



Acknowledgements:

First and foremost, Dana Hargunani, Oregon's Child Health Director, provided instrumental assistance and expertise at every turn, connecting the dots for us in countless ways. She and the following individuals in Oregon graciously took the time to share their experience, provided critical clarification of key concepts and/or thoughtfully reviewed an earlier version of this publication: Michele Bergeron; Jim Carlough; Pam Curtis; Tina Edlund; Charles Gallia; R.J. Gillespie; Cathy Kaufmann; Suey Linzmeier; Jada Rupley; and Teresa Waite. Charles Bruner of the Iowa Child & Family Policy Center contributed to our research, and several NASHP colleagues provided helpful input, including Neva Kaye, Taylor Kniffin, and Jill Rosenthal, who offered us her invaluable guidance. Finally, Susan Hibbard of the BUILD Initiative asked (and encouraged us to ask and address) important questions that strengthened the final product; she and her organization made this work possible. Any errors or omissions are the authors'.

Bridging Health Care and Early Education System Transformations to Achieve Kindergarten Readiness in Oregon

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Introduction

The past several years have seen an increasing recognition that good health helps prepare children to learn, and a growing investment in and attention to improving health and education outcomes by transforming our nation's health care and education systems. Recent federal legislation demonstrates clear commitment to improving access to high-quality health care and high-quality education for young children. Federal activity and opportunities complement state-led action to transform health care and early education systems. Oregon is known nationally in health policy circles for its health care system transformation and by early care and education policy makers for its early education system reform, but innovations in these two areas often do not intersect. Connecting these system reforms is an opportunity to improve outcomes for children of color and children from low-income families as the same social determinants—such as community, income, and discrimination—are associated with education and health outcomes. This report describes Oregon's alignment of its two innovative system transformations to elucidate lessons for state policy makers for bridging health care and early education systems to achieve a common goal of kindergarten readiness.¹

“Oregon is known nationally in health policy circles for its health care system transformation and by early care and education policy makers for its early education system reform.”

Federal legislation including the Affordable Care Act of 2010 (ACA) and the American Recovery and Investment Act of 2009 (ARRA) have provided substantial funding and support to bolster and even reconfigure our health care and early education systems. The changes supported by the federal government

¹ Oregon has not yet formally defined kindergarten readiness statewide. Informally, Oregon defines it in the following way: "Children enter kindergarten with a rich set of early literacy and early math skills, demonstrate age-appropriate social, emotional, and self-regulatory skills, and are physically healthy. Communities and families support children's kindergarten readiness by providing high quality, language and literacy rich, and developmentally appropriate early learning environments. Schools support children's kindergarten readiness by proactively [engaging] families as equal partners, by forming intentional and sustained relationships with providers of early learning services, and by providing appropriate and differentiated supports to children as they transition to school."

are an opportunity for states and providers of health care and early education to better coordinate and integrate their respective systems of care. In addition to creating new health insurance coverage opportunities, the ACA established several programs to encourage new ways of delivering and organizing health care to improve patient experiences, encourage accountability for outcomes, and improve efficiency. The ACA also acknowledged the connection between health care and education by creating the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) to help state home visiting programs connect families to important early education, early intervention, and health care services.¹ These efforts build on earlier investments made in ARRA to health information technology² and public insurance programs, as well as education programs such as Head Start and other opportunities such as Race to the Top.³ The Race to the Top: Early Learning Challenge was established specifically to encourage states to improve the quality of early learning and developmental services delivered to young children with high needs.

Oregon has leveraged opportunities such as these to support a state-led, fundamental shift in how the health care and early education systems function and align with each other. The following sections answer why, what, and how Oregon is aligning these two systems. Then we turn to the state's next steps and remaining challenges, and finally, to lessons we can learn from Oregon.

Why Align?

When he took office in 2011, Governor John Kitzhaber outlined a clear vision for improved education outcomes in Oregon; he prioritized kindergarten readiness and identified good health as a component of ensuring children enter school ready to learn and succeed.⁴ The impetus for action was poor health indicators and education outcomes despite significant investments. One in four children in Oregon lives in poverty, and the state ranks in the bottom half of states in provision of certain preventive services for children, such as up-to-date immunizations and access to dental care.⁵ Similarly, a significant proportion—ranging from 25 to nearly 40 percent—of Oregon's children enter kindergarten without the necessary literacy skills (e.g., the ability to name multiple letters or letter sounds) or social-emotional behavioral skills (e.g., staying on task or following directions) that they need to succeed in school.⁶ Tellingly,

Oregon is in the bottom quartile nationally for high school graduation.⁷ Despite these outcomes, Oregon spends \$380 million annually for services—*excluding* health care, K-12 education, and child welfare—for children ages birth through 5 and their families.⁸ (At the same time, the [Early Learning Left Out](#) report shows that Oregon, like other states, makes quite small investments in developmental services for young children and their families, on a per capita basis, compared with those for school-aged children - 14 cents is spent on children from birth through age five for every dollar spent on education and development for children from age six to 17.) Leaders in the state attribute the disconnect between expenditures and outcomes to a lack of a streamlined approach that holds the various programs and sectors serving young children and families accountable for results.⁹ As a result, the state has undertaken a restructuring of its early education system to create a transformed, integrated system in which early care and education services are coordinated for children and families across home visiting, prekindergarten and child care providers.

The state's leaders made clear that the transformed early education system must incorporate health. Health factors affect children's ability to learn. Moreover, studies show that brain development prenatally and from birth to age five is critical to not only school readiness and success, but also long-term health and well-being.^{10,11} During this period, young children develop capabilities that become the foundation for subsequent cognitive, social, physical, emotional, moral, regulatory and linguistic capacities.¹² Negative experiences during this critical time are linked with chronic, costly conditions such as diabetes and cardiovascular disease later in life.¹³ Investments have the potential not only to improve education, social, economic, and health status, but also to produce substantial returns on investment. Given this evidence, the state established expectations and guidelines for aligning the new integrated early education system with statewide efforts to transform the *health care* system. Through health care system transformation, like the newly developing early education system, Oregon aims to improve outcomes and contain costs.

Bridging the two reforms is an opportunity to accelerate systems change to benefit young children by improving kindergarten readiness. It is an opportunity to improve outcomes particularly for vulnerable children, including children of color and children from families with low

incomes, who are served by both systems through programs such as Medicaid and Head Start. Differences in children’s capabilities emerge before kindergarten, and are associated with social and economic circumstances.¹⁴ Nationally, and in Oregon, (and then lower case the racial and ethnic minority populations disproportionately experience poor health and education outcomes.^{15,16,17} As part of its early education and health care system transformations, Oregon seeks to address these differences—also known as disparities or inequities—to ensure equity in education and health outcomes for all.

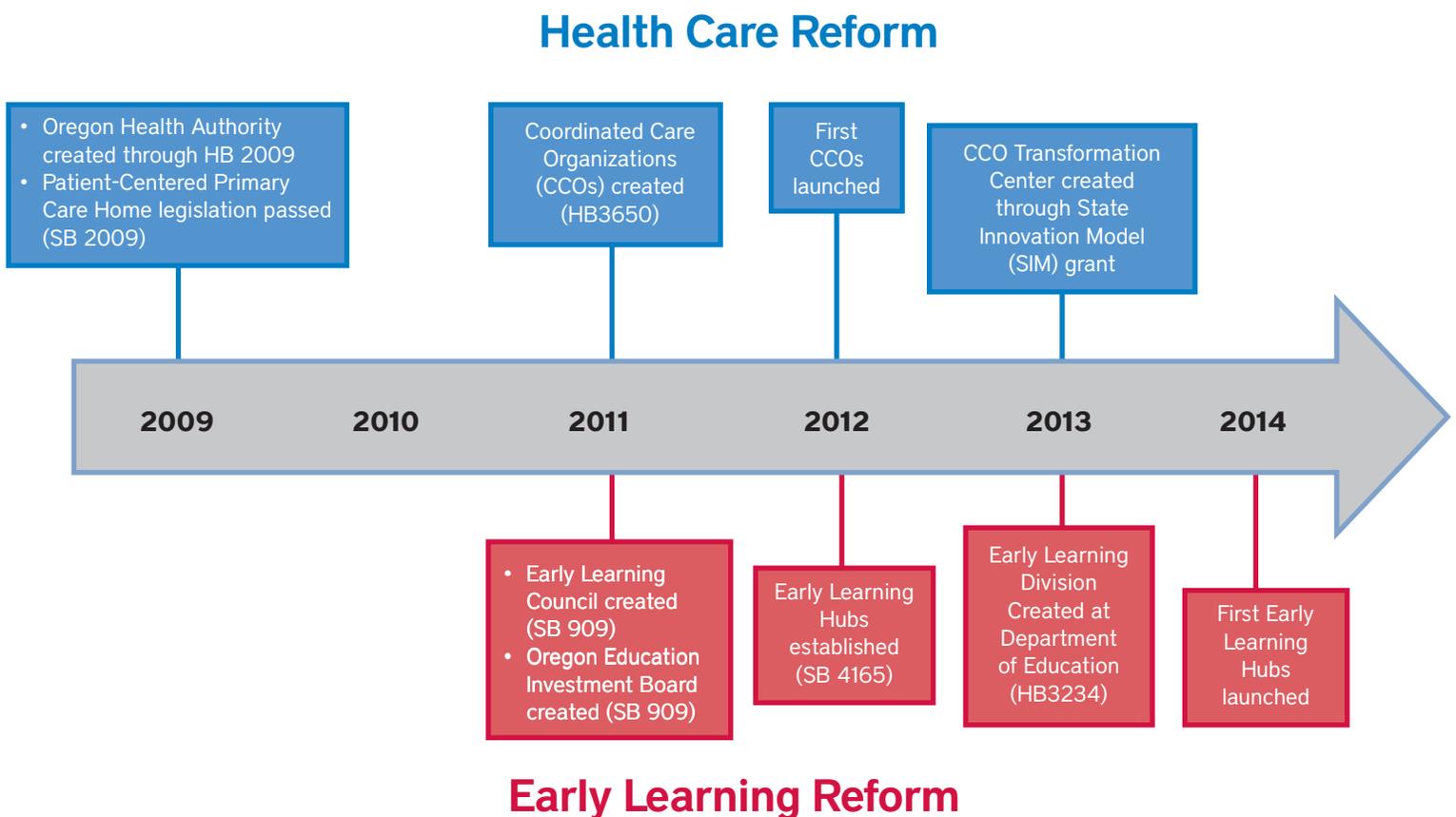
Oregon’s Definition of Educational and Health Equity

- **Equity (education):** “[T]he notion that *each* and *every* learner will receive the necessary resources they need individually to thrive in Oregon’s schools no matter what their national origin, race, gender, sexual orientation, differently abled, first language, or other distinguishing characteristic.”¹⁸
- **Equity (health):** Attainment of the highest level of health for all people. Health equity entails 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.¹⁹

What is Oregon Aligning?

Oregon has taken significant steps to independently transform its health care and early education systems. Major health reform initiatives include creating an advisory entity to guide change, implementing a statewide patient-centered medical home model, and launching a community-based accountable model of health care (both described in the next section). Many of the state’s recent early education reforms mirror those of the health care system, such as assembling an early learning advisory body and establishing community-based early education entities. (See Figure 1 for a list of key transformation milestones in each system).

Figure 1: Key Health Care and Early Learning System Transformation Milestones



Health Care System Transformation

In 2009, the Oregon Legislature introduced major changes to the state's health care delivery system with the establishment of the Oregon Health Authority, a centralized entity that houses state-based health care programs. Legislation also authorized the creation of the Oregon Health Policy Board to serve as the advisory and policymaking body for the Oregon Health Authority. The Board consists of nine members who are nominated by the Governor and confirmed by the Senate. The Board has been an influential force in Oregon's health care system transformation initiatives that aim to improve the overall health of the state, increase the quality and availability of care, and reduce health care costs. Since its inception, the Board has guided two major statewide delivery system initiatives: the Patient-Centered Primary Care Home Program and the launch of Coordinated Care Organizations.²⁰

In 2009, Oregon established the Patient-Centered Primary Care Home (PCPCH) Program, the state's patient-centered medical home model, for members of the state's Medicaid program, state employees and educators. The patient-centered medical home is an enhanced model of primary medical care in which a team of health care professionals, often led by a physician, provide comprehensive, accessible, coordinated, safe and whole-person (or whole-family) care to patients; in return, the medical home provider receives payment that accounts for the extra investment necessary to provide this type of care.²¹ Oregon's PCPCH program has a state-specific definition for a "primary care home" that includes similar medical home elements: proactive, comprehensive care; managed and coordinated care across the community services system; behavioral health integration; and case management services for chronic diseases.²² To gain PCPCH accreditation and be eligible for enhanced payments from the state Medicaid program, practices

must meet these state-specific standards, which include having screening protocols for developmental delays, or mental health or substance abuse conditions.²³

Oregon's PCPCH program has served as a foundation during Oregon's health system transformation including the launch of a statewide network of Coordinated Care Organizations (CCOs) in 2012. CCOs are designed to enhance the quality and contain costs for health care services for the state's Medicaid beneficiaries. CCOs are Oregon's version of an "accountable care organization," an entity that shares (with the state) financial and medical responsibility for providing coordinated care in order to limit unnecessary spending.²⁴ In Oregon, CCOs are essentially community-based partnerships of health care payers, providers, and community organizations that assume financial responsibility for the population they serve and are rewarded with performance-based incentive payments for providing high quality care. CCOs provide physical and mental health care, alcohol/substance abuse services, and oral health care. Care coordinators organize these various services and help families navigate among providers. In order to provide fully integrated and patient-centered care, CCOs are expected to support local providers and clinics in becoming certified as a PCPCH. The Oregon Health Authority provides CCOs with a fixed global budget that allows them the flexibility to implement new ways of paying for and delivering care, using strategies that are best suited for their members.

CCOs are charged with improving health equity and reducing health disparities. To ensure they are meeting the needs of their communities, CCOs, in collaboration with community stakeholders, must conduct a community health needs assessment and develop a community health plan to address the priority needs of the community. CCOs must also include community health workers or other members on each patient's care team to ensure culturally and linguistically appropriate care. In 2013, Oregon received a State Innovation Model Testing grant from the Center for Medicare and Medicaid Innovation that has enabled the state to provide additional support to CCOs through the creation of a Transformation Center housed in the Oregon Health Authority. The Transformation Center holds learning collaboratives and provides technical assistance to the 16 CCOs.²⁵ As of April 2014, about 87% of Medicaid beneficiaries are enrolled in a CCO, and in 2013 just over 400,000 clients under the age of 19 had an encounter with a CCO.²⁶



Both PCPCHs and CCOs have taken steps to ensure they meet the distinct needs of Medicaid-enrolled children. The PCPCH Program convened a Pediatric Standards Advisory Committee during the PCPCH development process that focused on recommending appropriate pediatric standards and measures. Examples of current PCPCH pediatric quality measures include immunization, developmental screening, weight assessment, and well-child care. CCOs also incorporate a focus on children through similar pediatric quality measures including developmental screening, follow-up care for children prescribed Attention Deficit Hyperactivity Disorder medications, well-care visits, and health assessments for children placed in state (Department of Health Services) custody.

These measures are all included in the 17 CCO incentive measures.²⁹ A particularly innovative feature of Oregon's health care system transformation is the linking of these 17 measures to a CCO quality pool fund. CCOs that meet a statewide benchmark or an individual improvement target for performance on these measures are eligible for awards from the quality pool (incentive payments).³⁰ Oregon seeks to transform the health care system by rewarding performance and outcomes.

Early Education System Transformation

Just as the health care system has transitioned to accountability and quality improvement, so too has the early education system. In 2011, the Oregon Legislature approved a “40-40-20” goal that outlines the following educational targets for the state to reach by 2025: 40% of adult Oregonians hold a bachelor's or advanced degree, 40% have an associate's or postsecondary certificate, and all (the remaining 20% of) adult Oregonians hold a high school diploma or the equivalent.³¹ To help achieve this goal, the Legislature created the Oregon Education Investment Board to guide the development of a coordinated public education system from birth to college and career, and the Early Learning Council to advise on early learning policies. The Early Learning Council consists of 18 members appointed by the Governor who meet regularly throughout the year. The Council is overseeing the implementation of a statewide Kindergarten Readiness Assessment and the transformation of Oregon's early learning system through the launch of Early Learning Hubs.

Oregon's statewide Kindergarten Assessment, implemented in 2013, covers the areas of early literacy, math and learning approaches.³² The findings help to assess kindergarten readiness and illuminate racial and ethnic disparities.

In 2013 Oregon created an Early Learning Division based in the Department of Education, and governed by the Early Learning Council, to direct initiatives under Oregon's early learning system.³³ Per legislation, the early learning system Director serves as the Division's administrative officer. The Early Learning Division consolidates a number of child-serving responsibilities, including Oregon's prekindergarten program, Healthy Start-Healthy Families home visiting services, and the Office of Child Care, which were previously separated across several divisions.³⁴ The early learning system focuses on improving education for children ages 0-6 and specifically on increasing kindergarten readiness. Oregon defines **early learning services** as “any service that supports the development of a child, allowing them to arrive at kindergarten prepared to learn.”³⁵ This “includes, but is not limited to: early education and child care settings, home visiting services, respite care, and developmental screening.”³⁶ Activities under the early learning system include developing Early Learning Hubs, integrating children's health care and education, increasing access to quality childcare, collaborating with Pre-K programs, implementing the various elements of the Race to the Top Early Learning Challenge Grant (discussed in detail later), and promoting early literacy.³⁷

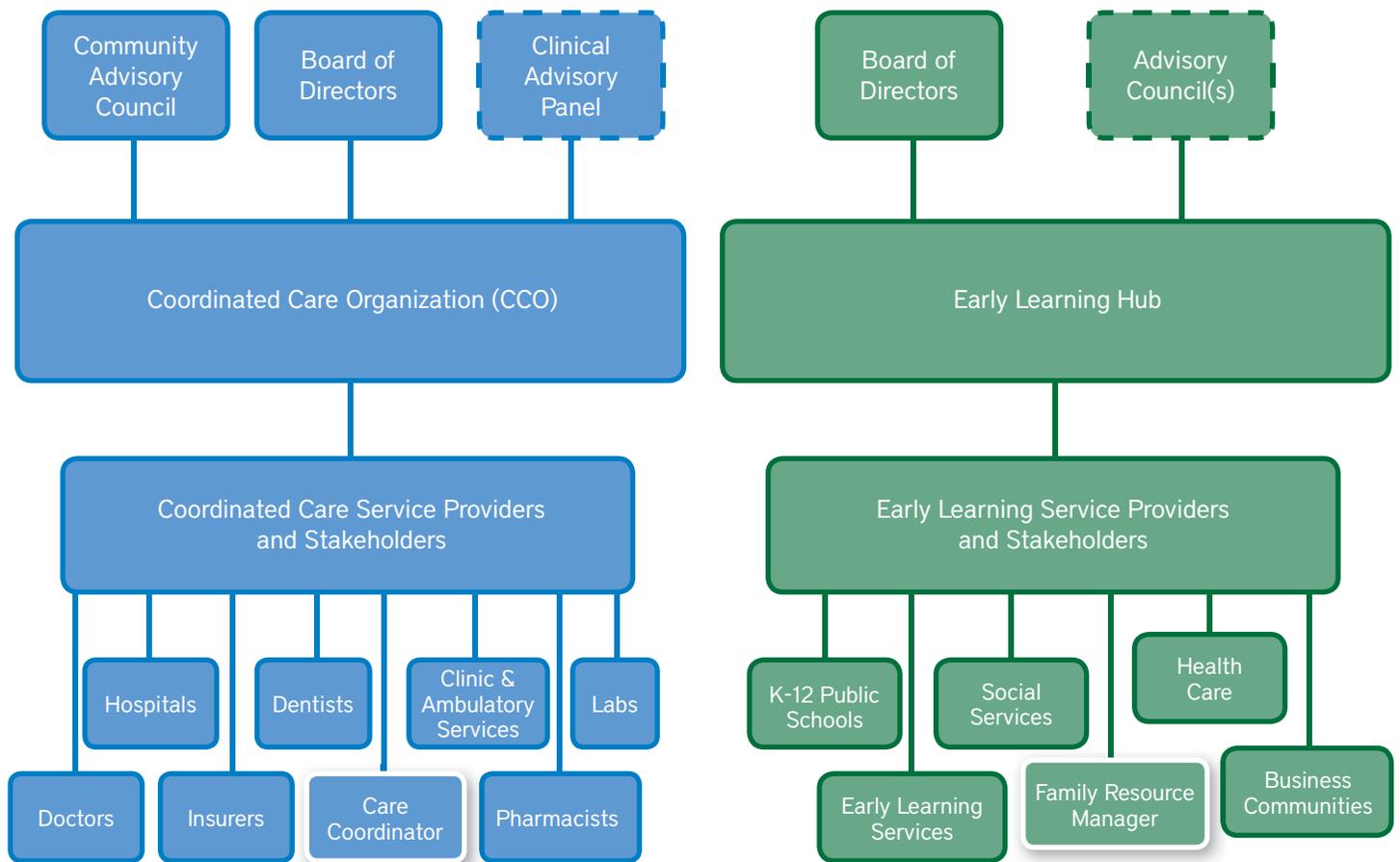
In 2013, Oregon also passed legislation to develop Early Learning Hubs – community-based entities that are similar to CCOs but focus on coordinating early childhood education and school readiness efforts. Hubs can be thought of as a community nucleus for early learning efforts where various sectors related to early childhood education collaborate and combine resources to work towards collective goals. Hubs are responsible for identifying children at risk of arriving at kindergarten unprepared for school; working with families to identify specific needs; connecting families to the supports or services that most meet their needs; working across traditional silos; and accounting for outcomes collectively and cost effectively.³⁸ They also are responsible for the same three outcomes: increased kindergarten readiness; family stability; and system coordination and efficacy.³⁹ Hubs propose their own geographic and population boundaries,

which are approved by the Early Learning Council. The Early Learning Council is responsible for ensuring Hubs, like CCOs, number no more than 16 and cover all children in the state.⁴⁰ Whereas a CCO employs care coordinators to coordinate health care services for families, Early Learning Hubs utilize family resource managers to work directly with families and address their needs for preparing children for kindergarten. To help Early Learning Hubs and other early education stakeholders pilot strategies to link early learning and kindergarten, the State Legislature created the Early Learning Kindergarten Readiness Partnership and Innovation Fund in 2013. The Early Learning Council manages this fund.

Like CCOs, Early Learning Hubs must place a special emphasis on equity and have population-specific initiatives to address disparities. This ensures Hubs will accomplish their goal of increased kindergarten readiness for all children. In creating expectations for health

equity, the Early Learning Council adopted the Oregon Education Investment Board's equity lens, through which members commit to identifying disparities in educational outcomes (with a primary focus on race and ethnicity) and target areas for action and improvement.⁴¹ As of June 2014, Oregon has approved 14 early learning hubs. All Hubs received one-time start up funds of \$50,000 and monthly coordination funds based on the number of at-risk children⁴² for which they expect to coordinate services.⁴³ Hub start-up funds come from the sunset of a 20-year old, county-based commission on children and families program. Similarly, Hub monthly coordination funds come from restructured former commission on children and families general funding. Federal Race to the Top-Early Learning Challenge Grant funding supports both Hub start-up and monthly coordination funds. The Early Learning Division provides guidance to Hubs on home visiting and other program funding available to support service delivery.

Figure 2: Organizational Chart with Sample CCO and Early Learning Hub Structure



**CCOs and Early Learning Hubs are allowed some flexibility in their governance structures and dotted lines in this diagram indicate optional entities. Clinical Advisory Panel's are encouraged but not required for panels and the formation of different types of Advisory Councils are up to the discretion of Early Learning Hubs.*

How Is Oregon Aligning These Systems?

Oregon has taken specific steps to align the newly transformed early education (hereafter referred to as “early learning” to reflect Oregon’s parlance) and health care systems. Oregon is aligning its health care and early learning systems in three ways: joint staffing and advisors, blended funding, and shared expectations. (For a timeline of these key alignment activities, see Figure 3).

Figure 3: Timeline of Key Alignment Activities in Oregon

Month and Year	Alignment Policy
November 2011	Child Health Director Position created in Oregon Health Authority (OHA)
December 2012	Joint Oregon Health Policy Board – Early Learning Council Subcommittee convened
February 2013	Oregon receives State Innovation Model (SIM) grant
March 2013	Transformation Center established in OHA
July 2013	SB 436 calls for Coordinated Care Organizations (CCOs) to coordinate with early learning system on community health improvement plans to the extent possible*
August 2013	Oregon receives Race to the Top: Early Learning Challenge Award
August 2013	HB 2013 requires OHA, CCOs, and the Early Learning Council to collaborate on metrics for prenatal care, delivery and infant care
August 2013	First Round Early Learning Hub Request for Applications released requiring Hubs to collaborate with CCOs
May 2014	Six initial Early Learning Hubs awarded, with expectation for coordination with CCOs
June 2014	Eight additional Early Learning Hubs announced, with expectation for coordination with CCOs

**Many of the CCOs had already completed their health improvement plans when the legislation was enacted*



Joint Staffing and Advisors

Oregon has created new positions or entities tasked with advising on, coordinating, or fostering alignment of Oregon’s early learning and health care systems. Specifically, the state has a:

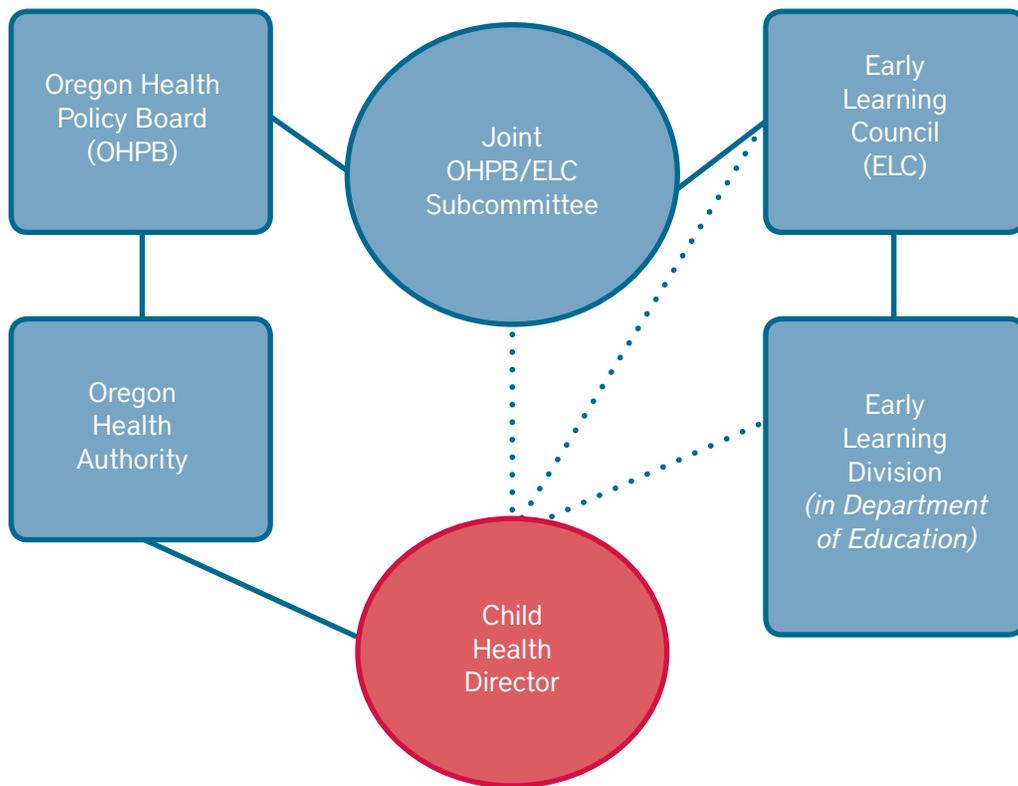
- **Dedicated staff liaison** between the Oregon Health Authority and Early Learning Division;
- **Joint Subcommittee** responsible for guiding alignment of early learning and health care system reforms; and a
- **Transformation Center** within the Oregon Health Authority that serves as backbone or nucleus of alignment between the early learning and health care systems.

In 2011, Oregon established a Child Health Director position within the Oregon Health Authority (see Figure 4). Oregon is the only state known to have such

a position. The Oregon Health Authority created the position after identifying a need to focus on health care quality and access in addition to insurance coverage during implementation of the state’s Healthy Kids program, which provides coverage to uninsured children under age 18 in Oregon. The Child Health Director ensures the state’s health care transformation sufficiently considers and addresses the needs of children. The position also liaises between the health care and early learning systems.

Although housed within a health care agency, the Child Health Director spends about half of her time working with the Early Learning Council and Early Learning Division staff. She regularly updates the health agency on early learning system developments and keeps the early learning system apprised of health care transformation developments. This cross-pollination across systems helps to ensure planning is coordinated and informed by the most complete information and feedback across agencies.

Figure 4: Organizational Chart with Child Health Director Position



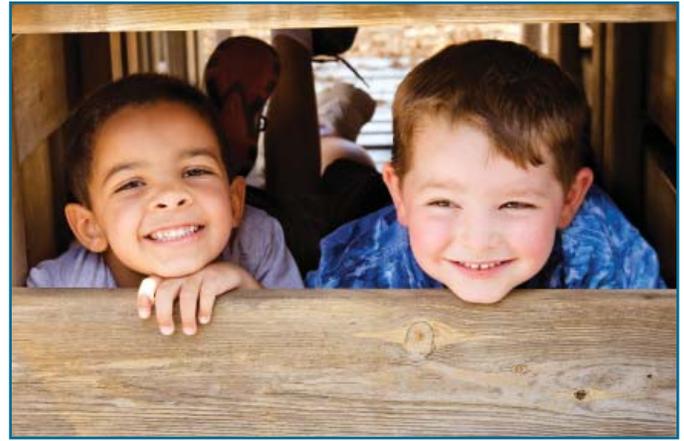
The dotted lines in this diagram indicate various connections the Child Health Director has with other entities. Though the Child Health Director position is located within the Oregon Health Authority, the Child Health Director also staffs the Joint OHPB/ELC Subcommittee, is a member of the ELC, and sits on the Early Learning Division Cabinet.

As a liaison between these two systems, the Child Health Director also staffs the Early Learning Council/Oregon Health Policy Board (ELC/OHPB) Joint Subcommittee. The ELC and OHPB established the Subcommittee voluntarily out of recognition of the importance of both entities in achieving mutual goals and the opportunity for aligning efforts. This Subcommittee guides alignment of early learning and health care system transformations. It began convening in 2012 and includes members from the entities responsible for advising early learning (ELC) and health care (OHPB) system reforms. In this way, it serves as a shared table or space from which stakeholders across systems collectively identify mutually beneficial goals to guide alignment. The Joint Subcommittee’s agenda is informed by a recent report⁴⁴ endorsed by both the ELC and OHPB with several recommendations supporting alignment across their respective systems. The endorsed recommendations include:⁴⁵

- Designating kindergarten readiness as a common agenda with a focus on equity;
- Establishing shared incentives linked to joint outcomes;
- Implementing shared communication strategies that foster local, cross-system learning; and
- Adopting and implementing a statewide system of developmental screening.

The Joint Subcommittee’s primary areas of focus include: developmental screening, care coordination and metrics. It is leading efforts to create standardized and well-coordinated screening practices across health and early learning entities and is currently considering opportunities for online screening, information exchange across providers, and consistent screening practices.⁴⁶ With kindergarten readiness now adopted as a shared goal for health care (OHPB) and early learning (ELC) systems, the Joint Subcommittee also is considering “avenues for shared responsibility” for this metric.^{47,48}

One of the proposals endorsed by the OHPB and ELC was that the Transformation Center within the Oregon Health Authority, which as previously noted was originally established to support CCOs, also serve as the entity providing support to local early learning and health care system stakeholders as they carry out alignment activities. The Center is referred to as the “backbone



structure” for alignment between the two systems and provides technical assistance and opportunities for peer-to-peer sharing for CCOs and Early Learning Hubs. For example, the Center is creating an online networking site for CCOs and Hubs. The Center will be working very closely with early learning officials to identify mechanisms for convening CCOs and Hubs to facilitate collaborative, mutually beneficial efforts to measure and meet shared goals (e.g., kindergarten readiness). Early learning staff is located in the Transformation Center’s office to support ongoing cross-agency coordination.

Blended Funding

Oregon also supports financial alignment through national grants such as Race to the Top and State Innovation Model awards as well as state dollars that local communities are leveraging to align early learning and health care system reform.

Oregon has integrated health into early childhood system improvement activities as part of its Race to the Top-Early Learning Challenge (RTT-ELC) Award. Oregon was one of five states awarded an RTT-ELC Award from the U.S. Department of Education and U.S. Department of Health and Human Services in 2012. The state ultimately will receive \$20 million over four years to strengthen its early childhood system and ensure children enter school ready to succeed. Through the grant, the state is developing a standard tiered system for childcare facility quality rating and improvement,⁵⁰ linking early learning system data in new ways, and developing workforce capacity and training for developmental screening, among other activities. In its application, the state noted, “Screening represents a crucial link in the state’s alignment and design of early childhood

health, education and social services”.⁵¹ With RTT-ELC funds, the Oregon Health Authority is helping to implement approved screening tools across the state and assisting with developmental screening training.

Oregon is similarly leveraging its State Innovation Model (SIM) Testing Award. Oregon was one of six states to receive a SIM Testing Award from the federal Center for Medicare and Medicaid Innovation last year. Under SIM, Oregon receives up to \$45 million over three and a half years to test a coordinated model of health care that: integrates physical, behavioral and oral health care; rewards high-quality care; fosters partnership with local public health systems; and reduces health disparities.⁵² Specifically, SIM supports implementation of Oregon’s CCOs. Oregon also established its Transformation Center as part of SIM. Although the main focus of SIM is health care delivery transformation, Oregon’s grant application highlighted the award as “an opportunity to test systems and supports that contribute to kindergarten readiness,” an outcome dependent on both health and education systems.⁵³ The Transformation Center will use SIM funds to support alignment. For example, it will develop learning collaboratives to test strategies for improving kindergarten readiness by coordinating services across CCOs and Early Learning Hubs. Additionally, a small amount of SIM funds will support shared learning between CCOs and Hubs on priority topics such as developmental screening.



Oregon’s SIM grant application highlighted the award as “an opportunity to test systems and supports that contribute to kindergarten readiness.”

The State Legislature also included \$30 million in the 2013–2015 budget for the Oregon Health Authority for a newly established Health System Transformation Fund, for strategic investments by CCOs.^{54,55}

Shared Expectations

CCOs and Early Learning Hubs each have their own measures and set of responsibilities to achieve their respective system transformations, but Oregon is ensuring a subset of expectations are either shared across both types of entities or referenced by the other system. Since CCOs were well underway by the time the Early Learning Hub

request for applications was being developed, Oregon began by incorporating coordination with CCOs as a part of the Early Learning Hub application. In addition, Early Learning Hubs must track and improve some of the same metrics for which CCOs are held accountable.

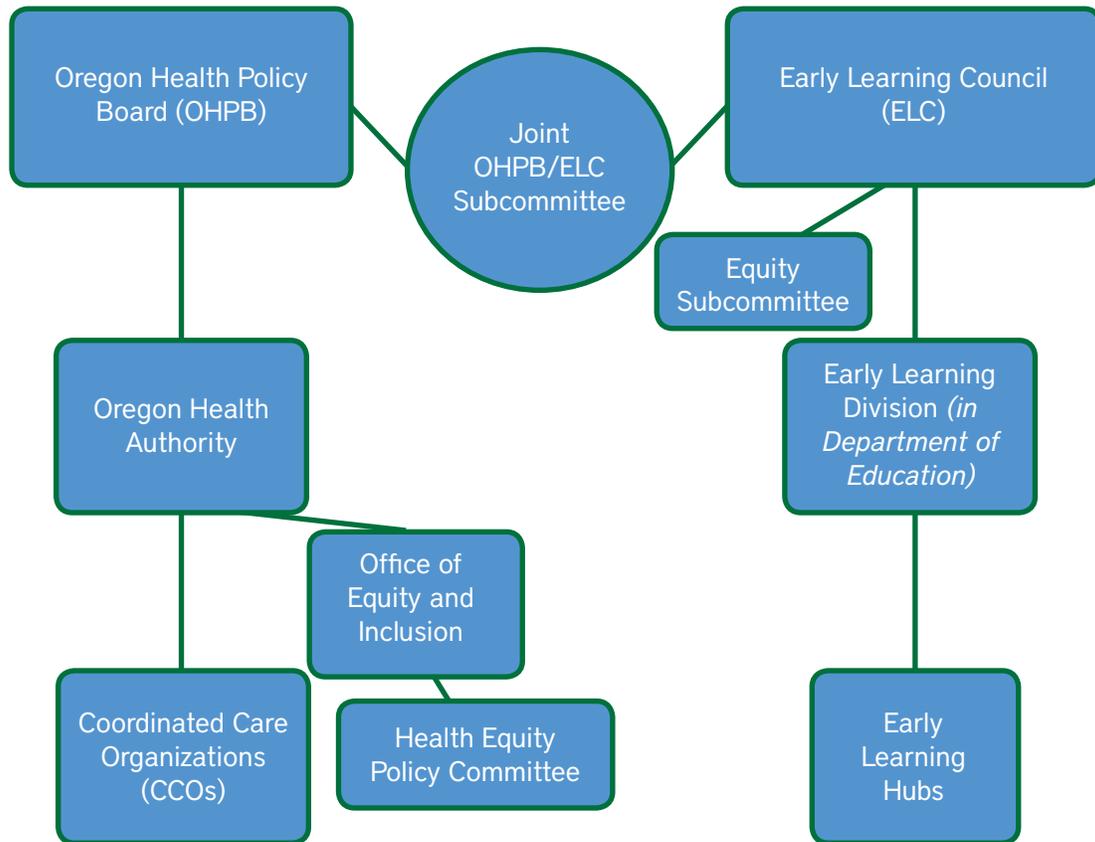
The Early Learning Hub application made clear that Hubs must collaborate with CCOs to improve metrics such as developmental screening and number of children with access to a patient centered primary care home (medical home). CCOs were allowed and encouraged to apply to be Early Learning Hubs. The two systems also are collaborating to develop a shared developmental screening tool for health care and child care settings. Hub applications were selected in part based on evidence of coordination with CCOs and involvement in CCO community health needs assessment and planning activities.

State legislation specifies similar expectations for CCOs. For example, CCOs must coordinate with the early learning system and other education partners to the extent possible in developing their community health needs assessments and community health improvement plans to ensure optimal alignment between the two systems.⁵⁶ Additionally, the Oregon Health Authority, Early Learning Council and CCOs must collaboratively develop prenatal care, delivery and infant care performance metrics that align with early learning outcomes.⁵⁷ In other words, Oregon is holding both its health care system and early learning system accountable for child outcomes by aligning expectations for improvement and outcomes.

Health policy makers at the Oregon Health Authority and those involved with establishing CCO metrics are in discussions to make kindergarten readiness a health system measure as well as an early learning system metric. To ensure a focus on equity within kindergarten readiness, the Early Learning Council has an Equity Subcommittee that is creating a toolkit to operationalize its adopted equity lens. (See Figure 5 for organizational chart illustrating equity committees). The toolkit will offer specific strategies Hubs can implement to prioritize and ensure equity. The toolkit could be provided to CCOs

and Hubs as part of the Transformation Center’s resources. The Oregon Health Authority’s Office of Equity and Inclusion is involved in CCOs, and works with the Transformation Center to support alignment between CCOs and Hubs.

Figure 5: Organizational Chart of Equity Committees within Oregon Health Care and Early Learning System Transformations



It is too early to tell how shared expectations will be met at the local level. Early activity in areas such as Yamhill County (see textbox), where the CCO and Early Learning Hub are the same entity, indicate that communities are searching for innovative ways to leverage shared expectations and funding to align efforts across health care and early learning systems to best meet the needs of young children and families.



Spotlight on Yamhill County

Oregon's alignment of early learning and health care reforms is especially evident in Yamhill County. As of February 2014, the Yamhill County CCO is also the community's Early Learning Hub. This unique structure provides optimal conditions for alignment. With a single entity serving as the CCO and Early Learning Hub, certain resources such as staff, workspace, data, and grant funds can be shared. The governing body for the Hub is the CCO's Board of Directors, making the CCO the true backbone of the Hub. CCO leadership believes the close alignment will allow the county to coordinate care for children and families in an unprecedented manner with the coordination of physical and behavioral health, dental care, and early learning services led by a single entity.



A small staff and three advisory councils support the Yamhill CCO's Board of Directors (see Figure 6). The councils include a Clinical Advisory Panel, Community Advisory Council, and an Early Learning Council that specifically advises on Hub issues pertaining to early education. The CCO is staffed by an Executive Director, part-time Project Coordinator, part-time Community Engagement Director, and part-time Health Strategy Officer. A new full-time Early Learning Hub Coordinator position has been established, and the CCO envisions a multi-pronged approach to fulfilling the family resource management functions required of it as an Early Learning Hub. The Early Learning Hub Coordinator will manage data, community outreach and systems coordination (including between early learning and health care). Data to be analyzed include CCO data about children birth to age six, e.g., if they are in a medical home, as well as other relevant metrics, such as early prenatal care entry. The Wellness Coordinator, who provides care coordination and serves as a gateway for community-based referrals, will work with medical homes, but also integrate early learning into referrals for follow-up medical, early learning or community-based services.

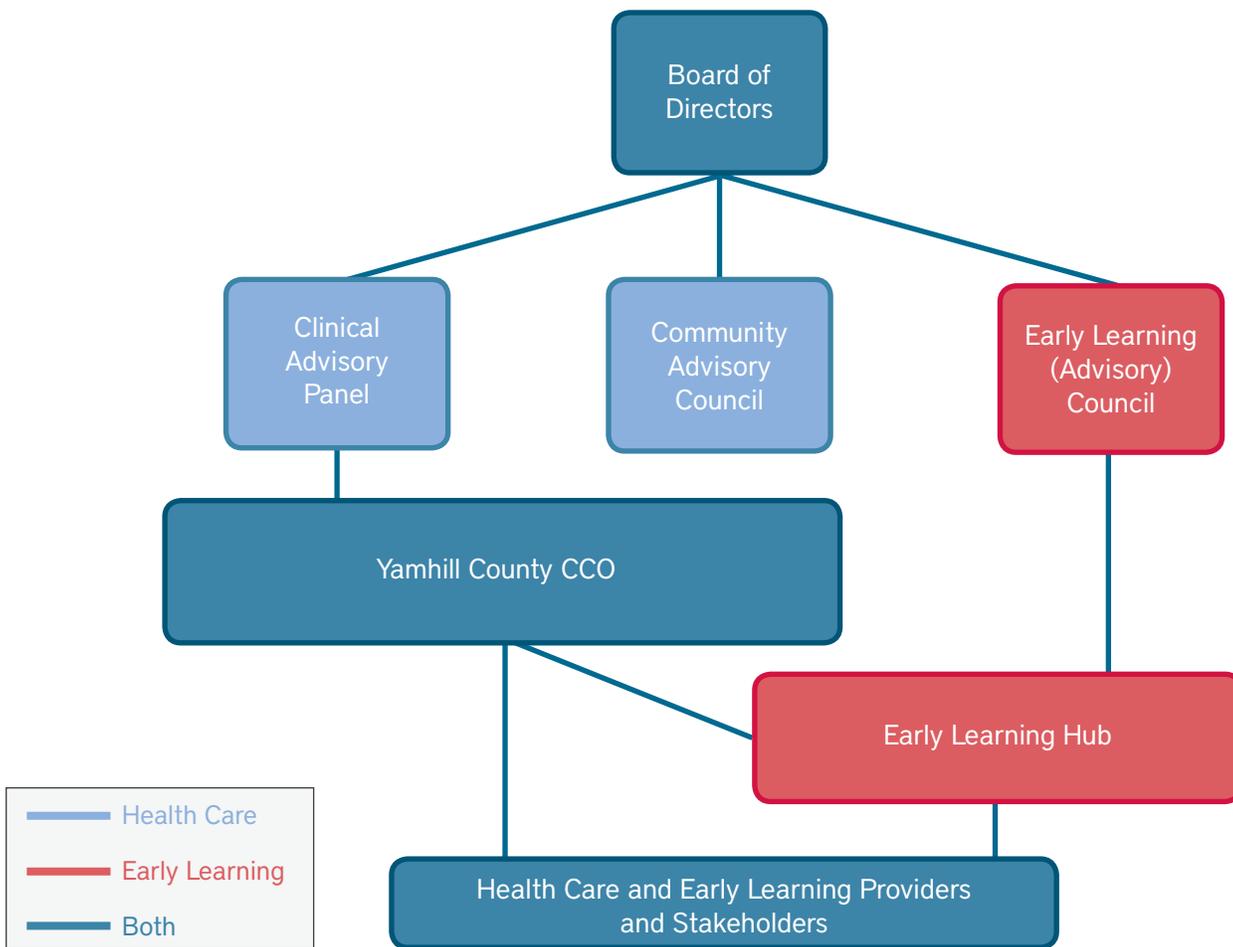
There are several examples of alignment in the community. Yamhill County developed a universal referral form for follow-up medical, early learning or community-based services, which most pediatricians use. Pediatricians in the county also recently adopted the same developmental screening instrument (Ages and Stages Questionnaire) used by early learning providers. The CCO is purchasing the questionnaire for primary care medical providers, as most early learning providers already purchase it. Since early learning and health care providers both screen children for developmental delay, the CCO is particularly committed to developing a system to avoid duplication and ensure a coordinated, efficient screening, referral and care coordination process for families.

In addition to establishing the family resource management functions, other immediate next steps for aligning early learning and health care include implementing a new "Reach Out and Read" program, a maternal medical home, and dental care coordination. The CCO received a literacy grant from the Department of Education to set up Reach Out and Read in all pediatric offices. Through the program, a child receives a new book with every well-child visit. The CCO will purchase books for two years and will support practices in finding ways to sustain the project post-grant funding. The CCO sees this project as a key mechanism for linking health and early learning. Additionally the implementation of a maternal medical home will combine CCO and Hub services to ensure pregnant women, babies, and families of newborns receive referrals for health care, home visiting, early learning or other needed services in a coordinated way.

Yamhill stakeholders point to representation of local Head Start and a pediatrician on the CCO Board as well as historical collaboration between early learning and health care communities as facilitating early success in aligning early learning and health care system transformation.



Figure 6: Yamhill County Organizational Chart with CCO and Early Learning Hub



What's Next?

Oregon's effort to bridge health care and early learning systems is still new, as are the state's respective system transformations. Having only recently been awarded, the first round of Early Learning Hubs are still being established. There are early indications of next steps from communities such as Yamhill County; however, it remains to be seen how state expectations and guidelines for alignment between early learning and health care will be realized at the community level. Stakeholders identified primary remaining challenges and next steps.

Remaining challenges and unresolved issues include:

- **Coordinating care coordinators.** Having a care coordinator in the health care system (at the CCO) and a family resource manager in the early learning system (at the Early Learning Hub) is intended to improve child and family experience by providing necessary assistance identifying and accessing community-based resources and referrals. However the presence of multiple individuals tasked with coordinating complementary services could potentially lead to confusion or duplication. Stakeholders are attuned to this issue and the need to coordinate across systems to ensure a streamlined experience for families.
- **Establishing a community utility.** Care coordinators and family resource managers can only refer to services and supports about which they know. Particularly for young children and their families, these include a variety of neighborhood-based programs and activities where families can bring their children, connect with one another, and engage in hands-on activities that strengthen their nurturing and support. Experiences from initiatives like Help Me Grow, Project LAUNCH, and MIECHV point to the importance of on-the-ground activity to continually identify and reach out to such programs to bring them into a network of known resources that care coordinators and family resource managers can draw upon, as well as to identify where there are gaps or needs for additional services.



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- **Creating shared accountability.** There is an Early Learning Kindergarten Readiness Partnership and Innovation Fund to support innovation in the early learning system; however, the bulk of financial incentives (specifically, payments) are currently provided to CCOs and health care providers. Early learning providers and Hubs do not have a similar incentive, yet they also are responsible for improving child outcomes. Early learning officials have fewer options and less precedence for offering incentive payments, yet there is a sense among some stakeholders that joint accountability requires early learning providers to share in financial rewards for improvement.

- **Making the case for investment in young children among payers other than Medicaid.** The Oregon Health Authority anticipates that some CCOs will expand to include individuals with insurance other than Medicaid, but private insurers cover fewer children than Medicaid. Since private payers serve a different population, stakeholders in Oregon anticipate it will be difficult to make the case to them to prioritize improving quality of care and health outcomes for children. There is a strong financial rationale for private payers to invest in strategies to better treat and improve outcomes among older, costly patients with multiple chronic conditions. Improvement occurs sooner (e.g., avoided hospitalizations or emergency visits) and savings are realized by the health care system. Improving child outcomes results in longer-term returns on investment that may accrue to the special education, Part C Early Intervention or juvenile justice systems as well as health care.

Oregon will continue to monitor and wrestle with these remaining challenges as partners move forward with individual system transformation and alignment efforts. The health care system is finalizing first-round incentive payments for measures such as well-child visits, and considering future CCO metrics (including kindergarten readiness), which will undoubtedly influence CCO improvement efforts in the year ahead. A workgroup of the Joint ELC/OHPB is exploring shared metrics that assess factors such as family risk, adverse childhood experiences and home environment, each of which affects health and early learning. Both the early learning and



health care systems are working to develop a shared developmental screening tool, and as indicated above, the early learning system is supporting the first round of Hubs as they unfold and announced a second round of Hubs in June 2014.⁵⁸

What Can We Learn From Oregon?

Although Oregon's efforts to bridge health care and early learning system transformations are still unfolding, leaders in the state reflected on their progress and shared several early lessons for other states that emerge from Oregon's activities to date:

- **Draw on catalytic leaders.** Stakeholders in Oregon have benefited from state and local champions of alignment—from the Governor to local leaders such as county health and human services directors who see the connection between early education and health care. These respected individuals communicate and continuously reiterate a strong message of alignment.
- **Foster and support innovation in practice as well as planning.** Oregon has many exemplary programs and initiatives and is involved in expanding or diffusing those practices. Often, such efforts are financed and supported initially through separate grants. But, their expansion and diffusion ultimately require that they are integrated into existing funding streams and are supported as routine practices. State-level planning should be more explicit in drawing upon community-level experience and expertise.

- **Prepare for a marathon rather than a sprint.** Change requires endurance and persistence; initial attempts to bridge systems might not succeed as planned. During his previous term 15 years ago, the current Governor supported a similar, smaller scale children's plan. The plan included screening requirements, e.g., hospitals were required to provide screening at birth to support the earliest possible alignment of health care and early learning. However, there were no implementation rules or a process developed to share results. Even with laws on the books, change was not realized. The recent policy changes include structural changes and a focus on outcomes to support transformation.
- **Create a common table** at which system leaders can come together. With its Early Learning Council/Oregon Health Policy Board (ELC/OHPB) Joint Subcommittee, Oregon established a neutral, shared space for early learning and health care system stakeholders to convene and discuss alignment. Having a mechanism and dedicated space for these discussions and decisions also conveyed the importance of and state commitment to alignment.
- **Identify a common language.** Oregon stakeholders became aware that the early learning and health care systems use different terms or sometimes the same terms but in different ways, which can lead to confusion. Examples include screening vs. assessment; surveillance vs. monitoring; and infant mental health vs. social-emotional development. Defining common phrases at the outset or reaching consensus on shared terms not only ensures clarity and mutual understanding, but also is a critical step in alignment.
- **Frame a shared agenda as the basis of moving shared goals forward.** To guide its work, Oregon's ELC/OHPB Joint Subcommittee has found points of intersection, such as kindergarten readiness and equity that are mutually beneficial and tied to early learning and health care systems. The subcommittee uses its shared goals as guideposts to develop action steps that propel forward movement.
- **"Be hard on outcomes and soft on strategies."** State and local stakeholders in Oregon emphasize the need for solutions to be community-based. To balance state and local control, state health care and early learning system leaders set goals for CCOs and Hubs to meet; they also facilitate the identification



Conclusion

The health care system and early learning system reforms underway in Oregon each represent an era of new accountability and what appears to be smarter infrastructure to better support achieving desired outcomes. By bridging the two system transformations, Oregon aims to maximize this opportunity for systemic change. Through joint staffing, blended funding, and shared expectations, Oregon encourages and requires previously siloed sectors to be strategic about their planning, spending, service coordination and overall improvement efforts. With rising costs and poor results for children that carry long-term health, educational and financial consequences, Oregon’s leadership decided the state had to change course. The state’s early experience to date offers options and considerations for other states striving to improve system accountability and outcomes for young children, and ensure equity for children of color and children from families with low incomes. Kindergarten readiness is a natural meeting place for health care and early education system stakeholders. States might consider other crosscutting goals affecting these or other state systems as a way to align system transformations.

and implementation of local solutions to meet those goals through structural change and support. Oregon’s Transformation Center provides funding and technical assistance opportunities to support communities (CCOs and Hubs) in developing and implementing strategies to improve child outcomes. As a result, CCOs and Hubs have the flexibility to implement the strategies they believe best fit their community strengths and will best enable them to meet the state’s goals.

- **Be strategic and supportive of existing efforts.** One of the challenges of aligning two system transformations is that it doubles the amount of change! State health policy leaders are cognizant of the requirements of CCOs and of provider fatigue, and continuously seek ways to minimize provider burden. The upside of aligning two system transformations is it provides an opportunity to borrow from an existing model of change and build on strengths in each system. Oregon strategically modeled its Early Learning Hub structure after CCOs.
- **Think creatively about making the case for investing in children.** Some stakeholders in Oregon reference the need for a mix of short-term and long-term health care investments (or “balanced portfolio”) to make the case to health care policy makers and providers for investing in children’s issues, which are a longer-term investment. Local experience (Yamhill County CCO) shows that communities can simultaneously invest in older and younger populations.

The Oregon Context

Source: FIFTY STATE CHART BOOK: Dimensions of Diversity in the Young-Child Population

22% of children birth to 17 years have special health care needs. Of that group, 32% are minority children.

3.8 million people

- 75% of the population lives in urban/metropolitan area
- 25% of population lives in rural area

6.2% are children 5 years and younger

- 21% of children 5 years and younger live at or below the poverty level
- 22% are Latino
- 37% are Black/African-American

9th largest state in the nation

The longest-standing federal efforts to link health and early learning are the Early Childhood Comprehensive Service (ECCS) grants, initiated in 2002. The most recent (ECCS) grants emphasized developmental screening and addressing social determinants of health in the requirements to states.

In Oregon, the ECCS grant is part of a larger systemic effort to build community hubs for both health care and early learning services. As articulated in the 2013 grant submitted by the Oregon Department of Human Services, the state will use these resources to coordinate statewide developmental screening activities for children birth to three years of age, capitalizing on the opportunities for conducting screenings in early care and education settings. In particular, the state will focus their energies on increasing access to screenings for those children at highest risk for negative outcomes based upon socio-cultural determinants of health. Throughout the ECCS State plan, there is a common thread of efforts to reduce the gaps in access to a family medical home for children in rural areas as well as for linguistic and cultural minorities.

The current ECCS grant (2013-2014) activities include:

- Design and implement a training curriculum focused on developmental screening for multiple early care, education, and home visitor providers;
- Evaluate and identify opportunities to expand child care health consultant capacity across the state;
- Leverage other statewide efforts to build capacity for sharing of developmental screening resources, care coordination and referral capacity, as well as to promote parent and public awareness regarding the importance of early childhood development and screening.

In addition to ECCS, Oregon has been significantly connected to other major federal and national initiatives related to children. Oregon received Project LAUNCH funding to develop birth-to-eight strategies to improve children's healthy development. The LAUNCH activities in Oregon are also targeted at increasing access to a family medical home for underserved populations.

Additionally, a focus on culturally and linguistically appropriate screenings and services for maternal mental health is a key part of the LAUNCH activities.

Oregon has joined two national initiatives that focus on improving children's healthy development – the Help Me Grow Initiative, and the National Improvement Partnership Initiative. Oregon was also an Assuring Better Child Health and Development (ABCD) state for both the third and fourth round of that initiative.

45,000 babies are born each year

- 20% are Latino
- Although only 5% of pregnant women do not access medical care, the percentages of this population are highest for Black/African American (9.3%) and Latina women (6%).

19% of Oregon's children have 3 or more risk factors for adverse childhood experiences

12% of Oregon's children are in foster care. Of that population, 42% are Native American, 23% are Black/African American

13% of parents in Oregon feel their families live in unsafe neighborhoods. Of that population, 16% are Black/African American and 20% are Latino.

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