Child & Family Well-Being Measures Workgroup

Final Report and Recommendations

Prepared for:

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

Submitted on September 11, 2015

EXECUTIVE SUMMARY

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

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

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

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

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

I. BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

II. DEFINITIONS

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

Child and family well-being

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

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

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

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

Domains

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

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

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

Measure selection criteria

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

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

III. MEASURE REVIEW PROCESS

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

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

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

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

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

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

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

Challenges

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

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

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

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

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

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

IV. RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

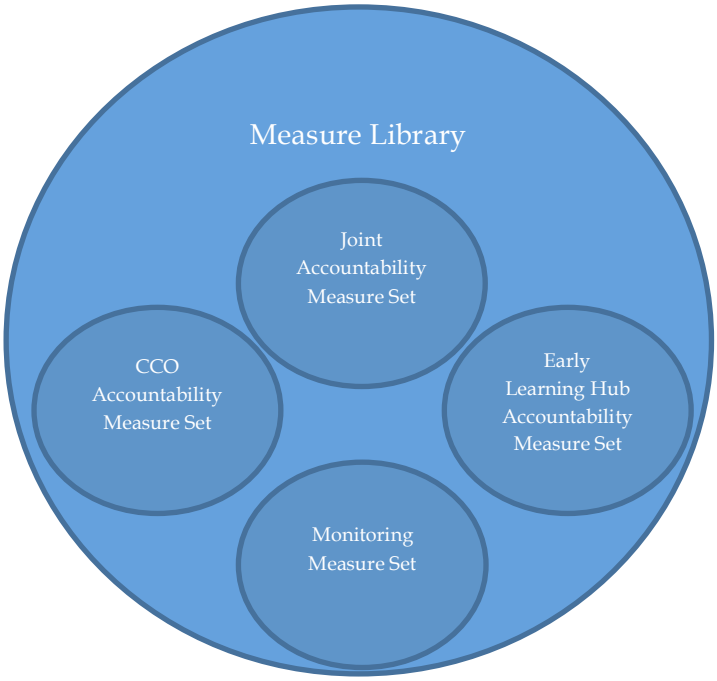
   The Department of Human Services does not currently utilize accountability measures in a similar manner as is used with CCOs or Early Learning Hubs. However, the workgroup recognizes that human services are critically important for assuring child and family well-being. As appropriate, the accountability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

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

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

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

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



Future measure development recommendations

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

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

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

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

V. CONCLUSION

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

Appendix A
Kindergarten Readiness Bundle

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

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

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

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

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

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

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

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

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

Timeline

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

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

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

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

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

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

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

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

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

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

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

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

Appendix E
Recommended Child and Family Well-being Monitoring Measures

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

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

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

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

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

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

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

[17] Oregon's EI/ECSE Data System

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

Appendix F
Future Considerations

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

Relationships

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

Economic Stability

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

Community

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

Comprehensive Person-Centered Health Care

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

Early Childhood Care and Education

- Access to parenting education
- Access to affordable child care

Person-Centered System Integration

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

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

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