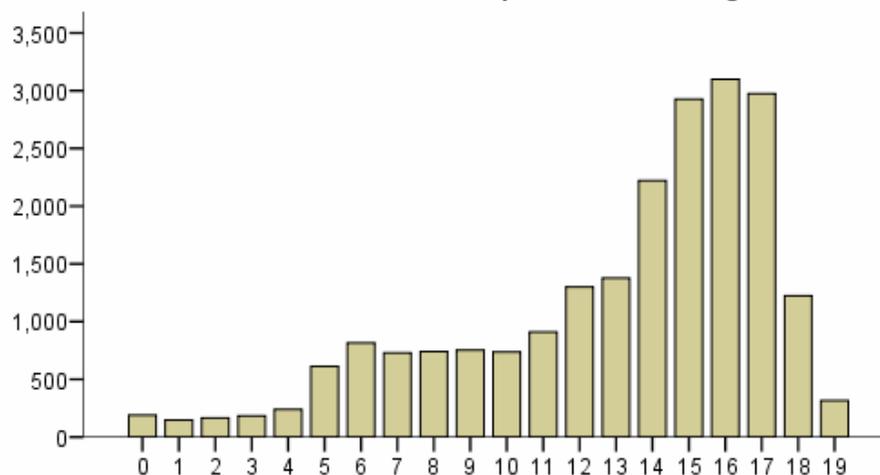
Services are provided to school-aged youth grades K-12 regardless of insurance status. Some SBHCs offer additional services to school staff or other community members through extended hours and agreements.

During the 2009-10 service year there were 69,468 visits made by 23,881 clients. Females (57 percent) were more likely to be an SBHC client than males (43 percent) and accounted for a larger proportion of all visits (63 percent). Clients reported their insurance status at the time of their first visit as 41 percent uninsured, 30 percent public, 24 percent private and 5 percent unknown.

Asian	4%
Black	6%
Native American	2%
More than 1 Race	2%
Native Hawaiian/Other Pacific Islander	1%
Unknown	13%
White	72%

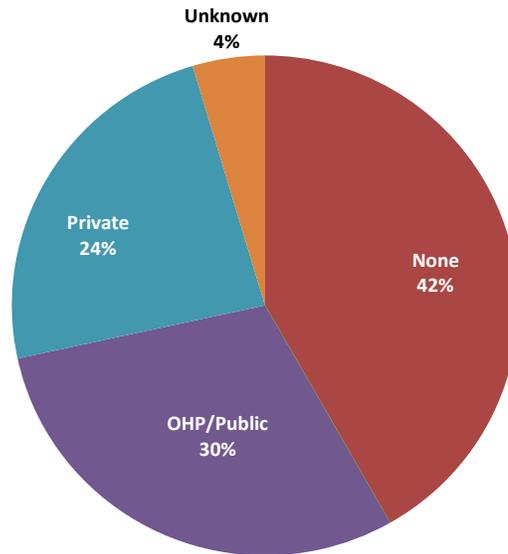


2009-2010 SBHC Encounter Data Unduplicated Clients Age 0 to 19



County	Clients	Visits
Baker	436	1595
Benton	1811	4479
Clackamas	291	630
Columbia	673	1131
Coos	236	530
Curry	114	226
Deschutes	1591	2281
Douglas	557	1541
Jackson	2058	7918
Josephine	1041	5505
Klamath	78	143
Lane	4395	11707
Lincoln	720	2935
Marion	301	479
Multnomah	5837	17919
Umatilla	1195	4885
Union	351	1050
Washington	1605	2966
Wheeler	184	479
Yamhill	407	1069

SBHC Client-reported insurance status at first visit
2009-2010



How services are delivered

Services are provided in SBHCs located on school property by qualified medical and mental health providers. The facility may be integral to the school's main building or in an adjacent modular unit specifically designed as a medical facility. Currently, 62 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 annually and counties with more than one certified SBHC receive \$41,000 annually for each center. The distribution and sharing of funds is determined at a local level after consideration of need, medical sponsorships and local agreements. The program estimates that every state General Fund dollar invested leverages three to five dollars in local investments.

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 cost efficient; and are overwhelmingly embraced by Oregonians across the state. Oregon's children and teens have an increasing number of health care needs while the number of uninsured among newborns to 18-year-olds also 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 reduce barriers to care and improve access to youth regardless of insurance status. SBHCs keep kids in the classroom, help 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 use and hospitalization.

Performance measures

Because preventive and early intervention services provided in SBHCs relate to so many other health indicators for school-aged youth, SBHCs are linked to several performance measures from a wide variety of agencies. These measures include KPM 18 (teen pregnancy), KPM 17 (teen suicide), KPM 19 (intended pregnancy), and KPM 21 (tobacco use).

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, including New York (206) and California (160), while less populous states like Alaska (3) and New Hampshire (1) had relatively few centers.

The chart below compares Oregon to the overall national response on operations, funding sources, and whether selected services were offered at the time of the 2007-08 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 by SBHCs, the following quality improvement plan was adopted for implementation.

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

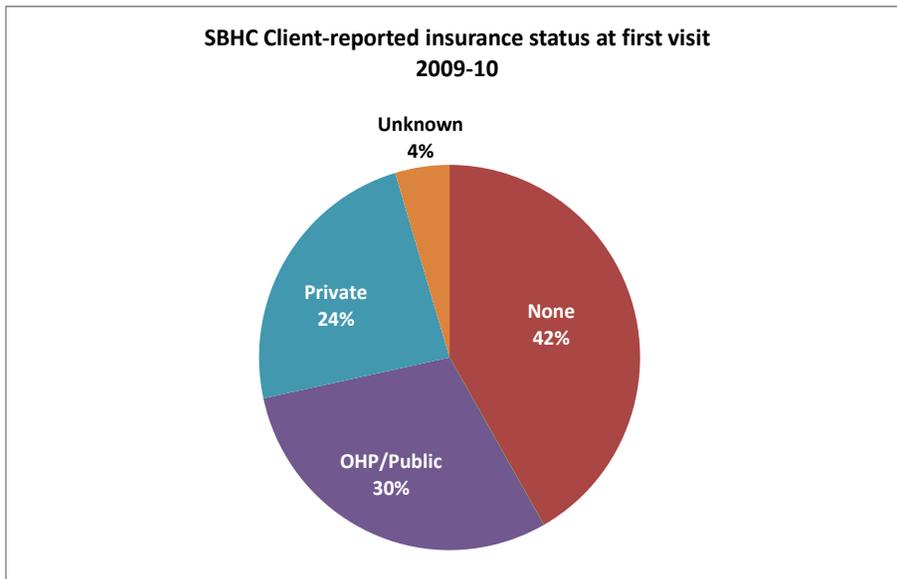
Approach: Year one of implementation (SY 2006-07) was an introduction to the tool and allowed time for sites to identify local system issues that might challenge completion or accurate data collection. Year two (SY 2007-08) was used to identify baseline targets for sites and statewide goals were set accordingly. Year three (2008-09) was full implementation of the key performance measures now tied to county contracts. 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 centers must meet statewide target goals within two years, otherwise funding may be reduced.

Measures:

Sentinel Condition	State Goal
1. Risk Assessment	Complete risk assessment done for children seen three or more times in one service year (2010-11 target 60 percent).
2. Comprehensive physical exam	Complete physical exam every two years for children seen three or more times in one service year (2010-2011 target 65 percent).
3. Height, weight and BMI	At least one recording of each measure for children seen three or more times in one service year (2010-11 target 90 percent).

Health disparities

School-Based Health Centers 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; their opportunities to receive health care services are limited because of transportation and financial barriers and concerns about stigma and confidentiality. The centers 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 2009-10, 42 percent of SBHC clients were uninsured, representing the largest insurance category.

The US Census data from 2009 reports 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 2009-10 service year, six percent of Oregon School-Based Health Center clients reported as black and 21 percent are of Hispanic origin.

School-Based Health Centers also reduce health disparities by the nature of their locations. Oregon's 55 SBHCs are located in both rural and urban communities. Two centers are frontier, 25 are rural and 28 are urban; 12 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 available for many miles.

Key budget drivers and issues

In 2010, Congress passed the Federal Patient Protection and Affordable Care Act (P.L. 111-148) a comprehensive overhaul of the health care system intended 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 safety net clinics as part of the larger solution to increasing the number of Americans who have affordable and comprehensive health insurance.

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

Section 4101(a) of the Affordable Care Act allows 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, or equipment. The first \$100 million in funding was issued by the Bureau of Primary Health Care (BPHC) in the Department of Health and Human Services in the fall of 2010 with the final grant application due January 12, 2011 and sites to be awarded July 1, 2011. HRSA expects to award approximately \$100 million for an estimated 200 SBHC grants in FY 2011.

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 (SCHIP) 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, laying the groundwork for further policy opportunities.

The availability of local matching and operational funds comprise the primary SBHC budgetary challenges. The current funding formula requires a three to five local match for every state dollar. Sustainability planning at the local level is influenced by factors including insurance coverage, service mix, reimbursement rates, billing capacity, business infrastructure, medical sponsorship and strength of community partnerships. The 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 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 two main program areas: Reproductive Health (RH) and the Breast and Cervical Cancer Program (BCCP), which includes WISEWOMAN (Well-Integrated Screening and Evaluation of Woman Across the Nation). The Women's and Reproductive Health section 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. Client services are supported by Oregon Contraceptive Care (CCare), formerly known as the Family Planning Expansion Project (FPEP), and a federal grant, Title X. Specific services 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. Clients also are provided screening for heart disease, stroke, tobacco use, obesity and diabetes through a grant called WISEWOMAN. The WISEWOMAN program provides women with risk reduction counseling to help prevent or reduce a woman's heart attack and stroke risk.

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 174 clinic locations. The table below shows the number of RH clients served during fiscal year 2010 by county of service.

County	Clients Served FY 2010	County	Clients Served FY 2010
Baker	480	Lake	256
Benton	3,630	Lane	12,296
Clackamas	3,647	Lincoln	1,228
Clatsop	958	Linn	1,940
Columbia	802	Malheur	1,040
Coos	1,660	Marion	7,560
Crook	500	Morrow	259
Curry	608	Multnomah	28,743
Deschutes	7,284	Polk	1,085
Douglas	2,480	Sherman	0
Gilliam	0	Tillamook	938
Grant	220	Umatilla	1,544
Harney	228	Union	756
Hood River	1,142	Wallowa	155
Jackson	8,463	Wasco	1,138
Jefferson	646	Washington	14,792
Josephine	3,274	Wheeler	20
Klamath	1,731	Yamhill	1,006

The Breast and Cervical Cancer Program works with about 90 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 10 of the 90 enrolling providers. The table below shows the number of clients served by BCCP during 2009-10 by county of service.

During the 2009-10 fiscal year, the BCCP program had 5,603 enrolled clients.

County	Clients Enrolled FY 09-10	County	Clients Enrolled FY 09-10
Baker	10	Lake	15
Benton	74	Lane	747
Clackamas	314	Lincoln	128
Clatsop	56	Linn	137
Columbia	34	Malheur	73
Coos	195	Marion	374
Crook	93	Morrow	5
Curry	68	Multnomah	760
Deschutes	322	Polk	34
Douglas	173	Sherman	5
Gilliam	7	Tillamook	103
Grant	22	Umatilla	131
Harney	21	Union	18
Hood River	42	Wallowa	4
Jackson	666	Wasco	49
Jefferson	57	Washington	439
Josephine	194	Wheeler	15
Klamath	22	Yamhill	196

Who receives services

Priority for RH services is given to individuals under 250 percent of the federal poverty level (FPL) through two programs: Title X (250 percent FPL) and Oregon Contraceptive Care (CCare), formerly known as FPEP (185 percent FPL). Women, men and teens all are eligible. Local clinics served 119,945 people during fiscal year 2010; this number includes 113,917 women and 6,028 men, and 88,377 clients below 100 percent FPL.

BCCP/WISEWOMAN services are offered to women ages 40-64 who are at or below 250 percent FPL and do not have insurance or are underinsured. 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. County health departments, Federally Qualified Health Centers, rural health centers, Planned Parenthood clinics, School-Based Health Centers and private medical professionals deliver reproductive health services.

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. More than 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 when unintended pregnancy is prevented.

The BCCP helps reduce cancer mortality and morbidity by screening medically underserved women for breast and cervical cancer at no cost to them and by making referrals to treatment for clients with a cancer diagnosis. The program's clients would be unlikely to access cancer screening without the BCCP and its provider network. The BCCP also provides a point of entry into the Oregon Health Plan (OHP) for breast and 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. The WISEWOMAN program helps to identify and reduce heart disease and stroke risk in women. The WISEWOMAN lifestyle interventions are designed to assist women to identify their risk and develop an action plan for change. For women who need treatment the program provides referrals for treatment.

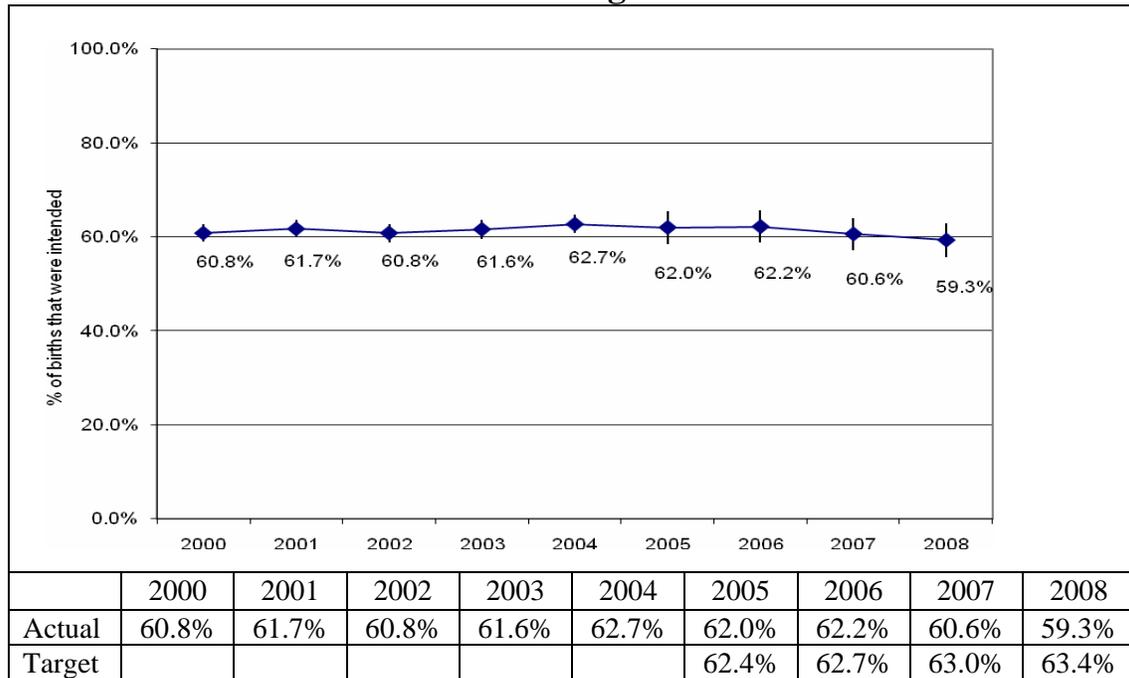
Performance measures (RH)

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

KPM 19: 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 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 29 states participating in the Pregnancy Risk Assessment Monitoring System during 2008. This is the most recent data available.

State	Percent of Pregnancies Intended (2008)
New York (excluding New York City)	70.4 percent
Rhode Island	58.6 percent
Oregon	59.3 percent
Washington	63.3 percent
Oklahoma	49.7 percent
Louisiana	50.4 percent
29 state average	58.5 percent

Nationally, the number of intended pregnancies increased by 1 percent between 2002 and 2008 (the most recent year for which data is 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)

Measure: BCCP 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 91 percent of the indicators. The national WISEWOMAN program is currently in the process of developing performance measures.

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 each year through BCCP for early detection of breast and cervical cancer. 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 has not been explained.

Quality and efficiency improvements (WRH)

The RH engages in varied quality improvement (QI) activities not only to assure regulatory compliance, but also to continually improve program performance and provider and client satisfaction. To better meet these obligations for CCare, RH designs and implements various screening and audit procedures used to assure program integrity and reduce risk of overpayment. Collectively, these procedures are referred to as the CCare Program Integrity Procedures (PIP). Approximately 500 client charts selected randomly from up to 35 local agencies are reviewed annually through PIP. During this past fiscal year, RH streamlined a more efficient process for verifying SSN and income of CCare applicants.

Other QI activities include a biennial client satisfaction survey of all family planning clients selected from a random sample of agencies throughout the state. Survey results are used to measure and improve customer satisfaction on a number of quality measures. RH also conducts an annual training needs assessment of local program staff and delivers 12 to 18 local staff training events (clinical, fiscal, administrative, management, QI, counseling, marketing, and more).

In October 2009, BCCP/WISEWOMAN began implementing Lean process improvement techniques into their program processes. The team began a rapid process improvement to merge two similar but separate medical service agreement implementation processes. This process reduced total steps from 56 to 28 (50 percent decrease), improving cycle time while building a foundation for business continuity between the two arms of the program. In August 2010, the team began rapid process improvement mapping to address situations when providers make changes that can affect their payments from the program.

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. All provider agencies, as well as the RH program itself, have conducted CLAS self-assessments and are developing strategies for improving performance. During fiscal year 2010, RH provided services to the following populations:

Race/Ethnicity	Clients Served FY 2010
White	96,823
African American	2,336
American Indian/Alaska Native	1,150
Asian	2,980
Hawaiian/Pacific Islander	1,061
More than race	309
Other/Unknown	15,285
Hispanic	23,495
Non-Hispanic	96,439

Key budget drivers and issues (WRH)

The program began a social marketing campaign late in 2009 to increase enrollment after citizenship verification became required and client participation severely declined for Oregon ContraceptiveCare (CCare). The 2010 enrollment figures are higher than those experienced in 2009, although significant budget cuts in late 2010 curtailed outreach efforts.

The key issue for the BCCP is limited funding for breast and cervical cancer screening and diagnostic services. The BCCP is funded by a grant from the CDC. These funds are used largely for direct services. BCCP leverages these federal dollars with matching funds from the Susan G. Komen for the Cure (Komen) SW Washington and Oregon Affiliate. The CDC provides \$3 for every \$1 Komen provides. To help expand services statewide, BCCP has partnered with Oregon Health & Sciences University (OHSU) to pilot a program of shared resources that jointly provides an estimated 400 more breast and cervical cancer screenings for

low-income women. At the current funding level, approximately 8,000 medically underserved women receive screening services for early detection of breast and cervical cancer each year through BCCP.

Nutrition and Health Screening Program (WIC)

Services provided

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

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

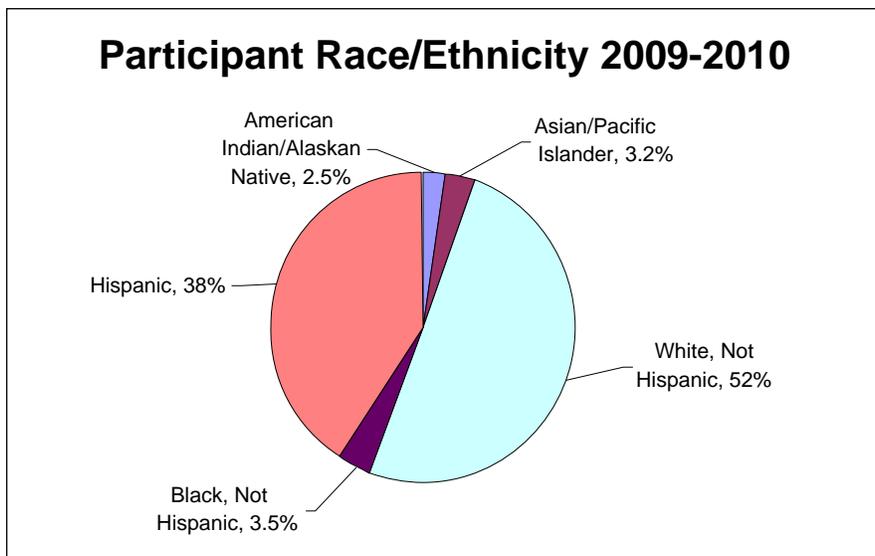
Where service recipients are located

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

Certified caseload of local agencies during November 2010

County	Clients Served	County	Clients Served
Baker	514	Josephine	2,932
Benton	1,552	Klamath	2,856
Clackamas	6,414	Lake	195
Clatsop	1,331	Lane	8,289
Columbia	1,496	Lincoln	1,523
Coos	2,001	Linn	3,937
Crook	654	Malheur	1,783
CT Umatilla	113	Marion	9,758
CT Warm	531	Multnomah	19,524

Springs			
Curry	634	Polk	1,461
Deschutes	4,443	Salud	10,439
Douglas	3,560	Tillamook	759
Grant	181	Umatilla/Morrow	4,649
Harney	230	Union	919
Hood River	978	Wallowa	134
Jackson	6,841	Wasco/Sherman	1,100
Jefferson	848	Washington	13,413
State Total:		115,992	



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 172,811 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. More than two-thirds of those served are in working families.

How services are delivered

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

Why these services are significant to Oregonians

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. Currently 38 percent of pregnant women and 33 percent of children in Oregon receive WIC services. These services may include nutrition and health assessments, nutrition education, a prescribed monthly food benefit, and referrals to relevant public health, community and medical resources.

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 \$65.4 million of nutritious foods at more than 630 stores statewide. The WIC Farm Direct Nutrition Program helps lower-income young families purchase \$400,000 in local fresh fruits and vegetables, supporting local farmers and communities through out the state.

Performance measures

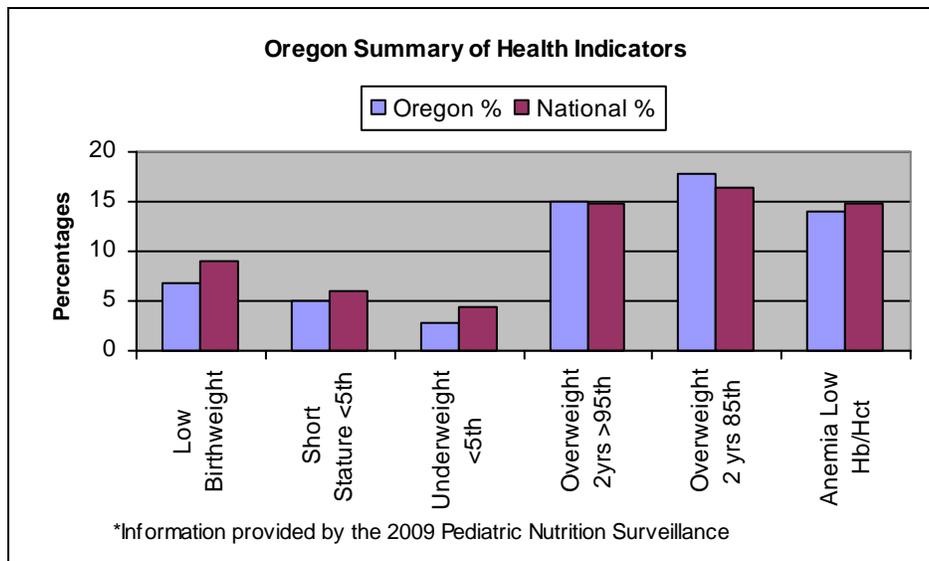
The WIC program is an important provider of preventive health services and economic security for lower-income young Oregon families. The program most strongly relates to key performance measures 11 (Food Stamp Utilization) and 20 (Early Prenatal Care) which are reported elsewhere.

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

eating, and increasing food security and physical activity for children and their families.

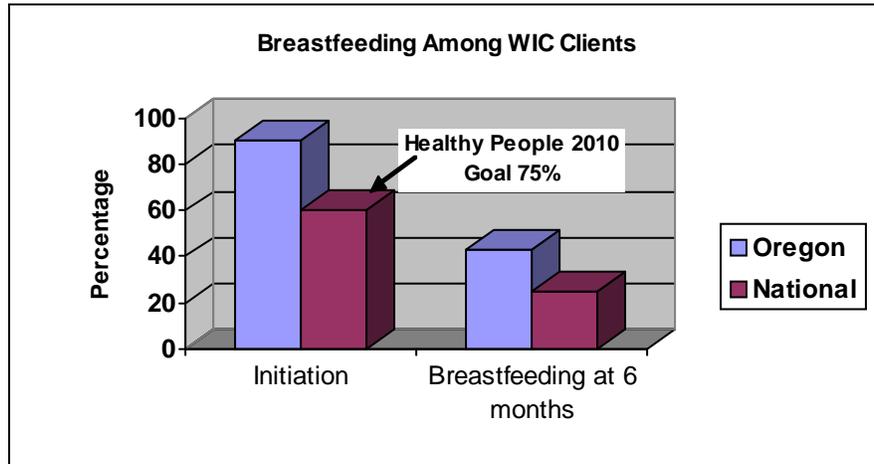
How Oregon compares to other states: Oregon scores better than the national average on most health indicators for the WIC child population, according to data from the 2009 Pediatric Nutrition Surveillance Survey. The survey collects data primarily from state WIC programs and includes most of the states and territories in the US. In particular, Oregon’s rate of low birth weight, underweight, and low iron are significantly better 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. However, Oregon is not among the states with the highest rates of overweight preschoolers. Oregon’s ranking does reinforce the idea that programs targeting the underlying influences 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 weight.



Oregon leads the nation in the number of mothers who begin breastfeeding (91.2 percent in Oregon vs. 62.0 percent nationally) and continue to nurse at six months and beyond (43 percent in Oregon vs. 27 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 (including 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 WIC staff to improve the quality of services provided to WIC clients. The training plan includes training support for new staff, for existing staff, for breastfeeding expertise, for new initiatives, quarterly in-services, and a statewide meeting every other year. The state WIC staff have begun to use interactive webinars and videoconferencing as cost-effective ways to deliver training and program updates to agency staff around the state.

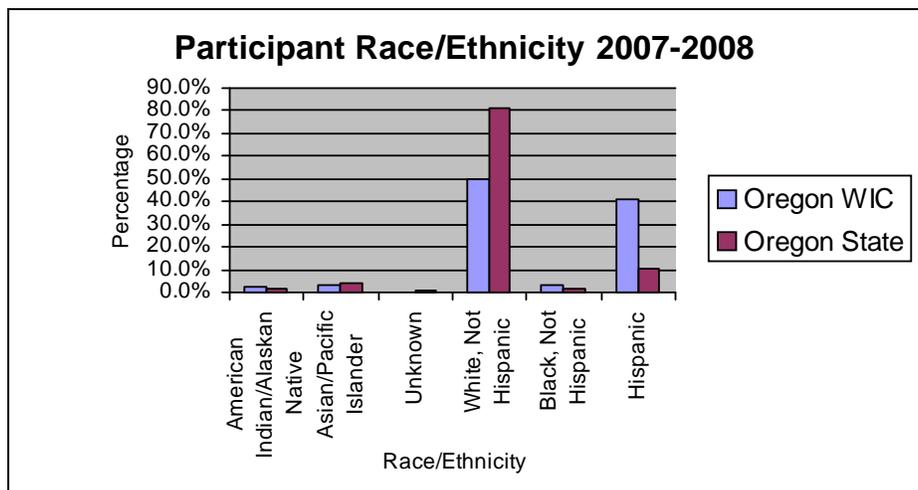
More than 90 percent of Oregon women start out breastfeeding in the hospital after delivery, the highest rate in the nation. Lack of breastfeeding support and barriers when returning to work make it difficult for most women to continue breastfeeding for the 12 months recommended by the American Academy of Pediatrics. For many lower income women, the Nutrition and Health Screening Program (WIC) 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 local non-English-speaking WIC staff for in-depth breastfeeding training and certification. In 2010 WIC expanded its Breastfeeding Peer Counselor program

from four to nine agencies, which has the potential to provide peer support to approximately 60 percent of the prenatal participants in WIC.

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 test scales at all clinics. Compliance monitoring and vendor training is carried out by state rather than local agency staff, freeing local agency time to focus on core WIC services.

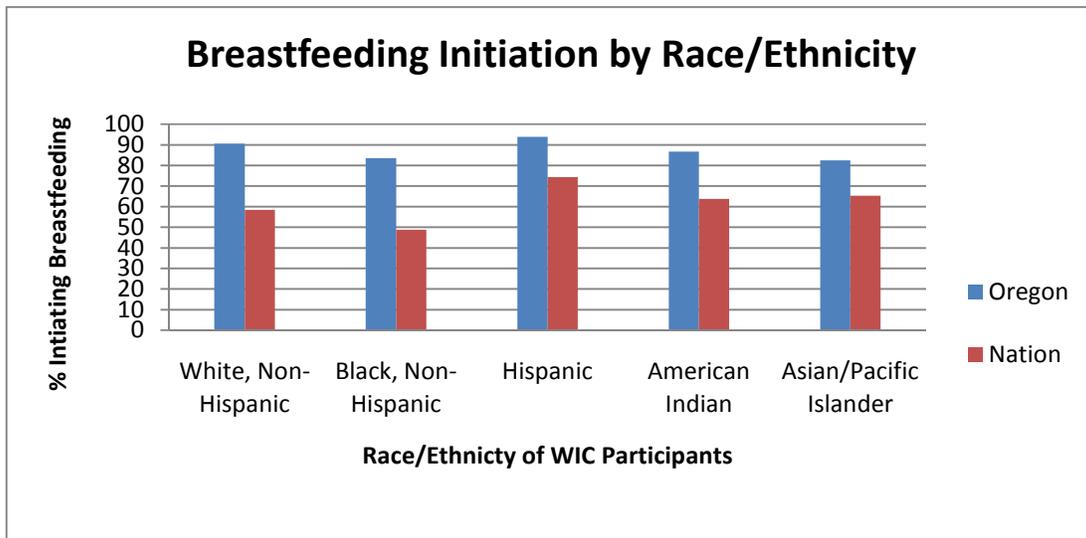
Health disparities

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 English- and Spanish-speaking women limit exclusive breastfeeding and how peer support may uniquely impact both populations. WIC has adapted a participant-centered nutrition education counseling approach to better engage and motivate participants and lead to improved health outcomes. Both research and adaptive programming contribute to WIC’s ability to increase the cultural competency of service delivery and help more mothers 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 successful in a population that nationally experiences substantial disparities, Oregon WIC conducted key informant interviews with black women who successfully initiated breastfeeding. Key findings from this study include the importance of a mother’s own internal motivators for breastfeeding and the importance of continued support beyond the first month of breastfeeding.



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 the full impact of the 2009 Healthy Hunger Free Kids Act which reauthorized WIC 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 potentially major federally mandated changes and increased county budget deficits will be problematic.

Immunization Program (IP)

Services provided

The Immunization Program (IP) provided services in 2010 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 merged the statewide immunization information system and the immunization electronic medical record system for local health departments into a comprehensive Immunization Information System (IIS) in 2010. The new IIS will be rolling out through mid-2011. This is part of the FamilyNet data system for the Office of Family Health. Finally, the program assesses immunization rates across the lifespan to measure progress, evaluate interventions and identify vulnerable populations.

Where service recipients are located

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

Who receives services

Immunization services are a high priority for all children, with special emphasis on children from birth through two years of age, at school entry and seventh grade. Adult immunizations generally target high risk populations, including those with diabetes, liver disease, immunodeficiency's, kidney failure, asplenia (the absence

of normal spleen functioning), and HIV, as well as health care workers, and those age 65 and older.

How services are delivered

Immunization services are delivered by both public and private providers, including pediatricians, family practice doctors, local health departments, federally qualified health centers, tribal health centers, and rural health clinics. One out of two children in Oregon is eligible for no-cost vaccine provided by the state, and more than half of those get their vaccines in private clinics. Of all children in Oregon — including those eligible for state programs and those who receive immunization services from their private health plans — an estimated 76 percent of all children in Oregon will receive their immunizations in the private sector and 24 percent in the public sector.

During federal fiscal year 2009-10, Oregon’s local health departments were responsible for administering over 500,000 doses of vaccine to people of all ages in their communities — providing a critical safety-net service toward keeping people healthy and safe. Each local health department, in cooperation with their satellite agencies and other safety net sites under their authority, administered vaccines between October 2009 and September 2010 as follows:

County	H1N1	Seasonal Flu	All Other Immunizations	Total
Baker	2,991	674	4,086	7,799
Benton	7,603	620	2,800	11,023
Clackamas	2,558	1,474	7,564	11,598
Clatsop	1,513	1,141	2,870	5,524
Columbia	3,519	256	668	4,443
Coos	7,465	216	1,898	9,589
Crook	2,921	239	1,033	4,193
Curry	2,719	230	1,808	4,757
Deschutes	17,808	765	9,806	28,427
Douglas	6,406	2,170	10,321	18,900
Grant	1,304	61	1,352	2,717
Harney	1,225	66	957	2,248
Hood River	2,730	1,425	2,775	6,930
Jackson	8,945	1,425	13,782	24,258
Jefferson	5,598	2,235	4,571	12,414

Josephine	4,585	215	3,749	8,549
Klamath	3,147	456	2,200	5,906
Lake	1,010	661	1,497	3,168
Lane	28,826	2,865	8,673	40,364
Lincoln	6,680	653	2,882	10,234
Linn	8,883	629	1,406	10,918
Malheur	3,610	96	3,602	7,321
Marion	19,158	8,835	36,761	64,838
Morrow	3,757	1,273	2,269	7,299
Multnomah	37,787	13,974	61,125	113,115
North Central Health Dist	3,396	312	2,317	6,025
Polk	6,803	1,152	7,360	15,744
Tillamook	2,581	922	2,806	6,317
Umatilla	9,282	1,216	10,220	20,718
Union	737	176	1,627	2,540
Wallowa	386	32	419	837
Washington	24,785	5,453	25,320	55,558
Wheeler	227	66	275	735
Yamhill	15,460	2,262	6,622	24,344
	256,405	54,245	247,421	559,350

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

- Diphtheria
- Tetanus
- Pertussis
- Polio
- Measles
- Mumps
- Rubella
- Hepatitis B
- Hepatitis A
- Varicella 1
- Hib (haemophilus influenza type b)

Tdap vaccine was required for seventh graders for the first time in school year 2008-09, and for seventh, eighth and ninth graders in school year 2010-11, marking the beginning of the phase-in through 12th grade to be completed in school year 2013-14. Hepatitis A vaccine was required for children in preschool, childcare, Head Start, kindergarten, 1st and 2nd grades. The third year of the phase-in through 12th grade is to be completed in school year 2014-15.

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

Why these services are significant to Oregonians

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

Performance measures

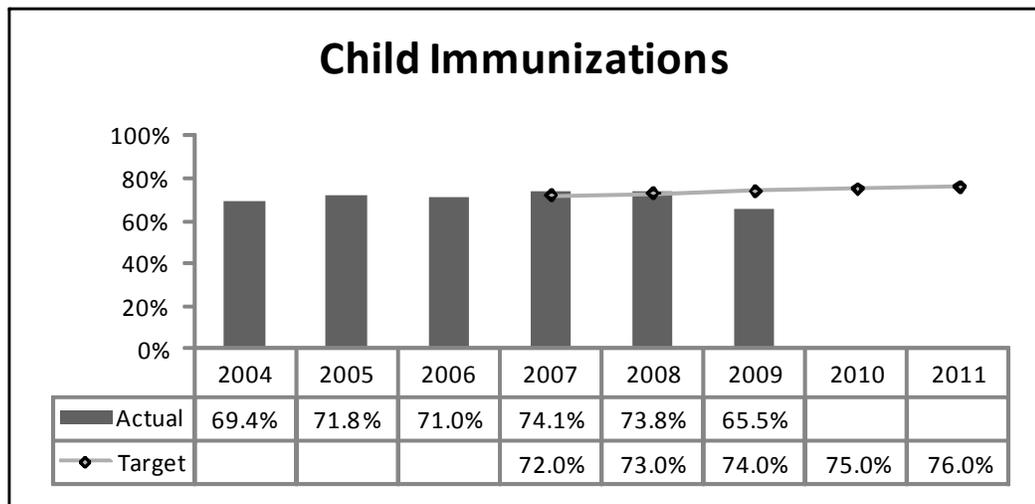
The Immunization Program has two key performance measures, and one new outcome measure.

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

Purpose: This performance measure is the percent of children 24 to 35 months of age immunized with four or more doses of diphtheria, tetanus and pertussis vaccine (DTaP); three or more doses of polio vaccine; one or more doses of measles, mumps and rubella vaccine (MMR); three or more doses of

Haemophilus Influenzae type b vaccine; three or more doses of hepatitis B vaccine; and at least one dose of varicella vaccine (4:3:1:3:3:1). The goal is to increase immunization rates to meet the Healthy People 2010 objective of 90 percent.

During 2009, 65.5 percent of two year old children were fully immunized. A national shortage of Haemophilus Influenzae type b vaccine drove the decline in 2009 vaccination rates. The shortage ended early in 2010.



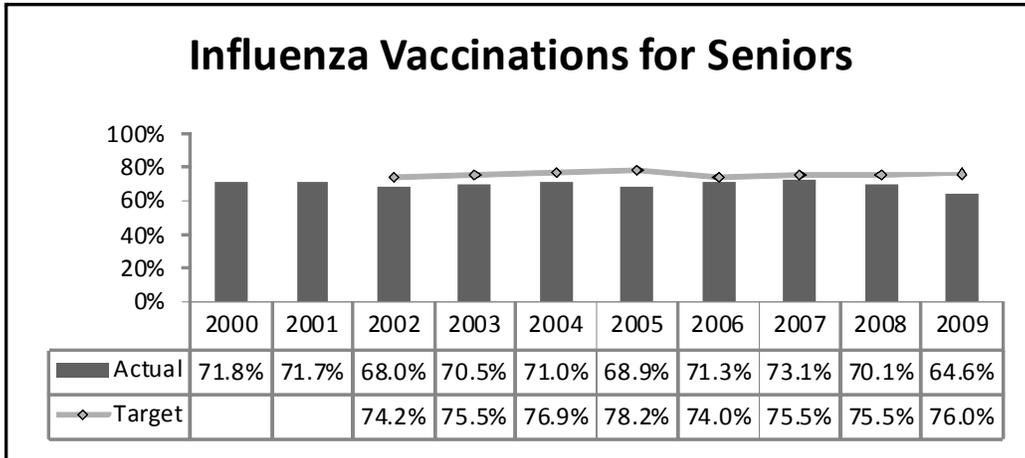
How Oregon compares to other states: The best comparison available to other states is the National Immunization Survey, a phone survey of residents in each state. The approximate national rate for 4:3:1:3:3:1 during 2009 based on the National Immunization Survey was 69.9 percent and 64.8 percent for Oregon. Oregon’s rates have been below the national average for several years. Several factors influence these lower rates. Infants start taking shots at a later age. A complicated immunization schedule makes it difficult for parents and providers to ensure that all shots are given when they are due, and there are persistent concerns about vaccine safety.

National Immunization Survey, 2009	
State	Immunization Rate 4:3:1:3:3:1
Massachusetts (ranked 1 st)	81.1% ± 5.7
Washington	70.3% ± 5.4
Oregon	64.8% ± 6.3
Nevada	59.4% ± 6.5
Idaho	51.7% ± 7.7
National	69.9% ± 1.2

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

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

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



How Oregon compares to other states: During 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.

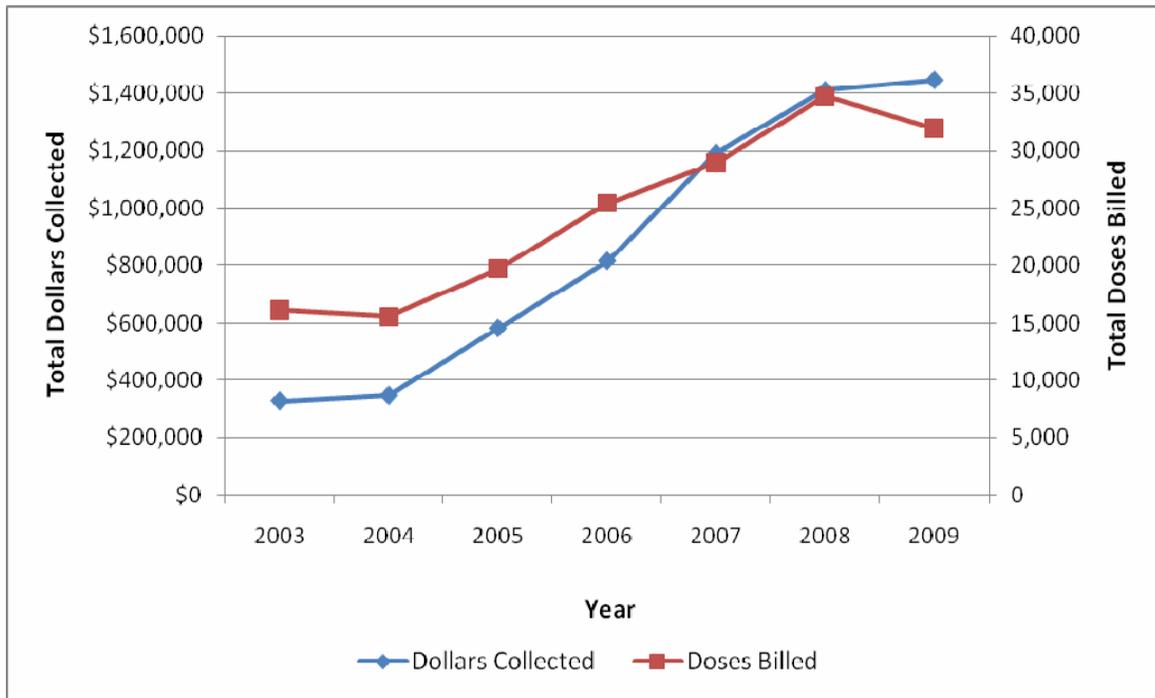
Behavioral Risk Factor Surveillance System, 2009	
State	Influenza Immunization Rate
Minnesota (ranked 1st)	76.7%
California	65.1%
Idaho	64.1%
Nevada	63.5%
Oregon (19th)	64.6%
Washington	70.1%
National	69.8%

Quality and efficiency improvements

During recent years the Immunization Program and the local health departments worked with public clinics to implement a new process and culture for billing insured clients and their health plans for the cost of vaccines provided in public clinics. The program stopped using taxpayer-funded vaccine to underwrite health plan coverage for immunization. Oregon's public clinics administered 30,449 doses of vaccine to fully insured clients, valued at \$1.4 million in FY 2009-10.

Revenue from this project is used to purchase additional vaccine for the well-insured clients being served in public clinics, and to fund special outreach projects to increase access to immunization services. The CDC has adopted this as a best practice nationally.

Oregon Immunization Program — Billable Project History



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 \$25,000 in annual staff time and substantially ease provider burden. In 2010, the majority of our providers were enrolled in two weeks — a process that took at least 25 weeks in 2009.

In an effort to improve vaccine ordering practices among Oregon providers, the Immunization Program has implemented the Enhanced Ordering Cycle (EOC) initiative. EOC uses historical ordering 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. This project reduced the number of vaccine orders by 28 percent while assuring adequate supplies in every office.

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

Health disparities

The Oregon 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. In 2009, OPIC partnered with the CDC and the Academy of Educational Development to develop and implement culturally appropriate vaccine messages for Korean, Vietnamese, Spanish-language, and tribal media.

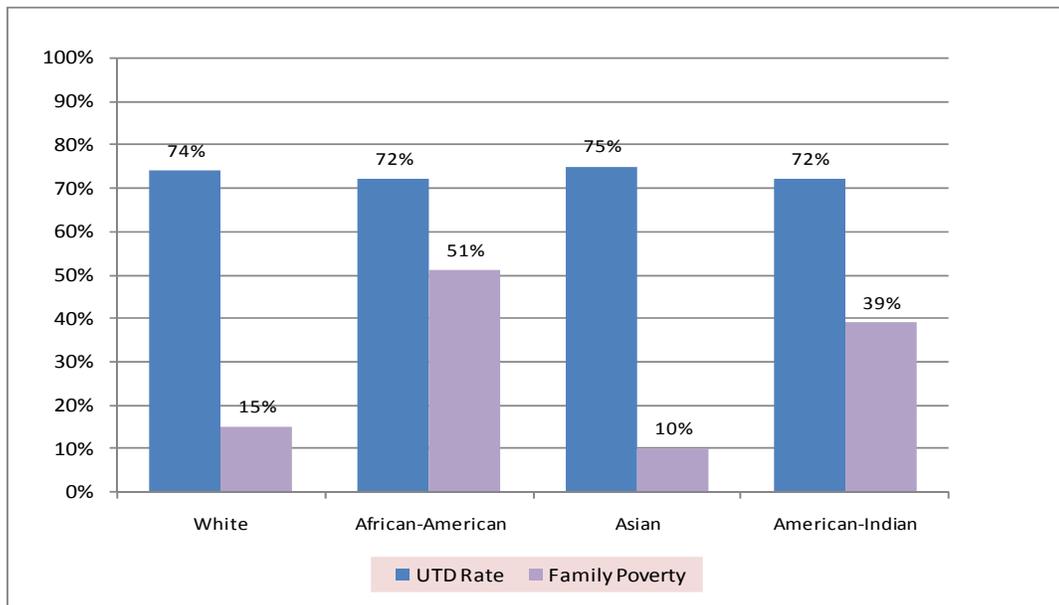
The Oregon Adult Immunization Coalition (OAIC), a statewide coalition to support immunizations across the lifespan, works with twelve nursing and pharmacy schools to train clinical students in vaccine administration, record keeping and storage and handling. Clinical schools, OAIC and local partners then offer offsite vaccination clinics to underserved adults. Sites for these clinics include migrant worker camps, homeless shelters, food banks, and community health fairs, as well as locations that target low-income students and non-English speakers. Vaccine and clinical supplies are gathered from donations, federal programs and partner agencies. In 2009, more than 6,500 vaccines (Tdap, Hep A/B, pneumonia, and influenza) were provided at 137 community clinics for underserved adults. In 2010, more than 100 community clinics were implemented at sites that provide other free services to underserved adults. Vaccines provided were Tdap, pneumonia, Hep A/B, influenza, and HPV. In total, 15,316 doses were provided under this project.

Immunization rates

Development of community-specific immunization rates helps the Immunization Program target interventions and coalition outreach activities. In a 2009 analysis, Oregon's Hispanic community (70.9 percent) had higher immunization rates than non-Hispanics (63.5 percent). Oregon's Asian and Pacific Islander population (68.9 percent), African American (65.3 percent) and American Indian/Alaskan Native population (66.1 percent) had immunization rates higher than those of the white population (64.7 percent) and at or above the state average (65.5 percent).

The Oregon Immunization Program is working with community partners to develop standard immunization rates that help the program and partners monitor vaccine uptake in relation to socioeconomic indicators that may influence health equities, as shown below with 2008 data.

**Oregon Immunization Up-to-Date (UTD) Rates by Race
Compared to Family Poverty Rates, 2008**

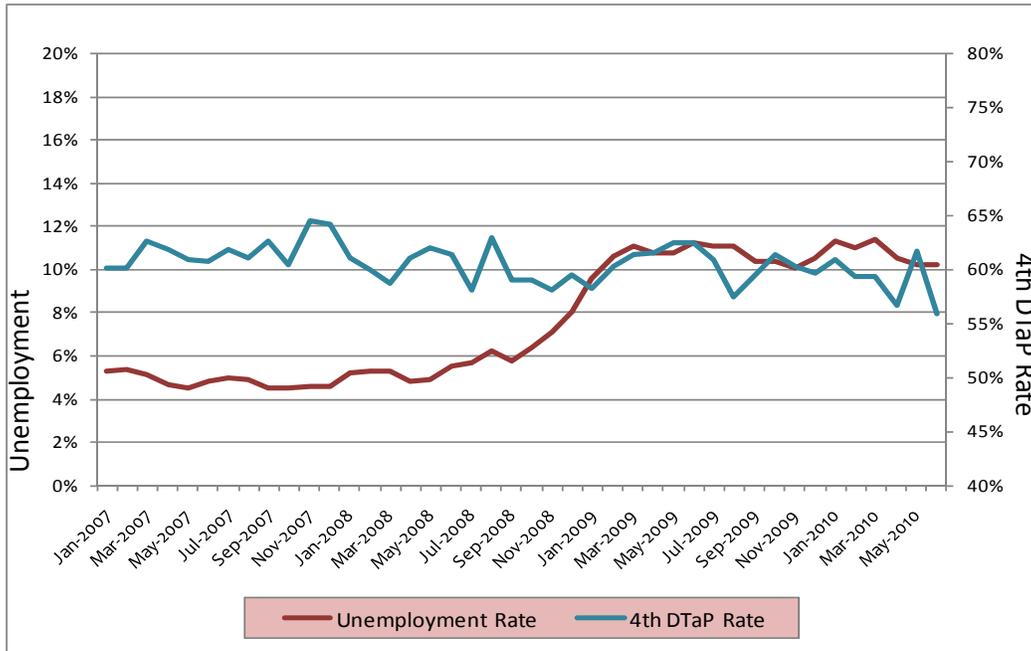


Sources: ALERT IIS, for a 431331 UTD rate for two year olds in 2008; and poverty rates from the American Community Survey, 2006-2008, for families with children under the age of 5.

The Oregon Immunization Program also participates in a national network of Immunization Sentinel Sites overseen by the CDC to use IIS data to identify vaccination trends. This informs national policy and decision-making as well as

serving Oregon’s need for timely data to monitor trends in vaccine uptake and health equity.

Sentinel Region Unemployment and Timely 4th DTaP Comparison



Source: Oregon ALERT IIS, & Oregon Employment Division, 2010

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. These partnerships were integral to the successful delivery of H1N1 vaccine and strategic national stockpile assets to tribal health clinics across the state.

Key budget drivers and issues

Oregon has three primary sources of vaccine funding.

- Vaccines for Children (VFC) is a federal entitlement program that covers children who are uninsured, on OHP/Medicaid, American Indian/Alaskan Native, and underinsured (insured but not for immunization) if served in a federally qualified health center. VFC covers all ACIP-recommended pediatric vaccines for children from birth through 18 years.

- Federal 317 funds are limited and have not increased significantly since late 1990. Currently, 317 funds support lifespan vaccine delivered in public clinics. Approximately fifty percent of 317 funding supports adult immunizations.
- Billable funds are collected by the Oregon Immunization Program from public providers for insured clients served in public clinics. 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 use limited Section 317 funds to cover most routine vaccines for these children. Prior to launching Oregon's unique billables project, these children did not have equal access. Since the billables project, underinsured children have been eligible for all routinely recommended vaccines (except males for HPV vaccine) and for the adolescent booster dose of meningococcal vaccine.

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, heart disease, stroke, asthma, arthritis risk reduction and management
- Ryan White base;
- Emerging infections;
- Epidemiology and laboratory capacity;
- Tobacco Use Reduction Account (Ballot Measure 44); and

The agency also collects fees from vital records and during the past biennium was eligible for extensive ARRA funding that provided grants to multiple programs:

- Emerging Infections — Healthcare acquired infections (HAI)
- Epidemiology and laboratory capacity — HAI;
- Emerging Infections — Vaccines;
- Epidemiology and laboratory capacity — Varicella;
- Healthy Worksites;
- Tobacco Control Integration Project; and
- Quitline.

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 investigating and controlling communicable diseases; investigates communicable disease outbreaks; and helps ensure that communicable disease threats, including bioterrorist threats, are responded to appropriately. In addition, ACDP provides information to the public, the media and 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

ACDP depends heavily on federal funding. Changes in federal appropriations for communicable disease programs and the failure of federal funding 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. The program also 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. Programs work to address the leading underlying risk factors for these diseases — tobacco use, physical inactivity and poor nutrition. HPCDP also provides information to the public, the media and policymakers about chronic diseases and their risk factors in Oregon.

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

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

While prevention of chronic diseases is a high priority for HPCDP, about 45 percent of Oregon adults already have at least one chronic disease. They need

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

Where service recipients are located

HPCDP services such as publication of chronic disease data, tobacco prevention media outreach and the Oregon Tobacco Quitline are provided to Oregonians statewide. All county and regional public health agencies and tribes provide local tobacco prevention programs and are currently extending their capacity to improve population health through nutrition, physical activity and chronic disease self-management.

Living Well has been offered in 29 of Oregon's 36 counties. To improve availability in those areas currently without programs, HPCDP continues to work through its local partners to develop infrastructure in all areas of the state.

Who receives services

HPCDP services and programs are provided to all Oregonians in all counties and tribal areas. By July 1, 2011, 14,000 Oregonians will have accessed the Oregon Tobacco QuitLine and received support and counseling for quitting tobacco use.

To date, 5,297 Oregonians with a chronic condition or their caregivers have participated in the Living Well program. Participants reported an average of three chronic conditions, with most participants reporting arthritis, high blood pressure, chronic pain, depression, high cholesterol or diabetes.

How services are delivered

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

Why these services are significant to Oregonians

Chronic diseases continue to take a huge toll on Oregonians; almost half of Oregon adults (45 percent) have at least one chronic disease. In 2007, chronic diseases caused more than 60 percent of the deaths in Oregon, with heart disease and cancer being the leading causes of death. Chronic diseases are enormous drivers of health care costs. Nationally, 83 cents and 96 cents of Medicaid and Medicare dollars, respectively, are spent treating chronic diseases. Hospitalization costs for chronic diseases in Oregon exceed \$2.22 billion a year. Many of these diseases are preventable by decreasing tobacco use and improving nutrition, physical activity and self-management.

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

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

Performance measures

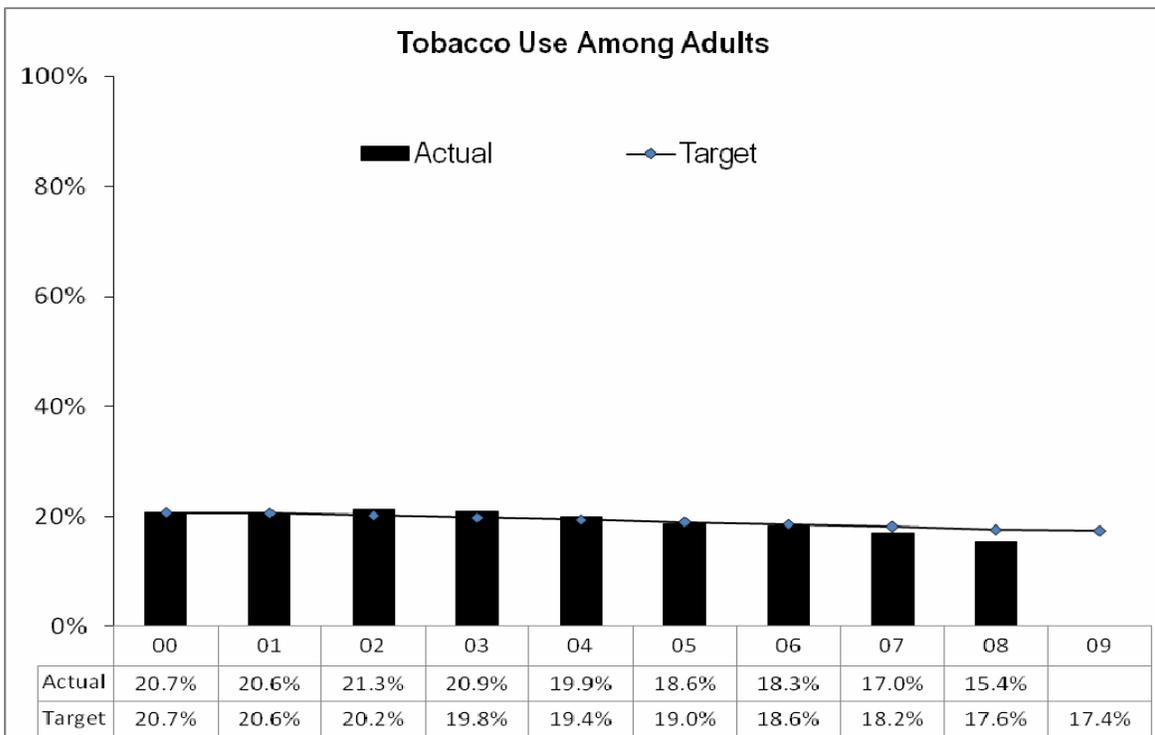
HPCDP has two OHA key performance measures.

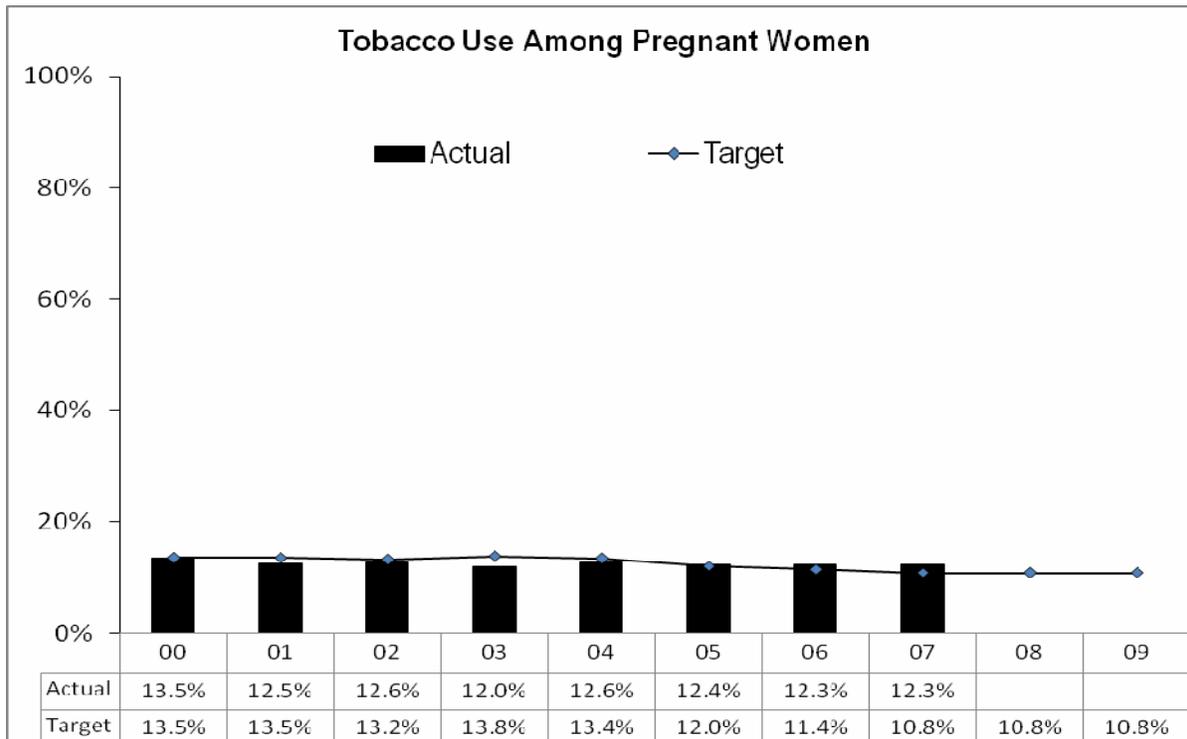
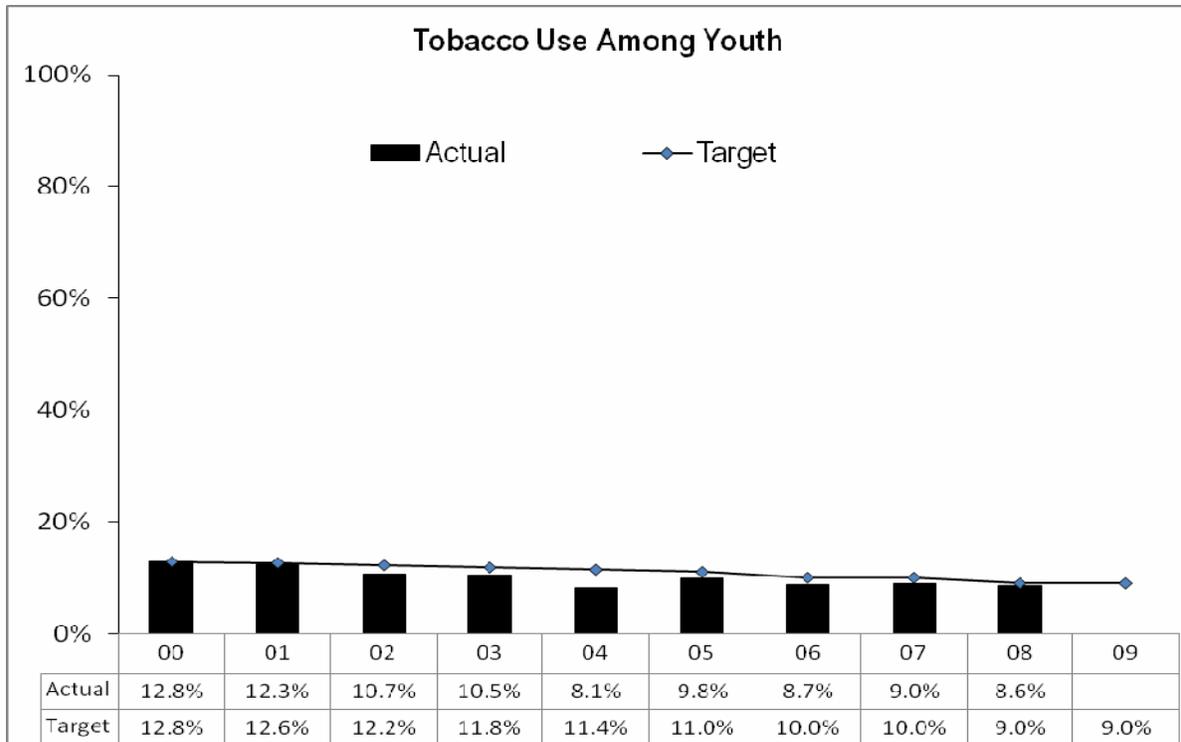
KPM 21: Tobacco use

Purpose: The goals of the Tobacco Prevention and Education Program (TPEP) include reducing tobacco use by youth, adults and pregnant women. Tobacco use is the leading preventable cause of death in Oregon and the nation.

Cigarette smoking is the most common form of tobacco use. Quitting tobacco at any age has significant health benefits. Studies show that 90 percent of adult

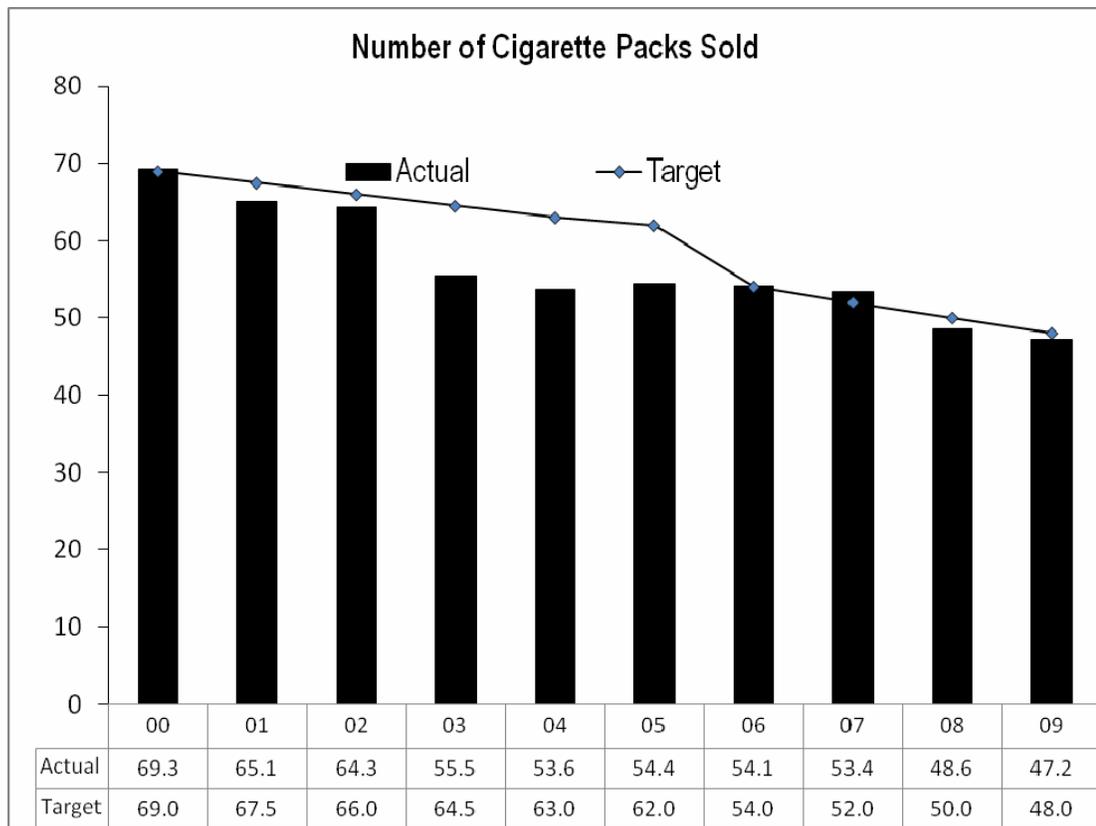
smokers started smoking before they were 18 years old. Preventing youth from starting to smoke will lead to lower smoking rates among adults in the years ahead. A woman’s use of tobacco during pregnancy is associated with serious, and at times fatal, health problems for the child, ranging from low birth weight and premature births to stillbirth and Sudden Infant Death Syndrome (SIDS). Successful efforts by TPEP to decrease the prevalence of tobacco use among youth, adults and pregnant women will lead to reduced morbidity and mortality, contributing substantially toward the OHA goal that “people are healthy” in both the short-term and long-term.





KPM 22: Cigarette packs sold

Purpose: The main goal of TPEP is to reduce tobacco use by youth, adults and pregnant women. Tobacco use is the leading preventable cause of death in Oregon and the nation. Cigarette smoking is the most common form of tobacco use. Quitting tobacco or reducing the amount smoked has significant health benefits. Reductions in the number of cigarette packs sold per capita results from two distinct phenomena — 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 TPEP’s inception in 1997, Oregon had greater per capita sales of cigarette packs than the rest of the country (92.1 in Oregon vs. 87.2 in the US). In 2005 US 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 county and regional public health agencies and tribes to create local partnerships that address all three of these risk factors and promote self-management of chronic diseases and timely screening for chronic diseases. This “healthy communities” program has been very well received. Funding counties and tribes to implement local plans developed with partners depends on availability of federal and funds. Living Well has been selected as a self-management intervention due to its ability to address the needs of people with various chronic conditions. Because Oregon has large rural and frontier areas, promoting statewide infrastructure for Living Well is more efficient than focusing on disease-specific self-management programs. Living Well complements disease-specific education available through the health care system and does not duplicate services.

Key budget drivers and issues

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

During the past few decades Oregonians’ weight has increased to the point that currently an estimated two-thirds of all adult Oregonians are either overweight or obese. The health consequences of this are serious and include diabetes and heart disease. Recent studies demonstrate that increases in obesity account for at least a third of the inflation in health care spending in Oregon, and this number will continue to climb if the root causes are not addressed. There currently is no funding for a statewide obesity prevention and education program in Oregon. If funding were available, it would fund state and local 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 includes two policy option packages with funding dedicated to the expansion of the Tobacco Prevention and Education Program. The first dedicates \$240 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 approximately 7,000 Oregonians each year.

The Health Promotion and Chronic Disease Program utilizes federal funding from multiple grants to support statewide infrastructure for the Living Well program. These funds support program materials, statewide marketing efforts, technical support and training for local partners, and long-term financial sustainability efforts. Local programs use community benefit dollars, grant funds, and minimal participant fees to provide workshops. In order for the program to reach large numbers of Oregonians with chronic conditions, benefit reimbursement will be necessary. The program is currently working with DMAP, the Health Services Commission, PEBB, OEBC, and other partners to develop strategies and plans for future sustainable program financing.

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

Where service recipients are located

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

The electronic Prescription Drug Monitoring Program (PDMP) will help health care providers state wide better treat their patients and prevent some of the problems associated with controlled substances. Data collection, analysis and dissemination guide the efforts of community level coalitions throughout the state. Police departments, hospitals, emergency departments and medical examiners in all counties work with program staff to maintain data systems. Evaluation activities conducted with partners throughout the state monitor the impact of all terrain vehicle rider education training, suicide prevention activities and community uptake of senior fall prevention.

Youth suicide prevention activities are being implemented in high schools in 22 counties, and intervention skills training is being implemented statewide. Elder fall prevention is being implemented in eight counties through community centers, senior centers, senior housing and hospitals.

Who receives services

Services are provided to all communities throughout Oregon.

How services are delivered

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

Why these services are significant to Oregonians

Injury is the third leading cause of death in Oregon, and is among the leading causes of hospitalization. Injury affects everyone, regardless of age, gender, or race. In fact, injury is the leading cause of death among Oregonians 1 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.

Four injury outcomes have been identified for priority prevention status:

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

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

- Relative rank of mortality;
- Number of hospitalizations;
- Years of potential life lost (YPLL);
- Trend of increase; and
- Potential for reducing the impact through the application of evidence-based prevention efforts.

Performance measures

Injury Prevention and Epidemiology has one OHA key performance measure:

KPM 17: Teen suicide

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

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

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

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

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

The purposes of the Prescription Drug Monitoring Program are to:

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

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

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

Key budget drivers and issues

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

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 the spread of these diseases include:

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

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

Where service recipients are located

The services are provided to Oregonians statewide.

Who receives services

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

How services are delivered

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

Why these services are significant to Oregonians

HIV is a life-threatening infection. Each year approximately 300 Oregonians are infected with HIV. Appropriate treatment of HIV infection not only extends life, but also reduces the risk of spreading HIV. Other STDs such as Chlamydia and gonorrhea are the most commonly reported communicable diseases in Oregon. They can facilitate HIV infection and also cause infertility. TB also is a life-threatening infection. Drug-resistant TB is a particularly serious problem that is increasing worldwide. Though still uncommon in Oregon, ensuring prompt identification and appropriate treatment of individuals infected with drug-resistant TB is critical to helping prevent the problem from growing.

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

Performance measures (HIV, STD, TB)

This program has one OHA key performance measure.

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

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

**2009 Interview not yet compiled and verified.*

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

Quality and efficiency improvements (HIV, STD, TB)

The HIV Care and Treatment Programs

The HIV community based medical case management program will complete its pilot project phase in 2011. This new model for case management and support services (in seven 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 one 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 several obsolete information systems. The new system will facilitate efficiency in investigation of diseases of public health importance, reduce time required to investigate 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 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 worked with the Oregon Public Health Laboratory to implement a modern nucleic acid amplification test for diagnosis of Chlamydia and gonorrhea in mid-2009.

Key budget drivers and issues

Collectively the HIV/Sexually Transmitted Disease/Tuberculosis (HST) program depends predominantly on federal funding. Reductions in federal appropriations for HIV, STD and TB programs during the past half decade and the lack of increases in federal funding for these programs 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 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 313 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 notified that they have a confirmed sexually transmitted infection;
- Reduce by 1,038 people each year the number of people who are tested for HIV, meaning that 20 infected people will not discover their HIV infection early; and
- Reduce by 131 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 for Oregonians, including birth, death and marriage certificates. During 2010, CHS registered 133,000 vital events and issued 185,000 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 2009-11 biennium CHS continued improving the Oregon Vital Event Registration System (OVERS) which includes the Electronic Death Registration System, Electronic Birth Registration and Fetal Death System. The Oregon Vital Event Registration System is a fully electronic secure web-based vital records system. This system allows all aspects of the vital records process, from registration at the data source to issuance of certified copies in the counties and state, to be electronic rather than paper-based. The implementation of this system provides for more timely, accurate and secure processing of these important documents for Oregonians. The center also 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 Induced Termination of Pregnancy to the electronic system, to convert older birth and death records on the mainframe to OVERS, and to electronically image older paper records.

Key budget drivers and issues

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 in controlling communicable diseases, identifies metabolic disorders in newborn infants, and ensures the quality of testing in clinical and environmental laboratories statewide.

During the 2011-13 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 2011-13 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 network consists of 88 laboratories that can package and ship biological and chemical specimens for testing. Of these, 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 federal funding sources for OSPHL include:

- Office of the Public Health Director;
- Office of Disease and Prevention and Epidemiology; and
- Office of Environmental Public Health.

Other leading funding sources for OSPHL are fees:

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

Where service recipients are located

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

Who receives services

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

How services are delivered

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

Why these services are significant to Oregonians

Disease control programs, including local health department clinics, rely heavily upon laboratory testing by OSPHL to identify and prevent the spread of infections in the community. The Office of State Public Health Laboratories 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 several KPMs. KPM 18 - early prenatal care for low income women - is supported by the provision of prenatal testing for hepatitis B, syphilis, Chlamydia, and rubella. KPM 28 - HIV rate - is supported by the performance of HIV testing. KPM 31 - safety net clinic use - is supported by the provision of testing for local health departments, community and migrant clinics and other safety net providers.

Quality and efficiency improvements

During the current biennium OSPHL has modernized and automated several of its testing methods. This has resulted in more analytical output per staff position and greater accuracy of test results.

The Office of State Public Health Laboratories has improved the quality of its services by adding new tests, using molecular methods for pandemic H1N1 influenza and several other respiratory agents, using noro-virus sequencing, *Mycobacterium* direct test for tuberculosis, and microcystin toxin in cyanobacteria. A new statewide courier service 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. 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.