Early Learning Council Meeting

May 25, 2016
3:45-6:00pm

Ty Taylor Fire Station – Leonard Hay Community Room
1785 Meyer Pkwy
Hood River, OR 97031

Members of the public who want to give public testimony must sign in.
Each individual speaker or group spokesperson will have 2 minutes.
Electronic testimony may be submitted to Alyssa.Chatterjee@state.or.us.

AGENDA

I. Board Welcome and Roll Call
Chair Pam Curtis

II. Home Visiting Budget Note Update – *Action Item*
Martha Brooks, Best Beginnings Committee Chair
Cate Wilcox, Maternal & Child Health Manager, Public Health Division, OHA

III. **Consent Agenda – *Action Item***
a. Acknowledge Receipt of Written Committee Reports
b. Healthy Families Oregon Recommendations

IV. Regulated Child Care Subsidy Rules – *Discussion Item*
Bobbie Weber, Child Care and Education Committee Chair
Lisa Pinheiro, Early Learning Policy Specialist
David Mandell, Director of Policy & Research, ELD

V. OHPB Strategic Plan Input – *Discussion Item*
Rebekah Bally, Oregon Health Care Quality Corporation

VI. Public Testimony

VII. Adjournment

***Times Approximate. Items may be taken out of order, meeting may convene early, and breaks may be added as needed.** All meetings of the Early Learning Council are open to the public and will conform to Oregon public meetings laws. The upcoming meeting schedule and materials from past meetings are posted online. A request for an interpreter for the hearing impaired or for accommodations for people with disabilities should be made to **Alyssa Chatterjee at 971-701-1535 or by email at Alyssa.Chatterjee@ode.state.or.us.** Requests for accommodation should be made at least 48 hours in advance.*

Board Action Summary- Best Beginnings

<u>AGENDA ITEM;</u> Home Visiting Budget Note

Summary of Recommended Board Action

ACTION:
Discussion and Approval**–** *Information provided on Budget Note recommendations.*

During the 15-17 session, HB 5507 included a budget note that directed the Early Learning Division and Oregon Health Authority to develop a set of recommendations for developing shared outcome metrics, an integrated professional development system, and a common screening tool. Given the scope of this work and it connection to the charge of the Best Beginnings workgroup, the ELC charged Best Beginnings with the task of working to develop the recommendations specified in the budget note, within the required time frame.

The purpose of today's presentation is to obtain Council's approval of the draft Budget note recommendations.

BACKGROUND:
The Best Beginnings Committee is responsible for developing a set of recommendations, as directed in HB 5507:

> *Given the expanded Healthy Families Oregon home visiting funding added to the Early Learning Division's budget, the Early Learning Division and the Oregon Health Authority are instructed to:*
>
> - *Develop a set of outcome metrics connected to evidence of impact for consideration by the Early Learning Council and the Oregon Health Policy Board that any home based service that receives state dollars must meet in order to continue to receive state funds, effective July 1, 2016;*
> - *Develop a plan and timeline for integrating the state's professional development system for early learning providers with the emerging professional development system for home visitors; and*
> - *Develop a common program agnostic screening tool to identify potential parent/child risk factors and intake form for families who are eligible for home visiting services and require implementation by state funded home visiting programs by July 1, 2016.*
>
> *The Early Learning Division and the Oregon Health Authority shall report on progress to the appropriate legislative committee.*

ACTION PRECEDING RECOMMENDED BOARD ADOPTION:

- January 14th: Best Beginnings Committee meeting; plan mapped out for developing budget note recommendations, including identifying staff leads to convener small groups in February.

- February 11th: Small budget note workgroup meeting to develop plan and timeline for the professional development component. Plan fleshed out and awaiting larger Committee approval.

- February 12th: Small budget not workgroup meeting to develop recommendations for outcome metrics. Plan fleshed out and awaiting larger Best Beginnings committee approval.

- March 2nd: Small budget note workgroup convened to develop recommendations for the program agnostic screening tool. Plan close to being fleshed out.

- March 7th: Budget note workgroup convenes to walk through the budget note recommendations produced by the three small workgroups. Feedback received and recommendations refined.

- March 10th: Best Beginnings Committee convenes with a broad agenda that includes a status update and review of the budget note recommendations.

- May 19th: Best Beginnings Committee convenes to share Budget Note report and recommendations.

BOARD MEMBER PRESENTING REPORT FOR ADOPTION:
Martha Brooks, Best Beginnings Committee Chair

CONTACT:
Nakeshia Knight-Coyle, Director of Early Learning Programs and Cross Systems Integration, ELD
Erin Deahn, Healthy Families Oregon Statewide Coordinator, ELD

Best Beginnings Committee of the Early Learning Council
SB 5507 Interim Budget Note Report

Table of Contents

Executive Summary

The purpose of the SB 5507 Interim Budget Note Report is to provide the Early learning Council (ELC) and Oregon Health Policy Board (OHPB) with preliminary information on a set of recommendations for integrating essential components of the state home visiting system. In addition, the report contains a recommended implementation timeline, information on the current home visiting system and suggests where future investments in the home visiting system could be put to best use.

Home visiting for pregnant women, mothers, infants, and young children has been shown to improve school performance, increase nurturing/stable parent/child relationships, reduce child maltreatment, increase employment rates, and reduce welfare use among participants[1]. In recognition of the positive outcomes achieved through home visiting programs and in an effort to create an more family focused system, in 2015, the Oregon legislature included a budget note in HB 5507 that focused on creating a more integrated home visiting system across three key areas: (1) Developing outcome metrics to be used across all of Oregon's state funded home visiting programs; (2) Developing a professional development system that aligns support for the home visiting workforce with the system in place for the rest of the early learning workforce; and (3) Developing a home visiting entry questionnaire that would identifies parent/ child risk factors for consistent use across state funded home visiting programs.

Through a series of eight meetings over a six month period, with the input and consultation of 17 state and national subject matter experts, the following recommendations emerged:

- Outcome Metrics: The recommendation is the adoption of five outcome categories[2] and associated measures for incorporation in 17-19 contracts in create shared and aligned accountability for home visiting programs. The outcome categories are (1) Improved cultural adaptation of programs: All family have equitable access to culturally and linguistically diverse services; (2) Improved maternal, infant, and family health and well-being: Children and families have a health home and are receiving physical, behavioral, and oral health care; (3) Prevention of childhood accidental injury, abuse, and neglect, and reduction in crime and family violence: Children live in stable, attached, and nurturing families, free of abuse, neglect, and violence; (4) Improved school readiness and achievement: Children are physically, socially, and emotionally on track by age three; and (5) Improved family self-sufficiency and coordination of community resources: Families have consistent and stable access to basic needs for their family to support healthy child development.
- Professional Development: The recommendation for developing an integrated early childhood professional development system for home visitors includes the development of the following essential components: (1) Tracking professional development through the enhancement of the Oregon Registry Online and the creation of a career lattice for home visitors that mirrors the one available to child care providers and preschool

[1] The PEW Center on the States, 2010.
[2] See preliminary measurements for each outcome on pages 9-11.

teachers in Oregon; (2) Developing a model for coaching and mentoring and linking supports for home visitors to Child Care Resource and Referral agencies; (3) Identifying and enhancing existing training resources for home visitors; (4) Strengthening relationships with community colleges and universities in support of cultivating a skilled work force; exploring the use of incentives; (5) Infusing equity into every component of the system to ensure the availability of culturally responsive services; (6) Including home visitors in the next early childhood education workforce study; and (7) Supporting parents as their child's first teachers, and engaging them in supports for their children.

- Home Visiting Entry Questionnaire: The recommendation is for a set of data elements to be collected by every home visiting program, regardless of funding source. There are several data elements found in research evidence that should inform the development of the Home Visiting Entry Questionnaire.

See the implementation timeline at the end of the full report for next steps.

Introduction

In the 2015 legislative session, the Oregon Legislature increased funding for the Healthy Families Oregon program through Senate Bill 5507. As a condition attached to that new funding, the Legislature passed a budget note aimed at better integrating Oregon's collection of home visiting programs into a more cohesive system. The budget note reads as follows:

> *Given the expanded Healthy Families Oregon home visiting funding added to the Early Learning Division's budget, the Early Learning Division and the Oregon Health Authority are instructed to:*
>
> - *Develop a set of outcome metrics connected to evidence of impact for consideration by the Early Learning Council and the Oregon Health Policy Board that any home based service that receives state dollars must meet in order to continue to receive state funds, effective July 1, 2016;*
> - *Develop a plan and timeline for integrating the state's professional development system for early learning providers with the emerging professional development system for home visitors; and*
> - *Develop a common program agnostic screening tool to identify potential parent/child risk factors and intake form for families who are eligible for home visiting services and require implementation by state funded home visiting programs by July 1, 2016.*

The Early Learning Division is submitting this report to the Early Learning Council and the Oregon Health Policy Board, in partnership with the Oregon Health Authority, to respond to this directive. In addition to providing recommendations responding to the budget note requirements, this report contains a recommended implementation timeline, information on the current home visiting system (see Appendix documents), and suggests where any future investments in the home visiting system could be put to best use.

Every year 45,000 children are born in Oregon, and approximately 40% of these children are exposed to a well-recognized set of socio-economic, physical, or relational risk factors that adversely impact their health and their ability to develop the cognitive and behavioral foundations necessary for later success in school.

For the past four years, Oregon has engaged in concurrent health and early education systems reform, with the overarching goal of addressing these entrenched challenges and improving the health and educational outcomes for our youngest Oregonians. Oregon statute lays out the following explicit goals for these efforts:

1. Improve the health of Oregonians through better care at lower costs; and
2. Ensure that children arrive at kindergarten prepared for school and that they are raised in healthy, stable and attached families.

Oregon recognizes that these goals are complex, ambitious and inextricably linked, and that a collective approach is necessary to achieve them. As a result, the two policy bodies overseeing Oregon's transformation (Oregon Health Policy Board and Oregon Early Learning Council) have explicitly tied them together, so that health IS an early learning goal, and early learning IS a health goal. Home visiting services, when implemented correctly, are some of the most effective strategies for impacting these shared goals for new parents, infants and toddlers.

Working Toward an Integrated Home Visiting System

Home visiting for pregnant women/new mothers/families, infants and young children has been shown to improve school performance, increase nurturing/stable parent/child relationships, reduce child maltreatment, increase employment rates, reducing involvement with the criminal justice system, and reduce welfare use among participants[3]. For example, a study of the Nurse-Family Partnership program (NFP), conducted 15 years after the program began, found that pregnant women who did not receive home visits had more than three times as many criminal convictions as women who participated in NFP. The study also found differences in the amount of time women spent in jail: the differences in rates found by the study indicated that, for every 100 women not offered NFP, they would spend over 100 days in jail, compared to just two days for the 100 women who received NFP.[4] The program also had an impact on daughters. By age 19, the daughters not served by NFP were nine times more likely to have been convicted than the girls provided NFP services as babies and toddlers.[5]

Early steps have been made toward aligning these systems, accelerated by the state's receipt of a Maternal Infant and Early Childhood Home Visiting (MIECHV) grant. However, plans to truly integrate home visiting services, around the needs of children, families and diverse geographic/racial/ethnic communities, have not yet fully been implemented.

Oregon is home to nationally recognized home visiting programs as well as other promising programs all of which focus on supporting families in their homes. However, without clarity about a common set of metrics for each program, and a more coordinated approach to assessing the needs of families and connecting them to the right program, we will not realize the full population level impact this strong programmatic foundation could help Oregon achieve.

This budget note has allowed the state to advance work, building on past efforts, to integrate our home visiting programs into a true system, where individual child and family needs are identified and matched with the best fit service/support and state and local resources are maximally leveraged.

Process of Developing Recommendations

As the Governor's oversight and governance body for early learning services across the system (per SB 909 and HB 4165) the Early Learning Council (ELC) was charged with setting up and

[3] The PEW Center on the States, 2010.

[4] Luckey, D. W., Olds, D. L., Zhang, W., Henderson, C., Eckenrode, M. K. J., Kitzman, H., & Pettitt, L. (2008). Revised Analysis of 15-Year Outcomes in the Elmira Trial of the Nurse-Family Partnership. Prevention Research Center for Family and Child Health, University of Colorado Department of Pediatrics

[5] Eckenrode, J., Campa, M., Henderson, C., Cole, R., Kitzman, H., Anson, E., Kimberly Sidora-Arcoleo K., Powers J., and Olds, D. "Long-term Effects of Prenatal and Infancy Nurse Home Visitation on the Life course of Youths: 19-Year Follow-up of a Randomized Trial." Archives of Pediatric and Adolescent Medicine, January 2010, 164(1), 9-15

approving a process through which recommendations to respond to the budget note could be crafted. The ELC is a 19 member appointed policy board that operates with several committees. The ELC chose to refer this work to its "Best Beginnings" policy committee (referenced in this report as the Committee), which focuses on policy issues related to parents and young children prenatally through age-3 and is charged with meeting the ELC goal of ensuring children are raised in healthy, stable, and attached families. The committee also serves as the Advisory Council to the state's multi-site Health Family Oregon (HFO) system, providing guidance and input on the planning and coordination of HFO services and activities.

In order to craft these recommendations the Committee met eight times over six months, beginning with creating a common definition of home visiting and setting the parameters for the age range covered through our work. Home visiting was defined as a service delivery model aimed at:

- Strengthening family bonds;
- Increasing understanding of human development;
- Supporting healthy growth and development; and
- Promoting family self-sufficiency.

The intended age range was defined as follows:

- The primary population of focus was defined prenatally to 5 years old.
- A secondary population was also identified as 6-8 years old.

Over the course of eight meetings, the Committee consulted with 17 experts representing ELD, OHA, the Department of Human Services, The Family Ford Foundation, and Oregon Health Sciences University; and received technical assistance and policy advice from Zero to Three.

The Committee also made a commitment to honor previous work that has been done toward the goal of a more integrated home visiting system including:

- The Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, a U.S. Department of Health and Human Services Health Resources and Services Administration grant that supports home visiting services and systems development. Through this grant, the state has been able to:
  - Develop a draft Home Visiting Entry Questionnaire and algorithm with input from stakeholders representing multiple home visiting programs (See Appendix A);
  - Develop the Oregon Home Visiting Core Competencies with input from multiple early childhood professionals (See Appendix B); and
  - Facilitate the integration of home visiting professional development with other early childhood professional development such as the Parenting Education and the AEYC conferences; and
- The Child and Family Well-being Measures Workgroup Final Report and Recommendations developed jointly by the Early Learning Council and Oregon

Health Policy Board. As a result of this work, the state has established a library of 67 measures. (See Appendix C)

- Early Childhood professional development system[6] administered by the Early Learning Division, which includes:
  - Oregon Registry Online system, which tracks the professional development of individuals providing services to children and families; and
  - Tiered Quality Rating and Improvement System developed through the federal Race to the Top grant in support of quality early learning environments.

Given the amount of work already under way in the field, the Committee focused on building recommendations for this report on existing work in order to prevent duplication of efforts. Development of common metrics is critical to our ability to monitor program quality and outcomes. The proposed metrics in this report are a first step toward the development of quality standards for all home visiting programs. From the performance indicators in the metrics, results can be tracked and professional training and development programs can be developed.

Finally, because we know it's important for parents to have choice in the services that support their needs, the development of common data elements at intake will allow for a path to the best fit program for the family, versus a path to whatever program is available. By building on existing system strengths, and inviting the input and engagement of stakeholders and experts, the Committee was able to prepare the recommendations contained in this report.

Workgroup Recommendations

The following recommendations address the three components of the Budget Note: Outcome Metrics, Professional Development and Home Visiting Entry Screening Tool.

Outcomes Metrics

SB 5507 Charge: Develop a set of outcome metrics connected to evidence of impact for consideration by the Early Learning Council and the Oregon Health Policy Board that any home based service that receives state dollars must meet in order to continue to receive state funds, effective July 1, 2016.[7]

Values and Guiding Principles:

The Committee was committed to identifying metrics that have been demonstrated as effective in making a difference and took the approach to build on existing metrics that already guide and drive the work of the Early Learning Hubs and the Coordinated Care Organizations. Home visiting works in, and serves as, a critical link between both health and early learning systems.

[6] Does not yet include home visiting professionals.

[7] The timeline for implementation is not realistic given the need to notify programs about the metrics and add language and expectations to 17-19 contracts. Outcome measures will be incorporated into contracts in the next biennium.

In addition, the Committee explored metrics used in other states that have similar home visiting standards and accountability systems, specifically, Vermont and New Mexico. Lastly, the Committee reviewed the Child and Family Well-Being Measures Workgroup report as a source of measures that have been vetted by a committee of experts across many disciplines and developed specifically for Oregon.

Recommendations:

Based on this guiding information, the Committee recommends grouping the metrics for home visiting program accountability into five categories:

1. Improved cultural adaptation of programs: All families have equitable access to culturally and linguistically diverse services.
2. Improved maternal, infant, and family health and well-being: Children and families have a health home and are receiving physical, behavioral, and oral health care.
3. Prevention of childhood accidental injury, abuse, and neglect, and reduction in crime and family violence: Children live in stable, attached, and nurturing families, free of abuse, neglect, and violence.
4. Improved school readiness and achievement: Children are physically, socially, and emotionally on track by age three.
5. Improved family self-sufficiency and coordination of community resources: Families have consistent and stable access to basic needs for their family to support healthy child development.

The following outcome measures address key factors that strengthen family bonds and understanding of human development to support healthy growth and development and family self-sufficiency.

1. Improved cultural adaptation of programs: All families have equitable access to culturally and linguistically diverse services.

Measure	Rationale/ Evidence	EL Hubs	CCOs
1.1. Percentage of home visiting programs that have policies and practices to serve culturally diverse populations	Cultural adaptation of policies and practices is essential to ensuring an equitable system of services and is a gold standard component of home visiting programs.	X	X
1.2. Percentage of home visiting programs that have staff who reflect the diversity of the populations served			
1.3. Percentage point disparity of children from priority populations served by home visiting programs compared to the community population of eligibility children			

2. Improved maternal, infant, and family health and well-being: Children and families have a health home and are receiving physical, behavioral, and oral health care.

Measure	Rationale/Evidence	EL Hubs	CCOs
2.1. Percentage of pregnant women who receive adequate prenatal care	Prenatal care is widely considered the most productive and cost-effective way to support the delivery of a healthy baby.	X	X
2.2.A Percentage of all mothers screened for depression both pre- and perinatally	Maternal depression prior to or following the birth of a child is highly prevalent in Oregon and left untreated may be detrimental to the mother, family, and well-being of the child.	X	X
2.2.B. Percentage of all mothers screened and referred for depression who engage in treatment			
2.3. Percentage of all children with 6 or more well-child visits by 15 months of age	Regular well-child visits are one of the best ways to detect physical, developmental, and social-emotional problems in infants. They are also an opportunity for providers to offer guidance and counseling to parents and are considered a component of gold standard programs.		

3. Prevention of childhood accidental injury, abuse, and neglect, and reduction in crime and family violence: Children live in stable, attached, and nurturing families, free of abuse, neglect, and violence

Measure	Rationale/Evidence	EL Hubs	CCOs
3.1.A. Percentage of mothers screened for substance abuse	Substance abuse and domestic violence are detrimental to family stability and harmony, and create a toxic environment for the health and well-being of the child both pre- and perinatally.	X	X
3.1.B. Percentage of mothers screened and referred for substance abuse treatment, who engage in treatment			
3.2.A. Percentage of families screened for domestic violence		X	
3.2.B. Percentage of families screened and referred for domestic violence treatment who engage in treatment			

3.3. Percentage of mothers who demonstrate improved parenting skills	Parenting skills are essential in developing a warm, nurturing, and attached parent-child bond that improved child development.		

4. Improve school readiness and achievement: Children are physically, socially, and emotionally on track by age three.

Measure	Rationale/Evidence	EL Hubs	CCOs
4.1. Percentage of children with a developmental screen completed by three years of age	Developmental and social-emotional screening helps detect delays or disabilities early in life and increase the likelihood of specialty care during this critical developmental period that may improve school readiness.	X	X
4.2. Percentage of children with a social-emotional screen by three years of age *Or* Percent of children served who are a 3 or 4 on the approaches to learning domain of the Kindergarten Assessment		X	X
Percentage of children identified as having a possible developmental disability or delay based on developmental screening who receive specialized follow-up services			

5. Improve family self-sufficiency and coordination of community resources: Families have consistent and stable access to basic needs for their family to support healthy child development.

Measure	Rationale/Evidence	EL Hubs	CCOs
5.1 Percentage of families identified without food insecurity	Improvements in child and family health and well-being are most likely to occur when basic needs are met and community services are aligned, coordinated, and	X	

5.2. Average length of time from referral to receipt of community services to meet basic needs and improve self-sufficiency	consistent in order to help families become self-sufficient.		

In order to effectively collect and track this data, there is a need to expand the current home visiting data system capacity to enable participation of all funded programs.

Professional Development

SB 5507 Charge: Develop a plan and timeline for integrating the state's professional development system for early learning providers with the emerging professional development system for home visitors.

Values and Guiding Principles:

The professional development (PD) workgroup sought to honor the uniqueness of the different home visiting, early learning and child care approaches, while working towards integrating the essential components of a professional development system for state-funded home visiting programs. While our focus for the budget note is on home visiting, there is a bigger opportunity for us to align professional development across the early childhood system, which is a focus of the Early Learning Council. A comprehensive professional development legislative concept has been developed for the 2017 session. While child care has made great strides in this area, there is room for growth, as home visitors require a unique skillset that may require additional professional development resources.

Considerations and Recommendations:

There are multiple factors that need to be considered during the planning and implementation process, including the following:

- Tracking professional development: Fully develop a career lattice for home visitors that mirrors the one available to child care providers and preschool teachers in Oregon. Build the tracking of professional development for home visitors into the Oregon Registry Online to track their professional advancement.
- Coaching: Develop a model for cross program mentoring and coaching for home visitors through the "focus network" professional support model. As Child Care Resource and Referral agencies continue to shift from referral agencies to professional development and support agencies, include professional training and support for home visitors into the array of services offered.
- Training: Determine what the existing training resources are and how they could be leveraged for a larger audience/ purpose. This includes identifying available trainings on wrap-around services; identifying substantive areas that need to be covered; determining how to build our state's capacity to train; identifying training needs across programs; and ensuring adequate opportunities for parent education.

- Community Colleges and Universities: Build and strengthen relationships that will help augment support for early learning professionals. This includes: (1) encouraging and exploring funding opportunities for students; (2) developing curricula that align with EL standards and home visitor competencies, and (3) working to ensure work currently happening to put in place articulation agreements for community based training, community college coursework and university degrees for child care providers and preschool teachers extends to home visitors as well.
- Incentives: Determine the most effective way of incentivizing both universities and students to participate in professional development opportunities and what role the state should play in funding such incentives.
- Equity: Infuse into all components of the system. Includes culturally responsive practices, trainings and the availability of tools in appropriate languages.
- Compensation: Develop a vision for what a livable wage would look like and include Home Visiting workforce in the next workforce study.
- Geography: Identify the nuances that exist across urban, rural, and frontier communities that will need to be considered.
- Parent Engagement: Develop plan for engaging parents, as the first teachers, on how to support their children. This includes strategizing on to ways to identify and support those who are coaching parents of young children.

Home Visiting Entry Questionnaire

SB 5507 Charge: Develop a common program agnostic screening tool to identify potential parent/child risk factors and intake form for families who are eligible for home visiting services and require implementation by state funded home visiting programs by July 1, 2016.

Values and Guiding Principles:

The workgroup used a number of principles to guide discussions and the development of recommendations. First, it sought to honor the state and local efforts that have preceded this Budget Note and workgroup. The group also prioritized the needs of families to ensure that they are connected to the most appropriate resource. Finally, an emphasis was placed on ensuring quality throughout the process and connecting the data elements collected to broader system outcomes.

Considerations and Recommendations:

Research evidence shows the following indicators are strongly related to foster care entry.[8]

- *Inadequate prenatal care/smoking during pregnancy
- *Low birth weight (< 2500 grams)
- Birth abnormality

[8] Center for Evidence Based Policy, "Pay for Prevention Final Report," Matt Chwierut, Pam Curtis, Chris Kelleher, 2015

- *Diagnosed with (recent) psychiatric issue/prior psychiatric events
- Substance abuse
- *Single mother or father unknown.
- *Mom on public assistance (SNAP, WIC, TANF, disability)
- *Any public assistance
- *Conviction of either parent
- Substandard housing
- * Mother didn't graduate high school

*indicates data elements with the greatest likelihood of predicting foster care entry.

This should be used to inform the development of the Home Visiting Entry Questionnaire. It is important to note that the presence of risks does not mean that a mother or father cannot become a loving and supportive parent, but can indicate that the family may need support to build their skills and become the parents they wish to be.

In Oregon, home visiting programs are administered in the Oregon Department of Education, Oregon Health Authority, and Department of Human Services. Local home visiting service delivery systems are typically funded through a blend of federal, state, local, and foundation financing. In recognition of this mix of administration and funding influence on the local delivery systems, the workgroup prioritized the promotion of a set of common data elements that would be universally collected regardless of the primary funding source. In addition, the workgroup aimed to avoid the risk of creating different entry processes for state funded services that were not utilized by the local home visiting network as a whole. There are a number of communities across the state that have already developed and implemented a common entry process. As such, it was considered important to explore existing efforts and processes underway in the state across the different home visiting programs.

Through the workgroup discussion process, it became evident that any questionnaire developed is only as effective as its system of support. To that end, there are further deliberations that will require attention such as data systems or other means of communicating information across programs, client privacy and adequate systems to release information, supporting single or multiple points of entry and sufficient training and support to be successful, respectful and family centered in the use of any tool.

The workgroup reviewed five existing examples of questionnaires: (1) The Home Visiting Entry Questionnaire (HVEQ) developed for use in MIECHV; (2) The New Baby Questionnaire (NBQ) used by Healthy Families Oregon; (3) The Family Coordinated 0-5 years Referral Exchange (Family C0RE) used in Yamhill County; (4) The Early Learning Family Support Referral Form (ELFSRF) used in Marion County; and (5) The Early Intervention Early Childhood Special Education (EI/ECSE) Universal Referral Form. The workgroup prioritized elements that were common in at least three of the five forms as recommended core elements for state use and what the evidence review shows are the factors most likely to create poor outcomes for families. In addition, there were a couple of elements that emerged as a best practices, such as the

inquiry regarding whether the number from which the family is calling is okay to call back if disconnected that are also recommended.

Fiscal and Administrative Considerations

In order to fully implement these recommendations, changes to the way the state finances and administers home visiting services must occur. It is outside the scope of this report to recommend what those changes should be, however, the Committee strongly recommends the Governor's Education Cabinet and Healthy and Human Services Cabinet discuss the work outlined in this report and factor the cost of implementation into discussions leading up to the release of the Governor's Recommended Budget in December 2016.

Global Timeline (subject to change)

<table>
<tr><th></th><th colspan="4">2016</th><th colspan="6">2017</th><th colspan="2">2018</th></tr>
<tr><th></th><th>Jan-Mar</th><th>Apr-Jun</th><th>Jul-Sep</th><th>Oct-Dec</th><th>Jan-Mar</th><th>Apr-Jun</th><th>Jul-Sep</th><th>Oct-Dec</th><th>Jan-Mar</th><th>Apr-Jun</th></tr>
<tr><td rowspan="2">Outcome Metrics</td><td rowspan="8">Initial report on progress made to ELC and OHPB

Three workgroups convene to flesh out recommendations for the budget note components

Budget note Workgroup convenes and finalizes recommendations

Best Beginnings Committee reviews and approves recommendations

Presentation to ELC on proposed recommendations</td><td rowspan="8">Presentation to Oregon Health Policy Board

Budget note report finalized and approved

Determination of BN activities/ work that require funding to support efforts

BB Committee makes preparations for ongoing Budget Note Workgroup work (ID chair, charter, timeline, etc.)</td><td rowspan="2">Determine membership for outcome metrics committee</td><td>Commence regular meetings</td><td colspan="6" rowspan="2">Regular outcome metrics meetings with periodic updates on progress to BB Chair and ELC
Chair Updates on work progress, decision points, questions, etc. to the BB Committee</td></tr>
<tr><td>Develop detailed work plan</td></tr>
<tr><td rowspan="4">Professional Development</td><td>Determine membership for long-standing PD advisory group meeting: ELD, PH, DHS, IMH, EI</td><td>Commence regular PD advisory group meetings</td><td colspan="6">Regular PD advisory group meetings
Chair Updates on work progress, decision points, questions, etc. to the BB Committee</td></tr>
<tr><td>Develop crosswalk of existing competencies: HV, EI-ECSE, CC, Parent Education</td><td>Update ELC on progress on BN Report recommendations and next steps</td><td colspan="6">Chair Updates on work progress, decision points, questions, etc. to the BB Committee</td></tr>
<tr><td>Identify program-specific and common competency areas</td><td rowspan="2">Workgroup chair Updates on work progress, decision points, questions, etc. to the BB Committee</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Develop workplan and assign key tasks and duties</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">Home Visiting Entry Tool</td><td>Form workgroup and develop a toolkit and support system for implementation</td><td>Develop toolkit and support system</td><td>Support local communities to implement</td><td colspan="5">Regular and appropriate reviews of the entry questionnaire by the BB to occur, making sure data points are current with research and relevant.
Chair Updates on work progress, decision points, questions, etc. to the BB Committee</td></tr>
<tr><td colspan="3">Engage communities in Learning Circles to promote deeper inter-program understanding and cooperation necessary to structurally support coordinated entry</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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Best Beginnings Committee Membership

Martha Brooks, Committee Chair

James Barta, Legislative Director, Children First for Oregon

Jessica Britt, HFO Program Manager – Umatilla & Union Counties

Mercedes Castle, Pedagogical Director PDX MC

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APPENDIX A: Home Visiting Entry Questionnaire

Oregon's Home Visiting System
Referral Questionnaire

Call: Date: _____ Time: _____
Referral Taken By: _____
Referral method: _____
Follow up made to client: _____
Follow up made to referral source: _____

How did you hear about XXXX? _____Reason for call?_____
Are you receiving Home Visits from another program? **Y N** _____ Or have you in the past? **Y N** _____
(NFP, HSHF, PHN, EHS, Relief Nursery)

REFERRAL SOURCE *(circle one)* Self Referral Agency Referral PCP Other: _____

Self Referral: **Is it ok if I ask you some questions to see what services I may be able to link you to?**
If yes (phone consent), screener initial here: _____

Agency/Other: Has the parent given permission for XXXX to call them? **Y N**

Referral source's name: _____ Agency/position: _____

Referral source's phone number: _____ Follow up requested: **Y N**

FAMILY INFORMATION

#1 Parent/Guardian Name: _____ DOB: _____ Race/Ethnicity: _____

Relationship to child: Mother Father Foster Parent Grandparent Other: _____

#2 Parent/Guardian Name: _____ DOB: _____ Race/Ethnicity: _____

Relationship to child: Mother Father Foster Parent Grandparent Other: _____

☐ Check here if additional parents or guardians (biological or foster) are listed on an attached page.

Language: _____

Address:_____ **Apt #** _____ **City:** _____ **Zip:** _____ **County:** _____

Phone: _____ **Home/Cell** Voice message ok? **Y N** Text message ok? **Y N**

Phone: _____ Home/Cell Voice message ok? **Y N** Text message ok? **Y N**

"Is this phone number OK for me to call you back at if we get disconnected?" _____initial

Do you have Health Insurance? _____ Do you have a regular family doctor? _____

PREGNANCY/CHILDREN

Are you pregnant? Y N If YES, what is your due date? _____ (NFP if <28 weeks) Are you connected to WIC? Y N

If YES - Is this your 1st pregnancy or 1st parenting experience? Y N Fathers? Y N (HSHF, PHN, EHS)
If not 1st parenting experience, how many children do you have? _____ (PHN, EHS)

If NO – How many children do you have? _____ (PHN, EHS, Relief Nursery)

If mother/father have only 1 child, is this the first parenting experience for either parent? Y N
(HSHF if baby is <90 days old, EHS, PHN)

Child's Full Name: _____Race/Ethnicity:_____ DOB:_____ Sex: M / F

Child's Full Name: _____Race/Ethnicity:_____ DOB:_____ Sex: M / F

☐ Check here if additional children are listed on an attached page.

Do you have any concerns about your child(ren)? **Y N** *(health, growth & development or behavior) (PHN, EI)*
Explain:_____

_____

Do you give verbal permission to refer (to give personal information) to services marked on Referral Checklist (page 3): **Y N**

Intake worker Name: _____ Signature: _____ Agency: _____ Referrals: _____

Oregon's HV System Referral Questionnaire, page 2

Can you tell me what programs you're already connect with? _____

[ ] Alcohol and/or drug Counseling, #xxx-xxx-xxxx _____

[ ] Birth Certificate, #xxx-xxx-xxxx _____

[ ] Child Birth Classes, (List): _____

[ ] Child Care Resource & Referral, #xxx-xxx-xxxx _____

[ ] Clothing, (List): _____

[ ] Dental Services, #xxx-xxx-xxxx:_____

[ ] DMV, #xxx-xxx-xxxx _____

[ ] Domestic Violence, #xxx-xxx-xxxx (office), #xxx-xxx-xxxx (24/7 crisis line) _____

[ ] Early Head Start (EHS), #xxx-xxx-xxxx _____

[ ] Early Intervention (EI), #xxx-xxx-xxxx _____

[ ] Energy Assistance, #xxx-xxx-xxxx _____

[ ] Food Assistance, Emergency, (List): _____

[ ] Head Start (HS), #xxx-xxx-xxxx _____

[ ] Health Start/Healthy Families (HSHF), #xxx-xxx-xxxx, _____

[ ] Healthy Kids, ,#xxx-xxx-xxxx, Fax: #xxx-xxx-xxxx:_____

[ ] Hospitals, #xxx-xxx-xxxx _____

[ ] Immunizations, #xxx-xxx-xxxx _____

[ ] Medical Providers, #xxx-xxx-xxxx _____

[ ] Mental Health Counseling, #xxx-xxx-xxxx _____

[ ] Nurse Family Partnership (NFP), #xxx-xxx-xxxx _____

[ ] OHP, #xxx-xxx-xxxx _____

[ ] Oregon's Mothers Care, #xxx-xxx-xxxx _____

[ ] Parenting Classes, (List): _____

[ ] Planned Parenthood, #xxx-xxx-xxxx _____

[ ] Public Health Nurse Home Visiting Program (PHN: MCM, Babies 1st, CaCoon): #xxx-xxx-xxxx _____

[ ] Relief Nursery, #xxx-xxx-xxxx, Fax, #xxx-xxx-xxxx _____

[ ] Self Sufficiency, SNAP, TANF, #xxx-xxx-xxxx _____

[ ] Shelters/Housing, (List): _____

[ ] Social Security Insurance (SSI), #xxx-xxx-xxxx _____

[ ] Teen Parent Support, ,#xxx-xxx-xxxx _____

[ ] Transportation, #xxx-xxx-xxxx _____

[ ] WIC, #xxx-xxx-xxxx _____

[ ] Sent packet in the mail which included the following information:_____

"I am going to call you back in about a week to see if you were able to connect with some of these programs." _____ *initial*

Oregon's Home Visiting System
Referral Questionnaire - OPTIONAL page 3

Parent/Guardian's name: _____

Can we spend time talking about some more specific things going on with your family? **Y N**

For this current/most recent pregnancy, how far along were you when you first saw a health care provider (like a doctor) for prenatal care?
Circle one: 0-12 weeks More than 12 weeks (or not at all) Haven't gone yet

For this current/most recent pregnancy, how many times did you see a health care provider?
Circle one: 5 or more times Less than 5 times Don't know, still pregnant

Parent's marital status: Married Partnered Single Divorced Widowed Separated Other: _____

Level of completed Education: No HS diploma HS Diploma GED Some College College Degree Some/Completed Grad School

Employment: Not employed Seeking Employment Seasonally Employed < ½ time ½ time Full Time (35+ hrs/wk) Other: _____

Partner's Employment: Not employed Seeking Employment Seasonally Employed < ½ time ½ time Full Time (35+ hrs/wk) Other: _____

Do you have a hard time paying for food or other basic living expenses? Most of the time Sometimes Never

Do you have a history of depression? (PHN) Mother: **Y N** *Tell me more about this*: _____

In the *past 2 weeks* have you been bothered by feeling down, depressed or hopeless? (HS/HF) Mother: Y N

In the *past 2 weeks* have you been bothered by having little interest or pleasure doing things? Mother: Y N
(HS/HF, MCM, PHN) *Tell me more about this*: _____

In the *past 2 weeks* have you been worrying a lot or been bothered by feelings of anxiety or felt stressed or overwhelmed? Mother: **Y N** (PHN) *Tell me more about this*: _____

How would you describe your current Relationships (s/o, family, etc.)?
Few/Minor Problems Some Problems Serious Problems

Do you feel safe? **Y N** *Tell me more about this*: _____

How many people could turn to for support or to talk to about problems, concerns or things that are bothering you?
0 1 2 3 or more

Do you or your partner feel a need to cut down on drinking or drug use (or has someone asked you or your partner to cut down)? **Y N** *Tell me more about this*: _____

Have either you or your partner had any Child Welfare/Protective Services involvement in the past or now?
Mother: **Y N** Father: **Y N** *Tell me more about this*: _____

Additional Notes/Information:

_____

_____

_____

_____

APPENDIX B: Home Visiting Core Competencies

THE OREGON HOME VISITING CORE COMPETENCIES

2015

Oregon Health Authority

PUBLIC HEALTH DIVISION
Maternal and Child Health Section

Oregon Core Competencies

For the Home Visiting Workforce

Vision

Oregon's Home Visiting workforce serving families prenatally through age five will be prepared to promote and support optimal development of infants, young children and their families. Oregon families will receive culturally competent, linguistically appropriate and relationship-focused home visiting services provided by a workforce that demonstrates a common set of core competencies.

What are Core Competencies?

The Oregon Home Visiting Core Competencies are a set of attributes, knowledge, and skills that reflect best practice for professionals in the field.

Expectations for what the workforce should know (knowledge) and be able to do (skills) in a respectful and competent manner (attributes) in their roles working with families. The Oregon Core Competencies are organized under 10 Content Areas. Please refer to the section titled Organization of the Oregon Core Competencies.

The competencies listed under each Content Area are not intended to be an exhaustive list; rather, they provide general guidance for best practice in working with families in a variety of home visiting programs.

The Oregon Home Visiting Core Competencies support and is aligned with the Core Body of Knowledge for Early Childhood Educators, Core Knowledge Areas for Parent Educators, the Early Learning Division Equity Lens and trauma informed practices.

Why have Core Competencies?

Core Competencies create a common thread of Professional Development expectations across the variety of home visiting programs for the ultimate benefit of families in Oregon.

They are established to provide a framework and a common language for workforce development planning that supports state, local, agency and individual workforce development. The Oregon Home Visiting Core Competencies is intended to be used as a tool by the workforce to conduct ongoing self-assessments as well as professional development planning.

How Were the Oregon Core Competencies Developed?

Maternal, Infant and Early Childhood Home Visiting (MIECHV), a program of the Oregon Public Health Division funded by the Health Resource Services Administration (HRSA), has served as a resource to, and facilitator of, the Oregon Core Competencies Workgroup in the development of the Oregon Home Visiting Core Competencies.

The Core Competencies were developed based on selected criteria including evidence-based practice, research, a review of best practices and alignment with early childhood core systems. The Core Competencies were defined based on research from the National Center on Child Care Professional Development Systems and Workforce Initiatives Center (PDW Center) and the Workgroup Summary Report on Core Competencies for the Prenatal through Age Three Field from Zero to Three. A careful review of many other state's documents were considered in the development of this document.

Input was gathered on The Oregon Home Visiting Core Competencies by stakeholders, statewide Home Visiting program model leads, and representatives from local Home Visiting programs throughout the state.

Organization of the Oregon Home Visiting Core Competencies

The Oregon Home Visiting Core Competencies are organized under the 10 domain areas listed below. Each domain area begins with a description followed by the competency, which is organized by attributes, knowledge and skills.

Attributes are considered to be those inherent traits, values or beliefs of an individual within the home visiting field. Knowledge is defined as the information needed within each domain required to effectively work within the home visiting field. Skills are defined as strategies for application of knowledge within the home visiting field.

1. Cultural and Linguistic Responsiveness:

Commit to understanding individuals and families within their cultural context and providing appropriate supports.

2. Dynamics of Family Relationships and Engagement:

Understand the complexity and diversity of family relationship, dynamics, and systems while working in partnership with families for the best interest of children.

3. Family Health and Well-Being:

Establish and maintain environments and supports that promote children's health, safety, nutrition, physical activity and adaptations for special needs, in partnership with families.

4. Family Self Sufficiency:

Actively engage family members in identifying and working towards self-sufficiency, as defined and desired by the family.

5. Human Growth and Development:

Apply the principles of development across the lifespan, including child growth and development; value each family member's unique biology, interests, needs and potential while nurturing relationships, starting with healthy infant-caregiver attachment.

6. Professional Best Practices:

Work with families in a professional, reflective manner; adhere to ethical standards, regulations and laws pertaining to the home visiting field.

7. Professional Well Being:

Examine one's own thoughts, attitudes, feelings, actions, strengths and challenges; seek appropriate supports and engage in self-care activities to ensure ability to effectively support families.

8. Screening and Assessment:

Use appropriate tools and methods for understanding child interactions, knowledge and skills as a means to support the child's development and make appropriate referrals for further evaluation.

9. Service System Coordination:

Understand the value of partnerships and collaborations between families and agencies/ organizations to meet family needs.

10. Social Emotional Well-being:

Understand supportive strategies for encouraging social emotional development and addressing challenging behaviors, and recognize the influence of temperament and emotional regulation capacity on behavior.

1. Cultural and Linguistic Responsiveness

Cultural and linguistic responsiveness requires an ongoing commitment to understanding individuals and families within their cultural context and providing appropriate supports. Cultural context includes age, cognitive and physical differences, communication, ethnicity, family composition, gender, race, religion, sexual orientation, language and socio-economic status. Home visitors acknowledge and respond with sensitivity to the unique culture of each family. They are aware of their own personal biases, judgments, and assumptions and seek to integrate culturally and linguistically responsive practices into their work.

Attributes	• Demonstrates an attitude of respect and sensitivity; builds on family cultural and linguistic diversity to support family outcomes. • Exhibits the ability to be respectful, responsive, and sensitive in interactions and relationships with families and community members. • Values ongoing education and training as a way to stay current with changing demographics and cultural factors in the population served. • Appreciates learning from members of the cultural group about cultural norms and behaviors; avoids making assumptions about practices.
Knowledge	**K.1.1** Understands that each person's culture shapes his or her values, beliefs, and behaviors, is a source of pride and is an asset to embrace and celebrate. **K.1.2** Recognizes that language and/or cultural values and beliefs influence the way families seek and access services. **K.1.3** Recognizes that a family's experience of systemic barriers such as limited resources, availability of services in their first language, lack of cultural responsiveness, immigration status and program policies may impact a family's readiness to access services. **K.1.4** Understands how disparities in program policies, design and practices impact equity in health and educational outcomes. **K.1.5** Comprehends how racial and ethnic inequities in healthcare, education, housing, employment, law enforcement and other systems may marginalize and traumatize families across generations, generate chronic stress and disease and create trauma responses that further limit access to needed resources. **K.1.6** Identifies how cultural identity and an individual's cultural community provide an important source of resiliency for families. **K.1.7** Recognizes and acknowledges how personal assumptions, perceptions, attitudes, beliefs and practices influence and contribute to successful relationships with families.
Skills	**S.1.1** Provides responsive supports that celebrate home language and cultures. **S.1.2** Demonstrates the ability to discuss and incorporate new culturally and linguistically relevant ideas and approaches into practices to engage and support families. **S.1.3** Partners with families to promote advocacy and empowerment on behalf of the family system. Works to assure that family voice is considered and that rights and responsibilities are honored. Seeks out quality, equity-based resources that meet families' language and cultural needs.

1. Cultural and Linguistic Responsiveness		
Skills	**S.1.4**	Supports a variety of individuals from varying backgrounds and cultures including ability, age, ethnicity, family composition, gender, race, religion, sexual orientation, language and socio-economic status.
	S.1.5	Employs a culturally responsive and trauma informed approach in working with families to work toward equitable access to needed resources.
	S.1.6	Empowers and supports families' connection to their cultural communities.
	S.1.7	Utilizes strengths-based perspective to understand cultural identity and practices to support families and improve family outcomes.

2. Dynamics of Family Relationships and Engagement Home visitors understand that parents are a child's first and most important teachers. They honor each family's unique values, beliefs, culture and community connections. Home Visitors understand the important role that families play in children's development and learning and overall family functioning. Home visitors engage families in the process of building and nurturing relationships and encourage participation in experiences that promote children's learning and development.		
Attributes	• Appreciates the importance of developing trusting, mutually respectful relationships with families. • Honors the diversity and uniqueness of each family. • Respects a family's decisions regarding parenting. • Appreciates the primacy of family-child relationships. • Respects the influence of culture on caregiving practices and family relationships. • Recognizes and respects the central role of families and parent/caregiver-child relationships in the care, development and well-being of unborn children, infants and toddlers.	
Knowledge	**K.2.1**	Understands the importance of first relationships to healthy development and attachment and recognizes the importance of nurturing, consistent, responsive and respectful parenting.
	K.2.2	Comprehends how family dynamics influence children's learning and development and how factors such as violence, addiction and mental health issues, incarceration, poverty, isolation and safety affect healthy family functioning.
	K.2.3	Is familiar with how to screen for domestic violence and how to provide appropriate referrals and support.
	K.2.4	Understands how family engagement in home visiting positively impacts children's learning and development; recognizes the importance of developing trusting, mutually respectful relationships with families to encourage engagement.
	K.2.5	Understands the importance of engaging families by assessing and building on existing family strengths and culture.
	K.2.6	Recognizes the primacy of the parent-child relationship and understands the impact of family, culture, religion, language, temperament and gender on these relationships.

2. Dynamics of Family Relationships and Engagement		
Knowledge	**K.2.7**	Is familiar with the influences of intergenerational relationships within the family structure.
	K.2.8	Understands the dynamics of various types of relationships: child to family, family to peer, family to community and the influence that culture has on these relationships.
	K.2.9	Recognizes the unique contributions of male caregivers in relation to children's learning and development
Skills	**S.2.1**	Supports healthy parent-child interaction and offers positive support and guidance to families as children develop.
	S.2.2	Promotes the primacy of the parent-child relationship and offers positive, culturally and linguistically supportive guidance to families as children develop. Supports healthy parent-child interactions.
	S.2.3	Effectively assesses for domestic violence and provides appropriate referrals to ensure that a safety plan and supports are in place as needed.
	S.2.4	Utilizes strategies to build rapport with families and to develop a trusting, mutually respectful relationship with families. Works to maintain this relationship and keep families engaged in the program throughout the home visiting process.
	S.2.5	Assesses protective and risk factors from a strengths-based perspective. Implements strategies to effectively communicate with families of linguistic or cultural backgrounds that are different from one's own.
	S.2.6	Promotes the primacy of the parent-child relationship and understands the impact of family, culture, religion, language, temperament and gender on these relationships. Offers positive, culturally and linguistically supportive guidance to families as children develop.
	S.2.7	Supports and encourages primary and extended family members' involvement and engagement with children's learning and development.
	S.2.8	Supports attachment relationships between families and children. Honors cultural and community influences and the unique qualities of these relationships.
	S.2.9	Supports and encourages the unique contribution of fathers and male caregivers in children's learning and development.

3. Family Health and Well-Being

Home Visitors value the culture and unique dynamics of each family and understand that to effectively support children they must understand and include the context and social connections of each family. Partnering with families by creating supportive and responsive relationships through a strength-based approach is crucial in ensuring the health and well-being of each child.

Attributes	• Values the importance of the caregiver's health and well-being on the family system. • Respects a family's decisions regarding health care and family health. • Values prevention and health promotion activities. • Respects the influence of culture on health care and healing practices.
Knowledge	**K.3.1** Understands how trauma has compounding effects on families and communities. **K.3.2** Recognizes the effects of chronic stress on a family system. **K.3.3** Understands how family well-being can be affected by poor health, poor birth outcomes, maternal depression, mental health challenges and other bio-psycho-social factors. **K.3.4** Comprehends preconception, prenatal and postpartum health and development and how these affect development across the lifespan. **K.3.5** Possesses knowledge in early childhood health and development and understands how to navigate healthcare systems to promote physical health. **K.3.6** Understands the principles of home safety for young children and how to assist families in creating safe environments for children while honoring the family's culture and beliefs. **K.3.7** Recognizes the signs and symptoms of abuse: is familiar with the definitions of child abuse and neglect according to Oregon law and understands mandatory reporting laws. **K.3.8** Understand the impact and importance of family planning and how birth intervals impact the health and well-being of parents and children. **K.3.9** Understands the concept of a medical and dental home and is familiar with resources for primary care in the community. **K.3.10** Recognizes that families may access health care, but not necessarily receive equitable services due to cultural biases or differences.
Skills	**S.3.1** Responds to families who have experienced various types of trauma with an approach that reflects trauma informed principles. **S.3.2** Works effectively with individuals exhibiting symptoms of chronic stress, including differences in perception and learning, emotional regulation, and impairments in planning, executing and processing functions. **S.3.3** Utilizes skills such Motivational Interviewing, coaching, reflective listening and other non-coercive and culturally responsive strategies for supporting behavior change related to health and well-being. **S.3.4** Provides culturally specific information to families about preconception, prenatal and postpartum health. Assists mothers in accessing healthcare services to promote healthy pregnancies and positive birth outcomes. Encourages healthy nutrition, participation in prenatal and postpartum visits and other health promotion activities.

3. Family Health and Well-Being		
Skills	**S.3.5**	Provides information to families about early childhood health and development. Utilizes a culturally-sensitive approach to assist families in accessing healthcare services and encourages healthy nutrition, participation in well-child visits, adherence with immunization schedules, and other health promotion activities.
	S.3.6	Assists families in developing culturally relevant safety and crisis plans; helps to create safe environments for children.
	S.3.7	Applies knowledge of child abuse and neglect reporting laws to appropriately report child maltreatment as required by law.
	S.3.8	Provides information to families about family planning and birth intervals; makes appropriate referrals to healthcare providers.
	S.3.9	Ensures that families are connected to a primary care provider and makes appropriate referrals. Assists families in accessing health care as needed**.**
	S.3.10	Empowers families to advocate on behalf of their health care needs. Responds in a culturally sensitive manner to support families experiencing challenges in accessing equitable, culturally and linguistically appropriate health care services.

4. Family Self Sufficiency

Home Visitors recognize that families are dynamic, complex and ever changing systems that include a variety of relationships. Self-sufficiency is the goal for all families and may look very different depending on many factors. Home visitors honor the culture of each family system and actively engage family members in identifying and working towards self-sufficiency, as defined and desired by the family.

Attributes	•	Appreciates the economic, societal, historical and cultural influences that contribute to the family context and identity.
	•	Appreciates how the above influences impact family self-sufficiency
	•	Believes in the importance of empowering families to utilize their inherent strengths, resources and skills.
	•	Values collaborative problem solving and culturally responsive strategies.
	•	Believes that successful goal setting is accomplished in partnership with families and that families should take the lead in goal setting activities.
Knowledge	**K.4.1**	Is familiar with strategies to guide families in goal setting and supports families through empowerment.
	K.4.2	Comprehends the impact of economic stability on family and self-sufficiency.
	K.4.3	Understands methods to help families identify and access a variety of community resources in order to work toward self-sufficiency; understands the elements of service planning, coordination and collaboration.
	K.4.4	Recognizes the impact of racism, bias and other forms of discrimination toward families.

3. Family Self-Sufficieny	
Skills	**S.4.1** Partners with families to identify goals and objectives that align with families' strengths, interests and needs. **S.4.2** Assists families in achieving economic self-sufficiency. Supports and promotes family's interest and desire in pursuing educational and career pathways as a means toward self-sufficiency. **S.4.3** Takes appropriate initiative to seek culturally appropriate supports for children and families; engages in collaborative problem solving with families and other service providers**.** **S.4.4** Coaches families in becoming advocates for themselves; respects the cultural norms and uniqueness of each family.

5. Human Growth and Development Home Visitors have applicable knowledge of human growth and development, and specific knowledge of development of children from birth to age five. They utilize this knowledge to support their work with children and families. They recognize that development occurs on a continuum and that individuals develop at their own paces. Home Visitors respond to each developmental stage in research-based, culturally and linguistically responsive ways.	
Attributes	• Appreciates the linkages between mental, dental and physical health and development, including nutrition, across the lifespan. • Values the relationships between children and their families. • Appreciates families as learners and educators. • Respects the influence of culture on caregiving practices and developmental expectations of children. • Accepts that growth and development is an individual progression for children and their families; respects the natural cycle that occurs for each individual. • Values empowering families to understand their options for improving health and well-being.
Knowledge	**K.5.1** Understands typical and atypical growth and development from conception through infancy and early childhood. Considers the social, emotional, cognitive, language, physical and motor domains and cultural influences on health and development. **K.5.2** Recognizes how critical health behaviors such as smoking, alcohol or drug abuse, poor nutrition, lack of sleep, sedentary lifestyle and environmental factors influence health and development. Recognizes the effects of alcohol, tobacco and drugs on family and children's learning and development. **K.5.3** Recognizes how environmental factors, such as food access, safe housing and transportation impact family health and child development. **K.5.4** Understands the effects of stress and adverse childhood events (ACEs) on family well-being and children's learning and development. **K.5.5** Articulates resiliency factors such as safe nurturing environment and healthy relationships.

5. Human Growth and Development		
Knowledge	**K.5.6**	Recognizes the importance of attachment and bonding on social-emotional development and relationships.
	K.5.7	Understands how developmental delay, physical impairments and other disabilities may impact learning and development.
	K.5.8	Is familiar with and respectful of child rearing practices from a variety of cultures.
	K.5.9	Understands the context of development within the parent-child relationship.
	K.5.10	Understands that school readiness is multi-faceted and influenced by family culture, including secure attachments and relationships, physical health and wellness, social- emotional health and development, resiliency, language, communication and literacy skills, cognitive development and strong family supports.
Skills	**S.5.1**	Integrates specific knowledge of prenatal, infant and toddler stages of development and learning into work with families. Shares information regarding human growth and development with families and community members in a culturally and linguistically responsive manner.
	S.5.2	Assesses the impact of health and nutrition practices that affect health and well-being. Provides information regarding the impact of critical health behaviors. Implements culturally relevant strategies to assist families in supporting children's health, development and learning.
	S.5.3	Integrates knowledge of stress and adverse childhood experiences (ACES) in order to appropriately respond to families with whom they work.
	S.5.4	Problem-solves with families and communities to address environmental challenges to family health and well-being.
	S.5.5	Promotes healthy attachment and bonding within family relationships.
	S.5.6	Assesses for a variety of resiliency factors and family strengths to support family well-being and children's learning and development.
	S.5.7	Utilizes culturally responsive developmental screening tools to link families with supports and resources when issues are identified. Responds to development that has been recognized as atypical by families and/or clinicians; provides follow up by providing culturally and linguistically appropriate referral sources and supporting families through the process.
	S.5.8	Seeks out information about child rearing practices across cultures and applies this knowledge when working with families.
	S.5.9	Discusses development with families in culturally and linguistically responsive ways to help them recognize their child's individuality and emerging milestones
	S.5.10	Promotes school readiness behaviors including literacy, concentration, self-control, self-confidence, self-regulation and the development of thinking, reasoning and problem solving skills.

6. Professional Best Practices Home visitors adhere to the highest ethical conduct and best practices in their work with families. They integrate information from new research and emerging practices and follow all laws and regulations. They are committed to serving children by valuing the uniqueness and culture of each family. Home visitors use appropriate and effective verbal and written communication skills.	
Attributes	• Values creating positive, goal-oriented relationships with families. • Maintains confidentiality at all times. • Engages in authentic and honest interactions. • Values a high standard of integrity. • Believes in the importance of reflecting on one's own trauma history and its influence on building relationships with families. • Maintains responsibility for how one's own biases, values and attributes influence one's decisions, interventions and relationships. • Demonstrates the ability to build positive, trusting and culturally respectful relationships
Knowledge	**K.6.1** Understands the legal and ethical practices and policies related to serving families. **K.6.2** Describes how laws relating to child maltreatment impact professional practice and responsibilities. **K.6.3** Is aware of community resources and continually seeks out new resources to assist children and families. **K.6.4** Understands that each family has their own unique perspective and culture that might not be the same as the home visitor. **K.6.5** Understands safety practices for home visits and in community settings. **K.6.6** Demonstrates knowledge in professional ethics and boundaries. **K.6.7** Possesses knowledge of research-based curriculum and family systems theory. **K.6.8** Understand the concepts and benefits of reflective practice. **K.6.9** Is aware of various strategies for working with families that align with the language and culture of the family. **K.6.10** Understands the need for ongoing professional development in order to increase knowledge and skills in working with families.
Skills	**S.6.1** Maintains written notes and records to monitor screening, assessment, and progress; document concerns as required by their employing agency and upholds appropriate confidentiality of these records. Sustains appropriate boundaries and interactions with co-workers, families and other service providers. **S.6.2** Complies with all legal requirements of child protection, including mandatory reporting laws, which pertain to the home visiting role. **S.6.3** Provides and/or assures service coordination, referrals to community resources, and appropriate follow up. Works to build collaborative relationships with community partners to assure that families have access to services and supports that best fit their needs, language and culture.

6. Professional Best Practices		
Skills	**S.6.4**	Recognizes own bias and is self-aware, reflective, and culturally responsive with families, colleagues and community partners.
	S.6.5	Practices personal safety on home visits and in community settings.
	S.6.6	Acts within professional ethics and boundaries.
	S.6.7	Uses evidence-based practices and data in decision making and continuous quality improvement across the work.
	S.6.8	Participates in reflective practice and/or supervision and seeks opportunities to improve practice.
	S.6.9	Demonstrates the ability to employ a variety of strategies to work in partnership with families.
	S.6.10	Participates in professional development and learning activities to continually enhance knowledge and understanding.

7. Professional Well Being Home visitors understand that in order to provide effective services to families they must provide care for themselves. By being self-aware and seeking supports, the home visitor ensures they are ready to support families in a variety of settings.		
Attributes	• Identifies and reflects on the personal impacts of working with high needs families. • Values self-care to assure they remain effective and present with families. • Explores and acknowledges how biases, values and attitudes influence decisions, interventions and relationships. • Maintains responsibility to physical and mental health, recognizing that health impacts interactions with families and other service providers. • Values building positive relationships. • Is able to seek guidance or supervision when needed.	
Knowledge	**K.7.1**	Understands the principles of vicarious trauma and how it may affect their work with families, as well their own emotional and physical health.
	K.7.2	Understands the importance of taking care of one's own emotional and physical health; recognizes the importance of balancing work and personal life.
	K.7.3	Comprehends the importance of self-assessment and self-reflection and knows how to ask for support when needed.
	K.7.4	Identifies personal biases, judgments and assumptions and recognizes the potential impact on building relationships with families.
Skills	**S.7.1**	Recognizes the importance of reflecting on one's own trauma history as it relates to building relationships with families. Utilizes reflective supervision as a tool to manage potential vicarious trauma.
	S.7.2	Implements self-care to remain effective and present with families.
	S.7.3	Participates in reflective practice and/or and utilizes the opportunity to improve practice.
	S.7.4	Strives to mitigate the effects of personal biases, judgments and assumptions on professional relationships.

8. Screening and Assessment

Home Visitors utilize and understand the benefits of standardized, valid and reliable screening and assessment tools in order to offer the appropriate supports and follow-up for each family. They also use multiple screening and assessment strategies, recognizing that each family is unique and their strengths and needs may not be captured through the use of a single tool.

Attributes	• Values the influences that home structure, culture and relational dynamics may have on the results of screening and assessment. • Believes that effective screening and assessment processes are implemented in partnership with families. • Respects the impact that the administration and results of screening and assessment can have on children and families. • Appreciates the benefits of using standardized screening tools to identify areas of developmental need.
Knowledge	**K.8.1** Appreciates the benefits and limitations of using standardized screening tools. Understands how to follow through when issues are identified. **K.8.2** Recognizes the influence that culture and home language have on screening and assessment processes and that results may not represent the full scope of a child's development if screenings and assessments are delivered in a language other than the individual's first language. **K.8.3** Identifies how developmental delays, physical and other disabilities impact learning and development. **K.8.4** Understands social-emotional development and how it affects other areas of growth and development. **K.8.5** Understands how to screen for domestic violence and how to provide appropriate referrals and supports that are culturally and linguistically responsive. **K.8.6** Understands brain development concepts and how these can impact screening and assessment.
Skills	**S.8.1** Uses screening, observation and/or assessment strategies to inform planning and provision of appropriate services that promote optimal development. **S.8.2** Utilizes screening and assessment tools in a culturally and linguistically responsive manner. **S.8.3** Assists families who need support for any area of development. Provides appropriate referral sources and interventions that are culturally responsive and linguistically appropriate. **S.8.4** Utilizes screening and assessment tools to refer families when mental health supports are needed. **S.8.5** Conducts screening for domestic violence and provides appropriate referrals and support. **S.8.6** Employs a variety of intake tools to gather information to better understand the family's needs.

9. Service System Coordination Home Visitors provide leadership through sharing knowledge, expertise, and resources within an integrated system of supports. By seeing the connections and services beyond their own work, home visitors promote a collaborative and integrated system of service for children and families.	
Attributes	• Values being an active team member; contributes knowledge, observations and recommendations to best meet the needs of families. • Believes that all agencies and organizations in the system have unique contributions that support families in the community. • Values and supports family driven decision-making. • Values confidentiality and ethical behavior for all aspects of sharing family information.
Knowledge	**K.9.1** Identifies the importance of partnering with families to develop goals and connecting with other service providers, as necessary, to support the achievement of goals for the family. **K.9.2** Understands the significance of clarity and consistency when communicating with families, team members and other service providers. **K.9.3** Is familiar with an array of local resources within the community to serve families. **K.9.4** Articulates the guidelines required to share family plans with community partners and other service providers. **K.9.5** Is familiar with resources for health insurance coverage for families. **K.9.6** Understands the potential emotional impact on families and home visitors as families transition into lower levels of care and/or out of the home visiting program. **K.9.7** Is familiar with resources and supports for families as they transition out of home visiting services.
Skills	**S.9.1** Engages with other services providers to create and maintain cross-agency and cross-work sector connections to best meet the individual needs of families. **S.9.2** Works collaboratively within a cross-sector team that may include members from multiple departments and agencies. Provides constructive feedback on referrals to the original source and fosters collegial relationships across disciplines to share outcomes. **S.9.3** Assists families to anticipate and obtain needed services from public and community resources. **S.9.4** Follows appropriate procedures for sharing family information and plans with partners and system organizations. **S.9.5** Assesses each family's health insurance status and provides resources and/or referrals for health insurance coverage as needed. **S.9.6** Partners with families to make decisions about appropriate levels of care based on need and program requirements. Engages in reflective practice and seeks supervision as needed to meet the home visitor's needs throughout transitions. **S.9.7** Develops transition plans with families that address short-term and long-term strategies for successfully transitioning out of home visiting. Makes appropriate referrals for other resources as needed. Encourages families to develop support systems in their families and communities.

10. Social Emotional Well-being

Home visitors understand that social-emotional well-being is a critical component of human growth and development. By understanding the impact that healthy relationships and attachment have on the development of both the child and the family, home visitors can educate and support families in respectful and culturally responsive ways.

Attributes	• Appreciates the unique social-emotional developmental process of each child. • Values all children as contributing members of their families and communities. • Values the strengths, capacities and individuality of each child. • Appreciates the critical role that healthy attachment has on child development.
Knowledge	**K.10.1** Understands social-emotional development of young children and how it affects other domains of learning and development. **K.10.2** Is familiar with the effects of Adverse Childhood Experiences (ACEs) and historical trauma. **K.10.3** Is able to describe the four types of attachment and how to assess the quality of attachment between the caregiver and child. **K.10.4** Understands how drug or alcohol abuse affects healthy family functioning and is able to respond and/or refer families in need of support. **K.10.5** Understands the relationship of the physical environment and healthy relationships: child-to-family, family-to-peer and family-to-community. **K.10.6** Recognizes the family's role in supporting the child's development of self-regulation. **K.10.7** Understands typical and atypical child development. Understands how children and other family members with special needs impact family dynamics and the overall health and well-being of the family.
Skills	**S.10.1** Assists families in supporting the social-emotional development of their children and provides strategies to support positive parenting behaviors. **S.10.2** Utilizes strategies to support families to effectively manage chronic stress and trauma. **S.10.3** Provides information to families about attachment and supports healthy attachment between the caregiver and child. **S.10.4** Identifies and refers families in need of supports for drug and alcohol abuse. **S.10.5** Supports the primacy of the parent-child relationship and understands the impact of family, culture, religion, language, temperament and gender on these relationships. **S.10.6** Educates families on supporting the child's development of positive social skills, self-expression and self-regulation. **S.10.7** Recognizes and supports family members with special needs. Provides information, referrals and coordination with other community agencies, as needed.

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Workforce Development Resources:
https://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HomeVisiting/Pages/WorkforceDevelopment.aspx

GLOSSARY OF TERMS

ACEs: The Adverse Childhood Experiences Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. It is critical to understand how some of the worst health and social problems in our nation can arise as a consequence of adverse childhood experiences. Realizing these connections is likely to improve efforts towards prevention and recovery.

Attributes: Attribute is defined as a quality or characteristic of a person, place or thing.

Atypical Development: When children exhibit behaviors that fall outside of the typical, or expected, range of development. These abilities emerge in a way or at a pace that is different from their peers.

Best Practice: A method or technique that has consistently shown results superior to those achieved with other means.

Bias: A particular tendency, trend, inclination, feeling, or opinion, especially one that is preconceived or arbitrary.

Birth Intervals: The time elapsed between a completed pregnancy and the termination or completion of the next pregnancy. Parents manage the interval between births for personal, psychological, or economic reasons. Intervals of less than 17 months or more than 5 years increase the risk of certain maternal and child health problems, such as preeclampsia, eclampsia, low birth weight, preterm birth, and maternal mortality.

Bonding and Attachment: The non-verbal emotional relationship between a child and a caregiver defined by emotional responses to the baby's cues as expressed through movements, gestures and sounds. The success of this relationship enables a child to feel secure enough to develop fully and affects how he/she will interact, communicate and form relationships throughout life.

Boundaries: The limits of one's personal space and time, including physical, psychosocial, and interpersonal domains.

Collaborative Problem Solving (CPS): CPS is an approach to understanding and helping children with behavioral challenges originated by Ross W. Greene and originally described in his book The Explosive Child. The CPS model views behavioral challenges as a form of learning disability or developmental delay. In other words, behaviorally challenging children are lacking crucial cognitive skills, especially in the domains of flexibility, frustration tolerance, and problem-solving. Dr. Greene's model seeks to create fundamental changes in interactions between children with behavioral challenges and their adult caregivers by having caregivers engage children in solving problems collaboratively.

Culture: The learned and shared knowledge that specific groups use to generate their behavior and interpret their experience of the world. It includes but is not limited to: thoughts, beliefs, languages, values, customs, practices, courtesies, rituals, communication roles, relationships, expected behaviors.

Cultural Competence: The process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms and values the worth of individuals, families and communities and protects and preserves the dignity of each. Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes.

Cultural Healing Practices: Treatments and remedies based in one's culture to heal sickness and illness. These may be alternative practices, or those outside of traditional Western medical practice.

Data Driven Services: Analyzing data and information to verify and measure the effectiveness of services. Using data helps organizations make informed policy and practice decisions, with the ultimate goal of improving outcomes for the families they serve.

Developmental Delay: When a child does not achieve developmental milestones within the typical range.

Disparity: Disparity is defined as a lack of similarity or equality, or a great difference. Although the term disparity is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.

Diversity: The concept of diversity encompasses acceptance and respect. It means understanding that each individual is unique, and recognizing our individual differences. These can be along the dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies. It is the exploration of these differences in a safe, positive, and nurturing environment. It is about understanding each other and moving beyond simple tolerance to embracing and celebrating the rich dimensions of diversity contained within each individual.

Engagement: Participation necessary to obtain optimal benefits from an intervention, i.e. the degree of attention during home visits.

Equity Lens: The Equity and Empowerment Lens (with a racial justice focus) is a transformative quality improvement tool used to improve planning, decision-making, and resource allocation leading to more racially equitable policies and programs. At its core, it is a set of principles, reflective questions, and processes that focuses at the individual, institutional, and systemic levels by: deconstructing what is not working around racial equity; reconstructing and supporting what is working; shifting the way we make decisions and think about this work; and healing and transforming our structures, our environments, and ourselves.
(Source: https://multco.us/diversity-equity/equity-and-empowerment-lens)

Evidence Based Program: A program is proven effective through research. Programs are considered to be evidence-based if they meet the following criteria: Evaluation research shows that the program produces the expected positive results; The results can be attributed to the program itself, rather than to other extraneous factors or events; The evaluation is peer-reviewed by experts in the field; and The program is "endorsed" by a federal agency or respected research organization and included in their list of effective programs.
Family System: The social interactions, patterns, and interdependence that exist between members of families.

Fetal Alcohol Spectrum Disorder (FASD): Fetal Alcohol Spectrum Disorder is a continuum of various permanent neurological and congenital birth defects caused by fetal exposure to alcohol during pregnancy.

FERPA: The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

Health Equity: Refers to the attainment of the highest level of health for all people. Health equity involves focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices.

High-risk Concerns: Unsafe conditions that can affect the family or child's safety, health or living situation in a negative way. For instance, domestic violence, substance abuse, untreated mental health disorders, and unsafe living conditions.

HIPAA: The Health Insurance Portability and Accountability Act of 1996 is a federal law that provides federal protection for individually identifiable health information and gives patients an array of rights with respect to that information.

Historical Trauma: Refers to cumulative emotional and psychological wounding, extending over an individual lifespan and across generations, caused by traumatic experiences. The historical trauma response (HTR) is a constellation of features in reaction to this trauma.

Inclusion: The act of creating environments in which any individual or group can be and feel welcomed, respected, supported, and valued to fully participate. An inclusive and welcoming climate embraces differences and offers respect in words and actions for all people. It is a respectful way of creating value from the differences of all members of our community, in order to leverage talent and foster both individual and organizational excellence.
Infant Mental Health: The ability to develop physically, cognitively, and socially in a manner which allows infants and toddlers to master the primary emotional tasks of early childhood without serious disruption caused by harmful life events. Because infants grow in a context of nurturing environments, infant mental health involves the psychological balance of the infant-family system. (World Infant Mental Health Association)

Intergenerational Trauma: Intergenerational trauma affects multiple generations of families. While each generation of that family may experience its own form and self-perceived degrees of trauma, the first trauma experience can be traced to current family challenges.

Marginalize: To put or keep someone in a powerless or unimportant position within a society or group.

Medical Home: A Medical Home is defined by seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

Motivational Interviewing: A collaborative, person centered form of guiding to elicit and strengthen motivation for change. Focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change.

Parallel Process: Parallel process occurs when two or more systems, individuals or groups, who have significant relationships with each other have similar thoughts, behaviors and cognition due to their relationship. One of the basic tenants of parallel process is "Do unto others as you would have them do unto others".

Preconception: Preconception health is a woman's health before she becomes pregnant. Understanding how health conditions and risk factors could affect a woman or her unborn baby if she becomes pregnant is at the forefront of preconception health.

Professional Burnout: Burnout can result from chronic exposure to suffering and often involves varying levels of exhaustion, cynicism, and reduced sense of accomplishment.

Prenatal: Prenatal care is the health care a woman receives while she is pregnant.

Protective Factors: Protective factors are conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk in families and communities that, when present, increase the health and well-being of children and families. Protective factors help parents to find resources, supports, or coping strategies that allow them to parent effectively, even under stress.

Reflective Supervision: Reflection in a supervisory relationship requires a foundation of honesty and trust. The goal is to create an environment in which people do their best thinking—one characterized by safety, calmness and support. Generally, supervisees meet with supervisors on a regular basis, providing material (like notes from visits with families, videos, verbal reports, etc.) that will help stimulate a dialogue about the work. As a team, supervisor and supervisee explore the range of emotions (positive and negative) related to the families and issues the supervisee is managing. As a team, they work to understand and identify appropriate next steps. Reflective supervision is not therapy. It is focused on experiences, thoughts and feelings directly connected with the work. Reflective supervision is characterized by active listening and thoughtful questioning by both parties. The role of the supervisor is to help the supervisee to answer her own questions, and to provide the support and knowledge necessary to guide decision-making. In addition, the supervisor provides an empathetic, nonjudgmental ear to the supervisee. Working through complex emotions in a "safe place" allows the supervisee to manage the stress she experiences on the job. It also allows the staff person to experience the very sort of relationship that she is expected to provide for infants, toddlers and families.
Reliable: Reliability refers to the repeatability of findings. If studies are done a second time, they have the same results, If more than one person is observing behavior or some event, all observers should agree on what is being recorded in order to claim that the data are reliable.

Research Based: Founded on facts and practices that have been based on research.

Resiliency factors: Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress — such as family and relationship problems, serious health problems or workplace and financial stressors. It means "bouncing back" from difficult experiences. A combination of factors contributes to resilience. Many studies show that the primary factor in resilience is having caring and supportive relationships within and outside the family. Relationships that create love and trust provide role models and offer encouragement and reassurance help bolster a person's resilience.

Retention: The act of keeping families enrolled and engaged in home visiting programs.

School Readiness: Children possessing the skills, knowledge, and attitudes necessary for success in school and for later learning and life.

Secondary Trauma Stress -also called Compassion Fatigue: Results from indirectly knowing about a traumatic event that has affected a significant other or trauma survivor. The symptoms are similar to posttraumatic stress disorder and can involve experiences of intrusion, avoidance and arousal.

Self-sufficiency: The ability to supply one's own needs without external assistance.

Self-reflection: Careful thought about your own behavior and beliefs.

Sexual orientation: A person's sexual identity in relation to the gender to which they are attracted.

Socio-economic status: The social standing or class of an individual or group. It is often measured as a combination of education, income and occupation.

Strengths-Based Approach: Strengths-based practice is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets. Working in a collaborative way promotes the opportunity for individuals to be co-producers of services and support rather than solely consumers of those services.

Stressor: A chemical or biological agent, environmental condition, external stimulus or an event that causes stress to an organism. An event that triggers the stress response may include: environmental stressors (elevated sound levels, over-illumination, overcrowding); daily stress events (e.g., traffic, lost keys, quality and quantity of physical activity); life changes (e.g., divorce, bereavement); workplace stressors (e.g., high job demand vs. low job control, repeated or sustained exertions, forceful exertions, extreme postures); chemical stressors (e.g., tobacco, alcohol, drugs); and social stressors (e.g., societal and family demands).
Stressors have physical, chemical and mental responses inside of the body.

Temperament: Traits which address an infant's level of activity, her adaptability to daily routines, how she responds to new situations, her mood, the intensity of her reactions, her sensitivity to what's going on around her, how quickly she adapts to changes, and how distractible and persistent she might be when engaging in an activity.

Trauma Informed Approach: Refers to how a program, agency, organization or community thinks about or responds to those who have experienced or may be at risk for experiencing trauma.

Trauma Sensitive: Working respectfully and collaboratively with an individual who has experienced trauma to promote personal healing and recovery.

Typical Development: When children's development usually follows a known and predictable course. The acquisition of certain skills and abilities is often used to gauge children's development. These skills and abilities are known as developmental milestones. Such things as crawling, walking, saying single words, putting words together into phrases and sentences, and following directions are examples of these predictable achievements. Although not all children reach each milestone at the same time, there is an expected time-frame for reaching these developmental markers.

Validity: Refers to the credibility or believability of research.

Vicarious Trauma: Is progressive and results from chronic exposure and engagement with trauma survivors. This form of work related trauma/stress results in changes in world views and sense of self – including sense of safety, trust, control, and spiritual beliefs.

Glossary Sources

Centers for Disease Control: Division of Violence Prevention: *http://www.cdc.gov/violenceprevention/acestudy/*
Explorable: *https://explorable.com/*
Learning Disabilities (LD) Online: *http://www.ldonline.org/*
Center on the Social Emotional Foundations of Early Learning:
http://csefel.vanderbilt.edu/resources/wwb/wwb23.html?utm_source=News+and+Notes+from+the+Field+No.+7+-+10-14-12&utm_campaign=news+%26+notes+Vol1&utm_medium=email
http://www.mentalhealth4kids.ca/healthlibrary_docs/PrinciplesOfStrength-BasedPractice.pdf
American Psychological Association: *http://www.apa.org*
Zero To Three: *http://www.zerotothree.org/*
World Infant Mental Health Association: *http://www.waimh.org/i4a/pages/index.cfm?pageid=1*
Help Guide- Mental health: *http://www.helpguide.org/mental/parenting_attachment.htm*

American Institute of Stress: *http://www.stress.org/military/for-practitionersleaders/compassion-fatigue/*
Healthypeople.gov: *http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities*
National Council on Aging: *http://www.ncoa.org/improve-health/center-for-healthy-aging/about-evidence-based-programs.html*
Office of Women's Health: *http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.html*
The Sanctuary Model: *http://www.sanctuaryweb.com/parallel-process.php*
Center for the Study of Social Policy: *http://www.cssp.org/reform/strengthening-families/2013/Core-Meanings-of-the-SF-Protective-Factors.pdf)*
US Dept. of Health and Human Services: *http://www.hhs.gov/ocr/privacy/hipaa/understanding/*
Motivational Interviewing Network: *http://www.motivationalinterviewing.org/*
Fetal Alcohol Spectrum Disorder Center for Excellence: *http://fasdcenter.samhsa.gov/askTheExpert/index.aspx*
US Dept. of Education: *http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html*
Healthy Families America:*http://www.healthyfamiliesamerica.org/home/index.shtml*
The Office of Head Start: *http://www.acf.hhs.gov/programs/ohs*
National Center for Cultural Competence: *http://nccc.georgetown.edu/*

APPENDIX C: Child and Family Well-being Measures Workgroup Final Report and Recommendations

Child & Family Well-Being Measures Workgroup

Final Report and Recommendations

Prepared for:

The Joint Subcommittee of the
Early Learning Council and the Oregon Health Policy Board

Submitted on September 11, 2015

EXECUTIVE SUMMARY

Leaders and advocates across Oregon have rallied around national research that highlights the impact of early experiences on long-term well-being. Informed and inspired by this research, and based on the tenets of collective impact[1], representatives of the Oregon Health Policy Board and Early Learning Council formed a joint body in 2012 to work together to advance a common agenda and shared goals that align Oregon's health and early learning transformation efforts. The Joint Subcommittee assigned to a technical advisory committee, the Child and Family Well-being Measures Workgroup, the development of a shared measurement strategy to inform program planning, policy decisions, and allocation of resources for child and family well-being in Oregon. This report summarizes the activities and results of the workgroup, including a recommended library of measures to support such a strategy.

The Child and Family Well-being Measures Workgroup adopted two definitions of child and family well-being (one long and one short), identified six well-being domains and adopted eight selection criteria to guide decisions about which measures it would endorse for inclusion in a final measure library and in specific component measure sets. The group researched, identified, and compiled potential measures for individual review, discussion, final selection, and classification as "accountability" or "monitoring" measures.

The workgroup met monthly from September 2014 through September 2015 and developed the following recommendations for consideration by the Joint Subcommittee:

1. Adopt the definitions of child and family well-being and associated domains.
2. Adopt the recommended 67-item child and family well-being *measure library*.
3. Implement the 15-item child and family well-being *measure dashboard* for high-level monitoring.
4. Encourage the Oregon Metrics and Scoring Committee, Oregon Health Authority, Early Learning Council and the Early Learning Division of the Department of Education to consider the child and family well-being measures in the *accountability measure sets* for their management and contracting arrangements with Coordinated Care Organizations and Early Learning Hubs.
5. Review performance for the measures in the *monitoring measure set* periodically.
6. Support a successor body to the workgroup to serve as custodian of the child and family well-being library and measure sets, and to adopt or develop other measures of interest as they become feasible.

[1] See www.fsg.org/approach-areas/collective-impact.

I. BACKGROUND

In 2009, Oregon Governor John Kitzhaber signed House Bill 2009 creating the Oregon Health Policy Board, a nine-member board charged with overseeing and developing policy for the Oregon Health Authority. The Oregon Health Policy Board is responsible for broad health care payment and delivery system reform in Oregon. Two years later, Governor Kitzhaber signed Senate Bill 909, an education reform bill that established the Oregon Early Learning Council. The Early Learning Council directs the State's early learning programs and support services for children and families across Oregon.

In the fall of 2012, these two bodies formed the Joint Subcommittee to work collectively to identify a common agenda and achieve a set of shared goals as guided by the collective impact framework. Representatives from the Oregon Health Policy Board and Early Learning Council sit on the Joint Subcommittee, as well as leadership from the Oregon Health Authority, the Early Learning Division of the Department of Education, the Department of Human Services, and the Yamhill Community Care Organization and Early Learning Hub. Joint Subcommittee members develop and implement policies and strategies that coordinate and align Oregon's health, early learning and human services transformation efforts. By integrating policies, sharing resources, and aligning goals, the Oregon Health Policy Board and Early Learning Council intend to help children in Oregon get the health care, education and other services they need to thrive and be healthy.[2]

To advance its goals, the Joint Subcommittee appointed a technical advisory committee, the Child and Family Well-being Measures Workgroup, to develop recommendations for a shared measurement strategy focused on child and family well-being across Oregon. The Joint Subcommittee envisioned that the child and family well-being measures would inform program planning, policy decisions, and allocation of resources for children from birth to six years of age and their families. Policymakers and organizations at the state and local levels could use the measures to track progress against goals, identify opportunities for improvement, and prioritize their work. The workgroup agreed to identify a library of appropriate measures and to divide the measures into related and sometimes overlapping child and family well-being measure sets.

1) Accountability Measures: A set of cross-sector measures intended to assess the performance of Early Learning Hubs and Coordinated Care Organizations and to hold them accountable for progress in specific areas; although not a primary objective in measure set design, these measures could also be considered by the Oregon Department of Human Services for use in its performance-based contracting.

2) Monitoring: A measure set intended to assess and track factors that both indicate and contribute to child and family well-being at the state and local levels.

[2] See www.oregon.gov/oha/Pages/elc-ohpb.aspx.

The Child and Family Well-being Measures Workgroup, united in their dedication to ensuring positive child outcomes, included representatives with expertise in health care, early learning and education, human services, public health, and analytics. Helen Bellanca, Associate Medical Director at Health Share of Oregon, a Coordinated Care Organization, and Tim Rusk, Executive Director of Mountain Star Family Relief Nursery and leadership council member of the Early Learning Hub of Central Oregon, co-chaired the workgroup. A list of workgroup members and their affiliation follows below.

Name	Title	Organization
Helen Bellanca *Co-Chair*	Associate Medical Director	Health Share of Oregon
Tim Rusk *Co-Chair*	Executive Director	Mountain Star Family Relief Nursery
Pooja Bhatt*	Early Learning Manager	United Way - Columbia Willamette
Cade Burnett	Child & Family Services Director	Head Start, Umatilla-Morrow Counties
Janet Carlson	County Commissioner	Marion County
Bob Dannenhoffer	Interim CEO	Umpqua Community Health Center
Donalda Dodson	Executive Director	Oregon Child Development Coalition
Aileen Alfonso Duldulao	Maternal and Child Health Epidemiologist	Multnomah County Health Department
R.J. Gillespie	Pediatrician; Medical Director	Oregon Pediatric Improvement Partnership
Andrew Grover*	Assistant Director of Oregon Operations	Youth Villages, Inc.
Matthew Hough*	Pediatrician; Medical Director	Jackson Care Connect CCO
Sujata Joshi*	Project Director	Improving Data & Enhancing Access, Northwest Portland Area Indian Health Board
Martha Lyon	Executive Director	Community Services Consortium for Linn, Benton and Lincoln counties, on behalf of Community Action Partnership of Oregon
David Mandell	Early Learning Policy and Partnerships Director	Early Learning Division, Oregon Department of Education
Alison Martin	Assessment and Evaluation Coordinator	Oregon Center for Children and Youth with Special Health Needs, Oregon Health & Science University
Katherine Pears	Senior Scientist	Oregon Social Learning Center
T.J. Sheehy	Research Director	Children First for Oregon
Bill Stewart	Director of Special Projects	Gladstone School District
Peter Tromba	Policy and Research Director	Oregon Education Investment Board

* Denotes a member who was unable to remain active for the full duration of the process.

Dana Hargunani, Child Health Director and Rita Moore, Policy Analyst, both with the Oregon Health Authority, provided staff assistance to the workgroup. Michael Bailit and Michael Joseph of Bailit Health provided additional support and expertise throughout the process, as did several state agency staff members with content and measurement expertise in areas considered by the workgroup.

The workgroup met on a monthly basis from September 2014 through September 2015 to develop and recommend a child and family well-being library and component measure sets that Early Learning Hubs (Hubs), Coordinated Care Organizations (CCOs), Department of Human Services, and other state and local leaders could use to support their efforts. This report details the endorsed measures, the process by which the measures were developed and recommendations for implementing and using the measures. It also suggests areas for future exploration and development.

II. DEFINITIONS

The group adopted the following definitions to ensure a common understanding of key terms, and to guide planning, development, and decision-making.

Child and family well-being

The group adopted two definitions of child and family well-being, including a long definition and a short definition. Each definition follows below.

- Child and family well-being is the state of having generally positive experiences with education and employment, good relationships with family and friends, adequate financial resources to meet basic needs and wants, physical health and comfort, resiliency, freedom from chronic stressors such as discrimination and oppression, and a consistent sense of belonging to a community.

- Child and family well-being is when families are happy, healthy and successful in achieving their own life goals.

The workgroup elected to focus on measures of the well-being of families with children from birth to six years of age. On occasion the workgroup elected to consider measures reflecting teen-aged populations when the measures had a strong relationship to the adolescent's future parenting abilities. In other instances, adult measures pertaining to health care needs were included since parental and perinatal health is a critical factor in children's well-being.

Domains

Domains provide a framework for categorizing measures into primary focus areas. When choosing domains and measures, the workgroup agreed to include both positive elements (e.g., access) and deficits (e.g., unmet need) in the domain list. The workgroup identified and adopted the following six domains:

1. Relationships: Social-emotional development and relationships within the family as well as with the larger community
2. Economic Stability: Economic characteristics of individuals as well as broader community economic characteristics

3. Community: The environment within which children and families live
4. Comprehensive Person-Centered Health Care: Physical health, behavioral health and oral health, in keeping with Oregon's transformation efforts
5. Early Childhood Care and Education: Early learning and development experiences and outcomes for young children
6. Comprehensive Person-Centered System Integration: System goal alignment and coordination and communication across systems in a way that meets the needs of families

Measure selection criteria

The workgroup applied measure selection criteria to assess whether measures qualified for inclusion in the final measure set. The workgroup individually evaluated each measure according to the following nine criteria:

1. Evidence-Based and Promotes Alignment: The measure has been endorsed by a national body and/or there is peer-reviewed research evidence supporting the measure's validity and reliability for the group being measured and the measure promotes alignment with state and/or national efforts specific to child and family wellbeing.
2. Actionable and Timely: The measurement results are available soon after the event(s) being measured and these results can be applied by those being measured or those conducting measurement to initiate change.
3. Outcome-Related: The measure addresses actual outcomes (e.g., dental decay addressed), or there is evidence that what is being measured has a strong association with or predicts a positive outcome (e.g., more young children being read to as a predictor of greater kindergarten readiness).
4. High Impact: The measure assesses a system attribute with significant impact on child and/or family well-being.
5. Transformative: Improving performance relative to the measure would positively transform service delivery.
6. Appropriate for Audience: The measure is meaningful and useful to those evaluating or monitoring the performance of the measured entity or system.
7. Data are Readily Available: The data for calculating the measure are readily available and the entity responsible for generating, calculating or otherwise obtaining measurements can do so with currently available resources and with large enough denominators to produce reliable results for the measured population.
8. Supports Racial and Ethnic Equity: The measure lends itself to stratification by race, ethnicity, gender, language and/or geography (e.g., county and sub-county) as appropriate to highlight relevant disparities that warrant action.

III. MEASURE REVIEW PROCESS

To begin the process, the workgroup researched, identified, and compiled potential measures of child and family well-being measures. The workgroup drew measures from many sources, most of which were national measure sets in use in Oregon and across the country. The repository served as a dynamic resource for gathering candidate measures and key information about them in order to evaluate their potential value for inclusion in the final measure library. It included fields identifying the population (e.g., child or family), current use in Oregon, the measure's steward, data source, and current frequency of data reporting. Oregon Health Authority project staff used the repository to document the workgroup's deliberations of each measure. Project staff supplemented the measure repository over time with additional measures recommended by workgroup members and workgroup staff and consultants.

The workgroup considered 245 possible child and family well-being measures and selected 67 for inclusion in the final library. When reviewing measures for the Comprehensive Person-Centered Health Care domain, the group discussed existing accountability metrics that have been adopted for CCOs. To promote alignment, Oregon Health Authority staff compiled a list of metrics focused on health care for young children including the existing CCO metrics (both the CCO incentive measures and state performance measures). Measures of adolescent health and wellness were generally not included unless they related to future parenting; otherwise, the workgroup mostly endorsed the existing CCO measures. The workgroup also reviewed and, as appropriate, aligned measure specifications with the state's Early Learning Hub and Department of Human Services measures.

To arrive at a final library of measures, the group reviewed all candidate measures individually for each of the identified domains. Through a high-level, "first pass" review, workgroup members discussed the potential use of each candidate measure and decided to include or exclude the measure.

Using the selection criteria, Bailit Health consultants and Oregon Health Authority staff evaluated the measures the workgroup initially endorsed, and assigned scores to each measure according to how well they met the measure selection criteria. The workgroup held additional discussions about those measures that did not align well with the selection criteria to decide if it wanted to retain or exclude those measures.

After the initial review, the workgroup examined the following questions:

- What are the potential units of measurement for the measure, e.g., state, region/county, CCO, Early Learning Hub?
- What is the performance time period(s) for each measure, e.g., monthly, quarterly, semi-annually, annually?
- How long after the performance period are measurement results reported?
- What are available national benchmarks, if any, and when and for what time periods are they reported?

The workgroup categorized the measures that remained as accountability or monitoring measures. The workgroup did not consider the accountability and monitoring categories mutually exclusive, e.g., a measure could be an Early Learning Hub accountability measure and a monitoring measure. Classification into the accountability measure sets involved identifying whether CCOs, Early Learning Hubs, or both should be the accountable entity. Ultimately, the workgroup identified measures for consideration by the Oregon Metrics and Scoring Committee and the Hub Metrics Workgroup/Early Learning Council, the entities with authority to determine accountability measures for Oregon's CCOs and Hubs, respectively. The workgroup envisioned that some measures would serve as accountability measures solely for Hubs or CCOs, while others would hold Hubs and CCOs jointly accountable. While not a primary objective in measure set design, the Oregon Department of Human Services may choose to adopt some child and family well-being accountability measures for use in its performance-based contracting.

Challenges

During the measure identification and selection process, the workgroup confronted some challenges. These were some of the most vexing challenges:

- There were areas the group desired to assess, but could not identify an appropriate or valid measure that would yield meaningful results.
- Data on children only exist when a child has interacted with a system that collects information, creating an incomplete and often negative picture of childhood well-being in the state.
- Data gaps exist due to limited financial resources devoted to systematic collection, implementation, and monitoring of data points related to child and family well-being in the state.

The workgroup identified two measurement areas that are critically important for understanding child and family well-being in Oregon and which can serve as rallying points for aligned transformation efforts moving forward. Measure identification proved particularly challenging for both areas, however.

The first such area of particular interest to the workgroup was Adverse Childhood Experiences (ACEs) and other forms of toxic stress and the extent to which they shape child well-being in communities as well as lifelong health and well-being. These experiences can include physical, emotional and sexual abuse, racism, and other forms of discrimination, historical trauma and neglect and family dysfunction. There is perhaps nothing that impacts child and family well-being more than these issues, yet there is currently no real-time way to measure the extent to which ACEs are present in communities. The current state data source for ACEs is the public health Behavioral Risk Factor Surveillance Survey, which asks adults living in Oregon about what they experienced as a child. This measure is recommended for inclusion in a dashboard of priority measures, even though the adults surveyed may or not be parents, and the ACEs they

are reporting could be decades old. The workgroup felt that these adults are the caregivers, teachers and adults in children's lives currently and their own ACEs are part of children's environment. The limitations of this measure, and the fact that it is included in the recommended dashboard despite those limitations, speak to how strongly workgroup members felt about this issue. The workgroup recommends prioritization and development of a future ACEs measure that is more specific to communities and more actionable than that currently offered by the Behavioral Risk Factor Surveillance Survey.

The second area of interest to the workgroup was to create a "bundled" measure[3] of education and health measures to assess kindergarten readiness. This effort was intended to be the strongest example of how CCOs and Hubs could work together toward improving child and family well-being and having collective impact. The measure developed by the workgroup is outcome-focused (instead of process-focused), but requires the type of data collection and communication across sectors that currently is not feasible. The Joint Subcommittee previously reviewed the proposal and recommended delaying this type of bundled measure until data systems advance in their capacity to generate this type of measurement. See Appendix A for a detailed description of the bundled measure developed by the workgroup. As an alternative, the workgroup strongly recommends a set of "joint accountability" measures that transcend individual early learning and health care realms and which can drive collective impact towards kindergarten readiness.

IV. RECOMMENDATIONS

1. **Adopt the definitions and domains of child and family well-being.** A commonly accepted vernacular for discussing and assessing child and family well-being is necessary in order to devise and monitor the impact of strategies to effect improvements.

2. **Adopt the recommended child and family well-being measure library**. The measure library provides a compilation of valid and informative indicators of child and family well-being in Oregon. As a result, it can serve as a valuable resource and tool for monitoring, policymaking, management, and performance improvement.

3. **Implement a child and family well-being measure dashboard**. The workgroup recommends the implementation of a dashboard of select priority measures that together provide a portrait of child and family well-being and where measurement results will inform action, such as developing policies, establishing program priorities, and/or allocating resources. The Joint Subcommittee, Oregon Health Authority, Early Learning Division of the Department of Education, and Department of Human Services should review dashboard measures on a regular basis to identify implications for child and family well-being strategies in the state.

[3] A "bundled" measure in this context is a composite measure made up of multiple individual measures. It can be calculated using multiple methods depending upon the nature of the component measures.

The workgroup recommends the dashboard be comprised of the following high priority measures:

Measure	Frequency
I. Relationships	
Child Abuse and Neglect per 1000 Children	Annual
Disproportionality in Foster Care: The percentage of children in out-of-home placement by race and ethnicity compared to overall percentage of the under-18 population by race and ethnicity	Annual
Children with an Incarcerated Parent per 1000 Children Ages 0-18	Annual
II. Economic Stability	
Child Poverty Rate: The percentage of children estimated to live in families with incomes at or below the Federal Poverty Level	Annual
Food Insecurity Among Children: The percentage of households with children that reported reduced quality, variety, or desirability of diet or uncertainty about having enough food for all household members	Annual
III. Community	
Child Lives in a Supportive Neighborhood: The percentage of survey applicants who respond in agreement to four questions regarding their neighborhood being supportive	Was every 4 years; now annual
Rate of Crimes Against Persons, Property and Behavioral Crimes: The Rate of Crime per 1,000 Population.	Annual
The percentage of Adults Who Have Had 4 or More Adverse Childhood Experiences	Annual
IV. Comprehensive Person-Centered Health Care	
The Percentage of Children Who Have Received Developmental Screening by 36 Months	Annual
The Percentage of Children Ages 3 to 6 That Had One or More Well-Child Visits with a PCP During the Year	Annual
V. Early Childhood Care and Education	
Kindergarten Assessment: Average Score by Domain[4]	Annual
Early Childcare and Education Slots Available per 100 Children	Biannual
VI. Comprehensive Person-Centered System Integration	
Percentage of Children Lifted Out of Poverty by Safety Net Programs Based on the Supplemental Poverty Measure	Annual, using a 3-year rolling average
Rate of Follow-up to Early Intervention after Referral	Annual
Kindergarten Attendance Rate	Annual

The workgroup recommends the dashboard measures be stratified when reported in order to assess possible disparities, with stratification minimally including race and ethnicity whenever possible.

[4] Final kindergarten assessment measure specifications to be aligned with those in development by the Oregon Department of Education/Early Learning Division.

4. **Encourage the Oregon Metrics and Scoring Committee, Oregon Health Authority, Early Learning Council and the Early Learning Division of the Department of Education to consider child and family well-being accountability measures in their management and contracting arrangements with CCOs and Early Learning Hubs**, as is appropriate. Thoughtful and reasonable systems for accountability are necessary to motivate and ensure substantive improvements in performance. The final, endorsed CCO, Early Learning Hub, and Joint Accountability measure sets are in Appendices B, C, and D, respectively.

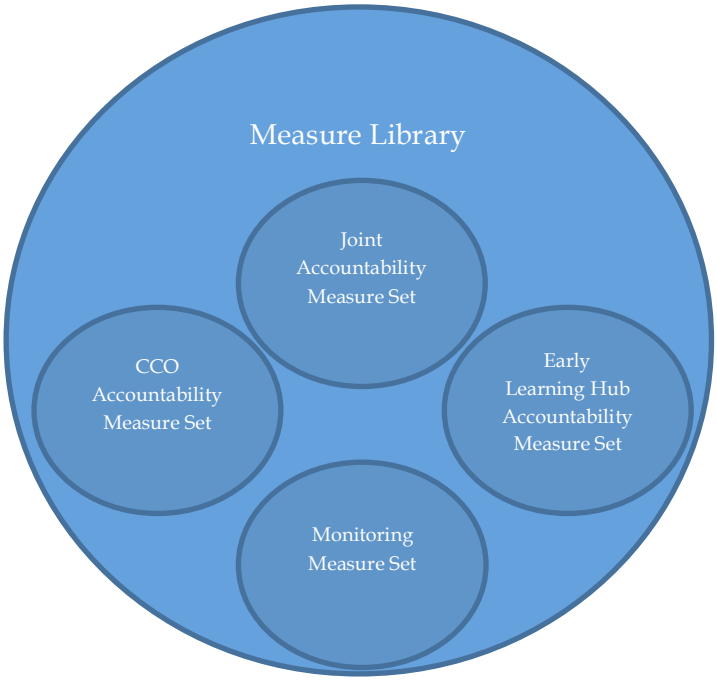
   The Department of Human Services does not currently utilize accountability measures in a similar manner as is used with CCOs or Early Learning Hubs. However, the workgroup recognizes that human services are critically important for assuring child and family well-being. As appropriate, the accountability measures recommended in this report may be considered by the Department of Human Services for use in its management and contracting arrangements.

5. **The Joint Subcommittee, Oregon Health Authority, Early Learning Division of the Department of Education and Department of Human Services should review performance for the measures in the monitoring measure set periodically**, but without the same level of priority assigned to review of the recommended dashboard. Appendix E includes the endorsed monitoring measures.

6. **The Joint Subcommittee should support a successor body to the workgroup to serve as custodian of the child and family well-being measure sets**. Ongoing modifications will be necessary as national measure sets change, new data sources become available, public policy priorities changes, and new opportunities for improvement present themselves.

Efforts to operationalize these recommendations should include, among other steps, making plans for measure generation, defining processes for dissemination of results to policy bodies and interested stakeholders (public and private), and defining processes for consideration of measurement results and taking action in response.

A visual depiction of the measure library and the individual measure sets contained within it follows below.



Future measure development recommendations

In addition to the above recommendations, the workgroup noted specific areas of measure development that it was unable to address, but feels are worthy of exploration.

- The workgroup recommends exploring future opportunities for implementing the kindergarten readiness bundled measure (see Appendix A), including an approach to addressing current data collection limitations.
- As noted earlier, the workgroup is interested in exploring improved measures that link to Adverse Childhood Experiences (ACEs) and the research on toxic stress.
- Future measure development related to incarcerated parents is a high priority for the workgroup, including a measure that provides community-level monitoring of the percentage of Oregon parents who are incarcerated.
- Further integration of human services into a child and family well-being measurement strategy is an important next step in advancing and aligning policies, strategies, and programs designed to evaluate, monitor, and improve child and family well-being in Oregon. The initial target for this group's work focused on children from birth to age six, but there is a desire to incorporate further measures specific to younger children (birth to three years of age) as such measures become available.
- Many of the desired measures are not currently feasible due to existing limitations in data sources. Families are the only source of information on many critical issues. The workgroup strongly suggests that the state consider reinstating a household survey. A household survey focused on child and family well-being would allow communities to

get a more comprehensive understanding of the strengths of Oregon's families as well as their challenges. It would allow the state and stakeholders to monitor many of the desired but currently unavailable measures and provide more timely data on the experiences of families. In particular, a household survey would allow the state to capture critical information about child care access and cost to families, neither of which are measurable with current data sources. The survey could also be designed in a way that provides improved sampling across race, ethnic, geographic and other subpopulation levels in order to highlight disparities that need to be addressed.

- Multiple additional areas of measurement for child and family well-being warrant future consideration and exploration (see Appendix F).

V. CONCLUSION

The recommended child and family well-being measures will enable the state and stakeholders to gain perspective on early learning, health and human service data points in the state for assessment, strategic planning and management. The measures promote cross-sector accountability and collective action toward a common goal of improving child and family well-being in the state. Local agencies should be encouraged to reference the measures set to guide decisions about disciplines and areas they should be monitoring, or to make comparisons across communities to identify where there may be an opportunity for reform. Entities that are not directly involved in early learning or early childhood health, for example departments of correction or the Governor's Reentry Council, may use the measures to make connections to their work and inform other transformative approaches to child and family well-being.

Appendix A
Kindergarten Readiness Bundle

The Child and Family Well-being Measures Workgroup identified *kindergarten readiness* as a key metric for both the health care delivery system and the early learning system. Whether or not children arrive at kindergarten ready to learn depends upon multiple health considerations (healthy growth and development, good dental care, control of chronic diseases), and also on whether or not they have acquired skills such as early literacy, numeracy and self-regulation. Kindergarten readiness depends on good health, family stability and community resources.

Measuring kindergarten readiness is a complex and daunting task. Indeed, some of the most important components of kindergarten readiness (such as healthy emotional bond with caregivers) are extremely difficult to measure. Nevertheless, the opportunity to build cross-sector accountability for kindergarten readiness is timely and unique in Oregon because of the joint transformation efforts in early learning and health care.

In April 2015, the workgroup presented the Joint Subcommittee with the following bundled measure proposal, including elements that meaningfully contribute to kindergarten readiness:

Kindergarten Readiness Bundled Metric Components
Denominator: Children who have their 5th birthday during the measurement year

Health Care Components
- Well-child check completed in past year
- Vision is normal or corrected
- Hearing is normal or addressed
- Immunizations are up to date
- Dental exam shows no active decay
- Children with a special health care need have a cross-system, family-centered, actionable shared care plan in place
- Family is screened for food insecurity/hunger
- Developmental screening has been completed in past year

Family components
- Parent/caregiver assessed for depression in past year
- Parent/caregiver assessed for substance use disorder in past year
- Parent/caregiver assessed for domestic violence in past year

Kindergarten Assessment components
- Children have behavior that facilitates learning (CBRS)
- Children have literacy skills
- Children have numeracy skills

Should the above kindergarten readiness bundle be implemented in the future, the workgroup recommends the following application:

- The measure should be implemented with a phased approach (see diagram below); the first two years should be dedicated to development and reporting only and not tied to an incentive pool.
- Year one implementation should focus on standardizing measure specifications via a technical advisory group.
- The kindergarten assessment (KA) should be further refined to address current limitations, such as the floor effect, before it is included as an accountability metric.
- Measures derived from the health system should be electronic health record (EHR)-based rather than measured through claims data.
- Measure should be an "all-or-nothing" measure, e.g., all components must be met to receive credit.
- At a minimum, measure should be disaggregated by race, ethnicity, and language
- Shared accountability for this metric will depend on the extent to which it is possible to build a shared incentive pool for both Hubs and CCOs.

Timeline

Phase 1: Development	Phase 2: Reporting	Phase 3: Accountability
Develop specifications on each of the elements Build EHR-based data tools CCOs and Hubs negotiate responsibility for elements and build cross-sector communication strategies	Reporting required for Health Care Components and Family Components Set benchmarks for all three components	KA components brought into bundle once ready Reporting on full bundle with incentive payment tied to performance in relation to benchmarks

Appendix B
Recommended Child and Family Well-being
Coordinated Care Organization (CCO) Accountability Measures[5]

Measure Name	Frequency of Data Update	Data Source
The Percentage of Children Who Received Well-Child Visits in the First 15 Months of Life	**Annual**	**Claims**
The Percentage of Children Who Have Received Developmental Screening by 36 Months	*Annual*	*Claims*
The Percentage of Children Ages 3 to 6 That Had One or More Well-Child Visits with a PCP During the Year	Annual	Claims
Among CYSHCN[6] who needed mental health/counseling, percent of CYSHCN who received all needed care	Annual	CAHPS[7]
Percentage of children less than 4 years of age on Medicaid who received preventive dental services from a dental provider in the year	Annual	Claims
Getting Care Quickly Composite - CAHPS 5.0H (child version including Medicaid and children with chronic conditions supplemental items)	**Annual**	**CAHPS**
Prenatal and Postpartum Care: Timeliness of Prenatal Care – The percentage of deliveries that received a prenatal care visit in the first trimester.	*Annual*	*Claims and Clinical Data*
Among CYSHCN who needed specialized services, percentage of CYSHCN who received all needed care.	Annual	CAHPS
Childhood Immunization Status: The percentage of children 2 years of age who have received specific immunizations.	*Annual*	*Claims and ALERT[8]*
Adolescent Well-Care Visit: The percentage of adolescents ages 12-21 who had at least one well-care visits with a PCP.	*Annual*	*Claims*
Percentage of patients with an outpatient visits who had alcohol or other substance misuse screening, brief intervention and referral to treatment	*Annual*	*Claims*

[5] Measures that are in italicized font are CCO incentive measures. Measures that are in boldface font are state performance measures per the state's CMS waiver.
[6] Children and Youth with Special Health Care Needs
[7] Consumer Assessment of Healthcare Providers and Systems survey version 5.0H (a child version including Medicaid and children with chronic conditions supplemental items). See www.cahps.ahrq.gov/.
[8] ALERT Immunization Information System. See https://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/alert/Pages/index.aspx.

Measure Name	Frequency of Data Update	Data Source
Percentage of women who adopted or continued use of effective contraception methods among women at risk of unintended pregnancy	*Annual*	*Claims*
Percent of Children with Sealants on Permanent Molars	*Annual*	*Claims*
Percent of Children with Mental, Physical and Dental Health Assessment within 60 Days for Children in DHS Custody	*Annual*	*Claims and DHS Data (OrKids)*

Appendix C
Recommended Child and Family Well-being
Early Learning Hub Accountability Measures

Measure Name	Frequency of Data Update	Data Source
I. Relationships		
Rate of Child Abuse and Neglect per 1000 Children	Annual	SACWIS[9]
Percentage of child population spending at least one day in foster care during federal fiscal year	Annual	SACWIS
II. Comprehensive Person-Centered Care		
The Percentage of Children with Well-Child Visits in the First 15 Months of Life	**Annual**	**Claims**
The Percentage of Children Who Have Received Developmental Screening by 36 Months	*Annual*	*Claims*
The Percentage of Children Ages 3 to 6 That Had One or More Well-Child Visits with a PCP During the Year	Annual	Claims
Percentage of children less than 4 years of age on Medicaid who received preventive dental services from a dental provider in the year	Annual	Claims
Childhood Immunization Status: The percentage of children 2 years of age who have received specific immunizations.	*Annual*	*Claims and ALERT*
II. Early Childhood Care and Education		
Percent of Children Meeting or Exceeding 3rd Grade Reading and Math Standards	Annual	Oregon Department of Education
Kindergarten Assessment: Average Score by Domain[10]	Annual	Oregon Department of Education
Availability of Rated Childcare Programs: Percent of regulated programs that have earned a step 3 or higher.	Biannual	QRIS[11]
Percentage of Children at Risk Enrolled in Rated Programs	Biannual	Childcare Research Partnership
Kindergarten Attendance Rate	Annual	Cumulative Average Daily Membership Collection

[9] Statewide Automated Child Welfare Information System. See www.oregon.gov/dhs/children/child-abuse/.../sacwis_2003.pdf.
[10] Final kindergarten assessment measure specifications to be aligned with those in development by the Oregon Department of Education/Early Learning Division.
[11] Quality Rating and Improvement System. See http://triwou.org/projects/qris.

Appendix D
Recommended Child and Family Well-being
Joint Coordinated Care Organization and Early Learning Hub
Accountability Measures

Domain	Measure Name	Frequency of Data Update	CCO Accountability	HUB Accountability	Joint
V. Early Childhood Care and Education	Kindergarten Assessment: Average Score by Domain[12]	Annual		X	X
V. Early Childhood Care and Education	Kindergarten Attendance Rate	Annual		X	X
VI. Comprehensive Person-Centered System Integration	Rate of Follow-up to Early Intervention after Referral	Annual			X
IV. Comprehensive Person-Centered Health Care	Percentage of children less than 4 years of age on Medicaid who received preventive dental services from a dental provider in the year	Annual	X	X	X
IV. Comprehensive Person-Centered Health Care	The Percentage of Children Ages 3 to 6 That Had One or More Well-Child Visits with a PCP During the Year	Annual	X	X	X
IV. Comprehensive Person-Centered Health Care	The Percentage of Children Who Have Received Developmental Screening by 36 Months	Annual	X	X	X

[12] Final kindergarten assessment measure specifications to be aligned with those in development by the Oregon Department of Education/Early Learning Division.

IV. Comprehensive Person-Centered Health Care	Among CYSHCN who needed specialized services, the percentage who received all needed care	Annual	X	X	X

Appendix E
Recommended Child and Family Well-being Monitoring Measures

Measure Name	Frequency of Data Update	Data Source
I. Relationships		
Rate of Child Abuse and Neglect per 1000	Annual	SACWIS
The Percentage of Adults Who Have Had 4 or Adverse Childhood Experiences (ACEs)	Annual	BRFSS[13]
Disproportionality in Foster Care: percentage of children in out-of-home placement by race and ethnicity compared to overall percentage of the under-18 population by race and ethnicity	Annual	U.S. Department of Health and Human Services, Children's Bureau, US Census Bureau Data
Absence of Repeat Maltreatment: percentage of abused/neglected children who were not subsequently victimized within 6 months of prior victimization	Annual	SACWIS
Connections to Community – Percent of Children Ages 0-5 Who Go on Outings	Historically every 4 years, going forward annual	National Survey of Children's Health
Pregnancy Related – Intimate Partner Violence Composite	Annual data at the state level are usually available 6 mos after the end of the survey year. National benchmark data are usually available with a 2-year delay.	PRAMS[14]
Percentage of Children Living in Single-Parent Families	Annual	US Census American Community Survey
Children Served by Child Welfare Residing In Parental Home	Annual	SACWIS
Percentage of Child Population Spending at Least One Day in Foster Care During Federal Fiscal Year	Annual	SACWIS
Intimate Partner Violence - Healthy Teens: Responses to two Survey Questions: Percent of 11th Graders Who	Biannual	Oregon Healthy Teens Survey

[13] Behavioral Risk Factor Surveillance System. See www.cdc.gov/brfss/.
[14] Pregnancy Risk Assessment Monitoring System. See www.cdc.gov/prams/.

Measure Name	Frequency of Data Update	Data Source
Reported Being Forced to Have Sexual Intercourse When They Did Not Want to. Percent of 11th Graders who Reported that Their Boyfriend or Girl Friend Physically Hurt Them.		
Rate of Emergency Department Visits Coded for Intimate Partner Violence	Annual, but with 18-22- month time lag for NEDS	OHA Oregon Emergency Department data/AHRQ for NEDS[15] data
Connections to Community - Children Participate in Extracurricular Activities – Percent of Children Ages 6-17 who participated in one or more extracurricular activities.	Historically every 4 years, going forward, annual	National Survey of Children's Health
II. Economic Stability		
Child Poverty Rate: The percentage of children estimated to live in families with incomes at or below the Federal Poverty Level	Annual	US Census Bureau - American Community Survey
Percent of Total Population by Federal Poverty Level	Annual	Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2012 and 2013 Current Population Survey Annual Social and Economic Supplements
Homeless students: percentage of all public school students without a decent, safe, stable, or permanent place to live	Annual	Oregon Department of Education Homeless Student Data Collection
Median Family Income	Annual	U.S. Census Bureau American Community Survey
TANF Family Stability: rate per 1,000 of children receiving TANF who subsequently entered foster care within 60 days	Annual	Client Maintenance System and Child Welfare Data Warehouse
Percent of Children In Low-Income Working Families By Age Group	Annual	U.S. Census Bureau American Community Survey
Percent of Children Living in Households Where No Adults Work	Annual	U.S. Census Bureau American Community Survey
Food Insecurity Among Children: The percentage of households with children that reported reduced quality, variety, or desirability of diet or uncertainty	Annual	Feeding America

[15] Nationwide Emergency Department Sample. See www.hcup-us.ahrq.gov/nedsoverview.jsp.

Measure Name	Frequency of Data Update	Data Source
about having enough food for all household members		
Percent of Children in Low-income Households with a High Housing Cost Burden	Annual	U.S. Census Bureau American Community Survey
III. Community		
Use of Fluorinated Water: Percent of population on public water systems receiving fluorinated water.	Biannual	CDC Water Fluoridation Reporting System
Children with an Incarcerated Parent per 1,000 Children Ages 0-18	Annual	Family Survey
Rate of Crimes Against Persons, Property and Behavioral Crimes: The rate of crime per 1,000 population.	Annual	Oregon Uniform Crime Reporting
Child Lives in a Safe Community: Percent of Children that Live in a Safe Community.	Historically, every 4 years, going forward, annual	National Survey of Children's Health
Neighborhood Amenities: Percent of children that live in neighborhoods with some of the following amenities: sidewalks and walking paths, a park or playground, recreation center, library or bookmobile.	Historically every 4 years, going forward, annual	National Survey of Children's Health
Child Lives in a Supportive Neighborhood: Percent of children that live in neighborhoods that their parents feel are supportive.	Historically every 4 years, going forward, annual	National Survey of Children's Health
IV. Comprehensive Person-Centered Health Care		
Percent of Women who Report Being Informed About Maternal Depression During and/or After Pregnancy by a Healthcare Worker	Annual. National benchmark data are usually available with a 2-year delay.	PRAMS
Percentage of Live Births Weighing Less Than 2500 Grams	Annual	Claims
Pregnancy Rate Among Adolescent Females Ages 14 and under and 15-19	Annual	Oregon Birth Records
Percentage of Preconception and Pregnant Women who Reported Drinking Alcohol	Annual. National benchmark data are usually available with a 2-year delay.	PRAMS
Infant Death Rate per 1,000 live births	Annual	Death Certificates
Percent of Mothers who Reported Breastfeeding 8 Weeks After Delivery	Annual. National benchmark data are usually	

Measure Name	Frequency of Data Update	Data Source
	available with a 2-year delay.	PRAMS
Percentage of Persons (Families, Parents, Mothers, Children and Adolescents) with Medical Insurance	Annual	National Health Interview Survey
Rate of Non-medical Exemptions for Immunizations	Annual	Oregon Immunization Data and ALERT
Getting Needed Care Composite	Annual	CAHPS
V. Early Childhood Care and Education		
5-year Completion Rate (GEDs, modified, extended, adult high school diplomas)	Annual	Oregon Department of Education High School Completers
Exclusionary Discipline Rates	Annual	Oregon School Discipline Data collection
Frequency of Reading to Young Children: Percent of children ages 0-6 read to during the week.	Annual going forward	National Survey of Children's Health
Kindergarten Assessment: Average Score by Domain[16]	Annual	Oregon Department of Education
Child Care Affordability Index	Biannual	Biennial Oregon Market Price Survey
Childcare and Education Availability: Early Childcare and Education Slots Available per 100 Children	Biannual	Childcare Research Partnership
Availability of Rated Childcare Programs Percent of regulated programs that have earned a step 3 or higher.	Biannual	Childcare Research Partnership
Compensation of Early Learning Center Workforce: Median low and median high wages for early learning center teachers and number of benefits offered.	Biannual	Childcare Research Partnership
Percentage of Children at Risk Enrolled in Rated Programs	Biannual	Childcare Research Partnership
Early Intervention (EI)/Early Childhood Special Education (ECSE) Child Outcomes	Annual	EI/ECSE Referral Data through ecWeb[17]
VI. Comprehensive Person-Centered System Integration		
Percentage of Low-income Oregonians Served by SNAP	Annual	DHS Food Stamp Management Information System and Census estimates
Percentage of Eligible Foster Youth Not Served by Independent Living Program Services	Annual	SACWIS
Percentage of Children Lifted Out of Poverty by Safety Net Programs Based on the Supplemental		Census Data: Supplemental Poverty

[16] Final kindergarten assessment measure specifications to be aligned with those in development by the Oregon Department of Education/Early Learning Division.

[17] Oregon's EI/ECSE Data System

Measure Name	Frequency of Data Update	Data Source
Poverty Measure	Annual, using a 3-year rolling average	Measure Public Use Research Files and Current Population Survey

Appendix F
Future Considerations

The workgroup identified the following areas for further exploration in measure development by the recommended successor body to the workgroup.

Relationships

- Perception of valuing one's cultural difference
- Parental engagement
- Parental stress
- Domestic violence

Economic Stability

- Savings/financial assistance
- Access to transportation
- Income gap, or upward mobility measure
- Housing stability
- Parental education level

Community

- Teen connectedness
- Social capital
- Livability
- Walkability
- Access to recreation/parks
- Food deserts

Comprehensive Person-Centered Health Care

- Maternal depression screening and follow-up
- Access to culturally responsive care
- Health disparities[18]

Early Childhood Care and Education

- Access to parenting education
- Access to affordable child care

Person-Centered System Integration

[18] The Oregon Health Authority reported that it had started work on a health equity composite measure for potential use with CCOs in 2017.

- Adequacy of service array
- Developmental screening and connected to resources
- Medicaid eligible and enrolled
- Shared care plan
- Obstetrician-to-pediatric care coordination
- Psychiatric medication follow-up for children in foster care
- Food insecurity screening and follow-up[19]

[19] The Metrics and Scoring Committee's technical advisory workgroup is currently working to develop specifications for an EHR-based food insecurity screening and follow-up measure

APPENDIX D: Home Visiting System Map

Oregon's Home Visiting System

GUIDING PRINCIPLES

Collaborative ● Accessible ● Timely ● Best Practices ● Outcome Driven ● Efficient ● Culturally Specific ● Family Driven

Through a comprehensive, coordinated and culturally responsive approach, it is the mission of Oregon's Home Visiting System to help pregnant women, children and families achieve optimal physical, mental and social wellbeing through partnerships, prevention, and access to appropriate and cost effective home visiting services and supports.

Referral In No Wrong Door

- Family Support Managers*
- 211
- Cultural Organizations
- Delivery/ Birth
- Faith Organizations
- Family, Friend, Neighbor
- Home Visiting Programs and Supports Agencies
- Libraries
- Other community services, resources and supports
- Prenatal Visit
- Schools
- Self Referral
- Shelters
- Social Services
- Well Child Visits/ Pediatrician

* As defined by the Early Learning Council

Home Visiting Entry Process

HV REFERRAL QUESTIONNAIRE: OBJECTIVE CRITERIA

Family Choice

- Eligibility
- Strengths/Needs
- Maximized use of evidence-based programs
- Program Capacity

Family Consent

SYSTEM WIDE DATABASE (shared database)

Current Home Visiting Program and Supports

- Babies First!
- CaCoon
- Early Head Start**
- Early Intervention
- Family Support and Connections
- Healthy Birth Initiative
- Healthy Start ~ Healthy Families Oregon**
- Maternity Case Mgt
- Nurse-Family Partnership**
- Parents as Teachers**
- Relief Nurseries

** Evidence-based program

Outcomes

Improvements in:

1) Maternal and Newborn Health
2) Child injuries, Child Abuse and Neglect (CAN), ER visits
3) School Readiness and Achievement
4) Domestic violence (DV)
5) Family Economic Self Sufficiency
6) Coordination of Referrals, Community Resources and Supports

Linkages to Community Services, Resources and Supports

- Cash Assistance
- Child growth and development resources
- Child safety and injury prevention resources
- Childcare
- Dental Care
- Early care and education
- Family Nutrition
- Family Supports
- Food Assistance
- Health Care
- Health Insurance
- Healthy pregnancy info and support
- Housing Assistance
- Jobs, training, adult education
- Mental Health
- Parenting supports and info
- Transportation
- 211/ Help me Grow

Revised: September, 2012: C:\Documents and Settings\NKNIGHT-COYLE\My Documents\September 22 Planning Committee\POST 9-22 MEETING MATERIALS-REVISED

Consent Agenda

- Committee Reports

Early Learning Council Child Care and Education Committee Report: May 25, 2016

Committee Charge: The Child Care and Education Committee (CCEC) is chartered to advise the Early Learning Council (ELC) on the issues, challenges, successes and priorities related to affordable, quality child care and early education programs in Oregon, to provide outreach and act as a liaison between citizens and the ELC through community forums and surveys to engage parents, early care and education providers and union representatives and to prioritize outcome based policies for child care and early education issues related to quality, affordability and system coordination.

Report:

The CCEC serves as the Early Learning Council's rule advisory committee for all rules related to early learning and development programs in Oregon under its authority. The CCEC has developed two workgroups to overview rules that govern programs funded by the Early Learning Division: Child Care workgroup with the current focus on rules for regulated subsidy providers; and the Preschool Promise workgroup and the full CCEC convened to provide the ELC recommendations rules for the Preschool Promise program.

Key Issues Discussed & Uncovered:

Review remaining Regulated Subsidy-Home-based rules that were not deliberated at last CCEC – the committee reviewed and offered suggestions written in the side-by-side (See attached)

Timeline and next steps for ELC

- May – first reading at ELC for Regulated Subsidy Provider rules
- June – ELC adopts rules for Regulated Subsidy Provider

Next steps for CCEC

- April/May – Regulated Subsidy provider rule recommendations to the ELC
- June 16th - Workgroup begin work on Relief Nursery rules – next meeting will be all education for the full CCEC
- Last day for public comments on RS is June 22nd at 5:00pm –
- Request to include a reminder in upcoming meetings with the date and location of where to submit public comments.

Upcoming Key Decisions:

The Child Care workgroup will meet in March to begin developing recommendations for the regulated subsidy provider. The Child Care workgroup will also design an input strategy process at their March meeting to ensure parents and providers are engaged to offer meaningful input.

Early Learning Council Best Beginnings Committee Report: May 25, 2016

Committee Charge: Advise the Early Learning Council on the issues, challenges, successes and priorities related to serving at risk families who are pregnant and/or have children age of 3 years old or under. Areas of responsibility include, but not limited to:

- Increasing access to home-based services
- Identifying state level policy changes that support family well-being and stability
- Increasing focus on critical aspects of development and attachment for children aged 0-3 and their families
- Finalizing and implementing a statewide screening tool and assessment protocol for family risk factors
- Developing best practice referral pathway for 0-3 services statewide

Committee Membership: Chair Martha Brooks, Vice-Chair Theresa Martinez, James Barta, Jessica Britt, Mercedes Castle, Christy Cox, Donalda Dodson, Beth Green, Lisa Harper, Marguerite Kenagy, Lindsey Manfrin, Salam Noor, Elena Rivera, Janet Dougherty-Smith

Report: The Best Beginnings Committee meets every-other month and will reconvene on July 21, 2016. The Committee met May 19, 2016.

Key Issues Discussed:
The announcement that Theresa Martinez, Early Learning Coordinator, Eastern OR Early Learning Hub will be the Vice Chair for the Best Beginnings Committee. Lisa Harper was welcomed to the committee as a new member.

Erin Deahn reported on a very successful HFO Managers Conference and Training held April 4-6, 2016. Feedback on the conference and training was very good with the hope that more of these events will happen. The sharing and exchanging of information and the in-person training is critical to the success, integrity, and fidelity of the statewide program. Erin Deahn and Linda Jones are commended for the great conference.

HFA Accreditation updated - HFO and all local sites will go through re-accreditation in 2017.

Upcoming Key Decisions:

The Best Beginnings Committee approved to move the Interim Budget Note Report out of committee and to the Early Learning Council. There will be a lot of work coming out of and through this budget note over the next 2 or more years for the Best Beginnings Committee, the Early Learning Council and the Oregon Health Authority Board to work on.

Home Visiting Budget Note recommendations – Continuation of the work from the budget note and assignment of committees for said work will start to occur through the Committee.

HFO Advisory Committee approved a change to the HFO Policy Manual for ASQ monitoring.

Donalda Dodson, Executive Director, Oregon Child Development Coalition and Christy Cox, Early Childhood Development Program Officer, Ford Family Foundation were appointed from the Best Beginnings Committee to serve on the Rules Committee reviewing Relief Nursery Rules. Meeting to start in June.

Staffed by:
Nakeshia Knight-Coyle, Program & Cross-Systems Integration Director, ELD
Erin Deahn, Healthy Families Oregon Statewide Coordinator, ELD

Early Learning Council Equity Implementation Committee **Report:** May 25, 2016

Committee Charge:
The Equity Implementation Committee is chartered to educate the Early Learning Council (ELC) on the issues, challenges, successes and priorities related to implementing the equity recommendations adopted by the Council on March 18, 2015. They are chartered to create an evidence-based, data driven plan relating to aligning early learning policy and practice with the equity lens, with a focus on culturally responsive practice, operating systems and data/resource allocation. The committee will assist the ELC in understanding equity issues from a data standpoint to help the ELC:

1. Actualize this information in setting policy for the early learning system.
2. Celebrate diversity.

Committee Membership: Lennie Bjornsen; Nicole Briggs; Cade Burnette; Carmen Ellis; Sadie Feibel Holmes; Joyce Harris; Rashelle Hibbard; Richard Hines Norwood; Charles McGee; Erin Moore; Francisca Perez; Eva Rippeteau; Lynne Saxton

Report:
The Equity Implementation Committee met May 16th in Portland.

Upcoming Key Decisions:

- What EIC would like to focus on moving forward – "caretakers of the forest"
  - Guidance to the greater ELC around adapting to the changing dynamics of diversity; trying to remove the "either/or" between poverty and race. Create an "either/and" dynamic.
  - Reviewing the EIC charge to make sure the work is reflected toward the ELC and we are doing the work we've committed to (pgs. 44-46)
  - Regular updates from program leads for equity reviews; encouragement to meet the equity lens
  - Programs EIC would like visits from:
    - Preschool Promise
    - QRIS Revision
    - Professional Development
    - Oregon Registry Online
    - Other committees/subcommittees of the ELC
  - June meeting: Preschool Promise presentation; QRIS revisions presentation; review of EIC guidelines

Staffed by:
Lillian Green, Equity Director, ELC
Karol Collymore, Public Affairs Director, ELD

Board Action Summary

AGENDA ITEM: Regulated Child Care Subsidy Rules

Summary of Recommended Board Action

ACTION: Discussion Item – First Reading of Regulated Subsidy Provider Administrative Rules

ISSUE: The Child Care and Development Block Grant Act of 2014 (CCDBG) requires states to develop health and safety requirements for all child care facilities that accept reimbursement through Child Care and Development Fund subsidy payments.

Oregon Revised Statutes 329A.505 authorizes the Office of Child Care to conduct on-site inspections when such inspections are required under federal Law and authorizes the Office of Child Care to require improvements or corrections necessary to bring provider into compliance. The administrative rules establish conditions and standards for compliance.

Due to these new requirements, the Early Learning Council must adopt administrative rules for regulation and monitoring of health and safety standards for programs that have been exempt from licensing due to the small numbers of children in care. The requirement becomes operative on November 19, 2016.

The Department of Human Services (DHS) is also promulgating administrative rules for requirements regarding eligibility and training which DHS is charged with regulating. Division staff is coordinating efforts with DHS to align Oregon Administrative Rules governing the program. DHS representatives serve on the CCEC workgroup making recommendations on Regulated Subsidy rules to ELC.

ACTION PRECEDING RECOMMENDED BOARD ADOPTION:

The Early Learning Division and the Department of Human Services conducted a series of engagement activities throughout the state on implementation of the new federal law. The primary goals of the engagement activities were to receive feedback on policy and rule considerations for the areas in which the state has interpretation flexibility. Input was gathered from diverse groups of stakeholders through open-ended questions on inspection approach and health and safety requirements; resources and supports for effective technical assistance; how standards might differ from licensed standards; concerns of providers and parents; training requirements; best methods of communication for parents and providers; and for centers, adult/child ratio.

The Child Care and Education Committee (CCEC), serving as the Council's Rules Advisory Committee, reviewed the feedback received through the statewide engagement activities already held and is developing further strategies and communication and outreach plans to solicit additional input from parents and providers.

The CCEC held three public meetings to review proposed administrative rules. There were areas which the CCEC deferred to the Council or did not reach consensus. Those issues and discussions are summarized in the supporting documents provided to the Council (5-19-16 Detailed Comparison of RF and RS rules).

At its March Council meeting, the Council received a briefing and reviewed a policy brief of the relevant policy issues.

BOARD MEMBER PRESENTING REPORT FOR ADOPTION: Bobbie Webber

CONTACT: Kim Parker, Chief of Staff
Dawn Woods, Child Care Director
Lisa Pinheiro, Policy Specialist

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Phone: 503-373-0066 | **Fax:** 503-947-1955

Child Care and Education Committee – Administrative Rule Summary

Title/OAR #: Chapter 414, Division 175 **Date:** May 25, 2016
Staff/Office: Dawn Woods, Child Care Director, Lisa Pinheiro, Early Learning Policy Specialist

☐ **Temporary Rule** ☒ **New Rule** ☐ **Amend Existing Rule** ☐ **Repeal Rule**
Hearing Date: ☐ **Hearings Officer Report Attached**
Prompted by: ☒ **State law changes** ☒ **Federal law changes** ☐ **Other**

Action Requested:
☐ **Adoption of Temporary Rule**
☒ **Adoption of Final Rule**

PROPOSED/AMENDED RULE RECOMMENDATION OPTIONS:

Adoption of Administrative Rules to set forth the Early Learning Division's Office of Child Care (OCC) procedures and requirements for the health and safety inspection of license-exempt child care homes subject to and in accordance with federal and state laws governing child care providers accepting subsidies.

BACKGROUND:

The Child Care Development Block Grant Act of 2014 requires the Early Learning Division to begin annual health and safety inspections of license exempt Child Care providers who accept federal subsidies. Oregon Revised Statutes 329A.505 authorizes the Office of Child Care to conduct on-site inspections when such inspections are required under federal Law and authorizes the Office of Child Care to require improvements or corrections necessary to bring provider into compliance. The administrative rules establish conditions and standards for compliance.

In addition to required areas the federal Office of Child Care suggests optional areas to consider when developing rules in states and territories. This document further identifies areas where the council may adopt general rules that are consistent with other sets of administrative rules for child care.

<u>Required under CCDBG</u>

Health and safety requirements

- The prevention and control of infectious diseases (including immunization) and the establishment of a grace period that allows homeless children and children in foster care to receive services while their families are taking the necessary action to comply with immunization and other health and safety requirements.

- Prevention of SIDS and use of safe sleeping practices.
- The administration of medication, consistent with standards for parental consent.
- The prevention of and response to emergencies due to food and allergic reactions.
- Building and physical premises safety, including identification of and protection from hazards that can cause bodily injury such as electrical hazards, bodies of water and vehicular traffic.
- Prevention of shaken baby syndrome and abusive head trauma.
- Emergency preparedness and response planning for emergencies resulting from a natural disaster or a man-caused event (such as violence at a child care facility).
- The handling and storage of hazardous materials and the appropriate disposal of bio contaminants.
- Appropriate precautions in transporting children.
- First aid and cardiopulmonary resuscitation (DHS rule)
- Minimum health and safety training, to be completed pre-service or during an orientation period in addition to ongoing training that addresses each of the requirements described above in the health and safety section. (DHS Rule)

Compliance with state and local health and safety requirements

- Providers and caregivers are in compliance with all applicable state and local health and safety requirements.

Compliance with child abuse reporting requirements

- The plan shall include that providers will comply with the child abuse reporting requirements.

Training and professional development requirements (in DHS rule)

- The plan shall describe the training and professional development requirements that are in effect within the state designed to enable child care providers to promote the social, emotional, physical and cognitive development of children and to improve the knowledge and skills of the child care workforce.
- The plan shall include the number of hours of training required for eligible providers and caregivers to engage in annually, as determined by the state.

<u>Optional under CCDBG</u>

- May include requirements relating to nutrition, access to physical activity or any other subject area determined by the state to be necessary to promote child development or to protect children's health and safety.

TIMELINE OF KEY ACTIVITIES & PUBLIC ENGAGEMENT:

The CCEC held three public meetings on Regulated Subsidy Provider administrative rules: February 18, March 31 and April 21, 2016. At the March public meeting, the committee reviewed public and stakeholder input on implementation of the new federal regulations.

Public comment on the proposed rule language is currently open and will close on June 22, 2016 at 5:00 p.m. Comments received will be summarized and made a part of the Council record.

ALIGNMENT WITH RULES PRINCIPLES:

1. Standards and rules aim to ensure that children are in safe environments that promote healthy physical, social, emotional and cognitive development and support high quality interactions among families and providers.

2. Standards and rules support and encourage diversity and equity; promoting equal access, especially for children from targeted populations**.**

3. Standards and rules are based on research, knowledge of child development, and best practices.

4. Standards and rules provide a foundation for high quality early learning and licensing rules serve as the first step of Oregon's Quality Rating and Improvement System.

5. In conducting its responsibilities for rule promulgation and revision, ELC is moving beyond a culture of compliance to one of continuous improvement.

6. ELC believes parents and children are primary stakeholders for all of its rules and will actively engage families and other impacted persons and organizations in rule promulgation and/or revision to ensure community/cultural norms are taken into consideration/reflected in rule.

7. ELC will aim for consistency across sets of rules over which it has authority, and will align rules with broader state goals and those of related agencies to the extent possible.

ISSUES/CONCERNS THAT SURFACED DURING RULE WORK:

There were a numbe of areas which surfaced during the Committee's discussions. Some include:

- Swaddling: CCEC discussed whether this rule violates a cultural norm of swaddling infants. Suggestion to allow parental permission to swaddle infants if the provider is trained in best practices, a parent may give consent for swaddling. CCEC did not reach consensus on this issue.

- Can a parent give permission to provider to give medication in instances and under the judgement of the provider.

- Safe Sleep:
    - Allowing a child to remain in a car set if the child is asleep when the child arrives at the child care home. Discussion of safe sleep. CCEC did not reach consensus on this issue.
    - Address flexibility in allowing for differences in cultural norms for appropriate sleeping arrangements.

- ADA requirements: Some of the ADA requirements are an issue for family homes, such as ramps.

- Monitoring and Inspections: Should providers be allowed private areas that are not subject to inspection?

- Following USDA Adult and Child Care Food Program: Meals and snacks must be based on the guidelines of the USDA Child Care Food Program. CCEC discussed whether this should be permissive or suggestive, but not mandatory. The CCEC did not reach consensus on this issue.

There were other areas which the CCEC deferred to the Council or did not reach consensus. Those issues and discussions are summarized in the supporting documents provided to the Council (5-19-16 Detailed Comparison of RF and RS rules).

FISCAL IMPACT:

Child Care facilities who accept federal subsidies are currently subject to health and safety requirements and self-attest compliance. These rules clarify and specifies health and safety rules and provides information on inspections as required by federal law. Because providers are already subject to health and safety requirements, we anticipate minimal fiscal and economic impact.

STAFF RECOMMENDATION:

☐ Adopt Temporary administrative rule
☒ Adopt Final administrative rule
☐ Repeal Rule
☐ No recommendation at this time

Comments: None

Regulated Child Care Subsidy Rules: Summary of Council Discussion on April 28, 2016

Overview:

When the Child Care Development Fund was reauthorized in 2014 it came with a requirement for a new set of rules around providers who are receiving CCDF funds to provide child care. One of the new rules is that all providers who are receiving subsidies, whether they are licensed or license-exempt, now need to be subject to regular health and safety monitoring. Since that regulatory monitoring function was something the Early Learning Division was already doing with licensing, the decision was to make the regulatory responsibility for providers under the Division since it was already aligned with work it was doing. This means the Council needs to make rules for these new health and safety monitoring for license-exempt providers.

Relative in Oregon the Reauthorization Act of 2014 left states the ability to put relatives under this or not. The Department of Human Services' decision around this with exempt providers was to not include relatives who are going to be exempt. Research shows that low-income families primarily use relatives, so we will see how large the population is that we are actually monitoring. A tight relationship exists between ELD and DHS; eligibility will remain with DHS, but health and safety inspections and rules reside within ELD. These rules will deal with health and safety and not with eligibility and training since those remain with DHS.

The CCEC has met many times and have identified two substantive issues within this work:

1) These rules are being written for a group of providers of care to children who are not regulated (legally-exempt – not an RF, CF or CC) and are home-based – think of them as friends and neighbors. We have a real challenge in terms of we have two goods we need to find the right balance for in the rules.
    a. One good relates directly to the families who use the subsidy program. Research shows that about 2/3 of them have barriers to using the regulated supply. Typically they work non-standard hours, unpredictable schedules or seasonal work, and/or they may be looking for cultural and linguistic congruity with their family. In these cases, it is really hard to find regulated care to meet these needs. These families have a real need for very flexible care. Oregon has created a subsidy program that does serve this population and gives these families the flexibility they need.
    b. The other good highlighted in the law is that these children deserve healthy, safe environments. They have maybe even more need for the kinds of protections that our rules processes are designed to provide children. That is clearly the legislative intent of Congress with the passage of the Reauthorization of 2014. No public dollars will be spent in a facility that we do not have evidence of providing a healthy and safe environment for children, and we can all agree to that.

So that challenge is that these two goods don't fit too well together, so CCEC has been trying to identify the "sweet spot." We are doing the best we can to find that, but you may disagree with this and we want you to think about this issue before you get the rules since you may think of a better way.

2) Issue 2 has to do with exempt centers. So we have in Oregon exempt centers who only provide part-day care or because they are run by a public agency and Oregon statute allows them to remain exempt. These programs typically don't serve the needs of this population very well because of their schedules, but for a very small population this is what these parents wants. We are still struggling with the estimate because estimating the publicly exempt is more complicated, but in terms of the other kinds of exempt part-day programs the estimate is very look and Bobbie's work has looked for years at where subsidy children are and it shows about less than1%. About half of our kids are in exempt family, friends and neighbor care. So the question that is in front of the Council – we already have a rather complex regulatory system for centers in

that we certify centers and we have something the legislature gave us called reported programs. They aren't required to be regulated, but they are required to tell ELD they exist and that their staff get criminal records checks. Whether they do it or not is not even completely clear; whether they know they need to isn't completely clear. The concern is that we would be adding a third category called Regulated Subsidy. Parents and providers have to understand what we are doing – is it really a good idea to add a third regulatory category for this small group of programs? Since this in the end would be the ERDC eligibility issue, this would also be a DHS policy. However, the ELC does have a role in communicating to DHS what we think is appropriate. We can as the Council give any advice that we think appropriate to DHS.

To clarify, these rules would only impact providers who are caring for less than 4 children from more than 1 family.

Takeaway:

The biggest takeaway is that we don't want to create an even more complex system or risk duplication of services between ELD and DHS. The Council has asked staff and the CCEC to determine how we comply with CCDF without placing so many burdens on families that they can't get the care they need because we are in a swirl of getting licensing inspections, etc. Staff have been tasked with providing a grid that shows the types of child care that exist in Oregon, the difference between those types, and an estimate of the children in each type of care.

To listen to the conversation in its entirety, watch the meeting at:

https://www.youtube.com/watch?v=ydfZZE-5GqE

Starts: 1:03:20

End: 1:59:21

Regulated Subsidy Administrative Rules

The Child Care and Development Block Grant Act of 2014 (CCDBG) requires states to develop health and safety requirements for all child care facilities that accept reimbursement through Child Care and Development Fund subsidy payments. In addition to required areas the federal Office of Child Care suggests optional areas to consider when developing rules in states and territories. This document further identifies areas where the council may adopt general rules that are consistent with other sets of administrative rules for child care.

Required under CCDBG

Health and safety requirements

- The prevention and control of infectious diseases (including immunization) and the establishment of a grace period that allows homeless children and children in foster care to receive services while their families are taking the necessary action to comply with immunization and other health and safety requirements.
- Prevention of SIDS and use of safe sleeping practices.
- The administration of medication, consistent with standards for parental consent.
- The prevention of and response to emergencies due to food and allergic reactions.
- Building and physical premises safety, including identification of and protection from hazards that can cause bodily injury such as electrical hazards, bodies of water and vehicular traffic.
- Prevention of shaken baby syndrome and abusive head trauma.
- Emergency preparedness and response planning for emergencies resulting from a natural disaster or a man-caused event (such as violence at a child care facility).
- The handling and storage of hazardous materials and the appropriate disposal of bio contaminants.
- Appropriate precautions in transporting children.
- First aid and cardiopulmonary resuscitation (DHS rule)

- Minimum health and safety training, to be completed pre-service or during an orientation period in addition to ongoing training that addresses each of the requirements described above in the health and safety section. (DHS Rule)

Child to provider ratio standards (for centers)

- The plan shall describe child care standards for group size limits for specific age populations, as determined by the state.
- The appropriate ratio between the number of children and the number of providers, in terms of the age of the children in child care, as determined by the state.
- Required qualifications for such providers, as determined by the state.

Compliance with state and local health and safety requirements

- Providers and caregivers are in compliance with all applicable state and local health and safety requirements.

Compliance with child abuse reporting requirements – in rule at DHS

- The plan shall include that providers will comply with the child abuse reporting requirements.

Training and professional development requirements – in rule at DHS

- The plan shall describe the training and professional development requirements that are in effect within the state designed to enable child care providers to promote the social, emotional, physical and cognitive development of children and to improve the knowledge and skills of the child care workforce.
- The plan shall include the number of hours of training required for eligible providers and caregivers to engage in annually, as determined by the state.

Optional under CCDBG

- May include requirements relating to nutrition, access to physical activity or any other subject area determined by the state to be necessary to promote child development or to protect children's health and safety.

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Federal Requirement Categories

(a) The prevention and control of infectious diseases (including immunization)

Registered Family Rules	Current DHS Rules	Suggested RS Rules	Yes/No - Suggestions
414-205-0100(1) The home must be a healthy environment for children.	461-165-0180(7) Each provider must: (n) Take reasonable steps to protect a child in his or her care from the spread of infectious diseases.	The child care home must be a healthy environment for children.	Yes
414-205-0100(1)(i) There must be at least one flush toilet and one hand-washing sink available to children. Steps or blocks must be available to ensure children can use the toilet and sink without assistance.		There must be at least one flush toilet and one hand-washing sink available to children.	Yes
414-205-0100(2) First aid supplies and a chart or handbook of first aid instructions shall be maintained in one identified place and kept out of reach of children. (a) The first aid supplies shall include: band aids, adhesive tape, sterile gauze pads, soap or sealed antiseptic towelettes or solution to be used as a wound cleaning agent, scissors, disposable plastic gloves for handling blood spills, a solution for disinfecting after a blood spill, a sanitary temperature taking device and CPR mouth guards.	DHS will consider rule for provider who is a relative	First aid supplies and a chart or handbook of first aid instructions shall be maintained in one identified place and kept out of reach of children. The first aid supplies shall include: band aids, adhesive tape, sterile gauze pads, soap or sealed antiseptic towelettes or solution to be used as a wound cleaning agent, a solution for disinfecting after a blood spill, a sanitary temperature taking device.	Yes as revised (blue language)
414-205-0100(4) A provider shall not admit or retain in care, except with the written approval of the local health office, a child who: (a) Is diagnosed as having or being a carrier of a child care restrictable disease, as defined in Oregon Health Authority administrative rule; or (b) Has one of the following symptoms or combination of symptoms or illness;		Except for mild cold symptoms that do not impair a child's daily functioning, sick children shall not be in care. A provider shall not admit or retain in care, except with the written approval of the local health office, a child who: (a) Is diagnosed as having or being a carrier of a child care restrictable disease, as defined in Oregon Health Authority administrative rule; or	Yes as revised

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(A) Fever over 100°F, taken under the arm; (B) Diarrhea (more than one abnormally loose, runny, watery or bloody stool); (C) Vomiting; (D) Nausea; (E) Severe cough; (F) Unusual yellow color to skin or eyes; (G) Skin or eye lesions or rashes that are severe, weeping or pus-filled; (H) Stiff neck and headache with one or more of the symptoms listed above; (I) Difficulty breathing or abnormal wheezing; (J) Complaints of severe pain.		(b) Has one of the following symptoms or combination of symptoms or illness; (A) Fever over 100°F, taken under the arm; (B) Diarrhea (more than one abnormally loose, runny, watery or bloody stool); (C) Vomiting; (D) Nausea; (E) Severe cough; (F) Unusual yellow color to skin or eyes; (G) Skin or eye lesions or rashes that are severe, weeping or pus-filled; (H) Stiff neck and headache with one or more of the symptoms listed above; (I) Difficulty breathing or abnormal wheezing; (J) Complaints of severe pain.	
414-205-0100(4)(b) A child, who, after being admitted into child care, shows signs of illness, as defined in this rule, shall be separated from the other children, and the parent(s) notified and asked to remove the child from the provider's home as soon as possible.		A child, who, after being admitted into child care, shows signs of illness, as defined in this rule, whenever possible will be separated from the other children, and the parent(s) notified and asked to remove the child from the provider's home as soon as possible.	Yes Note: correct rule citation will be added in final language.
414-205-0100(5) If a child has mild cold symptoms that do not impair his/her normal functioning, the child may remain in the provider's home and the parent(s) notified when they pick up their child.		If a child has mild cold symptoms that do not impair his/her normal functioning, the child may remain in the provider's home and the parent(s) notified when they pick up their child.	Yes as revised.
414-205-0100(6) Parents must be notified if their child is exposed to an outbreak of a communicable disease.		Parents must be notified if their child is exposed to an outbreak of a communicable disease.	Yes
414-205-0100(12) Any animal at the family child care home shall be in good health and be a friendly companion for the children in care.		Any animal at the provider's home shall be in good health and be a friendly companion for the children in care.	Yes
414-205-0100(12)(b) Dogs and cats must be vaccinated according to a licensed veterinarian's recommendations.		Dogs and cats must be vaccinated according to a licensed veterinarian's recommendations.	Yes

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414-205-0100(12)(c) Dogs and cats shall be kept free of fleas, ticks and worms.		Dogs and cats shall be kept free of fleas, ticks and worms.	Yes
414-205-0100(13) Animal litter boxes shall not be located in areas accessible to children or areas used for food storage or preparation.		Animal litter boxes shall not be located in areas accessible to children or areas used for food storage or preparation.	Yes
414-205-0100(15) Exotic animals, including, but not limited to: reptiles (e.g. lizards, turtles, snakes) amphibians, monkeys, hook-beaked birds, baby chicks and ferrets are prohibited unless they are housed in and remain in a tank or other container which precludes any direct contact by children. Educational programs that include prohibited animals and are run by zoos, museums and other professional animal handlers are permitted.		Exotic animals, including, but not limited to: reptiles (e.g. lizards, turtles, snakes) amphibians, monkeys, hook-beaked birds, baby chicks and ferrets are prohibited unless they are housed in and remain in a tank or other container which precludes any direct contact by children. Educational programs that include prohibited animals and are run by zoos, museums and other professional animal handlers are permitted.	Yes
414-205-0120(1) Pre-mixed sanitizers and disinfectants that are EPA registered and meet Oregon Health Authority criteria may be used in all areas of the home per manufacturer instructions.		Pre-mixed sanitizers and disinfectants that are EPA registered and meet Oregon Health Authority criteria may be used in all areas of the home per manufacturer instructions.	Yes
414-205-0100(2) All caregivers and children must wash their hands with soap and warm, running water: (a) Before handling food; (b) Before assisting with feeding; (c) Before and after eating; (d) After diapering; (e) After using the toilet; (f) After assisting someone with toileting; (g) After nose wiping; (h) After playing outside; and (i) After touching an animal or handling pet toys.		All caregivers and children must wash their hands with soap and warm, running water: (a) Before handling food; (b) Before assisting with feeding; (c) Before and after eating; (d) After diapering; (e) After using the toilet; (f) After assisting someone with toileting; (g) After nose wiping; (h) After playing outside; and (i) After touching an animal or handling pet toys.	Yes
414-205-0120(3) Hand sanitizers shall not replace hand washing. If hand sanitizers are present in the home, they shall be kept out of children's reach and shall not be used on children.		Hand sanitizers shall not replace hand washing. If hand sanitizers are present in the home, they shall be kept out of children's reach and shall not be used on children.	Yes

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414-205-0120(4) All toys, equipment and furniture used by children must be cleaned, rinsed and sanitized regularly and whenever soiled.		Clean toys, equipment and furniture used by children when soiled.	Yes
414-205-0120(5) Diaper changing surfaces must be either: (a) Non-absorbent and easily disinfected; (b) Disposed of after each use; or (c) Laundered after each use.		Diaper changing surfaces must be either: (a) Non-absorbent and easily disinfected; (b) Disposed of after each use; or (c) Laundered after each use.	Yes
414-205-0120(6) The diaper changing area shall be located so that hand washing can occur immediately after diapering without contacting other surfaces or children.			Yes
414-205-0120(7) The building and grounds must be maintained in a clean and sanitary manner.	461-165-0180(7)(o)(F) The building, grounds, any toy, equipment, and furniture are maintained in a clean, sanitary, and hazard free condition.	The building, grounds, any toy, equipment, and furniture are maintained in a clean, sanitary, and hazard free condition.	Yes
414-205-0120(8) All garbage, solid waste, and refuse must be disposed of regularly, in a safe and sanitary manner.		All garbage, solid waste, and refuse must be disposed of regularly, in a safe and sanitary manner.	Yes
414-205-0120(9) The home's water supply must be safe to drink.	461-165-0180(7)(o)(B) (B) The home or facility has safe drinking water.	The home has safe drinking water.	Yes
414-205-0120(10) Wading pools are prohibited for wading.		Wading pools are prohibited for wading. Child care children may engage in water play through the use of hoses and sprinklers. Wading pools are allowed for use as sand boxes.	Yes Add language about water play encouraged, sprinklers, hoses, etc. Wading pools can be used for sand boxes.
414-205-0075(1) The provider or a substitute provider is responsible for the children in care. At all times the provider or substitute provider must: (a) Be within sight or sound of all children; (b) Be aware of what each child is doing; (c) Be near enough to children to respond when needed;	461-165-0180(7) Each provider must: (j) Supervise each child in care at all times.	The provider is responsible for the children in care. At all times the provider must: (a) Be within sight or sound of all children; (b) Be aware of what each child is doing; (c) Be near enough to children to respond when needed;	Yes
414-205-0090(1) The provider must give the children's needs first priority, assuring that they get adequate care and attention.			Yes

414-205-0090(5) The provider must have routines for eating, napping, diapering and toileting, with flexibility to respond to the needs of each child.			Yes
414-205-0035(14) The provider must comply with local, state and federal laws related to immunizations, child care restrictable diseases, child safety systems and seat belts in vehicles, bicycle safety, civil rights laws, and the Americans with Disabilities Act.	461-165-0180(7) Each provider must: (s) Comply with state and federal laws related to child safety systems and seat belts in vehicles, bicycle safety, 461-165-0180(7) Each provider must: (m) Inform a parent of the need to obtain immunizations for a child.	The provider must comply with local, state and federal laws related to immunizations, child care restrictable diseases, child safety systems and seat belts in vehicles, bicycle safety, civil rights laws, and the Americans with Disabilities Act.	CCEC Discussion: Some of the requirements of the ADA are an issue for family homes, such as ramps.

(b) Prevention of SIDS and use of safe sleeping practices.

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0090(5)(b) Infants shall have a crib, portable crib or playpen with a clean, non-absorbent mattress. All cribs must comply with current Consumer Product Safety Commission (CPSC) standards. There shall be no items in the crib with the infant (e.g. toys, pillows or stuffed animals).	461-165-0180(7) Each provider must: (s) Comply with state and federal laws related to … crib standards under 16 CFR 1219 and 1220.	Infants shall have a crib, portable crib or playpen with a clean, non-absorbent mattress. All cribs must comply with current Consumer Product Safety Commission (CPSC) standards. There shall be no items in the crib with the infant (e.g. toys, pillows or stuffed animals).	Yes Must comply but does have financial impacts on family home providers. Address flexibility in use of sleeping arrangements for culturally appropriate sleeping norms.
414-205-0090(5)(a) An individual bed, mat or cot with individual bedding appropriate to the season shall be provided at nap time for each toddler and preschool-age child in the home and for each school-age child who wants to rest.			Yes
414-205-0090(5)(a)(A) Family beds or sofas may be used with individual bedding appropriate to the season.			Yes
414-205-0090(5)(a)(B)		If the parent(s) so request, siblings may share the same bed.	Yes

If the parent(s) so request, siblings may share the same bed.			
414-205-0090(5)(a)(C) The upper level of bunk beds shall not be used for children under ten years of age.		The upper level of bunk beds shall not be used for children under ten years of age.	Yes
414-205-0090(5)(a)(D) The upper level of bunk beds may be used for children ten years or older if the bed rail and safety ladder are in place.			Yes
414-205-0090(5)(c) If an infant uses a blanket, the blanket may not cover the infant's head or restrict the infant from moving.		If an infant uses a blanket, the blanket may not cover the infant's head or restrict the infant from moving.	**No Consensus** CCEC discussed whether this rule violates a cultural norm of swaddling infants. Suggestion to allow parental permission to swaddle infants if the provider is trained in best practices, a parent may give consent for swaddling.
414-205-0100(3) Infants must be laid on their backs on a flat surface for sleeping.	461-165-0180(7) Each provider must: (t) Place infants to sleep on their backs.	Infants must be laid on their backs on a flat surface for sleeping.	Yes
414-205-0100(11)(e) Children shall not be laid down with a bottle for sleeping.		Children shall not be laid down with a bottle for sleeping.	Yes

(c) The administration of medication, consistent with standards for parental consent.

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0100(7) Prescription and non-prescription medication shall only be given to a child if the provider has written authorization from the parent, as required in OAR 414-xxx-0130(3).	Considering rule for relative care	Prescription and non-prescription medication shall only be given to a child if the provider has written authorization from the parent.	CCEC Discussion: Is this a broad authorization or specific authorization for a specific medication? Can we allow a parent to give permission for the provider to use their best judgement in when and why to administer medication?
414-205-0100(8)		Prescription and non-prescription medications must be properly labeled and stored.	Yes

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Prescription and non-prescription medications must be properly labeled and stored.			
414-205-0100(8)(a) Non-prescription medications or topical substances must be labeled with the child's name.		Non-prescription medications or topical substances must be labeled with the child's name.	Yes
414-205-0100(8)(b) Prescription medications must be in the original container and labeled with the child's name, the name of the drug, dosage, directions for administering, and the physician's name.		Prescription medications must be in the original container and labeled with the child's name, the name of the drug, dosage, directions for administering, and the physician's name.	Yes
414-205-0100(8)(c) Medication requiring refrigeration must be kept in a separate, tightly covered container, marked "medication," in the refrigerator.		Medication requiring refrigeration must be kept in a separate, tightly covered container, marked "medication," in the refrigerator.	Yes
14-205-0100(9) Sunscreen is considered a non-prescription medication and may be used for child care children under the following conditions: (a) Providers must obtain written parental authorization prior to using sunscreen. (b) One container of sunscreen may be used for child care children unless a parent supplies an individual container for their child. The sunscreen shall be applied in a manner that prevents contaminating the container.		Sunscreen may be used with written parental authorization.	Yes.
414-205-0100(9)(b)(A) Parents must be informed of the type of product and the sun protective factor (SPF).			CCEC recommends not including this language
414-205-0100(9)(b)(B) Parents must be given the opportunity to inspect the product and active ingredients.			CCEC recommends not including this language

414-205-0100(9)(c) If sunscreen is supplied for an individual child care child, the sunscreen must be labeled with the child's first and last name and must be used for only that child.		.	CCEC recommends not including this language
414-205-0100(9)(d) Providers must reapply sunscreen every two hours while the child care children are exposed to the sun.		In instances where parent has provided written permission to use sunscreen, Providers must reapply sunscreen every two hours while the child care children are exposed to the sun.	Yes as revised.
414-205-0100(9)(e) Providers shall use a sunscreen with an SPF of 15 or higher and must be labeled as "Broad Spectrum".		Providers shall use a sunscreen with an SPF of 15 or higher and must be labeled as "Broad Spectrum".	Yes
414-205-0100(9)(f) Providers shall not use aerosol sunscreens on child care children.		Providers shall not use aerosol sunscreens on child care children.	Yes
414-205-0100(9)(g) Sunscreen shall not be used on child care children younger than six months.		Sunscreen shall not be used on child care children younger than six months.	Yes
414-205-0100(9)(h) Child care children over six years of age may apply sunscreen to themselves under the direct supervision of the provider or staff member.			CCEC recommends not including this language
414-205-0100(10) Parents must be informed daily of any medications given to their child or any injuries their child has had.		Parents must be informed daily of any medications given to their child or any injuries their child has had.	Yes
414-205-0130(1) The following records must be kept by the provider for at least one year and must be available at all times to OCC: (c) Medications administered, including the child's name, and the date and time of dosage and the dosage amount.		The following records must be kept by the provider for at least one year and must be available at all times to OCC: () Medications administered, including the child's name, and the date and time of dosage and the dosage amount.	Yes NOTE: Helpful for providers to have template and technical assistance in the information required to be collected from parents.

(d) The prevention of and response to emergencies due to food and allergic reactions.

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions

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414-205-0130(1)(a) The following records must be kept by the provider for at least one year and must be available at all times to OCC: (B) Any chronic health problem(s), including allergies, the child has; (I) Health history of any problems that could affect the child's participation in child care.		The following records must be kept by the provider for at least one year and must be available at all times to OCC: (B) Any chronic health problem(s), including allergies, the child has; (I) Health history of any problems that could affect the child's participation in child care.	Yes NOTE: Helpful for providers to have template and technical assistance in the information required to be collected from parents.
414-205-0130(3) The provider must have a written statement from the parent(s) regarding whether or not the provider is authorized to: (a) Obtain emergency medical treatment for a child.	Considering rule for relative care	The provider must have a written statement from the parent(s) regarding whether or not the provider is authorized to: (a) Obtain emergency medical treatment for a child.	Yes. Discussion occurred about creating an enrollment form that would include giving permission

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(e) Building and physical premises safety, including identification of and protection from hazards that can cause bodily injury such as electrical hazards, bodies of water and vehicular traffic.

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0100(1)(j) The room temperature must be at least 68°F during the hours the child care business is conducted.		The room temperature must be at least 68°F during the hours ~~the child care business is conducted.~~ child care children are in care.	Yes as revised.
414-205-0100(1)(k) Rooms occupied by children must have a combination of natural and artificial lighting.		~~Rooms occupied by children must have a combination of natural and artificial lighting.~~ Rooms child care children are predominantly occupying must have a combination of natural and artificial lighting.	Yes as revised. Discussion occurred about if this should be every room, including bathrooms. The intent where children spend the majority of their day when in child care. Use language that "rooms child care children are predominantly occupying".
414-205-0100(1)(l) Floors must be free of splinters, large unsealed cracks, sliding rugs and other hazards.		Floors must be free of splinters, large unsealed cracks, sliding rugs and other hazards.	Yes
414-205-0100(12)(a) Potentially aggressive animals must not be in the same physical space as the children.		Potentially aggressive animals must not be in the same physical space as the children.	Yes

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414-205-0110(1) Children shall be protected from fire and safety hazards. Providers must have the following protections in place: (a) All exposed electrical outlets in rooms used by preschool or younger children must have hard-to-remove protective caps or safety devices installed when the outlet is not in use. (b) Extension cords shall not be used as permanent wiring; (c) All appliance cords must be in good condition; (d) Multiple connectors for cords shall not be used; (e) A grounded power strip outlet with a built-in over-current protection may be used;		Children shall be protected from fire and safety hazards. Providers must have the following protections in place: (a) All exposed electrical outlets in rooms used by preschool or younger children must have hard-to-remove protective caps or safety devices installed when the outlet is not in use. (b) Extension cords shall not be used as permanent wiring; (c) All appliance cords must be in good condition; (d) Multiple connectors for cords shall not be used; (e) A grounded power strip outlet with a built-in over-current protection may be used;	Yes
414-205-0110(1) (f) A stable barrier shall be installed to prevent children from falling into hazards, including, but not limited to: fireplaces, heaters and woodstoves that are in use when child care children are present; (g) A secure barrier shall be placed at the top and/or bottom of all stairways accessible to infants and toddlers;	461-165-0180(7)(o)(D) Each fireplace, space heater, electrical outlet, wood stove, stairway, pool, pond, and any other hazard has a barrier to protect a child. Gates and enclosures have the Juvenile Products Manufacturer's Association (JPMA) certification seal to ensure safety.	(f) A stable barrier shall be installed to prevent children from falling into hazards, including, but not limited to: fireplaces, heaters and woodstoves that are in use when child care children are present; (g) A secure barrier shall be placed at the top and/or bottom of all stairways accessible to infants and toddlers;	Yes
414-205-0110(1) (h) A working smoke detector on each floor and in any area where children nap;	461-165-0180(7)(o)(C) The home or facility has a working smoke detector on each floor level and in any area where a child naps.	The home has a working smoke detector on each floor level and in any area where a child naps.	Yes
(i) A working fire extinguisher with a rating of at least 2-A:10-BC;			Yes
(j) Firearms, BB guns, pellet guns and ammunition kept under lock, with ammunition stored and locked separately. Firearms, BB guns and pellet guns must remain unloaded;	461-165-0180(7)(o)(E) Any firearm, ammunition, and other items that may be dangerous to children, including but not limited to alcohol, inhalants, tobacco and e-cigarette products, … are kept in a secure place out of a child's reach.	Firearms, BB guns, pellet guns and ammunition kept under lock, with ammunition stored and locked separately. Firearms, BB guns and pellet guns must remain unloaded;	Yes

(m) If any preschool age or younger children are in care, poisonous plants must be kept out of the reach of children;		If any preschool age or younger children are in care, poisonous plants must be kept out of the reach of children;	Yes
(n) All clear glass panels in doors clearly marked at child level.		(n) All clear glass panels in doors clearly marked at child level.	Yes
414-205-0110(2) All floor levels used by children must have access to two useable exits, as defined in OAR 414-xxx-0010(32), to the outdoors. (a) If a basement is used for child care purposes, the requirement for two useable exits may be met by one of the following: (A) A sliding glass door or swinging door to the outside and a window that meets the definition of a useable exit; or (B) A window which meets the definition of a useable exit and an internal stairway to ground level that has unobstructed and direct access to the outdoors. (b) If a window, which meets the definition of a useable exit, is used: (A) Steps must be placed under the window to allow children to exit without assistance; and (B) The window must be kept in good working condition. (c) If a window used as an exit has a window well, a mechanism must be in place to allow children to exit the window well.	461-165-0180(7) Each provider must: (o) Ensure that the home or facility where care is provided meets all of the following standards: (A) Each floor level used by a child has two usable exits to the outdoors (a sliding door or window that can be used to evacuate a child is considered a usable exit). If a second floor is used for child care, the provider must have a written plan for evacuating occupants in the event of an emergency.	Each provider must: (o) Ensure that the home where care is provided meets all of the following standards: (A) Each floor level used by a child has two usable exits to the outdoors (a sliding door or window that can be used to evacuate a child is considered a usable exit). If a second floor is used for child care, the provider must have a written plan for evacuating occupants in the event of an emergency.	Yes
414-205-0110(3) Second floors (does not apply to providers registered continuously at the same address before 2009, unless the provider has moved the child care license to a new residence): (a) Child care children shall not sleep on the second floor or above;			CCEC recommends not including this language

(b) Care shall not be provided for infants and toddlers on the second floor or above; (c) Night care shall not be provided on the second floor or above; (d) Children may be allowed on the second floor to use the bathroom if the only bathroom is on the second floor; (e) Care can be provided for preschool and school-age children on the second floor or above, if: (A) There are two staircases to the ground level and all children are mobile enough to exit safely; or (B) The designated fire marshal has approved the use of the upper floor.			
414-205-0110(5) A telephone in working condition must be in the family child care home.	461-165-0180(7)(o)(G) The home or facility has a telephone in operating condition.	The home has a working telephone or telephone service. ~~in operating condition~~.	**For ELC Consideration:** Yes with revisions. CCEC Discussion: Do we need to clarify that this includes a cell phone? Staff identified that there are some limitations with cell phones that can decrease access from 911. Some members agreed that how it is written now is fine.
414-205-0110(5)(b) Emergency telephone numbers for fire, ambulance, police and poison control and the provider's home address must be posted in a visible location.		Emergency telephone numbers for fire, ambulance, police and poison control and the home address must be posted in a visible location.	Yes
414-205-0110(6) The building, grounds, water supply, and toys, equipment and furniture used by children must be maintained in a hazard-free condition.	461-165-0180(7)(o)(F) The building, grounds, any toy, equipment, and furniture are maintained in a clean, sanitary, and hazard free condition.	The building, grounds, water supply, and toys, equipment and furniture used by children must be maintained in a hazard-free condition.	Yes
414-205-0110(6)(a) Broken toys, furniture and equipment must be removed from areas accessible to children.		Broken toys, furniture and equipment must be removed from areas accessible to children.	Yes
414-205-0110(6)(b)		~~Both the exterior and interior of the home must be maintained in good repair.~~	Yes. Delete rule language We could leave this out; a person may not have control of the exterior paint.

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Both the exterior and interior of the home must be maintained in good repair.			Addressed in the rule above and below.
414-205-0110(6)(c) Painted surfaces must be in good condition, both inside and outside, to avoid exposing children to lead paint.		Painted surfaces must be in good condition, both inside and outside, to avoid exposing children to lead paint.	Yes
414-205-0110(6)(d) The provider shall report to OCC any damage to the building that affects the provider's ability to comply with these requirements, within 48 hours after the occurrence.			CCEC recommends not including this language
414-205-0110(7) If a caregiver is transporting children, the caregiver must have a valid driver's license and proof of appropriate insurance.		If a caregiver is transporting children, the caregiver must have a valid driver's license and proof of appropriate insurance.	Yes
414-205-0110(8) The number of children transported shall not exceed the number of seat belts or child safety systems available in the vehicle.	DHS: 461-165-0180(7) Each provider must: (s) Comply with state and federal laws related to child safety systems and seat belts in vehicles, bicycle safety,	The number of children transported shall not exceed the number of seat belts or child safety systems available in the vehicle.	Yes
414-205-0110(9) Car seats are to be used for transportation only. Children who arrive at the provider's home asleep in a car seat may remain in the car seat until the child awakens.		Car seats are to be used for transportation only. Children who ~~arrive at~~ are brought into the provider's home asleep in a car seat may remain in the car seat until the child awakens.	**No Consensus** Clarify that the child must be brought into the home . Sleeping in a car seat is not safe sleep.
	Creating rule for relative care	The provider must take precautions to protect children from vehicular traffic.	Yes
414-205-0110(10) 15-passenger vans shall not be used to transport child care children after January 1, 2018.		15-passenger vans shall not be used to transport child care children.	**The ELD is securing further clarification around the law – may have additional language for consideration.** **Staff is looking at how to clarify this.** **Different vans are classed differently.** **A mini van meets the standards, there are different classes of vans. The intent is that we are aligning with federal motor vehicle standards**

(f) Prevention of shaken baby syndrome and abusive head trauma.

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0085(6) The following behaviors by caregivers are prohibited: (a) Using any form of corporal punishment, including, but not limited to: hitting, spanking, slapping, beating, shaking, pinching or other measures that produce physical pain, or threatening to use any form of corporal punishment	Considering rule for relative care	The following behaviors by caregivers are prohibited: (a) Using any form of corporal punishment, including, but not limited to: hitting, spanking, slapping, beating, shaking, pinching or other measures that produce physical pain, or threatening to use any form of corporal punishment	Yes

(g) Emergency preparedness and response planning for emergencies resulting from a natural disaster or a man-caused event (such as violence at a child care facility).

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0110(4) The provider must have a written plan for evacuating and removing children to a safe location in an emergency. The plan must be posted in the home, familiar to the children and the caregivers, and practiced at least every other month and must include: (a) Procedures for notifying parents or other adults responsible for the children, of the relocation; (b) Procedures to address the needs of individual children, including those with special needs; and (c) An acceptable method to ensure that all children in attendance are accounted for.	Creating rule for relative care	The provider must have a written plan for evacuating and removing children to a safe location in an emergency. The plan must be posted in the child care home, familiar to the children and the caregivers, and practiced at least every other month and must include: (a) Procedures for notifying parents or other adults responsible for the children, of the relocation; (b) Procedures to address the needs of individual children, including those with special needs; and (c) An acceptable method to ensure that all children in attendance are accounted for.	Yes
414-205-0110(5)(a)		Parents must be given the telephone number so they can contact the provider if needed.	Yes

Parents must be given the telephone number so they can contact the provider if needed.			

(h) The handling and storage of hazardous materials and the appropriate disposal of bio-contaminants.

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0110(1)(k) Cleaning supplies, paints, matches, lighters, and plastic bags kept under child-safety lock.	461-165-0180(7)(o)(E) … matches and lighters, … are kept in a secure place out of a child's reach.	Cleaning supplies, paints, matches, lighters, and any plastic bags large enough to fit over a child's head kept under child-safety lock.	Yes as Revised Language change: add any plastic bag that can fit over a child's head.
414-205-0110(1)(l) Other potentially dangerous items, such as medicine, drugs, sharp knives and poisonous and toxic materials kept under child-safety lock.	461-165-0180(7)(o)(E) … any legally prescribed or over-the-counter medicine, cleaning supplies, paint, plastic bags, and poisonous and toxic materials are kept in a secure place out of a child's reach.	Other potentially dangerous items, such as medicine, drugs, sharp knives and poisonous and toxic materials kept under child-safety lock.	Yes

(I) Appropriate precautions in transporting children.

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0110(7) If a caregiver is transporting children, the caregiver must have a valid driver's license and proof of appropriate insurance.	DHS: 461-165-0180(7) Each provider must: (s) Comply with state and federal laws related to child safety systems and seat belts in vehicles, bicycle safety,	If a caregiver is transporting children, the caregiver must have a valid driver's license and proof of appropriate insurance.	Yes
414-205-0110(8) The number of children transported shall not exceed the number of seat belts or child safety systems available in the vehicle.	DHS: 461-165-0180(7) Each provider must: (s) Comply with state and federal laws related to child safety systems and seat belts in vehicles, bicycle safety,	The number of children transported shall not exceed the number of seat belts or child safety systems available in the vehicle.	Yes
414-205-0110(10) 15-passenger vans shall not be used to transport child care children after January 1, 2018.		If a passenger van is used to transport child care children it must meet Federal Motor Vehicle Safety Standards for transporting children in education settings.	**The ELD is securing further clarification around the law – may have additional language for consideration.** **Staff is looking at how to clarify this.** **Different vans are classed differently.**

			A mini van meets the standards, there are different classes of vans. The intent is that we are aligning with federal motor vehicle standards.
414-205-0130(3) The provider must have a written statement from the parent(s) regarding whether or not the provider is authorized to: (c) Take a child on a field trip or other activity outside the home or participate in any water activity; and (d) Transport a child to or from school or allow a child to bus or walk to or from school or home.		The provider must have a written statement from the parent(s) regarding whether or not the provider is authorized to: (c) Take a child on a field trip or other activity outside the child care home or participate in any water activity; and (d) Transport a child to or from school or allow a child to bus or walk to or from school or child care home.	Yes

The law also requires:

COMPLIANCE WITH STATE AND LOCAL HEALTH AND SAFETY REQUIREMENTS

Providers and caregivers are in compliance with all applicable state and local health and safety requirements. (covered in other rules)

ENFORCEMENT OF LICENSING AND OTHER REGULATORY REQUIREMENTS

(c) Requires an annual inspection of each license-exempt provider in the state receiving funds under this subchapter for compliance with health, safety and fire standards at a time to be determined by the state.

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0035(12) The provider shall allow an inspection of all areas of the facility that are accessible to child care children, and a health and safety review of other areas of the facility to ensure the health and safety of child care children.	461-165-0180(7) Each provider must: (d) Allow the Department to inspect the site of care while child care is provided.	The provider shall allow an inspection of all areas of the child care home that are accessible to child care children, and a health and safety review of other areas of the child care home to ensure the health and safety of child care children.	**No Consensus** CCEC Discussion: Should providers be allowed private areas that are not subject to inspection? What does CCDBG require? Move forward to ELC

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COMPLIANCE WITH CHILD ABUSE REPORTING REQUIREMENTS

The plan shall include that providers will comply with the child abuse reporting requirements.

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0035(15) Any caregiver who has reason to believe that any child has suffered abuse (physical injury, mental injury, neglect that leads to physical harm, sexual abuse and/or exploitation, or threat of harm) must report the information to the Department of Human Services Child Welfare (DHS) or to a law enforcement agency. By statute, this requirement applies 24 hours per day.	461-165-0180(7) Each provider must: (i) Report suspected child abuse of any child in his or her care to CPS or a law enforcement agency.	Any caregiver who has reason to believe that any child has suffered or is currently suffering from abuse (physical injury, mental injury, neglect that leads to physical harm, sexual abuse and/or exploitation, or threat of harm) must report the information to the Department of Human Services Child Welfare (DHS) or to a law enforcement agency. By statute, this requirement applies 24 hours per day.	Yes with revisions. CCEC wants to make sure that it is not just abuse that a child has suffered, but may be currently suffering.

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Optional Rules: The rules in the section below are all "optional" areas suggested by the federal Office of Child Care to consider when developing rules in states and territories.

(l) May include requirements relating to nutrition, access to physical activity or any other subject area determined by the state to be necessary to promote child development or to protect children's health and safety. All of these requirements are optional.

(A) Nutrition.

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0100(11)(a) Meals and snacks must be based on the guidelines of the USDA Child Care Food Program.	DHS will add rule	Meals and snacks must be based on the guidelines of the USDA Child Care Food Program.	**No Consensus** CCEC Discussion: "may" rather than "must" ELD offered that the USDA offers guidelines for healthy meals/snacks for children receiving subsidy who could likely benefit from a solid food program **Take to ELC**
414-205-0100(11)(b) Foods must be stored and maintained at the proper temperature.		Foods must be stored and maintained at the proper temperature.	Yes
414-205-0100(11)(d) Infants must be held or sitting up for bottle feeding. Propping bottles is prohibited.		Infants must be held or sitting up for bottle feeding. Propping bottles is prohibited.	Yes

(B) Access to physical activity.

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0090(2) Providers must make available activities, materials, and equipment for both indoor and outdoor play that provide a variety		Providers must make available activities, materials, and equipment for both indoor and outdoor play that provide a variety of experiences geared to the ages and abilities of the child(ren) with a balance of active and quiet play.	Yes. CCEC Discussion: Adding "weather permitting" – Would be difficult to monitor. Most agreed that weather permitting is unmeasurable.

of experiences geared to the ages and abilities of the child(ren).			
414-205-0090(3) The children's activities must allow choice and develop skills based on each child's age and abilities.			**Take to ELC for further direction** "Must" and "may" is an issue in the language. The term "should" is another one to consider
414-205-0090(4) A balance of active and quiet play must be provided, both indoors and outdoors.			**Take to ELC for further direction** "Must" and "may" is an issue in the language. The term "should" is another one to consider

(C) Any other subject area determined by the state to be necessary to promote child development or to protect children's health and safety.

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0035(11) The provider or substitute must allow a representative from the Office of Child Care access to the home any time child care children are present.	461-165-0180(7) Each provider must: (q) Provide evidence of compliance with the Department's administrative rules, upon request of Department staff.	The provider or substitute must allow a representative from the Office of Child Care access to the child care home any time child care children are present.	Yes
414-205-0035(13) The provider must allow parents or legal guardians of child care children access to the home during the hours their child(ren) are in care.	461-165-0180(7) Each provider must: (l) Allow the custodial parent of a child in his or her care to have immediate access to the child at all times.	The provider must allow parents or legal guardians of child care children access to the child care home during the hours their child(ren) are in care.	Yes
414-205-0085(7) Parental request or permission to use any form of behavior listed in subsection (6) of this rule, does not give the provider or substitute provider permission to do so.		Parental request or permission to use any form of behavior listed in subsection (6) of this rule, does not give the provider or substitute provider permission to do so.	Yes
414-205-0090(6) Child care children shall not be exposed to more than two hours of screen time per day. All media exposure must be developmentally and age appropriate.		Child care children shall not be exposed to more than two hours of screen time per day. All media exposure must be developmentally and age appropriate.	Yes with clarification through definition of "screen time". Include in definition what "screen time" means. Discussion occurred about how screen time is assessed or enforceable. The ELD discussed how they currently assess this with Registered Family through daily programming and schedules, as well as whether the provider has policy books to

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			determine how many hours of the day children are allowed screen time. It is also an assurance to parents that their children will be engaged in more educational opportunities
414-205-0100(1)(a) No person shall smoke or carry any lighted smoking instrument, including an e-cigarette or vaporizer in the family child care home or within ten feet of any entrance, exit, or window that opens or any ventilation intake that serves an enclosed area, during child care hours or when child care children are present. No person shall use smokeless tobacco in the family child care home during child care hours or when child care children are present. No person shall smoke, carry any lighted smoking instrument, including an e-cigarette, or vaporizer or use smokeless tobacco in motor vehicles while child care children are passengers.	461-165-0180(7)(o)(H) No one may smoke or carry any lighted smoking instrument, including e-cigarettes or vaporizers, in the home or facility or within ten feet of any entrance, exit, window that opens, or any ventilation intake that serves an enclosed area, during child care operational hours or anytime child care children are present. No one may use smokeless tobacco in the home or facility during child care operational hours or anytime child care children are present. No one may smoke or carry any lighted smoking instrument, including e-cigarettes and vaporizers, or use smokeless tobacco in motor vehicles while child care children are passengers.	No person shall smoke or carry any lighted smoking instrument, including an e-cigarette or vaporizer in the child care facility or within ten feet of any entrance, exit, or window that opens or any ventilation intake that serves an enclosed area, during child care hours or when child care children are present. No person shall use smokeless tobacco in the child care home during child care hours or when child care children are present. No person shall smoke, carry any lighted smoking instrument, including an e-cigarette, or vaporizer or use smokeless tobacco in motor vehicles while child care children are passengers.	**No Consensus** CCEC Discussion: what are the health concerns of allowing smoking in the child care home at any time of day (regardless of whether child care children are present), given the impact on air quality of residual smoke.
414-205-0100(1)(b) No one shall consume alcohol on the family child care home premises during child care hours or when child care children are present. No one shall be under the influence of alcohol on the family child care home premises during child care hours or when child care children are present.	461-165-0180(7)(o)(I) No one may consume alcohol or use controlled substances (except legally prescribed and over-the-counter medications) or marijuana (including medical marijuana) on the premises (see section (11) of this rule) during child care operational hours or anytime child care children are present. No one under the influence of alcohol, controlled substances (except legally prescribed and over-the-counter medications) or marijuana (including medical marijuana) may be on the premises during child care operational hours or anytime child care children are present. No one may consume alcohol or use controlled substances (except legally prescribed and over-the-counter medications) or marijuana (including	No one shall consume alcohol on the child care home premises during child care hours or when child care children are present. No one shall be under the influence of alcohol on the child care home premises during child care hours or when child care children are present.	Yes

	medical marijuana) in motor vehicles while child care children are passengers.		
414-205-0100(1)(c) Notwithstanding OAR 414-205-0000(5), no one shall possess, use or store illegal controlled substances on the family child care home premises. No one shall be under the influence of illegal controlled substances on the family child care home premises.	461-165-0180(7)(o)(L) Controlled substances (except lawfully prescribed and over-the-counter medications), marijuana (including medical marijuana, marijuana edibles, and other products containing marijuana), marijuana plants, derivatives, and associated paraphernalia may not be on the premises during child care operational hours or anytime child care children are present.	No one shall possess, use or store illegal controlled substances on the child care home premises. No one shall be under the influence of illegal controlled substances on the child care home premises.	Yes
414-205-0100(1)(d) Notwithstanding OAR 414-205-0000(5), no one shall grow or distribute marijuana on the premises of the registered family child care home. No adults shall use marijuana on the registered family child care home premises during child care hours or when child care children are present.		No one shall grow or distribute marijuana on the premises of the child care home. No adults shall use marijuana on the child care home premises during child care hours or when child care children are present.	Yes
414-205-0100(1)(e) No adult under the influence of marijuana shall have contact with child care children.	461-165-0180(10) Child care providers and any individual supervising, transporting, preparing meals, or otherwise working in the proximity of child care children and those completing daily attendance and billing records shall not be under the influence. 461-165-0180(11)(b) "Under the influence" means observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the individual has used alcohol, any controlled substances (including lawfully prescribed and over-the-counter medications), marijuana (including medical marijuana), or inhalants that impairs their performance of essential job function or creates a direct threat to child care children or others. Examples of abnormal behaviors include, but are not limited to hallucinations, paranoia, or violent outbursts. Examples of impairments in physical or mental	Child care providers and any individual supervising, transporting, preparing meals, or otherwise working in the proximity of child care children and those completing daily attendance and billing records shall not be under the influence. "Under the influence" means observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the individual has used alcohol, any controlled substances (including lawfully prescribed and over-the-counter medications), marijuana (including medical marijuana), or inhalants that impairs their performance of essential job function or creates a direct threat to child care children or others. Examples of abnormal behaviors include, but are not limited to hallucinations, paranoia, or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to slurred speech as well as difficulty walking or performing job activities.	Yes

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	performance include, but are not limited to slurred speech as well as difficulty walking or performing job activities.		
414-205-0100(1)(h) Effective July 1, 2015, all marijuana, marijuana derivatives and associated paraphernalia must be stored under child safety lock.		All marijuana, marijuana derivatives and associated paraphernalia must be stored under child safety lock.	Yes with revision (definition or examples of derivatives). Include examples of marijuana derivatives. "a derivative includes … but is not limited to…" Marijuana edibles were discussed. The term derivative was intentional to allow and encompass all of the products that are created with marijuana – oils, lotions, salves, etc.
414-205-0130(1) The following records must be kept by the provider for at least one year and must be available at all times to OCC: (a) Information from the parent(s) for each child at the time of admission: (A) Name and birth date of the child; (C) Date child entered care; (D) Names, work and home telephone numbers and addresses, and the work hours of the parent(s) or legal guardian(s); (E) Name and telephone number of person(s) to contact in an emergency; (F) Name and telephone number of person(s) to whom the child may be released; (G) The name of the school attended by the child care child; and (H) Name, address and telephone number of the child's doctor and dentist. (b) Daily attendance records, including dates each child attended and arrival and departure times for each day. Times shall be recorded	461-165-0180(7) Each provider must: (e) Keep daily attendance records showing the arrival and departure times for each child in care and billing records for each child receiving child care benefits from the Department. The provider must keep written records of any attendance that is not able to be recorded in the Child Care Billing and Attendance Tracking (CCBAT) system. These written records must be retained for a minimum of 12 months and provided to the Department upon request.	The following records must be kept by the provider for at least one year and must be available at all times to OCC: (a) Information from the parent(s) for each child at the time of admission: (A) Name and birth date of the child; (C) Date child entered care; (D) Names, work and home telephone numbers and addresses, and the work hours of the parent(s) or legal guardian(s); (E) Name and telephone number of person(s) to contact in an emergency; (F) Name and telephone number of person(s) to whom the child may be released; (b) Daily attendance records, including dates each child attended and arrival and departure times for each day. Times shall be recorded as the child care children arrive and depart; (c) Injuries to a child.	Yes

as the child care children arrive and depart; (d) Injuries to a child.			
414-205-0130(2) Injuries to a child which require attention from a licensed health care professional, such as a physician, EMT or nurse, must be reported to OCC within seven days.		Injuries to a child which require attention from a licensed health care professional, such as a physician, EMT or nurse, must be reported to OCC within seven days.	Yes. CCEC Discussion. Why seven days? This information is required so an aggregate report can be posted according to CCDBG. Is there some logic to not have it more restrictive than other rules?

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Other general rules

General Requirements

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0035(1) The home in which child care is provided must be the residence of the provider.	461-165-0180(7) Each provider must: (h) Report to the Department's Direct Pay Unit within five days of occurrence: (C) any change to the provider's name or address including any location where care is provided.	The home in which child care is provided must be the residence of the provider.	ELD Staff are conducting further review of this rule.
414-205-0035(6) OCC registration records are open to the public on request. However, information protected by state or federal law will not be disclosed.		OCC records are open to the public on request. However, information protected by state or federal law will not be disclosed.	**No Consensus** CCEC Discussion: What information would be open? Concern expressed about sharing personal address information. ELD clarified that someone could file a public request. The ELD has a process for which they address public information requests. To comply with the new federal requirements The language does not create a new requirement given the existing law. The ELD has a mechanism to identify information where there is a risk for safety of a provider. What records? Address and information could concerning if protection was being considered due to Domestic Violence matters Public records requests could include everyone that receives subsidy.
414-205-0035(7) The name, address, telephone number, and registration status of providers is public information. However, OCC may withhold from the public a provider's address and telephone number if the provider		The name and status of providers is public information.	Yes

makes a written request documenting that disclosure of the address and/or telephone number would endanger him/her or a family member living in the home (OAR 137-004-0800). The request must be on a form supplied by OCC.			
414-205-0035(18) If an applicant or a provider wishes to provide child foster care, the provider must receive approval from OCC and DHS, prior to placement of the foster child(ren).	461-165-0180(7) Each provider must: (a) Obtain written approval from their certifier or certifier's supervisor if the provider is also certified as a foster parent.	If an applicant or a provider wishes to provide child foster care, the provider must receive approval from OCC and DHS, prior to placement of the foster child(ren) or the child care children.	Yes

Exceptions to Rules

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0150(1) A provider may request an exception to a rule.		A provider may request an exception to a rule.	Yes
414-205-0150(1)(a) An exception must be requested on a form provided by OCC;		An exception must be requested on a form provided by OCC;	Yes
414-205-0150(1)(b) The provider must provide a justification for the requested exception and an explanation of how the provider will ensure, through safeguards or other conditions, the health, safety and well-being of the children.		The provider must provide a justification for the requested exception and an explanation of how the provider will ensure, through safeguards or other conditions, the health, safety and well-being of the children.	Yes
414-205-0150(2) The provider must be in compliance with the rule as written until the provider has received approval for the exception from OCC.		The provider must be in compliance with the rule as written until the provider has received approval for the exception from OCC.	Yes
414-205-0150(4) No exception to a rule shall be granted unless the health, safety, and well-being of the children are ensured.		No exception to a rule shall be granted unless the health, safety, and well-being of the children are ensured.	Yes
414-205-0150(5)		An exception is valid only for the specified dates for which it is issued.	Yes

An exception is valid only for the specified dates for which it is issued.			
414-205-0150(6) The granting of an exception to a rule shall not set a precedent, and each request shall be evaluated on its own merits.		The granting of an exception to a rule shall not set a precedent, and each request shall be evaluated on its own merits.	Yes

Complaints

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0160(2) New applicants for registration will be given a copy of OCC's complaint procedures at the time of the on-site health and safety review. The complaint procedures are also available upon request.		New applicants will be given a copy of OCC's complaint procedures at the time of the on-site health and safety review. The complaint procedures are also available upon request.	Yes

Grievance Review and Sanctions

RF Rules	DHS Rules	Suggested RSP Rules	Yes/No - Suggestions
414-205-0170(1) A provider has the right to a review of any finding made by OCC. New applicants for registration will be given a copy of OCC's findings review procedures at the time of the on-site inspection. Information on the OCC findings review process will be in complaint letters. The OCC findings review procedures are also available upon request.		A provider has the right to a review of any finding made by OCC. Provider will be given a copy of OCC's findings review procedures at the time of the on-site inspection. Information on the OCC findings review process will be in complaint letters. The OCC findings review procedures are also available upon request.	Yes

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Phone: 503-373-0066 | **Fax:** 503-947-1955

TO: **Early Learning Council**

FROM: **Lisa Pinheiro, Early Learning Policy Specialist**

RE: **Child Care Characteristics Table**

DATE: **May 25, 2016**

Introduction

At the April Council meeting, staff were asked to produce a grid that shows which administrative rules apply to which types of child care in order to help the Council better see how (or if) rule sets are aligned. It is the intent of the grid to show how the rules progress in a logical way as the level of regulatory oversight increases

The attached document "Oregon Child Care Characteristics" displays some of the program requirements covered in administrative rule for license exempt subsidy providers (now called "regulated subsidy"), to recorded programs, to registered family, certified family, and certified centers.

Background

The Child Care and Education Committee (CCEC), serving as the Council's Rules Advisory Committee, utilizes a similar though more comprehensive grid to compare and contrast the rigor of regulatory oversight for child care providers and facilities subject to regulation. It is the intent of the CCEC through administrative rules to establish a natural progression in the rigor of the rules, closely linked to the rigor necessary to protect the health and safety of children in child care settings.

	OREGON CHILD CARE GENERAL CHARACTERISTICS						
		Family, Friends and Neighbors (Informal) Child Care[1]	License Exempt Recorded Child Care Centers[2]	License Exempt Provider accepting Subsidy[3]	Registered Family Child Care[4]	Certified Family Child Care[5]	Certified Child Care Center[6]
1	Number of Children served or licensing capacity	unknown	52,611	7,227	23,200	10,067	60,000
2	Maximum Group size (for ages 3-4)	3	No restriction on group size	3	10	16	20
3	# of Facilities	unknown	463[7]	2,753	2,320	714	1,208
4	Funding (program allotment or payment made on behalf of parent for all or part of the fee)	Private pay	Private pay	CCDF, State General Fund. DHS subsidy voucher per child Payment made by DHS on behalf of enrolled parent	Private pay, unless providing care to a child whose parent is enrolled in DHS subsidy program.	Private pay, unless providing care to a child whose parent is enrolled in DHS subsidy program.	Family pays tuition, unless providing care to a child whose parent is enrolled in DHS subsidy program.
5	Program Standards	NO	NO	NO	NO	Yes. Written program of activities specific to age group	Yes. Written program of activities specific to age group

[1] Caring for less than three children by family, friends and neighbors.
[2] Preschool and School-age programs that operate fewer than four hours per day; typically churches, municipalities; not licensed, but recorded with the state.
[3] License-exempt providers who accept subsidy payments; now under regulation per Child Care Development Block Grant Act of 2014.
[4] Home-based child care program with up to 10 children.
[5] Home-based child care program with up to 16 children.
[6] Center-based child care program with more than 13 children.
[7] Includes children in recorded preschool and school age programs

6	Health and Safety Inspection by State	NO	NO	YES	YES	YES	YES
7	Environmental Health Inspections	NO	NO	NO	NO	YES	YES
8	Fire Marshall inspection required	NO	NO	NO	NO (OCC CHECKS)	NO (OCC CHECKS)	YES
9	Immunization records required	NO	Yes - Preschools must submit to Health Dept.(State Law) No - for before and after school programs.	YES – In-home providers must maintain records. Centers must submit to Health Department	YES – must maintain records. Do NOT submit to Health Department	YES – must submit to Health Department	YES – Must submit to Health Department
10	Toxics under lock	NO	NO	Rule currently under consideration by CCEC	YES	YES	YES
11	Guns under lock	NO	NO	Rule currently under consideration by CCEC	YES	YES	Firearms prohibited
12	Must follow USDA CACFP guidelines	NO	NO	Yes (under DHS Rule)	YES	YES	YES
13	Provider/Head Teacher Training and Qualifications	NO	Not statutorily allowed or required	CCDBG act of 2014 allows for preservice or completion during	Overview First aid/CPR RRCAN Food Handlers Health and Safety. 10	First aid/CPR RRCAN Food Handlers I/T 30 clock hours specific training.	Varies. 15 hours annually. 18 years + 6 months qualifying

				orientation period: First aid/CPR RRCAN Health and Safety course	hours every 2 years. 18 years of age	15 hours annually. 18 years + one year qualifying teaching experience or 20 /30 credits in ECE or Step 8 in the Oregon Registry.	teaching experience plus 10 credits in ECE or Step 8 in the Oregon Registry.
14	**Mandatory reporters for abuse or neglect**	NO	YES	YES	YES	YES	YES
15	**Criminal Background Reg.**	NO	Self-attest	YES	YES	YES	YES

Acronyms used in this document:

USDA CACFP: US Department of Agriculture's Child and Adult Care Food Program
CCDBG: Federal Child Care Development Block Grant
CCDF: Federal Child Care Development Fund
DHS: Oregon Department of Human Services
ECE: Early Childhood Education
OCC: Early Learning Division, Office of Child Care
RRCAN: Recognizing and Reporting Child Abuse and Neglect training

Board Action Summary

AGENDA ITEM: OHPB Strategic Plan Input

Summary of Recommended Board Action

ACTION: No Action – Discussion Item Only

ISSUE: Oregon Health Care Quality Corporation (Q Corp) is gathering key members of the health care community to seek feedback related to how the state collects and uses data. This work is being done on behalf of the Oregon Health Authority, which has been tasked to create a Strategic Plan for the collection and use of data by Senate Bill 440 passed in 2015. The goal of the plan is to identify what data would best support the identified goals of the Oregon Health Policy board, and help demonstrate whether those goals have been achieved.

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SB 440 Strategic Plan Overview

General Information

- SB 440 directs the Oregon Health Policy Board (OHPB), in consultation with agencies including OHA, DHS and DCBS, to develop a strategic plan for health care data collection and use for submission to the legislature by Sept. 1, 2016.
- The plan is intended to support the health care transformation goals and vision articulated by the OHPB and the health care community, and can serve as a resource for the OHPB and internal agencies to help shape their implementation strategies in further support of health care transformation.
- SB 440 also calls for the convening of a committee in 2017 to select a set of metrics for use in state measurement efforts. The selection of that committee and the setting of its work plan are separate processes from the creation of this Strategic Plan.

Plan requirements

The final plan must:

- Outline a five-year vision and implementation timeline, including clear objectives for how health care data will be collected and used to support health system transformation in alignment with the Triple Aim.
- Identify what gaps would need to be filled in order to help the community know they have achieved transformation goals in the future.
- Provide critical information to support the work of the Health Plan Quality Metrics Committee (to be convened in 2017), though it will not serve to direct the work of the committee.
- Include strategies to ensure that the State's collection, use and measurement of health care data advances payment reform and supports implementing, measuring and reporting on alternative payment methodologies.

Stakeholder engagement requirements:

- Beyond state agencies, the plan is intended to reflect the input and needs of health care community stakeholders including patients, providers, employers and health plans.
- Wherever possible, Q Corp will engage with groups that can reflect input from a broad community of stakeholders, including patient advocates, providers, employers, community-based service organizations and health plans; the Collaborative for Health Information Technology in Oregon, which is comprised of Oregon Association of Hospitals and Health Systems, Oregon Health Leadership Council, OCHIN and Q Corp, is one such group.

Q Corp's engagement process:

- Q Corp will engage with stakeholders to understand their perspectives on data available or needed to support health system transformation; this work will be conducted using a variety of channels including individual and group interviews, listening-session type meetings, and an electronic survey.
- Q Corp will synthesize the information and feedback collected, and ensure it is appropriately represented in the resulting work.
- Q Corp will work with OHA and key stakeholders to facilitate review checkpoints throughout the project, to ensure stakeholder reflection and input throughout.

OHA's role:

- As staff to OHPB, OHA will facilitate and manage the project throughout, keeping the OHPB and agency leadership informed about ongoing progress.
- OHA will help Q Corp connect with the appropriate agency key informants for the purposes of gathering feedback.
- OHA will also help to assemble and provide relevant source documentation regarding strategy and goals for health care transformation from across the Authority.
- OHA staff will provide feedback to Q Corp on key deliverables throughout the project.

Major Deliverables:

- The first weeks of the project will be spent working closely with OHA, DHS and Q Corp to finalize project plans and assess opportunities to leverage existing agency inventory and analysis work.
- A **progress report** will be completed **May 13.**
- The final **Data Gap Analysis**, and a **Report on Survey Activities**, will be completed by **June 17.**
- A comprehensive **Stakeholder Input Summary**, including survey instruments, discussion and interview guides will be completed **August 5**.
- Q Corp will make a presentation on the Plan to the **OHPB** on **August 2**, incorporating feedback generated by that presentation into the final draft of the document.
- Q Corp will submit two **drafts of the Plan** for review, on **July 22** and **August 12**, with the **final report** and appendixes due **August 26**.

OHBP Priority Areas:

The Oregon Health Policy Board (OHPB) is responsible for monitoring, oversight, and policy development in the following priority areas:

1. Health System Transformation (including Coordinated Care Organizations)
2. Healthcare workforce issues
3. Health Information Technology
4. Public Health system & Modernization efforts

Additionally, the OHPB has identified the following timely priority areas:

1. Health Equity
2. Behavioral health issues and integration with the physical health system
3. Oral health issues and integration with the physical health system
4. High-cost pharmacy issues
5. Value-based payment/Payment reform

Group Discussion Guide

Date: May 20, 2016

Introduction

The purpose of our time today is to have an open, honest and interactive discussion about health care data collection and use for health care transformation in Oregon. The results of our discussion will be synthesized into a strategic plan that will be submitted to the Oregon Health Authority and then the state legislature.

This discussion is part of the larger SB 440 work completed under the direction of the Oregon Health Policy Board (OHPB), in consultation with agencies including OHA, DHS and DCBS, to develop a strategic plan for health care data collection and use.

This discussion will be audio recorded so we don't have to take extensive notes but can instead focus on what everyone has to say. We have several questions to walk through that should take no longer than an hour of your time. May we begin recording?

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- Thinking at a high level about data and information needed for transformation and the goals outlined above, what data do you think we need to be able to support those priorities? *Prompt if needed[can focus on one or two rather than all]:*
    - Monitor and track the successes and challenges of Health System Transformation (HST)
    - Behavioral health system policy development and oversight
    - Public health system policy development and oversight
    - Health Equity
    - Behavioral health improvements
    - Integration of health systems (physical, behavioral, oral)
    - Alternative payment methodologies (value-based payments)
    - Pharmacy
- How do we get that data [in response to answers from above]? *Prompt if needed:*
    - Is this data currently available? If yes, where and what? If no, what is missing?
    - What is the best way to acquire this data?
- What other data and information needs do you have in your work?
    - What do you think is the best approach to acquire that data?
- What do you think is the most valuable data we currently have that could be better used to support health?
- What is the biggest data-related barrier you think the state will need to overcome to effectively support health system transformation?
- Are there other examples of data repositories or access systems this project should consider as models?
- What else should OHPB consider for the development of this strategic plan?