Oregon's Infant Toddler State Self-Assessment Data

IN PROGRESS DRAFT July 14, 2017

Data collection performed using
INFANTS AND TODDLERS IN THE POLICY PICTURE: A SELF-ASSESSMENT TOOLKIT FOR STATES
Developed by the ZERO TO THREE Policy Center, October 2015
Full toolkit available online at: http://www.zerotothree.org/public-policy/self-assessment-toolkit.html

Note: Data collection is currently in progress and this tool remains a living document. Notes have been provided within the tool to indicate areas where data requests are currently pending or data is not available.

Oregon's Data - Table of Contents

OVERVIEW OF FAMILIES WITH INFANTS AND TODDLERS IN OREGON

This section can be completed by a state agency or statewide organization for better understanding of the demographics of infants and toddlers in the state. The information required is available in state databases as well as in the following sources:

- ZERO TO THREE (ZTT), *State Baby Facts* [50-State Profiles]: www.zerotothree.org/public-policy/state-community-policy/infant-and-toddler-state-fact-sheets.html
- National Center for Children in Poverty (NCCP), *Early Childhood State Profiles*: www.nccp.org/profiles/early_childhood.html
- The Annie E. Casey Foundation's KIDS COUNT Data Center: http://datacenter.kidscount.org/

Demographic	Oregon	National Comparison[1]	Suggested Source for State Data	Comments
Total population under age 3	**138,213**	11,886,860	ZTT *State Baby Facts*	
2. Percent of children less than 18 years old who are infants and toddlers	**16%**	16%	ZTT *State Baby Facts*	
3. Children less than 6 years old by race/ethnicity	**White: 63.6%** **Black: 2.2%** **Hispanic: 22.2%** **Asian: 3.8%** **Other: 7%** **American Indian: 1.3%**	White: 50% Black: 13% Hispanic: 26% Asian: 5% Other: 5% American Indian 1% [2]	NCCP *Early Childhood State Profiles*	

[1]Source for national all data in this table, unless indicated otherwise: ZERO TO THREE, *State Baby Facts*, updated June 2015. Original sources available online at: www.zerotothree.org/public-policy/state-community-policy/baby-facts/related-docs/state-baby-facts-2015-references.pdf

[2]National Center for Children in Poverty, *Early Childhood Profiles*, updated May 2015. Available online at: www.nccp.org/profiles/early_childhood.html

4. Percent of births to foreign-born mothers	**33% (2014)**	22%[3]	KIDS COUNT Data	Available through OHA Vital Stats – Oregon births: Region and selected country of mother's birth by continent of father's birth. (volume 1, 2015, Table 2-12) 2015 Oregon births n = 45,656 2015 births to mothers born in the US n = 37,082 Race, ethnicity, and place of birth of mother by selected demographic characteristics, 2015 births – Table 2-13. (moms born in or outside of the US) Parent's language is not collected on Oregon birth certificate/vital statistics.
5. Percent of infants and toddlers who live in families that are poor or near-poor	**21% poor (at or below 100% of the federal poverty level [FPL])** **23% near-poor (100%–200% of the FPL)**	25% poor (at or below 100% of the federal poverty level [FPL]) 23% near-poor (100%–200% of the FPL)	ZTT *State Baby Facts*	
6. Percent of infants and toddlers living with an unmarried parent	**28%**	34%	ZTT *State Baby Facts*	

[3] Annie E. Casey Foundation, KIDS COUNT Data Center, available online at: http://datacenter.kidscount.org/

7. Percent of mothers (of infants) who are in the labor force	**59%**	62%	ZTT *State Baby Facts*	
8. Percent of children less than 6 years old whose mothers have a high school education or less	**31%**	34%[4]	NCCP *Early Childhood State Profiles*	
COMMENTS: 278,600 Children birth to five 136,681 Children birth to 3 Add race and ethnicity chart on pp page 11 Oregon Vital Statistics (birth certificate) data available for age of mother. 2015 Table 2-1 is births by age of mother. Table 2-13 has multiple characteristics including age and mother's place of birth. Table 2-17 is Prenatal Care by mother's age. Table 2-27 is age of mother by birthweight. Also Vital Statistics 2015 Tables 4-1 through 4-13 are specific to teen pregnancies.				

[4]National Center for Children in Poverty, 2015.

GOOD HEALTH

Policies that promote good health for infants and toddlers, including children's physical health, social–emotional health, and access to developmental screening, are critical in promoting long-term health and learning. For more information on state policy strategies to promote good health, additional ZERO TO THREE resources are available at: www.zerotothree.org/public-policy/policy-toolkit/good-health-policy-toolkit.html.

1. How are infants, toddlers, and their families doing?
This section can be completed by a state agency or statewide organization using the most recent data available from state data sources. The information required is available in state databases as well as in the following sources:

- ZERO TO THREE (ZTT), *State Baby Facts* [50 state profiles]: www.zerotothree.org/public-policy/state-community-policy/infant-and-toddler-state-fact-sheets.html
- The Annie E. Casey Foundation's KIDS COUNT Data Center: http://datacenter.kidscount.org/
- The Child and Family Center and the BUILD Initiative, *Fifty State Chart Book: Dimensions of Diversity and the Young Child Population*: http://buildinitiative.org/TheIssues/DiversityEquity/50StateChartBook/50StateChartBookOverview.aspx

It may be helpful to seek stakeholder input for the Comments section.

Child & Family Data	**Oregon**	**National Comparison[5]**	**Disparities[6]** (Provide available data indicating any notable disparities by family income, race, ethnicity, or gender.)	**Comments** (Provide any relevant information on state context or trends.)	**Suggested Source for State Data**
1. Percent of babies born to mothers receiving	**79%**	71%	Oregon Vital Statistics Data shows 79% percent of Oregon births in 2015 were to mothers receiving first trimester care.	Vital Statistics data is from the Oregon birth certificate, which collects the	Oregon Vital Statistics Data, 2015

[5]Source for national data in this table, unless indicated otherwise: ZERO TO THREE, *State Baby Facts,* updated June 2015. Original sources available at: www.zerotothree.org/public-policy/state-community-policy/baby-facts/related-docs/state-baby-facts-2015-references.pdf

[6]The following is a good source of state data on ethnic and racial disparities: The Child and Family Center and the BUILD Initiative, *Fifty State Chart Book: Dimensions of Diversity and the Young Child Population.* Available online at: http://buildinitiative.org/TheIssues/DiversityEquity/50StateChartBook/50StateChartBookOverview.aspx

early prenatal care			However, prominent disparities exist when looking at Inadequate Prenatal Care (Less than 5 prenatal visits or care began in the third trimester). Percentage of births with inadequate prenatal care, any mention race and ethnicity (Oregon Vital Statistics, 2015): White: 5.3 African American: 10.3 American Indian: 9.7 Asian: 5.2 Hawaiian/Pacific Islander: 19.5 Other: 6.6 Unknown: 10.7 Hispanic: 6.8	date of the first prenatal care visit and the total number of prenatal care visits. This is mother report and so can be assumed to include care received in other states/countries. Inadequate prenatal care is defined as less than five prenatal visits or care began in the third trimester. Adequate care is defined as all other care. Rates of first trimester care are also available. These 2015 data are available here. Table 2-18 Prenatal Care by mother's race and ethnicity Table 2-17 Prenatal care by mother's age	
2. Percent of babies born pre-term	**7.7%**	11%	Oregon Vital Statistics Data demonstrate racial and ethnic disparities in pre-term birth rates. Percentage of 2015 births pre-term, any mention race and ethnicity: White: 7.4 African American: 9.0 American Indian: 8.3 Asian: 6.9 Hawaiian/Pacific Islander: 12.8 Other: 9.4 Unknown: 10.1 Hispanic: 8.1	Information is available here about some of the links between preterm birth and low birthweight (WHO).	Oregon Vital Statistics Data, 2015
3. Percent of babies with low-birth weight	**6%**	8%	Oregon Vital Statistics Data demonstrate racial and ethnic disparities in babies with low birthweight. Percentage of	Information is available here about some of the links between preterm	ZTT *State Baby Facts*

			2015 births classified as low birthweight, any mention race and ethnicity: White: 6.1% African American: 8.9% American Indian: 6.6% Asian: 7.6% Hawaiian/Pacific Islander: 10.6% Other: 8.5% Unknown: 8.2% Hispanic: 6.7%	birth and low birthweight (WHO).	
4. Percent of births covered by Medicaid	**45%**	45%	The most recent Pregnancy Risk Assessment & Monitoring Survey (PRAMS) data shows that higher proportion of Hispanic pregnant women (71.4%) and black women (74.7%) report Medicaid coverage for prenatal care, than white women (45.5%). Low-income women who would otherwise qualify for Medicaid but do not have citizenship documentation can qualify for full Medicaid benefits during pregnancy through the CAWEM Plus program.		ZTT *State Baby Facts*
5. Infant mortality rate	**5.1 deaths per 1,000 live births** n = 704	6.4 deaths per live 1,000 births[7]	Oregon Vital Statistics Data demonstrate prominent disparities in infant mortality by race/ethnicity (deaths that occur in the first year of life, 2012-2014 birth cohort, rate per 1,000 live births): Non-Hispanic White: 4.9 (n = 460) NH Black: 8.6 (n = 24) NH American Indian: 10.6 (n = 16) NH Asian: 4.8 (n = 31) NH Pacific Islander: Not calculated (fewer than 5 deaths in this category, n = 4) NH Other and not stated: 23.4 (n = 12)	Data available for neonatal (less than 28 days of age), postnatal (day 28 through 364 after birth) and infant deaths (within 1 year of birth). By maternal characteristics, including age, race, education, tobacco use, prenatal care (Birth cohort 2012-2014): Table 7-18. By maternal characteristics, including	Oregon Vital Statistics, 2015

[7]Kaiser Family Foundation, *State Health Facts: Infant Mortality Rate.* Available online at: http://kff.org/other/state-indicator/infant-death-rate/

			NH Multiple races: 5.3 (n = 25) Hispanic: 5.2 (n = 132)	age, race, education, tobacco use, prenatal care (Birth cohort 2014): Table 7-17.	
6. Percent of infants and toddlers with up-to-date immunizations	**75% of 2-year-olds fully immunized**	73% of 2-year olds fully immunized	Oregon ALERT IIS rate for 2015 for two-year olds fully up-to-date on the 4:3:1:3:3:1 immunization sequence (also used for CCO metric) is **75%**. Within that: Hispanic: 81% White: 74% African American: 70% Asian: 79% American Indian/Alaska Native: 70% Hawaiian/Pacific Islander: 67% Multiple Race: 73% Other/Unknown: 73% http://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/Documents/county/OregonPBR.pdf	From 2016 Year End Medicaid data: 68.4% of 2yo on Medicaid fully immunized White: 66.3% African American/black: 65.4% Hispanic/Latino: 80.5% American Indian/Alaska Native: 72.4% Asian American: 82.8% Hawaiian/Pacific Islander: 64.5% http://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Pages/HST-Reports.aspx	
7. Percent of children less than 6 years old with no health insurance	**5%**	6%			ZTT *State Baby Facts*
8. Percent of infants on Medicaid who have received at least one EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) screening	**93%**	90%		2015 EPSDT data from is 92% for infants: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html	ZTT *State Baby Facts*
9. Percent of children less than 6 years old under who have received a developmental screening	62.2% of children covered by Medicaid have received a	30%	ZTT State Baby Facts for Oregon states that 32% of all children under age 6 have received a developmental screening. The Oregon Health Authority's 2016 Performance Report	n = 47,754 (CY 2016, OHP children age 0-3) NOTE: Completion of developmental screening by this metric does not necessarily include or reflect referrals to follow-up	Oregon Health Authority 2016 Performance Report:

	screening by age 3		states that 62.2% of children on Medicaid have received a screening by age 3 (this is a CCO incentive measure and Early Learning Hub metric, and the rate has been rapidly increasing throughout the state) OHA also has the measure disaggregated by race/ethnicity: - White: 61.8% - Hispanic/Latino: 63.8% - African American/Black: 56.9% - Asian American: 61.1% - American Indian/Alaska Native: 55.4% - Hawaiian/Pacific Islander: 48.5% Biggest disparities are for non-English and non-Spanish speakers; the ASQ isn't translated into other languages and its cultural sensitivity is not acceptable	services for those children screening at risk for a developmental delay. This metric also does not necessarily reflect screenings occurring in early learning settings.	http://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/CCO-Metrics-2016-Final-Report.pdf
10. Percent of WIC Women, Infants, and Children (WIC) Program recipients who are infants	**20%**	23%		*Data Source: Oregon WIC 2016 Annual Report*	ZTT *State Baby Facts*
Oral health status of young children			In 2012, 19% of 6 to 9 year old children in oregon were in need of early or urgent dental care (this means that on any given day, as many as 3,800 children in grades 1-3 in Oregon may be in school suffering from dental pain or infection. (Oregon Smile Survey, 2012).	Very limited data available in terms of oral health status of very young children; state surveillance focuses on young school age children.	
Percentage of young children receiving dental			Mid-2016 data for children enrolled in Medicaid:		http://www.oregon.gov

services			24.4% children aged 0-2 received any dental service during the measurement year. 9.5% (age 1-2) received at least two topical fluoride applications during the measurement year. 8.9 % of children 0-6 had an oral health assessment in a primary care setting (does NOT include oral health assessments performed at dentist offices).		/oha/HPA/ANALYTICS/Documents/oral-health-ccos.pdf

COMMENTS: Overall, Oregon is performing better than national averages on many of these measures. However, we hear from communities and providers on the ground that there are vast disparities in access to health care by race/ethnicity and by geographic location.

Reports from the field indicate significant disconnects between children receiving developmental screenings and being connected to needed services when screening identifies a risk.

Limited data available both on oral health status of young children and dental services received by young children. Difficult to find service data beyond the Medicaid population.

2. Does your state have policies in place to support good health?

This section can be completed by a state agency or statewide organization with an understanding of current state policies. Much of the state information required is available through the National Center for Children in Poverty's *Early Childhood State Profiles*, available here: www.nccp.org/profiles/early_childhood.html and resources from the National Academy for State Health Policy (NASHP). In some cases, state agencies may have more up-to-date information. It may be helpful to seek stakeholder input for the Comments section.

Policy	Yes/No	No. of States with this Policy[8]	Comments on Policy Implementation Challenges (Note any barriers to effectively implementing this policy statewide. These may include lack of workforce capacity, limited geographic access, limited funding, etc.)	Suggested Source for State Information
Physical health				
1. Income eligibility for Medicaid/CHIP (Children's Health Insurance Program) is at or above 200% of the federal poverty level for pregnant women.	**No**	25 states	Medicaid eligibility in Oregon for pregnant women is up to 185% FPL.	NCCP *Early Childhood State Profiles*
2. State provides temporary coverage for pregnant women until Medicaid eligibility can be fully determined.	**No**	32 states	No presumptive eligibility for pregnant women for overall care. However, most pregnant women through 185% FPL qualify for Hospital Presumptive Eligibility (at participating hospitals) in Oregon which allows women to receive prenatal care services before Medicaid eligibility can be fully determined. Notably, Hospital Presumptive Eligibility does NOT cover labor and delivery. http://www.oregon.gov/oha/HSD/OHP/Pages/HPE.aspx	NCCP *Early Childhood State Profiles*
3. Income eligibility for Medicaid/CHIP is at or above 200% of the federal poverty level for children from birth to 5 years old.	**Yes**	46 states	In Oregon, CHIP eligibility has been extended to 300% FPL, and Medicaid eligibility to 133% FPL for this age group.	NCCP *Early Childhood State Profiles*
4. State provides temporary coverage for children until Medicaid/CHIP eligibility can be fully determined.	**No**	17 states	Hospital Presumptive Eligibility is available at participating hospitals for Medicaid children under age 1 (through 185% FPL) and age 1-18 (through 133% FPL) and for CHIP children under age 1 (above 185% through 300% FPL) and age 1-18 (above 133% through 300% FPL). http://www.oregon.gov/oha/HSD/OHP/Tools/Quick%20Guide%20to%20Income%20Eligibility%20for%20HPE%20Determinations.pdf	NCCP *Early Childhood State Profiles*

[8]Source for national data in this table, unless indicated otherwise: National Center for Children in Poverty, *United States Early Childhood Profile,* updated May 2015. Available online at: www.nccp.org/profiles/early_childhood.html

Policy	Yes/No	No. of States with this Policy[9]	Comments on Policy Implementation Challenges (Note any barriers to effectively implementing this policy statewide. These may include lack of workforce capacity, limited geographic access, limited funding, etc.)	Suggested Source for State Information
5. State requires newborn screening for the Recommended Uniform Screening Panel (metabolic, endocrine, hemoglobin and other disorders).[10]	**No**	8 states		NCCP *Early Childhood State Profiles*
6. State requires that children receiving Medicaid and/or CHIP have a medical home.	**Yes**	Data not available[11]	Oregon has mandatory enrollment in a CCO for Medicaid-covered individuals in most counties. CCOs are expected to utilize certified Patient-Centered Primary Care Homes (PCPCHs) to the maximum extent possible. Enrollment of covered individuals in PCPCHs is a CCO incentive measure, and at mid-year 2016, 90.6% of all CCO members had a PCPCH (children and adults). An additional CCO incentive measure is the percentage of children and adolescents with access to a primary care provider. At mid-year 2016, 88.9% of children and adolescents (age 12 months to 19 years) on Medicaid had a visit with a primary care provider. 93.5% of children age 12-24 months had a visit with a PCP, and 85.1% of children ages 25 months to 6 years) had a visit with a PCP. Within this metric there are some disparities by race/ethnicity, which vary by age group. For the overall metric (12 months to 19 years): - White: 88.9% - Hispanic/Latino: 90.0% - African American/Black: 87.9% - Asian American: 88.9% - American Indian/Alaska Native: 89.7% Hawaiian/Pacific Islander: 79.7%	Oregon Health Authority 2016 Mid-Year Performance Report: http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdf

[9]Source for national data in this table, unless indicated otherwise: National Center for Children in Poverty, *United States Early Childhood Profile,* updated May 2015. Available online at: www.nccp.org/profiles/early_childhood.html

[10]For more information on the Recommended Uniform Screening Panel, see http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/

[11]The following resources from the National Association of State Health Policy (NASHP) can help you examine your state's status in comparison with other states: http://nashp.org/resources-improve-medicaid-children-and-adolescents/ and http://nashp.org/care-coordination/

7. State has adopted its own Medicaid definition of "medical necessity" that is specific to children.	**No**	8 states[12]		NASHP, *EPSDT Resources to Improve Medicaid for Children & Adolescents*
State provides Medicaid reimbursement for early childhood oral health assessments performed in medical settings	**Yes**		OHP reimburses providers for oral health assessments in medical settings for children under age 6. To receive reimbursement, providers must have received recent training through Smiles for Life or First Tooth (offered through the Oregon Oral Health Coalition). Some CCOs have voluntarily extended this coverage to all children aged 19 and younger.	http://www.oregon.gov/oha/HPA/ANALYTICS/Documents/oral-health-ccos.pdf
Policy	**Yes/No**	**No. of States with this Policy[13]**	**Comments on Policy Implementation Challenges** (Note any barriers to effectively implementing this policy statewide. These may include lack of workforce capacity, limited geographic access, limited funding, etc.)	**Suggested Source for State Information**
8. EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) periodicity schedule for preventive pediatric health care meets American Academy of Pediatrics recommendations: ● Seven screenings	• Children less than 1 year: No • 1- to 2-year-olds: Yes • 3- to 5-year-olds: Yes	● Less than 1 year old: 13 states ● 1- to 2-year-olds: 44 states ● 3- to 5-year-olds: 50 states		NCCP *Early Childhood State Profiles*

[12]National Academy for State Health Policy (NASHP), *EPSDT Resources to Improve Medicaid for Children and Adolescents,* 2013. Available online at: http://nashp.org/resources-improve-medicaid-children-and-adolescents/ (Most states either adopt the federal definition or develop their own definition that is not specific to children.)

[13]Source for national data in this table, unless indicated otherwise: National Center for Children in Poverty, *United States Early Childhood Profile,* updated May 2015. Available online at: www.nccp.org/profiles/early_childhood.html

for under children less than 1 year old • Four screenings for 1- to 2-year-olds • Three screenings for 3- to 5-year-olds				
9. State policy requires regular schedule of immunizations and well-child visits for all maltreated infants and toddlers.[14]	**Yes**	12 states[15]	Oregon requires adherence to physical health/immunizations, dental health, mental/behavioral health, and developmental assessments and screening schedules for all maltreated infants and toddlers. Rules consistent with OAR413-015-0465 specify that "All children in paid substitute care will be referred for: a) A medical and dental assessment within 30 days of entering care; and b) A mental health assessment within 60 days of entering care." In addition, physical and mental health assessments for children ages **4+** in DHS custody is a CCO incentive measure. Under this metric, Oregon currently reaches 67.5% of children age 4+ on Medicaid in DHS custody with timely physical and mental health assessments.	ZTT and Child Trends, *Changing the Course for Infants and Toddlers* Oregon Health Authority Mid-year 2016 Performance Report: http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdf *Yes*
Policy	**Yes/No**	**No. of States with this Policy[16]**	**Comments on Policy Implementation Challenges** (Note any barriers to effectively implementing this policy statewide. These	**Suggested Source for**

[14]Most states rely on EPSDT or the American Association of Pediatrics to determine the required schedule of care.

[15]ZERO TO THREE and Child Trends, *Changing the Course for Infants and Toddlers: A Survey of State Child Welfare Policies and Initiatives*, September 2013, available online at: www.zerotothree.org/policy/docs/changing-the-course-for-infants-and-toddlers.pdf (Note that 46 states participated in the survey.)

[16]Source for national data in this table, unless indicated otherwise: National Center for Children in Poverty, *United States Early Childhood Profile,* updated May 2015. Available online at: www.nccp.org/profiles/early_childhood.html

			may include lack of workforce capacity, limited geographic access, limited funding, etc.)	**State Information**
10. State has adopted Medicaid expansion as part of the Affordable Care Act.	**Yes**	28 states		NCCP *Early Childhood State Profiles*
Developmental screening				
1. State Medicaid program requires standardized developmental screening as part of well-child visits.	**Yes**	14 states[17]	The Oregon Health Plan (Medicaid) uses the AAP Bright Futures guidelines, which recommend developmental screening at the 9 month, 18 month and 30 month visits. Developmental screening in the first three years of life is a CCO incentive measure and the screening rate has been rapidly improving throughout the state. Final report for OPIP Yamhill Project (CY 2016) on pathways to follow-up for developmental screening.	NASHP, *State Medicaid Policies that Require and Reimburse for Developmental Screening.*
2. State provides Medicaid reimbursement for use of a standardized developmental screening tool, in addition to the regular payment for a well-child visit.	**Yes**	26 states[18]	One implementation challenge is data sharing; there is a desire for early childhood providers to be able to share the developmental screenings they conduct with a child's primary care provider, but the data sharing mechanism is not available. Primary care providers must only review the developmental screening tool with the family (don't have to conduct the screening if one has already been conducted by another provider). Under this Medicaid reimbursement and CCO incentive metric, PCPs are not required to make referrals or provide follow-up services to children who screen at-risk for a developmental delay. Oregon screening rate data do not reflect the percentage of children receiving needed services.	NASHP, *State Medicaid Policies that Require and Reimburse for Developmental Screening.*
3. State policy requires a regular schedule of developmental monitoring/screening for all maltreated infants and toddlers.[19]	**Yes**	14 states[20]	Oregon requires adherence to physical health/immunizations, dental health, mental/behavioral health, and developmental assessments and screening schedules for all maltreated infants and toddlers. Rules consistent with OAR413-015-0465 specify that "All children in paid substitute care will be referred for: a) A medical and dental assessment within 30 days of entering care; and b) A mental health assessment within 60 days of entering care."	ZTT and Child Trends, *Changing the Course for Infants and Toddlers*

[17]National Academy for State Health Policy, *State Medicaid Policies that Require and Reimburse for Developmental Screening*, 2011, http://nashp.org/sites/default/files/abcd/ABCDresources.org/abcd3.devscreeningmap.052011.pdf (Note that 11 states did not respond to NASHP's survey.)

[18]*Ibid.*

[19]Most states rely on EPSDT or the American Association of Pediatrics to determine the required schedule of care.

[20]ZERO TO THREE and Child Trends, 2013.

			In addition, physical and mental health assessments for children ages 4+ in DHS custody is a CCO incentive measure. Under this metric, Oregon currently reaches 67.5% of children age 4+ on Medicaid in DHS custody with timely physical and mental health assessments.	Oregon Health Authority Mid-year 2016 Performance Report: http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-Year_Report.pdfyes
Policy	**Yes/No**	**No. of States with this Policy[21]**	**Comments on Policy Implementation Challenges** (Note any barriers to effectively implementing this policy statewide. These may include lack of workforce capacity, limited geographic access, limited funding, etc.)	**Suggested Source for State Information**
Social–emotional health				
1. State has a mechanism in place to ensure that clinicians can diagnose infant-toddler mental health conditions and receive Medicaid or other health insurance payment for appropriate treatment.[22]	**Yes**	Data not available.	Oregon's Health Evidence Review Commission recently approved a new billing code (Z63.8) to be able to provide mental health services to children ages 0-6 who are at-risk of poor outcomes as a result of their family and home environments. This is a prevention code to be able to identify and serve children with higher risk level before they reach diagnostic level. There are implementation challenges regarding provider awareness and utilization of this new code. Early childhood mental health treatment (including dyadic/family therapy) is billable, however Oregon does not have the infrastructure (resources, workforce, etc.) necessary to provide these services to all children who may need them.	NCCP Early Childhood Mental Health Survey
2. State Medicaid program recommends or requires that pediatric primary care clinicians use a standardized	**Yes**	Data not available.	Oregon follows AAP Bright Futures guidelines, which recommends conducting social-emotional screening using a standardized tool.	

[21]Source for national data in this table, unless indicated otherwise: National Center for Children in Poverty, *United States Early Childhood Profile,* updated May 2015. Available online at: www.nccp.org/profiles/early_childhood.html

[22]This includes states that have a mental health policy recognizing DC: 0-3R disorders for early childhood mental health treatment eligibility or a crosswalk from the DC: 0-3R to the DSM-5, ICD-10, and/or Current Procedural Terminology codes.

screening tool to assess social–emotional and behavior issues.				
3. State provides Medicaid reimbursement for use of standardized screening tool for social–emotional and behavior issues, in addition to the regular payment for a well-child visit.	**Yes**	Data not available.	Social-emotional screening is recommended (i.e. with ASQ-SE) and Medicaid will reimburse for providers doing the screening. This screening can be administered in non-medical settings, but the social-emotional screening can't be done on the same day as general development screen (which seems like an implementation challenge).	NCCP Early Childhood Mental Health Surveys
Policy	**Yes/No**	**No. of States with this Policy[23]**	**Comments on Policy Implementation Challenges** (Note any barriers to effectively implementing this policy statewide. These may include lack of workforce capacity, limited geographic access, limited funding, etc.)	**Suggested Source for State Information**
4. State requires a regular schedule of mental health/behavioral screening for all maltreated infants and toddlers.[24]	**Yes**	8 states.[25]	Oregon requires adherence to physical health/immunizations, dental health, mental/behavioral health, and developmental assessments and screening schedules for all maltreated infants and toddlers. Rules consistent with OAR413-015-0465 specify that "All children in paid substitute care will be referred for: a) A medical and dental assessment within 30 days of entering care; and b) A mental health assessment within 60 days of entering care." In addition, physical and mental health assessments for children ages 4+ in DHS custody is a CCO incentive measure. Under this metric, Oregon currently reaches 67.5% of children age 4+ on Medicaid in DHS custody with timely physical and mental health assessments.	ZTT Changing the Course for Infants and Toddlers, 2013 Oregon Health Authority Mid-year 2016 Performance Report: http://www.oregon.gov/oha/Metrics/Documents/2016_Mid-

[23]Source for national data in this table, unless indicated otherwise: National Center for Children in Poverty, *United States Early Childhood Profile,* updated May 2015. Available online at: www.nccp.org/profiles/early_childhood.html

[24]Most states rely on EPSDT or the American Association of Pediatrics to determine the required schedule of care.

[25]ZERO TO THREE and Child Trends, 2013.

				Year_Report.pdf
5. State has a policy in place to promote maternal depression screening at prenatal visits, after birth, and/or at a well-child visit.[26]	**Yes**	Data not available	Medicaid will reimburse for maternal depression screenings (don't know if there is a set recommended interval or a limit on the number of screenings that Medicaid will pay for). Some states allow Medicaid to pay for maternal depression screenings under the child's Medicaid ID, which allows for far greater reach. Oregon hasn't adopted this policy. As a result of HB 2666, in 2010 OHA produced a comprehensive Maternal Mental Health Work Group Report that includes recommendations for implementing and promoting maternal depression screening and other activities to address maternal mental health: https://public.health.oregon.gov/HealthyPeopleFamilies/Women/MaternalMentalHealth/Documents/HB2666-mmh-report.pdf	NCCP Early Childhood Mental Health Survey
6. State has adopted early childhood mental health competencies to build the capacity of professionals working with young children in addressing mental health needs.	**No**	26 states[27]	Oregon recently purchased IMH-E® from the Michigan Infant Mental Health Association, and is promoting the endorsement throughout the state. The endorsement includes a comprehensive set of early childhood mental health competencies. These have not been adopted by the state as competencies that all early childhood professionals must have.	ZTT *State Policy Tracker*

3. Does the state allocate state or federal funds to services that promote good health?

This section can be completed by a state agency or statewide organization by reviewing agency budgets, Web sites, and other available state data. It may be helpful to seek stakeholder input for the Comments section.

Policy	**Yes/No**	**Funded Statewide or in Selected Communities?**	**Data on Population Served** (Provide any available state data on the population served by this program.)	**Comments on Population Served** (Is funding adequate? What populations, if any, are underserved?)

[26]This may include a state requirement to offer screening and/or a policy allowing for Medicaid reimbursement.

[27]ZERO TO THREE state policy tracking, January 2015.

Physical health				
1. State allocates funds to support health care consultation for early care and education providers.	**No**	OHA does limited and minimally funded work on child care policy issues as needed, but is not funded to provide child care health consultation.		
2. State allocates funding to health and safety initiatives, including: ● Oral health ● Obesity prevention (e.g. nutrition/physical activity) ● Environmental hazards (e.g. lead poisoning)[28] ● Car seat safety ● Safe sleep ● Shaken Baby Syndrome	**Yes**	State allocates GF for prenatal, BabiesFirst! and child and adolescent populations; these topics (in first column) are addressed in prenatal and BabiesFirst! home visiting. WIC and MCH work on breastfeeding and obesity prevention statewide. Other topics are addressed through child care policy work, Title V priorities, mini-CoIIN projects. Seven counties and two tribes selected oral health as a priority to work on as part of the Title V MCH Block grant during 2016.	Oral health: No state data available specifically for all children 0-3; seven counties and two tribes working on Title V oral health priority. Medicaid data available for some oral health services (varying age groups). Other topics: Because so much of the work is wrapped into Title V, home visiting, public education/prevention and other work, it is difficult to parse out this data. Home visiting numbers are available but not representative of the full picture of infants and toddlers impacted by these initiatives.	Oral health: Title V grantees that selected oral health are working on strategies to increase the number of dental visits for pregnant women and children. These strategies include: ● Integrating oral health into medical well-child visits and nurse home visiting programs; ● Supporting oral health during pregnancy; and Providing oral health education and referral services.
Social–emotional health				
1. State allocates funding to support mental health consultation for early care and education providers and other professionals working with young children.	**No**	Need to investigate further; may be happening but on an ad hoc basis?		

[28]Gebhard, Barbara, Initiatives Related to Environmental Hazards, ZERO TO THREE, October 2015, www.zerotothree.org/enviroinits

2. State allocates funding to promote screening for maternal depression and referrals to treatment.	**No**	As a result of HB 2666, in 2010 OHA produced a comprehensive Maternal Mental Health Work Group Report that includes recommendations for implementing and promoting maternal depression screening and other activities to address maternal mental health: https://public.health.oregon.gov/HealthyPeopleFamilies/Women/MaternalMentalHealth/Documents/HB2666-mmh-report.pdf		
3. State allocates funding to support efforts to co-locate mental health clinicians in pediatric primary care.	**Sort of…**	Oregon does not specifically allocate funding for this purpose; however, Oregon is in the process of integrating behavioral health into the CCOs serving the Medicaid population; as part of this process, some CCOs are selecting to co-locate behavioral health specialists in pediatric clinics.		
Developmental screening				
1. State supports Help Me Grow[29] or similar initiatives to expand access to developmental screening and referrals to	**Yes**	Statewide and Local: Medicaid incentive metric plus state-funded local pilots to develop effective pathways for connecting children who screen at-risk with needed	Developmental screening by age 3 is an incentive metric for Oregon's CCOs, with 62.2% of children on Medicaid currently receiving screening. NOTE: Completion of developmental screening by this metric does not include or reflect referrals to follow-up	Local pilot funded by OHA serves children receiving Medicaid in Yamhill County. Local pilot funded by ODE/Willamette ESD serves children in Marion, Polk & Yamhill County who screen at risk for developmental delays but are not eligible for Early Intervention services.

[29]For more information, see: www.helpmegrownational.org

needed services.		services.	services for those children screening at risk for a developmental delay. This metric also does not reflect screenings occurring in early learning settings.	
Other relevant state health investments				
1. Cover All Kids		Approved by 2017 Legislature, Medicaid coverage of undocumented children begins January 1, 2018		
2. WIC		Additional $1m allocated by 2017 Legislature		

STRONG FAMILIES

State policies that promote strong families support the capacity of parents and other family members to nurture children's development. This includes policies addressing families' basic needs, supporting high-quality parent education and home visiting programs, meeting the needs of young children in the child welfare system, and promoting paid family leave.

For more information on state policy strategies to promote strong families, additional ZERO TO THREE resources are available at: www.zerotothree.org/public-policy/policy-toolkit/strong-families-policy-toolkit.html

For states interested in more in-depth examination of home visiting or child welfare state policies, ZERO TO THREE has developed more detailed state policy self-assessment tools on these two topics:

- State home visiting systems: www.zerotothree.org/public-policy/webinars-conference-calls/home-visitation-tool-june-16-2010.pdf; and
- State child welfare services for infants, toddlers and their families: http://main.zerotothree.org/site/DocServer/PDF__1_-Child_Welfare_Tool.pdf?docID=13381

1. How are infants, toddlers and their families doing?

This section can be completed by a state agency or statewide organization, using the most recent data available from state data sources. The information required is available in state databases, as well as the following sources:

- ZERO TO THREE (ZTT), *State Baby Facts* [50 state profiles]: www.zerotothree.org/public-policy/state-community-policy/infant-and-toddler-state-fact-sheets.html
- The Annie E. Casey Foundation's KIDS COUNT Data Center, available at: http://datacenter.kidscount.org/
- The Child and Family Center and the BUILD Initiative, *Fifty State Chart Book: Dimensions of Diversity and the Young Child Population*: http://buildinitiative.org/TheIssues/DiversityEquity/50StateChartBook/50StateChartBookOverview.aspx

It may be helpful to seek stakeholder input for the Comments section.

Child & Family Data	State	National Comparison[30]	Disparities[31] (Provide available state data indicating any notable disparities by family income, race, ethnicity, or gender.)	Comments (Provide any relevant information on state context or trends.)	Suggested Source for State Data
1. Percent of young children experiencing three or more risk factors* Percent of young children exposed to 1-2 risk factors *Defined as poor, single parent, teen mother, low parental education, nonemployed parents, residential mobility, households without English speakers and large family	**17%*** **43%**	18%[32]	Percent of children under 18 who have experienced 2 or more ACE[ss33] (2011-12): -Black 52 (6,800) -Non-Hisp. White 26 (138,000) -Hispanic 20 (35,900) -American Indian/Alaska Native: NA -Asian/Pacific Islander: NA Total: 25% (225,600) Source for above data: Kids Count Data Center/Children's First for Oregon, based on 3-year Census ACEs data for 2009-	Data from the 2011/2012 National Survey on Children's Health included Adverse Family Experiences. Oregon's data showed : 12.6% of 0-5 year olds had already experienced 2 or more ACEs (national average 12.5%), 22.7% of 0-5 year olds had already experienced 1 ACEs (national average: 24.1%). The numbers of children ages 6-11 with ACEs of two or more jumped significantly.	NCCP *Early Childhood State Profiles* ***Data Source:** National Center for Children in Poverty Early Childhood State Profiles, 2009-11 American Community Survey

[30]Source for all national data in this table, unless indicated otherwise: ZERO TO THREE, *State Baby Facts*, updated June 2015. Original sources available at: www.zerotothree.org/public-policy/state-community-policy/baby-facts/related-docs/state-baby-facts-2015-references.pdf

[31]The following is a good source of state data on ethnic and racial disparities: The Child and Family Center and the BUILD Initiative, *Fifty State Chart Book: Dimensions of Diversity and the Young Child Population*: http://buildinitiative.org/TheIssues/DiversityEquity/50StateChartBook/50StateChartBookOverview.aspx

[32]National Center for Children in Poverty (NCCP), *United States Early Childhood Profile,* updated May 2015, available online at www.nccp.org/profiles/early_childhood.html. State-level data are available in individual state profiles. NCCP's analysis of risk factors includes the following: poor, single parent, teen mother, low parental education, nonemployed parents, residential mobility, households without English speakers, and large family size.

[33] Adverse Child Experiences (ACES) 10 experiences that can affect brain development: physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, a mentally ill or depressed parent, a substance abusing parent, witnessing domestic violence, incarceration of a family member, and loss of parent due to abandonment/death/divorce

size.			2011.		
2. Percent of maltreated children who are less than 3 years old	**27%*** **(3622)**	27%	Oregon DHS -Child Welfare FFY 2015 Percent of maltreated children who are less than 3 years old by race/ethnicity:: -AI/AN: 3 (126) -A/PI: 1 (52) -Black/AA: 6 (208) -Hispanic: 12 (438) -Other: 13 (492) -White: 63 (2305) Total: 3622	Source: 2015 DHS Child Welfare Data Book. OR-Kids Case Management Data system.	*ZTT *State Baby Facts*
3. Percent of children less than 3 years old who are experiencing residential mobility	**27%**	23%		Residential mobility: having moved at least once in the past 12 months. 19,490, or 1 in 14 children under age 6 are estimated to be homeless in Oregon. Data Source: Administration for Children & Families " A Look at Early Childhood Homelessness, Oregon"	ZTT *State Baby Facts*
4. Percent of children less than 6 years old with no parent in the labor force	**7%**	10%	Race/ ethnicity data sought	65% of children under 6 have all available parents employed. Data Source: Kids Count Data Center 2015	ZTT *State Baby Facts*
5. Percent of children from birth to 18 years old living in census tracts with poverty levels of 40% or higher	**0.7%**	4%[34]	21.9% of children ages 0-8 live in households below 100% of the Federal Poverty Level. 44.1% are Black 36.8% are Hispanic 16.7% are White 17.9% Other	Source data for this Chart Book is 5-year Census ACS covering the period of 2008 to 2010.	BUILD Initiative, *Fifty State Chart Book*

[34]The Child and Family Center and the BUILD Initiative, *Fifty State Chart Book: Dimensions of Diversity and the Young Child Population*. Available online at: http://buildinitiative.org/TheIssues/DiversityEquity/50StateChartBook/50StateChartBookOverview.aspx

			46.9% of all 0-8 year-olds live in households at or below 200% of the Federal Poverty Level. 71.5% Latino/Hispanic 62.7% Black 41.1 % Other 38.9% White		
6. Percent of children from birth to 5 years old with family employment affected by child care issues	**9%**	14%		Measure would be difficult to operationalize with admin data because of the implied causation (employment status is a result of child care issues).	ZTT *State Baby Facts*
7. Percent of TANF (Temporary Assistance to Needy Families) Program families with at least one child less than 3 years old	**57%**	37%		Source: DHS State FY2016	ZTT *State Baby Facts*
8. Percent of Supplemental Nutrition Assistance Program (SNAP) recipients who are less than 5 years old	**11%**	14%		In March 2017, the total number of Supplemental Nutrition Assistance Program (SNAP) participants were 534,168. Source: Oregon SNAP Caseload Flash Report, DHS. Data disaggregated by child age is not available.	ZTT *State Baby Facts*
9. Percent of children entering foster care who are less than 3 years old	**34%**	31%	FFY 2015 Count of Oregon Children Age 0-3 Entering into Foster Care by Race: American Indian/Alaska Native: 82 (5%) Asian/Pacific Islander: 2 (1%) Black/African American: 91 (5%) Hispanic: 230 (14%) Other: 26 (1%) White: 1141(71%)	Source: DHS FFY 2015- OR-Kids Case Management System	ZTT *State Baby Facts*

			Total: 1590		
10. Percent of households receiving LIHEAP (Low Income Home Energy Assistance Program) heating assistance with a child less than 6 years old	**24%**	22%			ZTT *State Baby Facts*
11. Veteran families with children	**84,955 households** (1,333,723 total households in Oregon)* *Census data	6,386,836 households		Data not broken out by child ages.	National Center for Veteran Analysis and Statistics: Veteran Households with Children, 2015 data
12. 211 Requests for assistance from households with infants and toddlers			From May 2016-March 2017, there were 3509 requests for assistance to 211 from families identifying as pregnant, or having at least 1 child under the age of 2 living in the household. .06% African 13.9% African American/Black 4.3% Alaskan Native & Native American 2.4% Asian 19% Hispanic/Latino .28% Middle Eastern and Northern African	Types of referrals requested: Housing 6,101 requests Utility Assistance 3,031 Individual, Family & Community SUpport 2,388 Food/Meals 1, 259 Health Care 1, 034 Income Support and Assistance 1,020 Legal, Consumer and Public Safety Services 650 Clothing, Household, Personal Needs 520 Information Services 381 Transportation 421 mental Health/Addictions 326 Education 120 Other: Employment, Disaster Services, Arts, Culture and	211 Data System Custom Report

			1.9% Native Hawaiian and Pacific Islander 57.2% White	Recreation, Volunteers/Donations, and other Government/Economic Services	

2. Does your state have policies in place to support strong families?

This section can be completed by a state agency or statewide organization with an understanding of current state policies.

- Most of the state information required is available through the National Center for Children in Poverty (NCCP), *Early Childhood State Profiles*, available here: www.nccp.org/profiles/early_childhood.html, though states may have more up-to-date information.
- Information on state child welfare policies is available here: ZERO TO THREE and Child Trends, *Changing the Course for Infants and Toddlers" A Survey of State Child Welfare Policies and Initiatives:* www.zerotothree.org/policy/docs/changing-the-course-for-infants-and-toddlers.pdf

It may be helpful to seek stakeholder input for the Comments section.

Policy	**Yes/No**	**States with This Policy in Place**[35]	**Comments on Policy Implementation Challenges** (Note any barriers to effectively implementing this policy statewide. This may include lack of workforce capacity, limited geographic access, limited funding, etc.)	**Suggested Source for State Information**
Basic needs				
1. TANF (Temporary Assistance to Needy Families) policies: ● Exempt single parents from the work requirement until youngest child is at least 1 year old. ● Reduce the	**No**	● 25 states	Current TANF policy: A parent is exempt from employment for 6 months after giving birth. They may volunteer to work. If under 20 years of age, they are exempt during the first 16 weeks after giving birth.	NCCP *Early Childhood State Profiles*

[35]Source for national data in this table, unless indicated otherwise: National Center for Children in Poverty, *United States Early Childhood Profile,* updated May 2015. Available online at: www.nccp.org/profiles/early_childhood.html

work requirement to 20 hours or less for single parents with children less than 6 years old. • Offer exemptions and/or extensions of the TANF benefit time limit for women who are pregnant or caring for a child less than 6 years old.	**No** **No**	• 30 states • 19 states	The federal participation requirement for work hours for single adults with a child under the age of 6 is 20 hours. Oregon utilizes some flexibility around the work requirement, based on family needs. Exemption periods may be extended, based on family need, but no extension of the TANF lifetime benefit of 60 months.	
2. State has a state minimum wage that exceeds the federal minimum wage of $7.25 per hour.	**Yes**	29 states[36]	Senate Bill 1532, enacted by the Oregon Legislature in 2016, established a series of annual minimum wage rate increases through 2022. In addition to the new standard rate, ($9.75 per hour through July 1, 2017), separate rates apply to employers in the urban growth boundary of metropolitan service districts (currently $ 9.75 per hour) and for non urban counties (currently $9.50 per hour).	*National Conference of State Legislatures*
3. State exempts single-parent families with children less than 3 years old below the poverty level from	**No**	41 states	No additional data.	NCCP *Early Childhood State Profiles*

[36]National Conference of State Legislatures, www.ncsl.org/research/labor-and-employment/state-minimum-wage-chart.aspx#1

personal income tax.				
4. State offers a refundable state earned income tax credit.	**Yes**	20 states	Oregon offers Earned Income Tax Credit, which is 8% of the federal earned income tax credit. The EITC is 11% for families with children under the age of 3. Source: Oregon Dept. of Revenue	NCCP *Early Childhood State Profiles*
5. State offers a refundable state dependent care tax credit.	**Yes**	11 states	Oregon offers the Working Family Household and Dependent Care Credit which is 8-40% of child care expenses, depending on gross income. Source: Oregon Dept. of Revenue	NCCP *Early Childhood State Profiles*
Home visiting/parent education				
1. State has statewide centralized or coordinated intake system(s) to help connect families to an appropriate home visiting or parent education program.	**No**	4 states have centralized statewide intake. Another 7 states have a statewide system of regional/local intake systems.[37]	Since 2012,MIECHV dollars have funded staffing and resource to develop regionalized hubs to coordinate home visiting systems. Regions are in varying degrees of system development. it is not anticipated that Oregon will take a centralized approach for all home visiting system coordination, rather that regional systems will align together around specific outcomes and data systems.	Oregon DOE-Early Learning Division, and Oregon Health Authority
2. State has core competencies for parent education/home visiting professionals.	**Yes**	11 states[38]	Since 2009 MIECHV dollars in Oregon have funded a home visiting workforce development coordinator, leading to the completion of these core competencies in 2015.	ZTT *State Policy Tracker*
Child welfare				
1. State requires frequent visitation with	**Yes**	15 states require		ZTT and Child Trends,

[37]Maternal, Infant, and Early Childhood Home Visiting Technical Assistance Coordinating Center, *MIECHV Issue Brief on Centralized Intake Systems,* October 2014.

[38]ZERO TO THREE state policy tracking, January 2015.

birth parents for infants and toddler in out-of-home care (foster/kinship care) when safe and appropriate.[39]		visitation at least once a week. [40]		*Changing the Course for Infants and Toddlers*
2. State policy requires more frequent case reviews for infants and toddlers in out-of-home placements than for older children.	**No**	4 states		ZTT and Child Trends, *Changing the Course for Infants and Toddlers*
3. State policy requires more frequent permanency hearings for infants and toddlers in out-of-home placements than for older children.	**No**	6 states		ZTT and Child Trends, *Changing the Course for Infants and Toddlers*
4. For infants and toddlers in out-of-home placements, state policy specifically promotes keeping young children in their first placement.	**Yes**	39 states		ZTT and Child Trends, *Changing the Course for Infants and Toddlers*

[39]When safe and appropriate, a visitation plan should allow for frequent visits/contact between young children and their parents, including therapeutic supervision of visits.

[40]Source for all national data in the child welfare section:
ZERO TO THREE and Child Trends, *Changing the Course for Infants and Toddlers" A Survey of State Child Welfare Policies and Initiatives*, September 2013, available online at: www.zerotothree.org/policy/docs/changing-the-course-for-infants-and-toddlers.pdf (Note that 46 states participated in the survey.)

5. State initiates concurrent planning as soon as possible (or within 24 hours of removal) to ensure that infants and toddlers in out-of-home placement are expeditiously moved into permanent placement.	**No**	14 states		ZTT and Child Trends, *Changing the Course for Infants and Toddlers*
Family leave				
1. State has paid family leave policy providing full or partial replacement of wages after birth or adoption.	**No –** unpaid leave	3 states[41]	A paid family leave bill made inroads but ultimately failed in the Oregon Legislature in the 2017 session. The Oregon Family Leave Act allows employees to request unpaid leave for family reasons after 6 months of employment. http://www.ncsl.org/research/labor-and-employment/state-family-and-medical-leave-laws.aspx http://archives.abetterbalance.org/component/content/article/48-sick-leave/350-oregon Additional information: http://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/DATAREPORTS/PRAMS/Documents/Family%20Leave%20Fact%20Sheet_March2017.pdf	*National Conference of State Legislatures*
2. State has a policy requiring employers to provide paid sick leave that allows parents to take paid time off when a child is sick.	**Yes-**	4 states[42]	Oregon law requires employers to offer up to 40 hours of "protected sick time" which can be used for the care of sick children.	A Better Balance, *Overview of Paid Sick Leave Laws in the U.S.*

3. Does the state allocate federal or state funds to services that promote strong families?

[41]ZERO TO THREE state policy tracking, January 2015.

[42]A Better Balance: The Work and Family Legal Center, *Overview of Paid Sick Leave Laws in the United States*, available online at: www.abetterbalance.org/web/images/stories/Documents/sickdays/factsheet/PSDchart.pdf

This section can be completed by a state agency or statewide organization by reviewing agency budgets, Web sites, and other available state data. It may be helpful to seek stakeholder input for the Comments section.

Policy	**Yes/No**	**Funded Statewide or in Selected Communities?**	**Data on Population Served** (Provide any available state data on the population served by this program.)	**Comments on Population Served** (Is funding adequate? What populations, if any, are underserved?)
Basic needs				
1. State funds supplement federal resources for nutrition programs that reduce food insecurity for young children.	**Yes**	Statewide through the Food Assistance Program		Restrictions apply for immigrants/refugees
2. State allocates funding to initiatives addressing: ● Affordable housing ● Homelessness ● Job training ● Domestic violence ● Substance abuse		Lift program: Selected Communities SHAP- Statewide JOBS and WorkSource Oregon: Statewide, however access is rural areas can be challenging	Housing: Multiple bills are currently under consideration in the Oregon Legislature to incentivize affordable housing rental and development. Oregon allocates funding for a menu of housing related needs including rental assistance, foreclosure prevention and home ownership. In 2015 the Oregon Legislature committed $40 million of general obligation bonds to fund the Local Innovation and Fast Track (LIFT) Housing Program to build new affordable housing for low-income households. Homelessness: The State Homeless Assistance Program (SHAP) offers state funds to help meet emergency needs of homeless individuals by providing operational support for emergency shelters and their supportive services. Job Training: Low-income families receiving Temporary Assistance for Needy Families (TANF) access the Jobs Opportunity and Basic Skills program(JOBS). State funding supports WorkSource Oregon as a resource for employment. DV: In 2016, 6,307 children ages 12 and under were served by community-based domestic and sexual violence programs in Oregon. Services for children	Housing: No. the national Low Income Housing Coalition has identified an affordable housing gap in every county which is broken out by income level. There are, for example, 26 affordable units available for every 100 households earning 30% of the median family income in OR State, leaving a *gap* of 74 units per 100 Oregon households. Homelessness: No. Add homelessness data disaggregated by race/ethnicity Job Training: Add data here DV: In 2013-115, $8,238,256 Oregon state funds were spent on emergency assistance for victims of domestic violence through TA-DVS. An average of 447 families escaping domestic

			totaled 4,143 contacts; from crisis response and child care to support groups, follow-up and referrals. Data Source: Striving to Meet the Need,DHS Child Safety Unit, April 2017. *How many families with children served annually/monthly in TA-DVS??* <u>Substance Abuse</u>: THere is an unmet need for treatment of alcohol and illicit drug abuse and dependency in Oregon, with 2.7% of Oregonians reporting they had an unmet need for treatment for illicit drug use, and 7.1% of Oregonians reporting they had an unmet need for treatment for alcohol. Source: National Survey on Drug Use and Health, 2011-2012. .There are approximately 12 treatment centers for women with children in Oregon, primarily located in urban/suburban areas of the state, in which children under 5 can reside with their parents. Programs have a high variability in services for the children. In 2015, SAMHSA awarded Oregon $33,428,782 in substance abuse funds, of which 1% were awarded to programs serving infants and toddlers. Source: SAMHSA state Summaries FY 2015-16 .	violence received emergency payments from TA-DVS each month. Data Source: 201 5DHS Report to the Legislative Assembly Pursuant to ORS 411.154, August 2016. Oregon DHS Self-Sufficiency operates Temporary Assistance for Domestic Violence Survivors (TA-DVS) to address emergent/safety needs. Families must meet TANF eligibility requirements and the DHS SS definition of domestic violence. Eligible families can access up to $1200 to meet safety and stabilization needs, and are referred to other resources for further support. No child-level data available. DHS contracts with local non-profit agencies to provide 56 co-located DV/sexual assault advocates in branches across the state. Advocates also provide training and support to DHS field staff. Additional data pending.
Home visiting/parent education				

1. State allocates funds to evidence-based home visiting programs for expectant parents and families of young children.	**Yes**	Selected	High risk families meeting program model eligibility criteria can access state/federally funded home visiting programs such as Healthy Families Oregon, Nurse Family Partnership, Early Head Start and Relief Nurseries, administered through the Early Learning Division and the Oregon Health Authority. 841 slots are funded through federal MIECHV dollars. Home visiting programs in Oregon include: Babies First(ages 0-5): 4,076 children Healthy Families Oregon (0-3): 2,549 families Maternity Case Management: 2,060 mothers CaCoon (0-21 years): 1,922 children Migrant/Seasonal EHS (0-3): 1,565 children EHS Home-Based (0-3)serving: 1,173 children Family Support and Connections: (0-18) 3762 children Parents As Teachers-Affiliates (0-3): 944 children Data shown is from most recent year (calendar or fiscal) provided by State agencies overseeing programs (ELD, OHA, Self-Sufficiency)as of April 2017	84% of Oregon parents with children ages 0-3 do not receive a new parent home visit after their child's birth. Data Source: Kids Count Data Center. HV not available in all communities, and communities need multiple models to meet needs of families. Parents as Teachers is a model utilized by a large number of culturally specific organizations, with families that speak Spanish, Russian, Romanian, Moldovan, Ukrainian, Vietnamese, Cambodian, Laotian, Somali,Swahili, Turkish,, Burmese, Ethiopian?Amharic, Oromo, Maya indigenous languages, Mandarin and Cantonese
2. State allocates funds to evidence-based or research-informed parent education programs in early childhood programs, pediatric primary care, or other settings.[43]	**Yes**	ROR: 31	Data pending: Reach out and Read - Who sponsors? How many reached? Is about serve and return relationships. Car seat safety—training/funding for purchasing car seats. - Who offers?	Note: The 2017 Oregon Legislature passed a law requiring that children under age 2 must ride in rear-facing car seats.
3. State supports dissemination of parenting information to a wide range of parents through	**Yes-some**	Both	Vroom, Hub websites, OPEC, Early Learning and Development Guidelines	

[43]For more information on evidence-based parent education programs, see: Child Welfare Information Gateway, *Parent Education to Strengthen Families and Reduce the Risk of Maltreatment*, 2013. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. https://www.childwelfare.gov/pubPDFs/parented.pdf#page=5&view=Evidence-Based%20and%20Evidence-Informed%20Programs

Web sites, print materials, text messages, or other mechanisms.				
Other relevant state investments supporting strong families				
Early Learning Hubs			$18.7M allocated for Early Learning Hubs (2015-17): system coordination, school readiness, and family stability, and includes infant and toddler metrics.	
Oregon Parent Education Collaborative (OPEC) OPEC operates in 27 Oregon counties to support the delivery of high-quality parenting education programs and supports collaborative efforts to strengthen regional parenting education systems through coordination and planning. It is funded through a partnership between private foundations and Oregon State University. This initiative has helped expand parenting education classes offered through other funding, increasing the overall accessibility of parenting education in Oregon.			From 2010-2016, OPEC Hubs served 5,401 parents attending parenting ed series, 5,437 new families through home visits, 35,765 parents in parent workshops, and 179,034 family members at parent support activities. OPEC small grants served 2,164 parents attending parenting ed series, 833 new families through home visits, 2032 parents in parent workshops, and 4,865 parents and children attended parent support activities. DATA SOURCE: Oregon Parenting Education Collaborative 6-Year Summary Report 2010-2016	<u>Pending: Data disaggregated for prenatal and infant and toddler families</u> <u>From 2010-2016 OPEC Hubs served</u> 69% women; 24% men (7% did not specify gender) 67% White; 17% Hispanic; 4% Native American; 1% Black/African American; 1% Asian and 10% Other/ Non-Specified. 62% parenting with a partner, 24% parenting alone; 14% did not specify 62% of the families completing PSLs utilized at least one service designated for low-income households. <u>From 2010-2016 OPEC small grants served</u> 70% women; 27% men; (3% did not specify gender) 30% White; 44% Hispanic; 7% Asian; 9% Black/African/American; 2% Native American; and 8% Other or Non-Specified. 66% parenting with a partner; 27% parenting alone; 7% did not specify. 80% of the families completing PSLs utilized at least one service designated for low-income households. DATA SOURCE: Oregon Parenting Education Collaborative 6-Year Summary Report 2010-2016

POSITIVE EARLY LEARNING EXPERIENCES

State policies supporting access to and quality of child care, Early Head Start (EHS), and early intervention promote early learning and development and help prepare children for success in school. For more information on state policy strategies to promote positive early learning experiences, additional ZERO TO THREE resources are available at: www.zerotothree.org/public-policy/policy-toolkit/positive-early-learning-policy-toolkit.html

For states interested in more in-depth examination of how to use a state quality rating and improvement system (QRIS) to strengthen early learning experiences for infants and toddlers, ZERO THREE has developed a more detailed state self-assessment tool on this topic: www.zerotothree.org/public-policy/building-early-childhood-systems/qris/qris-cover-self-assessment-10-27-14.pdf

1. How are infants, toddlers and their families doing?

This section can be completed by a state agency or statewide organization, using the most recent data available from state data sources. The information required is available in state databases, as well as the following sources:

- ZERO TO THREE (ZTT), *State Baby Facts* [50 state profiles]: www.zerotothree.org/public-policy/state-community-policy/infant-and-toddler-state-fact-sheets.html
- The Annie E. Casey Foundation's KIDS COUNT Data Center, available at: http://datacenter.kidscount.org/
- The Child and Family Center and the BUILD Initiative, *Fifty State Chart Book: Dimensions of Diversity and the Young Child Population*: http://buildinitiative.org/TheIssues/DiversityEquity/50StateChartBook/50StateChartBookOverview.aspx

It may be helpful to seek stakeholder input for the Comments section.

Demographic	**State**	**National Compari**	**Disparities**[45] (Provide available state data indicating any notable disparities by family income, race, ethnicity, or gender.)	**Comments** (Provide any relevant information on state context or trends.)	**Suggested Source for State Data**

[45]The following is a good source of state data on ethnic and racial disparities: The Child and Family Center and the BUILD Initiative, *Fifty State Chart Book:*

		son[44]			
1. Percent of parents or family members who read to their child (newborn to 5 years old) every day	**55%**	48%	National comparison of 3-5 year olds read to daily: White -56 %, Black -34%, Hispanic- 25%. Low income households: 40%	HFO: 91% read to children at least 3x per week (NPC Research 2015). ORN: reading increased from 32% to 52% after 6 months. (PSU, Green & Mitchell, 2012)	ZTT *State Baby Facts*
2. Percent of parents or family members who tell stories and sing to their child (newborn to 5 years old) every day	**59%**	59%		Data Source: ZTT Baby Facts	ZTT *State Baby Facts*
3. Settings where infants and toddlers are in care. If available, provide data on settings where infants and toddlers are in care. For example, provide		Data not available	Oregon: 17 visible slots per 100 children under age 13. DATA SOURCE: Child Care and Education in Oregon and Its Counties: 2014, OSU, Weber and Harman.	See TRI infographic for QRIS data. http://triwou.org/pages/show/qris-data-facts	State agency administering child care programs

Dimensions of Diversity and the Young Child Population: http://buildinitiative.org/TheIssues/DiversityEquity/50StateChartBook/50StateChartBookOverview.aspx

[44]Source for national data in this table, unless indicated otherwise: ZERO TO THREE, *State Baby Facts,* updated June 2015. Original sources available at: www.zerotothree.org/public-policy/state-community-policy/baby-facts/related-docs/state-baby-facts-2015-references.pdf

any data available on the percentage of young children who are primarily in: - Parental care - Child care centers - Family child care - Family, friend, and neighbor care					
4. Cost of infant care in child care centers as percentage of income for single mothers	**52%**	37% (national median)	Median annual price of toddler care in a child care center in Oregon: $11,976. Care of a toddler as a percent of the annual income of a minimum wage worker: 63% SOURCE:OSU		ZTT *State Baby Facts*
5. Percent of children receiving federal child care support who are less than 3 years old	**23%**	27%		Data Source: ZTT Baby Facts Seek additional info from DHS	ZTT *State Baby Facts*
6. Percent of eligible infants and toddlers receiving Early Head Start	6	4.5%[46]		Data Source: OSU, Weber & Hartman, 2014	State Head Start Collaboration Office
7. Percent of children, 4 months old to 5 years old, determined	**21%**	26%		Data Source: ZTT Baby Facts	ZTT *State Baby Facts*

[46]ZERO TO THREE, *Fact Sheet: Early Head Start*, available online at: www.zerotothree.org/policy/docs/ehs-fact-sheet-ztt-04-04-2014.pdf

to be at moderate or high risk for developmental or behavioral problems					
8. Percent of infants and toddlers who receive Part C early intervention services.	**2%**	3% - single day count[47]		Data Source: ZTT Baby Facts	ZTT *State Baby Facts*
9. Available slots for eligible children in Early Head Start	**8.1%**		**2639 slots out of 32, 480 eligible children**	Highlight	Oregon EHS Percent Served Report 2016-17 draft 2016 Oregon Program Information Report
10. 0-2 year olds served through EHS	**3195** ¤1691 Migrant Seasonal HS *73* Tribal EHS 229 Homeless MSHS 7 Homeless		¨Settings ¤1173 Home-based ¤ 854 Combination ¤ 581 EHS-CC Partnership ¤89 Pregnant Women ¤ 43 Family Child Care 8 Local design option		2016 Oregon Program Information Report

[47]States will soon be required to report the percentage of children served per year. This figure is likely about twice as high as the single-day count provided here. As a comparison point, the Centers for Disease Control and Prevention finds that approximately 15% of children 3–17 years old have one or more developmental disabilities: www.cdc.gov/ncbddd/developmentaldisabilities/about.html

	Tribal				
11. Number of Pregnant Women served through EHS	**206**				Oregon Program Information Report

2. Does your state have policies in place to support positive early learning experiences?
This section can be completed by a state agency or statewide organization with an understanding of current state policies. Much of the state information required is available through the
National Center for Children in Poverty's *Early Childhood State Profiles* available here: www.nccp.org/profiles/early_childhood.html and other resource indicated below. In some cases, state agencies may have more up-to-date information.

It may be helpful to seek stakeholder input for the Comments section.

Policy	**Yes/No**	**States with This Policy in Place[48]**	**Comments on Policy Implementation Challenges** (Note any barriers to effectively implementing this policy statewide. This may include lack of workforce capacity, limited geographic access, limited funding, etc.)	**Suggested Source for State Information**
Early intervention				
1. State includes at-risk children in the definition of eligibility for IDEA (Individuals with Disabilities Education Act) Part C Early Intervention program.	**No**	6 states	**Data Source: NCCP**	NCCP *Early Childhood State Profiles*
Child care				

[48]Source for all national data in this table, unless indicated otherwise: National Center for Children in Poverty, *United States Early Childhood Profile,* updated May 2015. Available online at: www.nccp.org/profiles/early_childhood.html

1. Family eligibility for child care subsidies is at or above 200% federal poverty level (FPL).	**No**,	14 states	Initial eligibility is below 185% FPL, ongoing eligibility is below 250% FPL or 85% of the State Median Income, whichever is higher. DATA SOURCE: Oregon Department of Human Services.	NCCP *Early Childhood State Profiles*
2. State child care reimbursement rates are at or above the recommended 75th percentile of the market rate.	**Yes**	1 state meets criteria for all programs; some states meet this criteria for certain quality-rated programs	Data Source: Oregon Department of Human Services	NCCP *Early Childhood State Profiles*
3. States offer higher subsidy reimbursement rates to programs providing infant–toddler care than to programs serving older children to help defray the higher cost of care.	**Yes**	21 states[49]	Data Source: Oregon Department of Human Services	State agency administering child care programs
4. Child care subsidy copayments do not exceed 7.2% of family income for families at 100% FPL.	**No**	35 states[50]	Families at 100% FPL have copayments that do not exceed approximately 11% of the family income. DATA SOURCE: Oregon Department of Human Services	National Women's Law Center, *Turning the Corner: State*

[49]CLASP, *Better for Babies: A Study of Infant-Toddler Child Care Policies,* 2013.

[50]National Women's Law Center, *Turning the Corner: State Child Care Assistance Policies 2104,* available at: http://www.nwlc.org/resource/turning-corner-state-child-care-assistance-policies-2014
(Note that 7.2% of family income is the national average for all families that pay for child care.)

				Child Care Assistance Policies
5. State meets recommendations of Stepping Stones Caring for Our Children in group size and ratio requirements for infants and toddlers in licensed center-based and family child care.[51]	**No**	For example: • 3 states meet recommended ratio of 3:1 for infants in centers.[52] • 12 states meet the recommended ratio of 4:1 for toddlers in centers.[53]	There are very significant differences between what is recommended by the CFOC, and Oregon's ratio requirements for infants and toddlers in care, which allow for an additional 6-10 children in care depending on the setting and the number of infants and toddlers present. For example, for Family Providers CFOC does not allow any children over the age of two to be in care if there are 2 children under the age of two present, whereas OCC allows for up to 8 children to be present in addition to the 2 children under the age of two. However, OCC further defines allowed ratio for children that are preschool-age or younger. OAR 414-205-0065(2)(a) states: "A maximum of 6 children preschool age or younger, including the providers children, of which only 2 children may be under 24 months of age." See specific data provided by Oregon's Office of Child Care. A major barrier to decreasing the ratio would be the significant loss of income to child care providers, reducing their already low wages.	Compare state licensing requirements to recommendations in: Stepping Stones to Caring for Our Children
6. State has implemented a	**No**	41 states have a statewide QRIS[54]	None are currently in place, however Oregon QRIS standards are currently under revision and the recommendation is to call out specific	ZTT *State Policy*

[51] Full recommendations are available here: http://nrckids.org/default/assets/File/Products/Stepping%20Stones/Stepping%20Stones%203%20%20v5.pdf

[52] CLASP, 2013.

[53] *Ibid.*

[54] ZERO TO THREE state policy tracking, January 2015.

statewide early care and education QRIS that includes quality indicators specifically for programs serving infants and toddlers. If yes, provide any available data on the percentage of programs at each QRIS level that serve infants and toddlers.			indicators within the standards for high quality care for infants and toddlers.	*Tracker*
7. State policy requires that there is a primary caregiver for every infant and toddler in child care centers.	**No**	24 states include this requirement in licensing; 1 state also addresses this through QRIS.[55]	Current Oregon child care regulations do not specify the need for consistent caregiver assignment. Data Source: Oregon Office of Child Care	National Center for Child Care Quality Improvement, *Comparison of State Licensing and QRIS Standards*
8. State policy promotes or requires that child care centers offer	**Yes**	14 states include this requirement in licensing; four states address this	Oregon Administrative Rules for Child Care Section 414-300 for Physical Settings and Program of Activities. QRIS Standards do not call this out, for example, by addressing minimum of floor time, or maximum time allowed in stationary equipment.	National Center for Child Care Quality

[55]National Center on Child Care Quality Improvement, Comparison of State Licensing and QRIS Standards for Infants and Toddlers in Child Care Centers: Learning Environment, Developmental Domains, and Assessment. Available online at: https://childcareta.acf.hhs.gov/sites/default/files/public/learningenv_assess_standards.pdf

activities that actively encourage and support infants' and toddlers' exploration of the environment.		through QRIS.[56]		Improvement, *Comparison of State Licensing and QRIS Standards*
9. State policy promotes or requires that center-based programs offer a variety of opportunities for interaction with parents throughout the year.	**Yes**	2 states require through licensing; 20 states address this through QRIS[57]	Not in OARS, but addressed in the QRIS Standards specific to family partnerships: 1. The program uses family input and feedback to guide program planning and policy decisions; 2. The program meets the individual needs of children though mutually respectful, two-way communication with families; 3. Families are encouraged to be regular and frequent participants in the program, and 4. The program provides support and information to assist families in meeting their child's needs and goals. SOURCE: TRI	National Center for Child Care Quality Improvement, *Comparison of State Licensing and QRIS Standards (Family Engagement)*
10. State has early learning guidelines for infants and toddlers.	**Yes**	48 states[58]	Oregon has adopted the Head Start Early Learning Outcomes Framework: Ages Birth to Five	ZTT *State Policy Tracker*
11. State has	**Yes**	38 states[60]	The Oregon Center for Career Development (OCCD) has	ZTT *State*

[56]Ibid. Note that some states address this through both licensing and QRIS, while others do so through only through one mechanism.

[57]National Center of Child Care Quality Improvement, Comparison of State Licensing and QRIS Standards for Infants and Toddlers in Child Care Centers: Family Engagement. Available online at: https://childcareta.acf.hhs.gov/sites/default/files/public/family_engagment_standards.pdf. Note that some states address this through both licensing and QRIS, while others do so through only through one mechanism.

[58]ZERO TO THREE state policy tracking, January 2015.

[60]*Ibid.*

developed or adopted core knowledge and competencies for early care and education providers, including those who work with infants and toddlers.[59]		5 of these states have developed or adopted specific knowledge and competencies for infant–toddler providers.	developed Core Knowledge Categories for early Childhood care and education providers, which does include individuals who work with infants and toddlers but is not solely specific to this population. Categories are: Diversity, Families & Community Systems, Health, Safety & Nutrition, Human Growth & Development, Learning Environments & Curriculum, Observation & Assessment, Person, Professional & Leadership Development, Program Management, Special Needs, and Understanding & Guiding Behavior. SOURCE: OCCD.	*Policy Tracker*
12. State has developed or adopted an infant–toddler professional credential.	**Yes**	28 states[61]	The Oregon Registry Infant Toddler Professional Credential is an optional credential for early childhood care and education providers in Oregon. http://www.pdx.edu/occd/infant-toddler-professional-credential	ZTT *State Policy Tracker*
13. State requires or encourages infant–toddler professional development that is credit-based and includes career pathways that lead to higher education degrees.	**Yes**	Data not available	In Oregon several community colleges have credentials/certificates that can be earned through college course credit. These credentials are pathways leading to higher education degrees within this field. These pathways are encouraged but are not required, as there are many different options to become qualified as an early childhood infant-toddler teacher. SOURCE: OCCD.	State agency administering child care programs
14. State has a workforce registry or	**Yes**	43 states have a workforce	Oregon's registry is the Oregon Center for Career Development in Childhood Care and Education (OCCD). The OCCD works closely	National Workforce

[59] *ZERO TO THREE Critical Competencies for Infant-Toddler Educators™* details the essential skills educators need to optimize the social-emotional, cognitive, and language and literacy development of all infants and toddlers. More information is available at www.zerotothree.org/CriticalCompetencies

[61] *Ibid.*

other data system to track the qualifications and professional development of the early care and education workforce.		registry.[62]	with individuals to track their qualifications, guide them through their professional development plan and help navigate the workforce. The individual's training and education is displayed on a document called a "Professional Development Statement". Upon request from the individual, a Registry Step (ranging from 1-12) is awarded based on the total number of training hours and college course credit the individual has taken.	Registry Alliance, *Map of Registries*

3. Does the state allocate federal or state funds to promote positive early learning experiences?
This section can be completed by a state agency or statewide organization by reviewing agency budgets, Web sites, and other available state data. It may be helpful to seek stakeholder input for the Comments section.

Policy	**Yes/No**	**Funded Statewide or in Selected Communities?**	**Data on Population Served** (Provide any available state data on the population served by this program.)	**Comments on Population Served** (Is funding adequate? What populations, if any, are underserved?)
1. State allocates funding (outside of the Child Care Development Block Grant) to support high-quality early care and education programs for infants and toddlers.	**Yes**	Both	**Relief Nurseries served 2,560 children ages 0-5 (average age at intake: 1.59 yrs) 201-12: 4% African America, 63% White, 26% Hispanic, 2% Multi-ethnic** **Healthy Families served 7,681 families with screening and 2,549 with home visits 2014-15.** **3% African-American, 44% White, 28% Hispanic, 4% Asian, 1% American Indian, 7% multi-racial, 2% other**	**State also funds 64 EHS slots and federal $ funds 846 home visit slots with MIECHV. RTT funds developmental screenings in child care settings. Need to compare local demographics with service demographics.**

[62]National Workforce Registry Alliance, *Map of Registries,* available online at: http://www.registryalliance.org/about-us-top/map-of-registries

2. State allocates funding to initiatives to promote early language and literacy, including providing books to low-income families and/or providing guidance to parents on talking and reading with their children.	**Yes**	Mixed		Vroom: Funding goes to the Hubs $84,40 from the Bezos Foundation currently supports the VROOM initiative.
EHS				
1. State allocates funding to supplement EHS in order to increase the number of families served, extend the day, and/or improve the quality of services.[63]	**Yes**			¨$793,155 in state funds provides 64 of the EHS slots in order to increase the number of families served
Child care				
1. State allocates funds for a network of infant–toddler specialists that provide on-site technical assistance to child care providers.	**No**			Some regional Child Care Resource and Referral agencies fund infant-toddler specialists.
2. State allocates funds to grants, incentives (e.g.	**Yes**			**Oregon provides a higher Employment-Related Day Care subsidy for Infants and Toddlers.**

[63]More information on state efforts to supplement EHS described here: CLASP and ZERO TO THREE, *Expanding Access to Early Head Start: State Initiatives for Infants & Toddlers at Risk*, September 2012. Available online at: www.clasp.org/resources-and-publications/publication-1/ehsinitiatives.pdf

tiered subsidy reimbursement), or resources to programs to promote high-quality care and early learning for infants and toddlers.				**Oregon also provides provider incentives (tiered reimbursements) to programs with a star rating in Oregon's QRIS.**
3. State allocates funds to scholarships or other supports to help infant–toddler professionals gain additional skills.	**No**			**Oregon provides universal support to early learning professionals via scholarships however they are not specific to the IT population**
4. State allocates funds to wage enhancements or other supports to help infant–toddler professionals increase compensation and/or benefits.	**No**			**Oregon has a universal system of providing Education awards based upon a provider's step on the Oregon Professional Development Registry (based upon training and education). However, there are not specific awards regarding infant/toddler enhancements.**
5. State allocates funding to staffed family child care networks to support quality improvement in family child care programs.[64]	**Yes**	Oregon has focused family child care networks in each of its 16 Hub regions.		**Oregon had $2.3 million of General Fund investment which will be ending June 30, 2017. Note $2.0 millon for 17-19**

[64]For more information on this strategy, see ZERO TO THREE, *Staffed Family Child Care Networks: A Strategy to Enhance Quality Care for Infants and Toddlers*, 2012. Available online at: www.zerotothree.org/public-policy/infant-toddler-policy-issues/fcc-staffed-networks.pdf

6. State allocates funds to grants or loans to early childhood programs to renovate or construct facilities to serve infants and toddlers.	**No**			
Other relevant state investments in early learning				
Infant Toddler Credential	Yes	Statewide		The purpose of the Oregon Registry Infant Toddler Professional Credential is to recognize professional knowledge, skills and achievements toward strengthening infant and toddler practice. There is a fee for the credential. The credential requires 60 clock hours of training specific to infant toddler care and education, and youth development. Providers can apply for general scholarships towards the cost of training and education.
Infant Toddler Mental Health Endorsement	Yes	Statewide		The intent of infant mental health endorsement is to recognize and document the development of infant and family professionals within an organized system of culturally sensitive, relationship-based, infant mental health learning and work experiences. Endorsement verifies an applicant has attained a level of education as specified, participated in specialized in-service trainings, worked with guidance

				from mentors or supervisors, and acquired knowledge to promote the delivery of high quality, culturally sensitive, relationship-focused services to infants, toddlers, parents, other caregivers and families. It is multidisciplinary and not limited to one profession and does not constitute a license to practice a particular profession. For early educators, the endorsement is Infant Family Associate and requires 30 clock hours of training, a CDA or AA or 2 years as paid work in infant, early childhood, and family field. Scholarships are available.

-End-

Appendix: List of April 6, 2017 data review meeting participants

	Name	Agency	Title
1.	Annette Diecker	Family Care - CCO	Health and Ed Systems Coordinator
2.	Begonia Rodrigues	?	? – will check on this!
3.	Benjamin Hazelton,	Oregon Health Authority (OHA)	MIECHV Coordinator
4.	Cate Drinan	211/Help me Grow	Program Manager, Help Me Grow
5.	Cori Brownell	The Research Institute	Early Learning Specialist
6.	Crystal Persi		Special Populations Quality Improvement Specialist
7.	Elena Rivera	Children's Institute	Health Policy and Program Advisor
8.	Elisabeth Underwood	ELD	Program Analyst
9.	Elizabeth Carroll	Multnomah County Health Department	Multnomah

10.	John Collins	Oregon Child Development Coalition	Data Analyst
11.	Julie Weatherston	State Capacity Building Center	Infant Toddler Specialist Region X
12.	Kerry Cassidy Norton	OHA	Home Visiting Workforce Development Coordinator
13.	Kristy May	Linn Benton Lincoln Early Learning Hub	Early Learning Hub Director
14.	Kristyn Keefer	ELD	Support Staff
15.	Laurie Theodorou	OHA, Child and Family Behavioral Health	Early Childhood Mental Health Policy Specialist
16.	Leslie Moguil	Parenting Together, WA Co.	Sr. Program Coordinator
17.	Lillian Green	ELD	Equity Director
18.	Liz Stuart	Center for Prevention and Health Promotion, OHA	Child Systems Collaboration Coordinator
19.	Lawrence Piper	Department of Human Services	

20.	Maria Ness	OHA	OHA Research Analyst
21.	Meredith Russell	ELD	Program Development Lead
22.	Molly Day	Multnomah Early Learning Hub	Director
23.	Nakeshia Knight-Coyle	ELD	Director of Programs and Cross System Integration
24.	Sarah Scott	Oregon Child Care	
25.	Peg King	Heatlh Share's Early Life Health Manager Kindergarten Readiness manager	Health Share
26.	Roni Pham	ELD	Professional Development Lead
27.	Rishona Hinsee	Department of Human Services-Self-Sufficiency	Ops and Policy Analyst