Oregon's 2020 Title V

Maternal, Child, and Adolescent Health Needs Assessment Data Tools

Prepared for Title V Stakeholder Meeting, January 14-15, 2020

Oregon Health Authority
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Maternal and Child Health Section

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January 3, 2020

Dear Title V Maternal, Child, and Adolescent Health (MCAH) partners:

We look forward to gathering with all of you at the Title V MCAH Stakeholder meeting to share ideas, and plan for our future work together on behalf of Oregon's women, children, youth, and families, including those with special health needs.

Oregon's Federal Maternal and Child Health Block Grant is jointly administered by the Oregon Health Authority and the Oregon Center for Children and Youth with Special Health Needs (OOCCYSHN). Collectively, the Title V Maternal, Child and Adolescent Health (MCAH) program provides a foundation for ensuring the health of Oregon's MCAH population through programming and funding at the state, local, and tribal levels.

Every five years Oregon conducts a MCAH Needs Assessment. We use the results of this assessment to guide selection and implementation of priorities for the work of the Title V block grant in the coming five years.

This booklet contains a set of data tools that summarize the findings of our 2020 MCAH Needs Assessment. We hope that they will provide useful information and help to inform your participation in the Stakeholder meeting.

A few helpful hints for using the data tools:

- The data tools are organized into:
  - **Population health domains,** which our Federal grant requires us to address (women's and maternal, perinatal and infant, child, adolescent, and children/youth with special health needs), and associated priorities for each;
  - **State-specific priorities** that Title V has worked on over the past five years; and
  - **Emerging priorities** that came about through the MCAH needs assessment.
- You will find included an overview tool for each of the five population domains, as well as a tool for each specific priority that we will discuss at the stakeholder meeting.
- In each data tool you will find: key background information about the topic and its significance, health status data, context for the work in Oregon, whether it was a

selected Title V priority for 2016-2020, and findings from the 2020 Needs Assessment.

- Within each of the five population domains, the priorities, their definitions, and how they are measured are federally determined.
- The state-specific and emerging priorities, and their definitions and measures, are determined by Oregon.
- The chart on the following page shows each of the priorities that will be discussed at the meeting, and how they align within the domains. This chart can also serve as a guide to the data tools and the order in which they appear in this booklet.

Please take some time before the meeting to review the data tools if you can. If you have questions about the data tools, the Title V Needs Assessment or the Stakeholder Meeting, please contact Nurit Fischler, Title V Coordinator (Nurit.r.fischler@state.or.us)., Alison Martin, OCCYSHN Assessment and Evaluation Manager (martial@ohsu.edu), or Maria Ness, Title V Research Analyst (Maria.N.Ness @state.or.us).

We thank you for your help with the Title V Needs Assessment over the past year, and your willingness to join other partners to discuss the future priorities and work of Oregon's MCAH Title V program. We look forward to seeing you on January 14th and 15th.

Sincerely,

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Title V MCH Director
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Benjamin Hoffman, MD
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Oregon Maternal, Child, and Adolescent Health Title V Block Grant Priority Options by Domain 2021 - 2025

- Among the national priority areas, states are required to select at least one priority area per population domain.
- New state priority areas will also be selected from among the current state priority areas, and emerging issues.

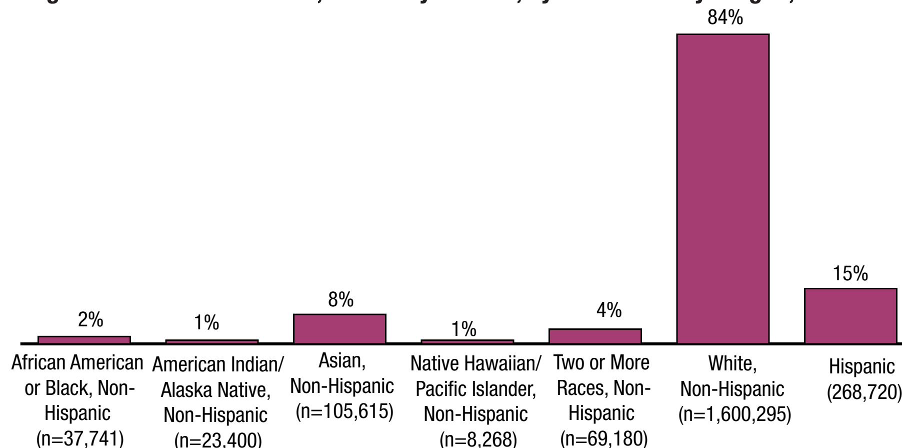
Population Domain	National Priority Areas						
Women's and Maternal Health	Well-Woman Care	Low-Risk Cesarean Delivery				Oral Health During Pregnancy	Smoking During Pregnancy
Perinatal and Infant Health	Breastfeeding	Safe Sleep					
Child Health	Developmental Screening			Child Injury	Child Physical Activity	Oral Health 0-11	Child Exposure to Secondhand Tobacco Smoke
Adolescent Health	Adolescent Well-Visit	Bullying		Adolescent Injury	Adolescent Physical Activity	Oral Health 12-17	Adolescent Exposure to Secondhand Smoke
CYSHCN	Medical Home	Transition to Adult Health Care					

State Priority Areas								
Current State Priority Areas	Toxic Stress, Trauma, Adverse Childhood Experiences and Resilience	Food Insecurity	Culturally and Linguistically Appropriate Services				
Emerging Issues	Drug Use and Misuse: Impact on Pregnant Women and Children	Adolescent Mental Health	Maternal Mental Health	Social Determinants of Health and Equity	Adult Alcohol Use	Child Care	Social Connectedness

Population Domain: Women's and Maternal Health

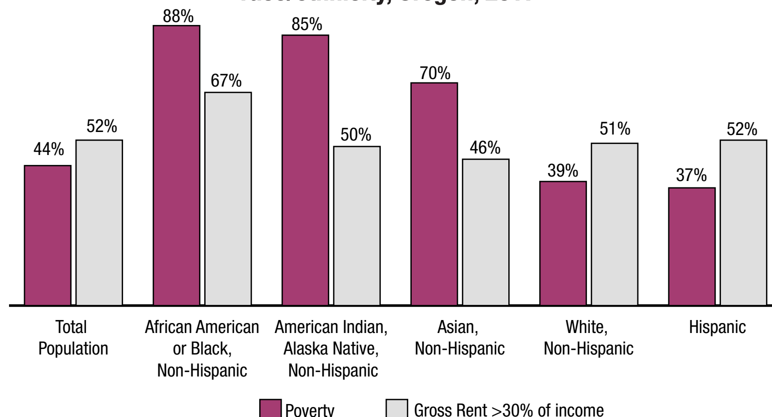
Oregon population profile

Figure 1. Percent of women, 18 to 44 years old, by race/ethnicity Oregon, 2018



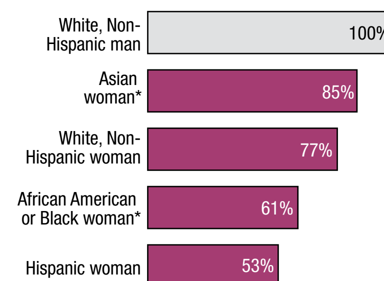
Source: American Fact Finder, United States Census Bureau, 2018 estimate based on April 1, 2010

Figure 2. Female headed households with children under 5 years old: percent in poverty, and percent paying >30% of income in rent, by race/ethnicity, Oregon, 2017



Source: Source: American Fact Finder, United States Census Bureau
Caution: Poverty data has large margin of errors for Asian, African American or Black, and American Indian populations.

Figure 3. Percent of women's earnings compared to White, non-Hispanic men's earnings, by race/ethnicity, Nationwide, 2017



Source: 2018 Annual Social and Economic Supplements, Current Population Survey, U.S. Census Bureau
** includes Hispanic and Non-Hispanic*

Key background & issues of concern for this population

Women's health throughout their lifespan is an important determinant of the health of the whole family and community. Addressing the social determinants of health and health disparities that affect women in a community can have a profound impact. These social determinants include healthy relationships, the ability to control fertility, access to education, policies that promote gender equity in the work place, and adequate child care.

Social determinants of health, stress, racism

- Pregnancy affects employment, income, housing, and educational opportunities, and these stresses are generally more significant when the mother has a lower socioeconomic status. There are also immediate health concerns in the form of pregnancy complications. In addition to the physical and mental effects those complications may have on the child, there are also emotional and physical health effects for mothers and families.
- Health disparities are rooted in the social, economic, and environmental factors that influence our day-to-day lives. These stressors are present across women's life-course but can be even more severe during pregnancy. For example, a pregnant mother who is working a low-wage job may have significant financial pressure to continue working as long as possible until the baby arrives, even if that means increased stress or even physical pain for the mother. Additional stresses such as those caused by racism and other forms of discrimination can also affect the health of the mother and future child.[1] The negative influences of toxic stress may also be transmitted inter-generationally though epigenetics.
- Women especially are at risk for the harmful health effects of caregiver stress. Caregiver stress is due to the emotional and physical strain of caregiving.[2]

Maternal mortality and morbidity

- Pregnancy-related deaths occur during pregnancy and up to a year following the end of the pregnancy. Maternal health experts are actively searching for answers about why the ratio of pregnancy-related deaths in the United States is higher than other developed nations, why it is increasing, and why the disparity by race/ethnicity is widening. It is also important to note that for every woman who dies, there are approximately 50 who suffer severe maternal morbidity–very severe complications of pregnancy, labor, and delivery that bring them close to death.
- One in four pregnancy-related deaths are related to heart conditions. Women also die of infections (including flu), bleeding, blood clots, and high blood pressure.
- Although the risk of dying of pregnancy complications is low, some women are at higher risk than others. African American women are 3 to 4 times more likely to die of pregnancy complications than White women. Women of color are also impacted by bias and racism at multiple levels throughout their lives, resulting in physical and emotional health problems related to toxic stress, as well as diminished access to quality, culturally-appropriate care. These factors contribute to increased risks of maternal morbidity and mortality.
- Women 35 to 39 years old are almost twice as likely to die of pregnancy complications as women 20 to 24 years old. The risk becomes even higher for women 40 years old or older.[3]
- Maternal mortality review committees (MMRCs) are important tools for states in the prevention of maternal mortality as well as maternal morbidity. Nationally, nearly 60% of maternal deaths investigated by MMRCs have been classified as being due to preventable causes. House Bill 4133 (2018) established an MMRC in the Oregon Health Authority (OHA). The committee is required to conduct studies and reviews of the incidence of maternal mortality and severe maternal morbidity and make recommendations to reduce the incidence of mortality and severe morbidity in the state.

National priority area options (2021-2025)

- Well-woman care
- Low-risk cesarean deliveries
- Oral health for pregnant women
- Smoking among pregnant women

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, well-woman care (health care access) was the most often mentioned need of the four possible women's and maternal health national priority areas, followed by oral health, then smoking, and lastly, low-risk cesarean delivery.

Partner survey

- In a statewide survey of partners, well-woman care was the most commonly selected national priority area in the women's and maternal health population domain, followed by smoking during pregnancy, then oral health during pregnancy, and lastly, low-risk caesarean delivery.
- Well-woman care was also rated highest within the women's and maternal health domain in terms of health impact, potential to effect health equity, and impact of applied resources.
- Well-woman care was also consistently rated highest priority among partners who serve American Indian/Alaska Native, Asian, African American or Black, Native Hawaiian/Pacific Islander, immigrant, and LGBTQ+ communities, as well as partners who serve individuals with disabilities.

Community voices

- Well-woman care was rated highest women's and maternal health priority among African American or Black, Latinx, immigrant/refugee, and rural families, followed by oral health during pregnancy, then smoking during pregnancy, and lastly, low-risk cesarean delivery.

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[1] Fairness Across Places? Your Health in Pierce County, 2015 Health Equity Assessment

[2] Caregiver Stress, Factsheet, Office of Women's Health

[3] Maternal Health, CDC, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

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Priority Area: Well-Woman Care

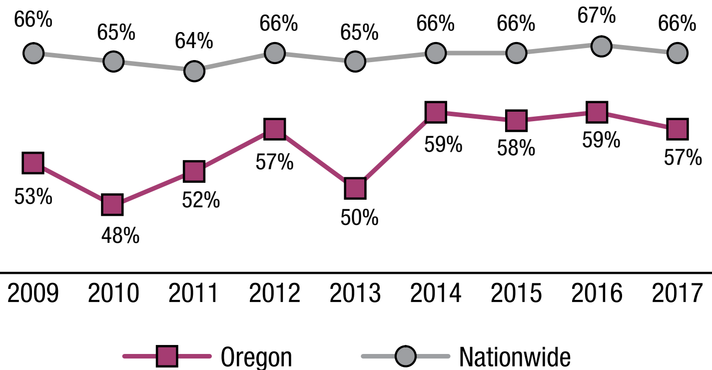
☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Significance of the issue

A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well-woman visit to promote women's health in general, as well as prior to and between pregnancies and improve subsequent maternal and perinatal outcomes.[1]

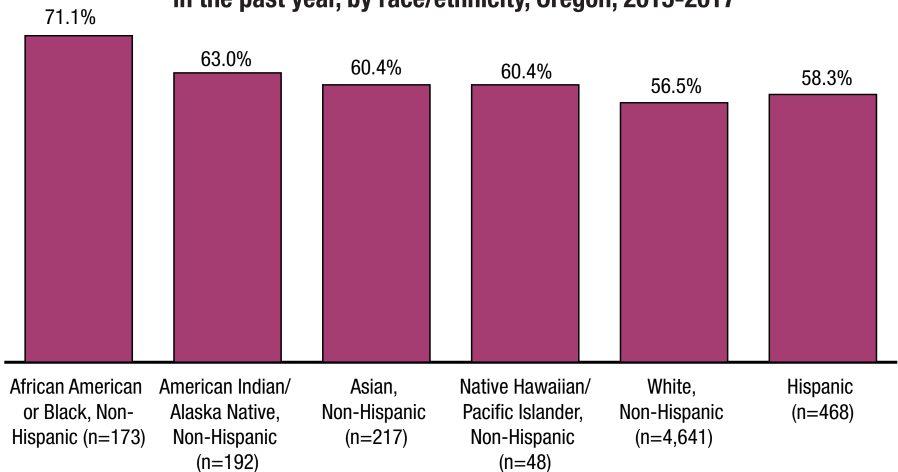
National performance measure

Figure 1. Percent of women, 18 to 44 years old, who had a routine checkup within the past year, 2009-2017



Source: Behavioral Risk Factor Surveillance System (BRFSS)

Figure 2. Percent of women, 18 to 44 years old, who had a routine checkup within the past year, by race/ethnicity, Oregon, 2015-2017



Source: Oregon BRFSS Race Oversample 2015-2017

Context for the issue in Oregon

Well-woman care was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V priority for 2016-2020, as well as a priority for partner agencies.

Health Status Data[2]

- Eighty-eight percent of Oregon women,
18 to 44 years old, were covered by health insurance in 2018.
- In Oregon, most women, 18 to 44 years old, with health insurance (91.5%) had a routine checkup within the past year, compared to fewer than 1 in 10 (8.5%) women without health insurance.

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[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report. Appendix of supporting documents. Rockville, MD: Author.

[2] Oregon Behavioral Risk Factor Surveillance System (BRFSS), 2018

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Successes

- Passage and initial implementation of Oregon's Maternal Mortality and Morbidity Review legislation, House Bill 4133 (2018).
- Postpartum Care incentive metric for Oregon's Coordinated Care Organizations (CCOs) adopted.
- Implementation of the Reproductive Health Equity Act House Bill 3391 (2017).
- Implementation of the Preconception Health Project in Southern Oregon, increased screening for pregnancy intendedness and use of long-acting reversible contraceptives (LARCs).

Challenges

- Well-woman care has not historically been a priority for health care systems in Oregon. Barriers to care reported by Oregon women included: health care provider and staff attitudes; distrust of health care providers/fear of practices; preventive care not being a priority; lack of culturally appropriate care; discomfort with pelvic examinations; transportation issues and; lack of child care.

Local Title V implementation

- Seven counties and one Tribe selected well-woman care as a Title V priority area for FY2020. Activities include working to support access through collaboration with Family Planning, using traditional and social marketing to educate the population and promote well-woman care, and education and training of providers to use the postpartum care visit to increase utilization of well-woman visits.

State level implementation

- Work is being undertaken at the state level to provide guidance and support to CCOs around the postpartum metric.
- Training and technical assistance to support public health programs around the state are working to implement pregnancy intention screening and reproductive life planning.

Partner alignment

- Postpartum care is an incentivized metric for CCOs.
- Healthy Start programs have a focus on well-woman care.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, well-woman care (health care access) was the number one most mentioned need of the four possible women's and maternal health national priority areas.

Partner survey

- In a statewide survey of partners, well-woman care was the most commonly selected national priority area in the women's and maternal health population domain.
- It was rated highest within the women's and maternal health domain in terms of health impact, potential to effect health equity, and impact of applied resources.
- It was consistently rated highest priority among partners who serve American Indian/Alaska Native, Asian, African American or Black, Native Hawaiian/Pacific Islander, immigrant, and LGBTQ+ communities, as well as partners who serve individuals with disabilities.

Community voices

- Well-woman care was rated highest women's and maternal health priority among African American or Black, Latinx, immigrant/refugee, and rural families.
- Immigrant and refugee families listed difficulty obtaining health care coverage and a lack of local providers as primary barriers to receiving well-woman care.
- Rural families reported some women's health services being unavailable at Tribal clinics, as a barrier to receiving care.

Priority Area: Low-Risk Cesarean Delivery

☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Significance of the issue

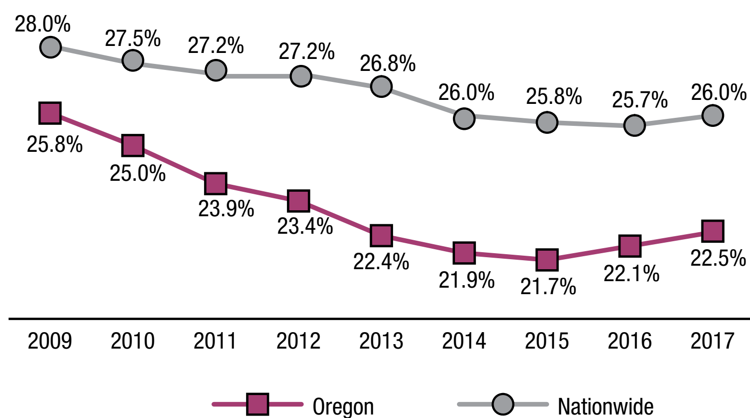
Cesarean delivery can be a life-saving procedure for certain medical indications. However, for most low-risk pregnancies, cesarean delivery poses avoidable maternal risks of morbidity and mortality, including hemorrhage, infection, and blood clots; risks that compound with subsequent cesarean deliveries. Much of the temporal increase in cesarean delivery (over 50% in the past decade), and wide variation across states, hospitals, and practitioners, can be attributed to first-birth cesareans. Moreover, cesarean delivery in low-risk first births may be most amenable to intervention through quality improvement efforts.[1]

Health Status Data

- In 2017, Oregon low-risk cesarean deliveries was similar in urban (22.8%) and rural areas (21.8%).[2]

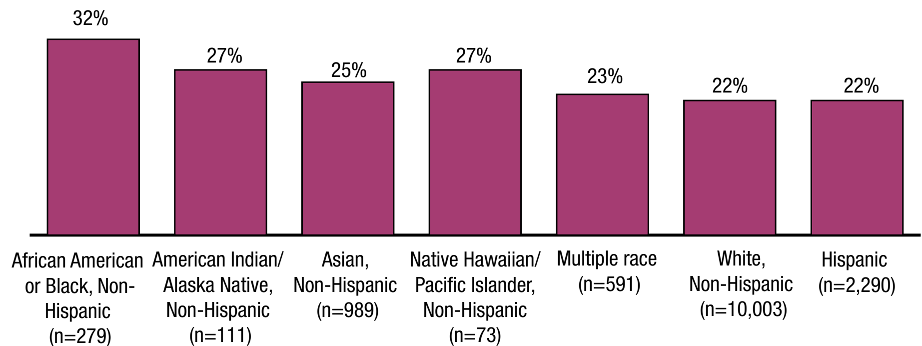
National performance measure

Figure 1. Percent of low-risk cesarean deliveries, 2009-2017



Source: National Vital Statistics System (NVSS) and Oregon Center for Health Statistics (OCHS), 2018

Figure 2. Percent of low-risk cesarean deliveries, by race/ethnicity, Oregon, 2018



Source: Oregon Center for Health Statistics (OCHS), 2018

Low-risk = singleton, term (37 or more weeks of gestation), vertex (head first) cesarean deliveries to women having a first birth per 100 women delivering singleton, term, vertex first births.

Context for the issue in Oregon

Low-risk cesarean delivery was not one of Oregon's selected Maternal, Child, and Adolescent Health (MCAH) Title V priorities for 2016-2020, however, work to reduce low-risk cesareans has been a focus of other Oregon partners during this period.

Successes

- Oregon's rate of low-risk cesarean deliveries is consistently lower than the national rate (Figure 1).
- The Oregon Perinatal Collaborative has succeeded in implementing a "hard stop" policy to end elective deliveries prior to 39 weeks of age.

Challenges

- There are significant racial/ethnic disparities in the rates of low-risk cesarean deliveries in Oregon (Figure 2).

Partner alignment

- The Oregon Perinatal Collaborative promotes its recommended strategies for successful vaginal births to Oregon Hospitals.
- Policy and programmatic supports are in place to increase the use of doulas in Oregon as a strategy to decrease cesarean rates.
- Internal, Oregon Health Authority (OHA), and external efforts exist to improve the safety of out-of-hospital births for low-risk pregnancies.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, low-risk cesarean delivery was the least mentioned need of the four possible women's and maternal health national priority areas.

Partner survey

- In a statewide survey of partners, low-risk cesarean delivery was the least selected national priority area in the women's and maternal health population domain.
- It was rated lowest within the women's and maternal health domain by partners in terms of health impact, potential to effect health equity, and impact of applied resources.
- It was also consistently rated lowest priority among partners who serve American Indian/Alaska Native, Asian, African American or Black, Native Hawaiian/Pacific Islander, immigrant, and LGBTQ+ communities, as well as partners who serve individuals with disabilities.

Community voices

- Low-risk cesarean delivery was rated the lowest women's and maternal health priority among African American or Black, Latinx, immigrant/refugee, and rural families.
- African American or Black families reported that there is a high rate of cesarean delivery in their communities, due to misconceptions about this route of delivery, and due to doctors offering it to African American or Black women without giving them other options.

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[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report. Appendix of supporting documents. Rockville, MD: Author.

[2] Pregnancy Risk Assessment Monitoring System (PRAMS), 2017

Priority Area: Oral Health During Pregnancy

☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Health Status Data

- In 2017, 65% of women surveyed approximately three months after delivery had their teeth cleaned within the previous year.[1]
- Oregon ranks 48th nationally for optimally-fluoridated public water systems, with only 22% of systems having fluoridated water.[2]

[1] Pregnancy Risk Assessment Monitoring System (PRAMS), 2017

[2] Community Water Fluoridation-CDC

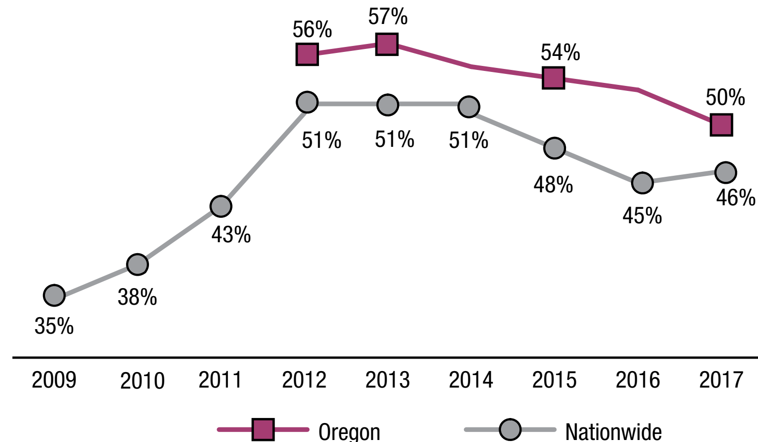
Significance of the issue

Good oral health is especially important for pregnant women, unborn babies and infants. Hormonal changes to the body during pregnancy can increase the risk of cavities and gum disease in pregnant women. Untreated cavities and gum disease may lead to serious health problems and increase the risk of delivering a pre-term, low-birthweight baby. It is safe to have dental care while pregnant and should not be delayed.

Tooth development also begins during pregnancy. Accessing oral health care, practicing good oral hygiene and eating healthy foods will build a foundation for a child's healthy teeth. After pregnancy, mothers can pass cavity-causing germs to their babies, and children of mothers with cavities are much more likely to develop cavities themselves.

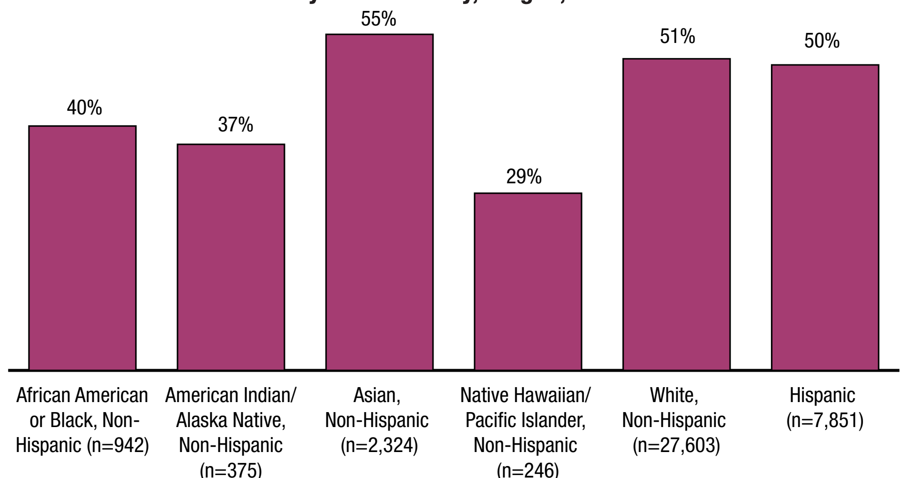
National performance measure

Figure 1. Percent of women who had a dental visit during pregnancy, 2009-2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS), 2009-2017

Figure 2. Percent of mothers who had a dental visit during pregnancy, by race/ethnicity, Oregon, 2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

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Context for the issue in Oregon

Oral health during pregnancy was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V priority for 2016-2020, as well as a priority for many partner agencies.

Successes

- Oregon takes a comprehensive approach to address oral health issues across the lifespan through building partnerships to support the integration of oral health in the Coordinated Care Organizations (CCOs), delivering school-based oral health programs, promoting oral health prevention during pregnancy and early childhood, and continued surveillance of the oral health status of all Oregonians.

Local Title V Implementation

- Fifteen local public health agencies and two tribes selected oral health as a Title V priority area for FY2020. Activities include following the American Congress of Obstetricians and Gynecologists (ACOG) oral health recommendations for pregnant women; providing oral health preventive services during nurse home visits; providing staff with the Oregon Oral Health Coalition's (OrOHC) Maternity Teeth for Two training; and educating pregnant women about oral health and the importance of dental visits.

Partner alignment

- Strategies to promote oral health for pregnant women align with these strategic plans:
  - » Strategic Plan for Oral Health in Oregon: 2014-2020
  - » State Health Improvement Plan (SHIP) 2020-2024 access to equitable preventive health care
  - » OHA Oral Health Roadmap
  - » PHD Maternal & Child Health Section Strategic Plan

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, oral health was the second most mentioned need of the four possible women's and maternal health national priority areas.

Partner survey

- In a statewide survey of partners, oral health during pregnancy was the third most commonly selected national priority area of four, in the women's and maternal health population domain.
- It was also rated third of four within the women's and maternal health domain by partners in health impact and potential to effect health equity, and second of four in impact of applied resources.
- It was rated third highest priority among partners who serve Asian, African American or Black, Native Hawaiian/Pacific Islander and immigrant communities, as well as partners who serve individuals with disabilities.

Community voices

- Oral health during pregnancy was rated second highest of four women's and maternal health priority areas among African American or Black, Latinx, immigrant/refugee, and rural families.
- Latinx and immigrant/refugee families reported that oral health is a problem in their communities because of health care coverage for adults not including dental care.
- Rural families reported a lack of dental providers and affordable dental care as barriers to women receiving necessary oral health care.

Priority Area: Smoking During Pregnancy

☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Health Status Data

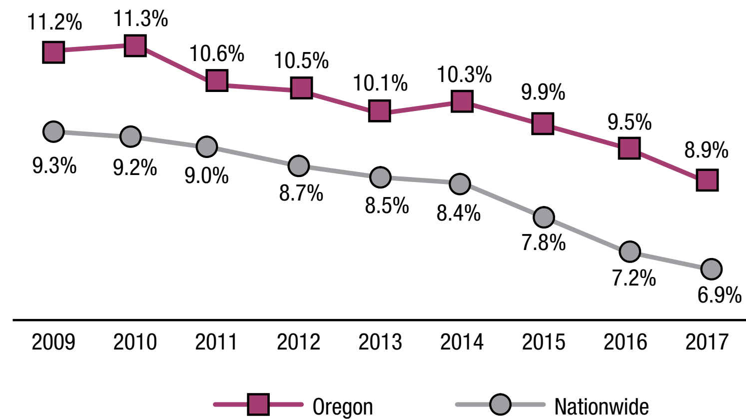
- During 2011 – 2017, Oregon PRAMS showed a drop among women smoking three months prior to pregnancy from 23.2% to 17.7%.
- In 2018, recent initiation (within the past 6 months) of tobacco use decreased significantly from 34% to 25% for youth, 13 to 17 years old, and from 23% to 18% for young adults, 18 to 20 years old.[2]
- American Indians, people with household incomes under $15,000, people on Medicaid, and those with no high-school diploma are significantly more likely to smoke in Oregon.[3]

Significance of the issue

Tobacco use during pregnancy is a special concern because of the effects of smoking to the mother and to her unborn baby. Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Further, secondhand smoke is a mixture of mainstream smoke (exhaled by smoker) and the more toxic side stream smoke (from lit end of nicotine product) which is classified as a "known human carcinogen" by the US Environmental Protection Agency, the US National Toxicology Program, and the International Agency for Research on Cancer. [1]

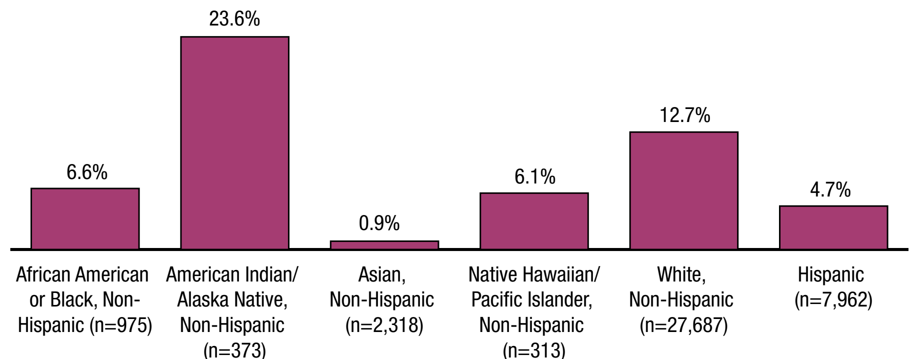
National performance measure

Figure 1. Percent of women who smoked during pregnancy, 2009-2017



Source: National Vital Statistics System (NVSS) and Oregon Center for Health Statistics (OCHS)

Figure 2. Percent of women who smoked during the last three months of their pregnancy, by race/ethnicity, Oregon, 2018



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Context for the issue in Oregon

Smoking during pregnancy was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V priority for 2016-2020, as well as a priority for many partner agencies.

Successes

- In August 2017, Oregon raised the minimum age to buy, possess, or consume tobacco or inhalant delivery products from 18 to 21 years old.
- The Maternal and Child Health (MCH) Program worked with Oregon's Tobacco Prevention and Education Program and the Oregon Health Authority (OHA) Health Transformation Center (HTC) to develop tobacco cessation training modules for providers, with a specific module focused on cessation for pregnant women.

MCAH Title V efforts and strategies

- Through Oregon's Mothers Care Program, pregnant women who smoke receive interventions and referral to the Oregon Quitline.
- State and local Title V programs are working to promote access to, and utilization of health insurance coverage benefits for pregnant and postpartum women.
- Title V grantees also incorporate smoking cessation into their home visiting and other MCH programs. Due to limited funding, many local grantees have chosen this strategy rather than conducting population level interventions aimed at cessation for all pregnant women.

Partner alignment

- Oregon's Coordinated Care Organizations (CCOs) will be monetarily incentivized for reducing cigarette smoking among their members.
- Oregon's Title V work on smoking during pregnancy also aligns with tobacco reduction work of partners including: Oregon's Tobacco Prevention and Education Program, Oregon's Adolescent Health Program, and Oregon's Medicaid Program.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, smoking was the third most mentioned need of the four possible women's and maternal health national priority areas.

Partner survey

- In a statewide survey of partners, smoking during pregnancy was the second most commonly selected national priority area of four in the women's and maternal health population domain.
- It was rated second of four within the women's and maternal health domain by partners in terms of health impact and potential to effect health equity, and third of four in impact of applied resources.
- It was the least selected priority among partners who serve Asian, African American or Black, Native Hawaiian/Pacific Islander, and immigrant communities, as well as partners who serve individuals with disabilities.

Community voices

- Smoking during pregnancy was rated third of four women's and maternal health priority areas among African American or Black, Latinx, immigrant/refugee, and rural families.
- Rural families reported that smoking during pregnancy is a highly prevalent issue in their communities.

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report. Appendix of supporting documents. Rockville, MD: Author.

[2] Oregon's Tobacco 21 Law: Impact Evaluation

[3] 2018 Oregon Tobacco Facts

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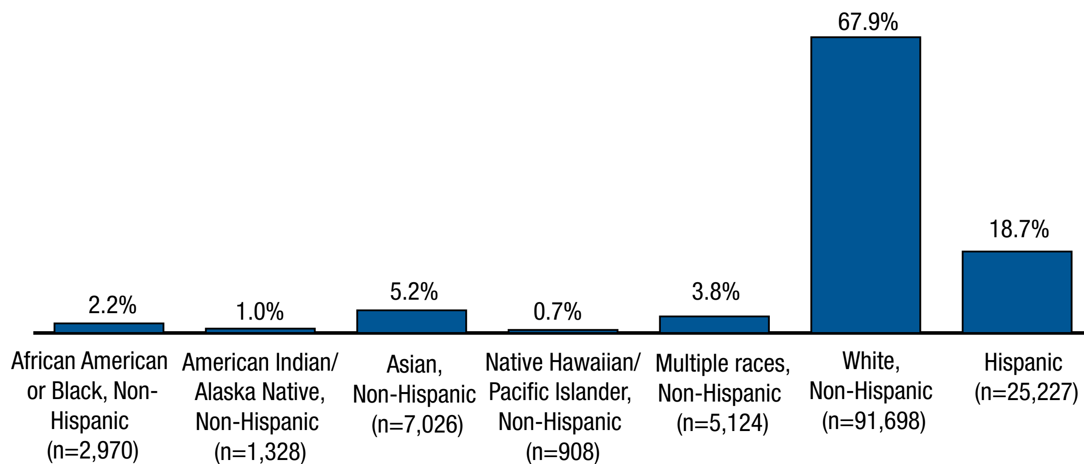
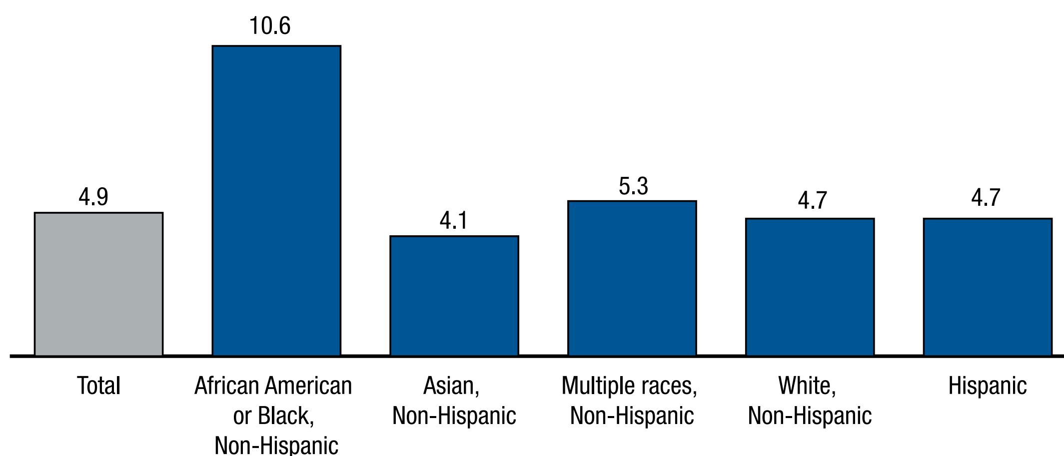
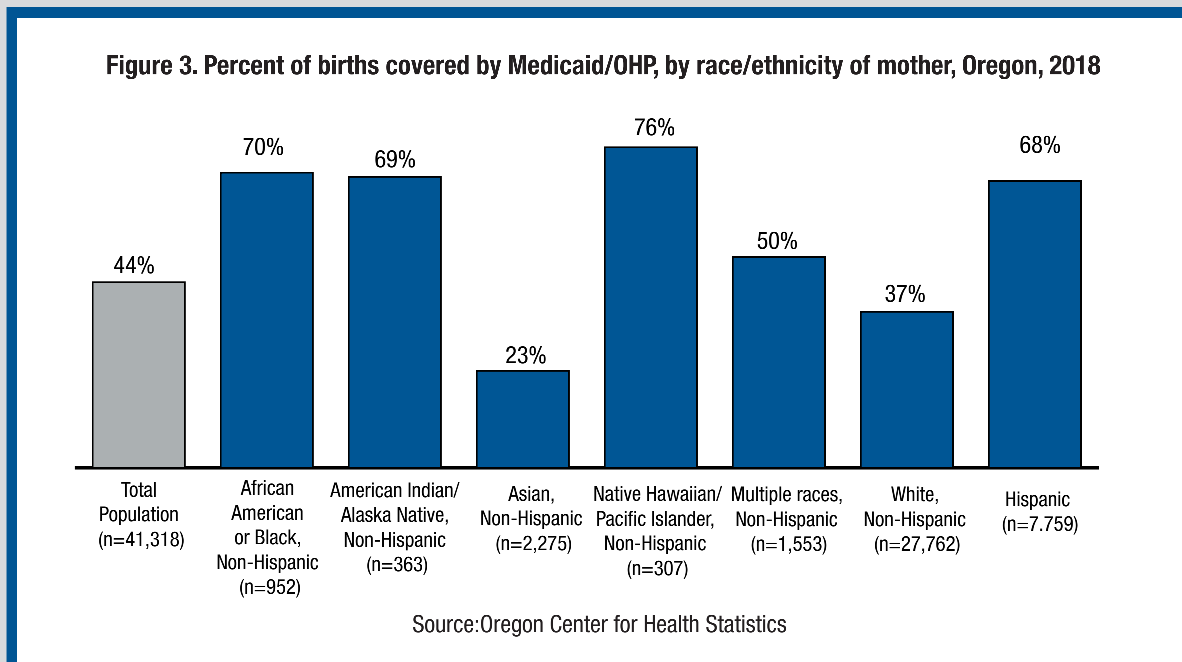
Population Domain: Perinatal and Infant Health

Oregon population profile







Key background & issues of concern for this population

A comprehensive approach to improving pregnancy outcomes and reducing infant mortality follows a life course approach, acknowledging and accounting for the interplay of biological, behavioral, and other factors influencing a woman's health throughout the life course and across generations.[1] Racism and systemic discrimination is harmful to perinatal and infant health and development. Racism can impact pregnant women and infants through limited access, opportunities and power, and the experience of prejudice and discrimination, all of which can contribute to developmental delays and poor health outcomes.

Brain development and attachment

- Relationships with parents and other caregivers are critical to a baby's early development.[2] Optimal brain development of infants (as well as their social, emotional, and cognitive development) depends on a loving bond or attachment relationship with a primary caregiver, usually a parent. Without a quality initial bond, children are less likely to grow up to become happy, independent and resilient adults.[3]
- The early years are the most active period for establishing neural connections. Early experiences affect the development of brain architecture, which provides the foundation for future learning, behavior, and health. The interactions of genes and experiences shape the developing brain.[4]
- During the infant and toddler years, there are many opportunities to promote social emotional health, to prevent emotional disturbances from taking root, and to treat mental health problems before they can manifest into more severe problems later in life.[5]
- Adverse experiences during pregnancy and infancy can cause toxic stress, which weakens the architecture of the developing brain, and can lead to lifelong problems in learning, behavior, and physical and mental health.[6]

Economic security

- Parent and child well-being are inextricably linked. Parents are crucial to children's healthy development and to families' ability to move out of poverty.[7]
- Lack of access to high quality affordable childcare impacts a family's economic security. Many families with young children in Oregon live in what experts have defined as a childcare desert, a community with more than three children for every regulated childcare slot.[8]

- Ensuring parents can further their education and participate in the workforce is critical. Parental employment not only improves families' economic circumstances but has also been shown to improve children's social and emotional wellbeing.[9]
- Poverty has lasting effects, particularly for those who live in poverty as children. Low-income children fare worse on a range of health, education, employment, and economic outcomes in childhood and into adulthood, when compared to their higher income peers.

National priority area options (2021-2025)

- Breastfeeding
- Safe sleep

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, breastfeeding was the most mentioned need of the two possible perinatal and infant health national priority areas, as compared to safe sleep.

Partner survey

- In a statewide survey of partners, breastfeeding was the most commonly selected national priority area in the perinatal and infant health population domain, as compared to safe sleep.
- Breastfeeding was also rated highest within the perinatal and infant health domain in terms of health impact, potential to effect health equity, and impact of applied resources.
- Breastfeeding was also consistently rated highest priority among partners who serve American Indian/Alaska Native, Asian, African American or Black, Native Hawaiian/Pacific Islander, immigrant, and LGBTQ+ communities, as well as partners who serve individuals with disabilities.

Community voices

- Breastfeeding was rated highest perinatal and infant health priority among African American or Black, Latinx, immigrant/refugee, and rural families, as compared to safe sleep.

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1 AMCHP Compendium on Infant Mortality

2 The Child Development Case for a National Paid Family and Medical Leave Program, Zero to Three

3 The importance of early bonding on the long-term mental health and resilience of children

4 Brain Architecture, Center on the Developing Child, Harvard University

5 The Basics of Infant and Early Childhood Mental Health: A Briefing Paper, Zero to Three

6 Brain Architecture, Center on the Developing Child, Harvard University

7 Parents and Children Thriving Together: The Role of State Agencies in Crafting a Statewide Two-Generation Strategy

8 Oregon's Child Care Deserts: Mapping Supply by Age, Group, Metropolitan Status, and Percentage of Publicly Funded Slots

9 Child Care Assistance: A Critical Support for Infants, Toddlers, and Families

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Priority Area: Breastfeeding

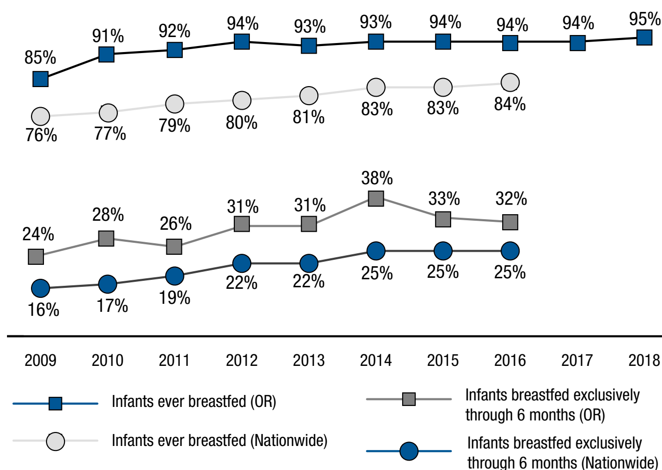
☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Significance of the issue

The American Academy of Pediatrics (AAP) recommends all infants exclusively breastfeed for about six months and continue breastfeeding at least a year as complementary foods are introduced. Human milk provides essential building blocks for brain development and unique nutritional and immunological properties that provide protection against infection and illness. Breastfeeding facilitates a naturally responsive style of infant feeding. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release, reduced risk for postpartum depression, and possible protective effects against breast and ovarian cancer and hypertension. Not breastfeeding increases risk for both infant and maternal morbidity and mortality.[1]

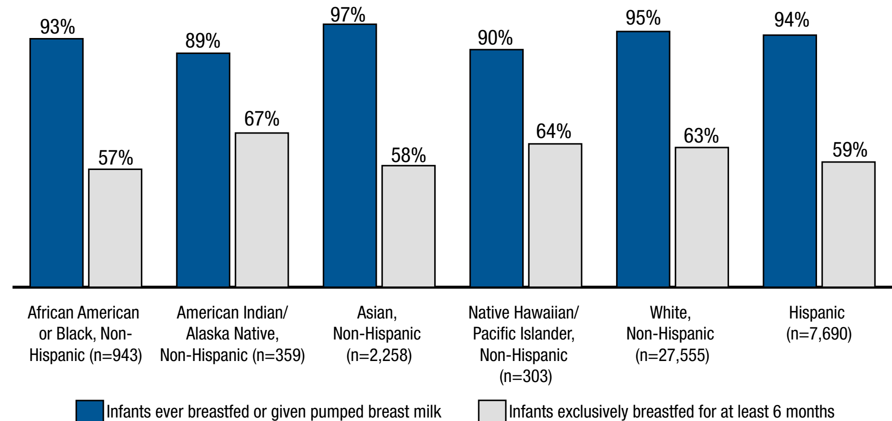
National performance measure

Figure 1. Percent of infants ever breastfed and exclusively through six months, Oregon and Nationwide, 2009-2018



Source: National Immunization Survey

Figure 2. Percent of infants ever breastfed or exclusively breastfed for at least six months, by race/ethnicity, Oregon



Source: "Ever breastfed" from National Vital Statistics System (NVSS); "At least six months exclusively breastfed" from Pregnancy Risk Assessment Monitoring System (PRAMS)-2, 2015.

Note: Population size for "ever breastfed" data."

Health Status Data

- Oregon continues to have breastfeeding initiation rates that are higher than the Healthy People 2020 target of 82%, showing that almost all parents want to breastfeed their infants.[2]
- Although breastfeeding exclusivity for six months duration meets Healthy People 2020 goals (25.5%), both Oregon and National rates fall short of medical recommendations that children be exclusively breastfed until 6 months of age.[3] Breastfeeding drops off at key times such as in the first two weeks after birth or when returning to work. Stopping breastfeeding is often due to lack of support – in the health care system, in the community or in the workplace.[4]
- Disparity exists for exclusive breastfeeding for six months with lower rates among African American or Black, Asian, and Hispanic Oregonians.

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V

[2] Healthy People 2020, Maternal, Infant and Child Health

[3] American Academy of Pediatrics Policy Statement.

[4] The Surgeon General's Call to Action to Support Breastfeeding (2011)

Context for the issue in Oregon

Breastfeeding was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V priority for 2016-2020, as well as a priority for many partner agencies.

Current state policy and efforts

- Oregon has laws and policies in place to protect and support breastfeeding: breastfeeding in public law, jury duty exemption, public pool regulations, and provision of break time and private space in the workplace for expressing milk. The newest law, House Bill 2593 (2019), relating to Expression of Milk in the Workplace, updates Oregon's previous lactation accommodation in the workplace law to align more closely with the federal law of the Fair Labor Standards Act. All employers must provide space and break time; the primary change in new law is lowering the undue hardship exemption to employers with 10 or fewer employees.
- New Paid Family and Medical Leave law, House Bill 2005 (2019), will allow 12 weeks of paid leave which provides an opportunity to support breastfeeding for a longer time.
- Oregon has licensure of International Board-Certified Lactation Consultant (IBCLC) which provides a mechanism for payment of medical lactation management.

Local Title V implementation

- For 2019-2020, 16 grantees selected this as a Title V priority. A range of strategies are selected from individually-focused interventions, to increasing training and access to high quality lactation services and increasing support in the workplace and child care settings.

Partner alignment

- Oregon has 10 Baby Friendly Hospitals providing maternity care practices supportive of breastfeeding.
- Oregon Women, Infants, and Children (WIC) supports and promotes breastfeeding with education and counseling, trained staff, breastfeeding peer counseling programs and additional healthy foods for breastfeeding women.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, breastfeeding was the more often mentioned need of the two possible perinatal and infant health national priority areas.

Partner survey

- In a statewide survey of partners, breastfeeding was the most commonly selected national priority area of the two options in the perinatal and infant health population domain.
- It was rated higher within the perinatal and infant health domain by partners in terms of health impact, potential to effect health equity, and impact of applied resources.
- It was also consistently rated higher among partners who serve American Indian/Alaska Native, Asian, African American or Black, Native Hawaiian/Pacific Islander, immigrant, and LGBTQ+ communities, as well as partners who serve individuals with disabilities.

Community voices

- Breastfeeding was rated higher of the two perinatal and infant health priority areas, among African American or Black, Latinx, immigrant/refugee, and rural families.
- African American or Black families reported needing more culturally competent care and support in their communities to support breastfeeding, including support for mothers to return to work while continuing to breastfeed. Immigrant/refugee families also reported needing more workplace breastfeeding support.
- Rural families reported that one of the barriers to breastfeeding in their communities is a lack of awareness of how challenging it can be, leading to women getting frustrated and ceasing breastfeeding.

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Priority Area: Safe Sleep

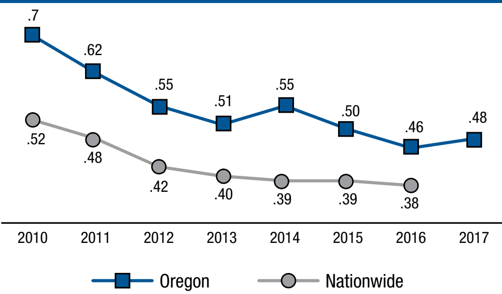
☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Significance of the issue

Sleep-related infant deaths (deaths in the first year of life), also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. In Oregon about 40 infants die in their sleep every year and we know that some of these deaths are preventable. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. In 2016, the AAP updated its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment, including use of the back-sleep position, a separate firm sleep surface (room-sharing without bed sharing), and the avoidance of soft bedding and overheating.[1]

Health Status Data

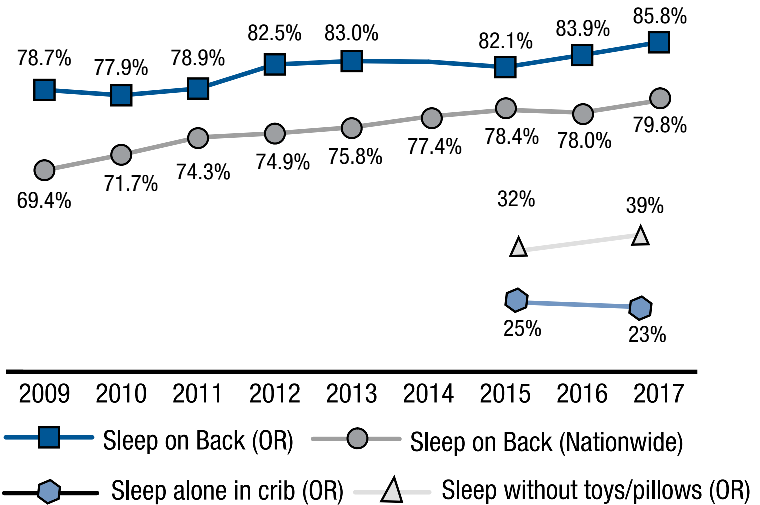
Figure 3. Sudden infant death syndrome (SIDS) death rates (per 1,000 live births), 2010-2017



Source: Centers for Disease Control and Prevention (CDC) WONDER

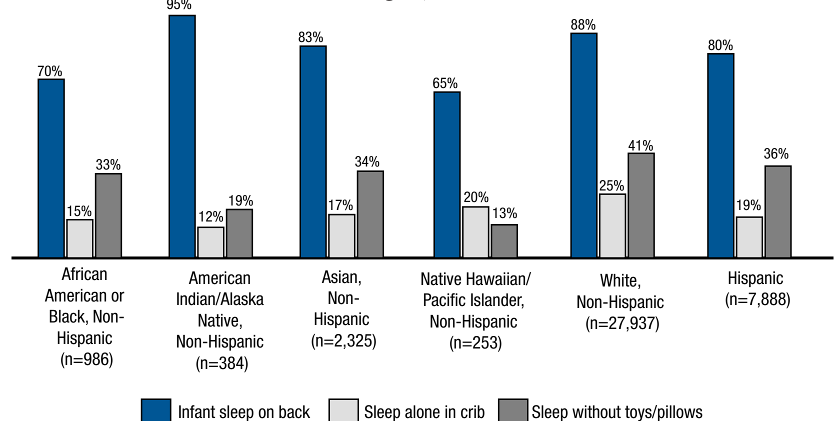
National performance measure

Figure 1. Safe sleep among infants, Oregon and Nationwide, 2009-2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Figure 2. Percent of mothers practicing safe sleep for infants, by race/ethnicity, Oregon, 2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS), 2017

Context for the issue in Oregon

Safe sleep was not one of Oregon's selected Maternal, Child, and Adolescent Health (MCAH) Title V priorities for 2016-2020. However, the MCAH Title V program and other Oregon partners have continued work to increase safe sleep practices during this period.

Successes

- The Maternal and Child Health (MCH) Section developed and shared safe sleep educational materials with public health programs as well as other partners.
- Public Health Nurse Home Visiting Programs promote safe sleep practices.
- Oregon's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program conducted a statewide Continuous Quality Improvement (CQI) project focused on its efforts to reduce rates of sudden unexpected infant death (SUID) through safe infant sleep practices.
- Oregon's statewide Child Fatality Review team reviews infant deaths and provides a forum for prevention discussions.
- Individual hospital systems trained staff and implemented policies to promote safe sleep.
- Local coalitions in Jackson and Marion Counties have worked to promote safe sleep practices.
- The Early Learning Division has recently changed its child care rules to promote safe sleep practices and require that child care providers are trained on safe sleep.
- The Confederated Tribes of Warm Springs have provided support to women in using traditional baby boards for safe sleep.

Challenges/gaps

- There is no statewide coordination of safe sleep efforts.
- Local teams review deaths but there is limited technical assistance or support provided to these teams so data is not always available and there may not be a prevention focus.

Partner alignment

- The Early Learning Council identified promoting safe sleep in partnership with the Oregon Health Authority (OHA) as a priority in their Strategic Plan.
- DHS Child Welfare is interested in partnering with the Oregon Health Authority to train Child Welfare workers in safe sleep practices.
- The Oregon Emergency Medical Services for Children program has expressed interest in promoting safe sleep through implementation of the Direct on Scene Education (DOSE) program by first responders.
- Senate Bill 526 (2019) will provide additional opportunities for home visitors to provide safe sleep education as the Universally-offered Newborn Home Visiting program is rolled out.
- Some of Oregon's Coordinated Care Organizations (CCO's) are distributing baby boxes and "pack n plays."
- Safe sleep is a priority of the national Infant Mortality Collaborative Improvement & Innovation Network (CoIIN).

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, safe sleep was the less often selected of the two possible perinatal and infant health national priority areas.

Partner survey

- In a statewide survey of partners, safe sleep was the less selected national priority area in the perinatal and infant health population domain.
- Safe sleep was rated lowest within the perinatal and infant health domain by partners in terms of health impact, potential to effect health equity, and impact of applied resources.
- Safe sleep was also consistently rated lower priority among partners who serve American Indian/Alaska Native, Asian, African American or Black, Native Hawaiian/Pacific Islander, immigrant, and LGBTQ+ communities, as well as partners who serve individuals with disabilities.

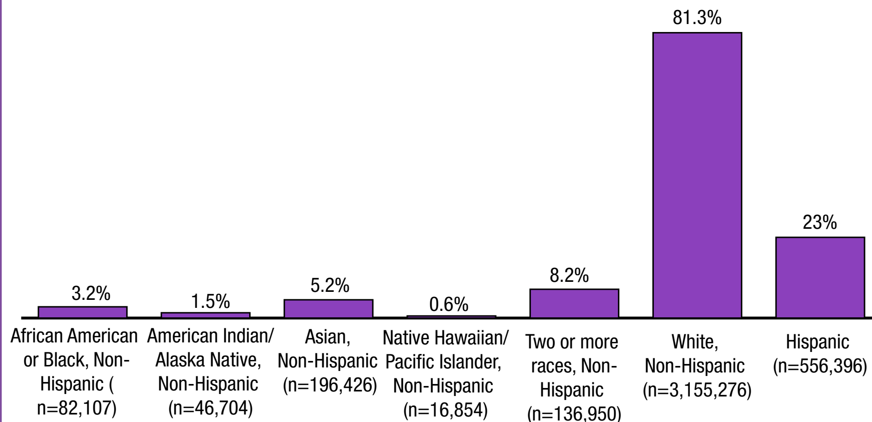
Community voices

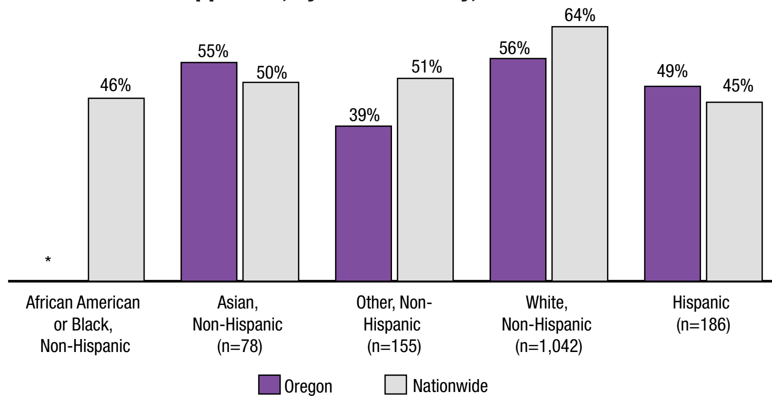
- Safe sleep was rated the lower of the two perinatal and infant health priority areas, among African American or Black, Latinx, immigrant/refugee, and rural families.

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report. Appendix of supporting documents. Rockville, MD: Author.

Population Domain: Child Health

Oregon population profile

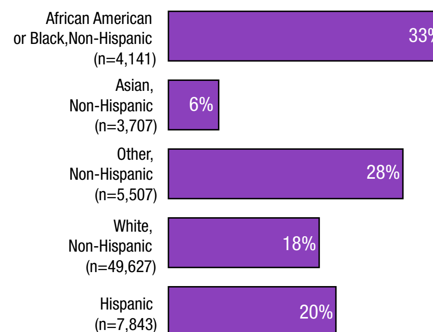




Source: Source: National Survey of Children's Health

** Oregon, African American or Black, Non-Hispanic not included due to low sample size.*

Note: The supportive neighborhood indicator is based on parents who "definitely agree" with one of the following statements and "somewhat" or "definitely" agree with the other two: "People in my neighborhood help each other out," "We watch out for each other's children in this neighborhood," and "When we encounter difficulties, we know where to go for help in our community."



Source: National Survey of Children's Health

Note: Other, Non-Hispanic includes American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, and some other race.

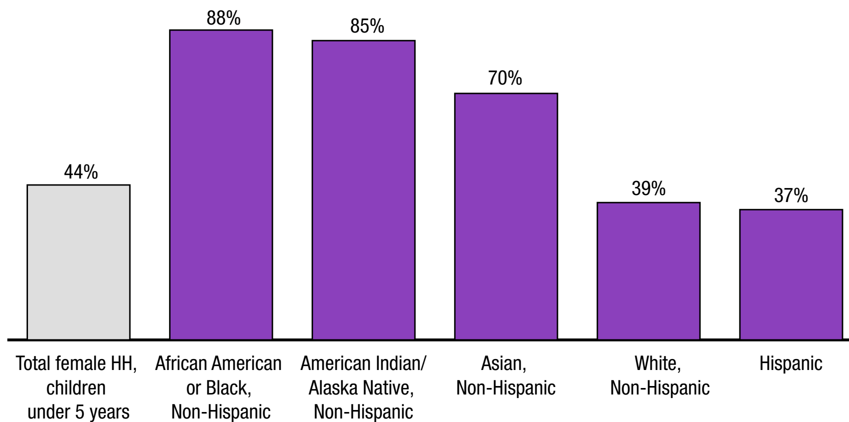


Figure 4. Percent of female headed households in poverty, with children under 5 years old, by race/ethnicity, Oregon, 2017

Source: U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates

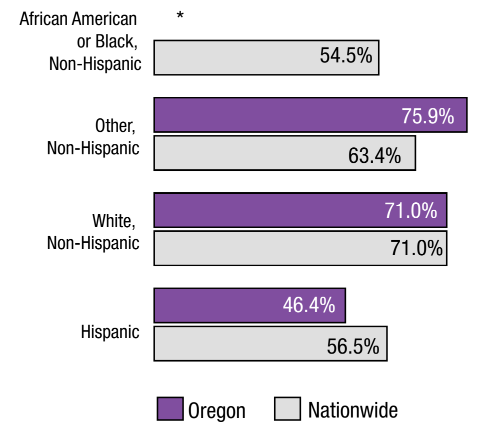


Figure 5. Flourishing among young children, 6 months to 5 years old, by race/ethnicity, 2016-2017

Source: National Survey of Children's Health
*African American or Black, Non-Hispanic not available for Oregon due to small sample size

Note: Other, Non-Hispanic includes Asian, American Indian/ Alaska Native, Native Hawaiian/Pacific Islander, and other race

Note: The Flourishing indicator is based on answers that parents give to four questions to assess curiosity and discovery about learning, resilience, attachment with the parent, and contentedness with life.

Key background & issues of concern for this population

Children, under 13 years old, represent approximately 16% of the population in Oregon. The future health and prosperity of Oregon is dependent on the health and well-being of these young children. The meals they eat, the homes and neighborhoods they live in, and the connections and supports available to their parents or caregivers all determine whether our children, and our state will thrive; or whether inequities that prevent them from reaching their full potential will persist. Investment in early childhood services and maternal and child health is a proven strategy to improve health outcomes and contain health care costs, as well as create notable returns on investment in education costs, workforce productivity, crime reduction, and reduced burden on safety net services. Evidence shows the most effective interventions to support healthy early childhood development are those that support parent-child connections and family stability, impacting two generations. It is difficult to sustain positive impacts on children without addressing the needs of their caregivers.[1]

Early childhood development

- Events and circumstances in the earliest years of life – starting with a mother's health before pregnancy – have lifelong impacts on health and well-being. Early childhood is a unique and critical opportunity to set a positive trajectory for long-term health. Healthy development requires responsive caregiving, and the serve and return interaction between children and their parents and other caregivers in their family or community.
- More than one million new neural connections are formed every second during the first few years of life. Early experiences affect the architecture of the developing brain, which provides the foundation for future learning, behavior, and health.[2]
- Research on adverse childhood experiences (ACEs) demonstrates that early life exposure to trauma and adversity damages the architecture of the developing brain, increases the likelihood of poor health later in life and creates barriers to adult success in multiple realms.

Health inequities in childhood

- Early childhood disparities persist in multiple areas of health and well-being, including infant and maternal mortality, physical and oral health, and exposure to ACEs, trauma and toxic stress. Disparities in other areas also impact early childhood health including: access to basic needs like food, diapers, and safe and stable housing. Children and youth with special health care needs and their families face significant barriers in accessing health care and other supportive services.[3] State and national data demonstrate

that children of color and children in poverty fare worse, overall, than white children and those of higher socioeconomic status.

- Racial, geographic, and economic disparities emerge early. Income, race, and zip code are powerful predictors of whether children and their families experience the conditions that are optimal for young children's development.[4]
- More than one in five children in rural Oregon live in poverty, and children of color are disproportionately represented among young children in poverty. Enhancing equitable opportunity for families and communities is essential to addressing child health disparities.[5]
- Racism and systemic discrimination against marginalized communities is harmful to children's development, social emotional, and physical health. Racism can impact children and their families through limited access, opportunities and power, the experience of prejudice and discrimination, and internalized devaluing of one's own worth and abilities; all of which can contribute to developmental delays and poor health outcomes.

National priority area options (2021-2025)

- Developmental Screening
- Injury
- Physical Activity
- Oral health
- Exposure to Secondhand Smoke

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, smoking was the most mentioned need of the five possible child health national priority areas, followed by oral health, then physical activity, then injury, and lastly, developmental screening.

Partner survey

- In a statewide survey of partners, child physical activity was the most commonly selected national priority area in the child health population domain, followed by developmental screening, then oral health among children, then secondhand/household smoking and lastly, child injury.
- Child physical activity was rated highest within the child health domain in terms of health impact, while oral health among children was rated highest in potential to effect health equity and impact of applied resources.
- Developmental screening was rated highest priority among partners who serve American Indian/Alaska Native, African American or Black, Native Hawaiian/Pacific Islander, and LGBTQ+ communities, as well as partners who serve individuals with disabilities. Developmental screening and oral health among children tied for highest priority among partners who serve Asian and immigrant communities.

Community voices

- Developmental screening was rated highest child health priority among African American or Black, Latinx, immigrant/refugee, and rural families, followed by child physical activity, then child oral health, then secondhand/household smoking, and lastly, child injury.

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1 CCO 2.0 Recommendations of the Oregon Health Policy Board
2 Harvard University Center on the Developing Child
3 Raise up Oregon: a statewide Early Learning System Plan
4 Ibid
5 CCO 2.0 Recommendations of the Oregon Health Policy Board

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Priority Area: Developmental Screening

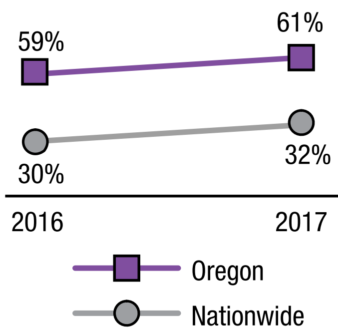
☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Significance of the issue

Early detection of developmental delays or disabilities and appropriate support is critical to the well-being of children and their families and helps to promote a child's development and long-term health. Developmental screening is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests begin at the nine-month well-child visit; however, screening may begin as early as one month and should be conducted whenever there is a concern. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.[1]

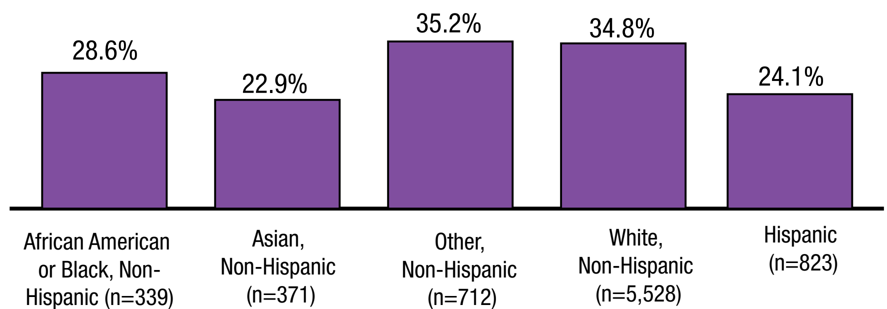
National performance measure

Figure 1. Percent of children, nine to 35 months (2 years), who completed a Standardized Developmental Screening tool in the past year



Source: National Survey of Children's Health

Figure 2. Percent of children, nine to 35 months (2 years), who completed a Standardized Developmental Screening tool in the past year, by race/ethnicity, Nationwide, 2016-2017



Source: National Survey of Children's Health

Note: Other, Non-Hispanic includes Asian, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, and some other race.

Health Status Data

- In Oregon, 9% of children, 0 to 17 years, received special services to meet their developmental needs such as speech, occupational, or behavioral therapy. Among children who received special services, 19% initiated services when less than 3 years old, 39% when 3 to 5 years old, and 42% when 6 to 17 years old.[2]
- Developmental screening is a Coordinated Care Organization (CCO) incentive metric. In 2018, 72.4% of children under three on Medicaid were developmentally screened.[3]

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[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report. Appendix of supporting documents. Rockville, MD: Author.
[2] National Survey of Children's Health, 2016-2017.
[3] CCO Metrics 2018 Final Report

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Context for the issue in Oregon

Developmental screening was not one of Oregon's selected Maternal, Child, and Adolescent Health (MCAH) Title V priorities for 2016-2020. However, work to improve developmental screening rates has been a focus of Maternal and Child health home visiting programs, as well as other Oregon partners during this period.

Successes

- Oregon has a CCO incentive measure to conduct screenings for risks of developmental, behavioral and social delays using standardized screening tools in the 12 months preceding their first, second or third birthday. This measure improved from 20.9% in 2011 to 72.4% in 2018.
- Oregon Health Authority (OHA) partnered with the Oregon Center for Career Development and the developers of the Ages and Stages Questionnaire – 3rd Editions (ASQ-3)™ to train trainers on a standardized curriculum (available in English, Spanish and Russian) for early learning professionals including home visitors, childcare providers and early learning educators to complete developmental screenings and referrals in partnership with families. This has resulted in training early childhood professionals in multiple languages throughout the state.

Challenges

- CCO data show some communities continue to have lower screening rates.

State efforts

- Oregon Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funded home visiting programs in 13 communities participated in a statewide project to improve developmental screening and referrals.
- Oregon home visiting programs conduct developmental screenings for all participating infants starting around four months of age.

Partner alignment

- Developmental screening is a priority across several partner organizations in Oregon: it is a CCO incentive measure, an Early Learning Hub performance measure, part of the quality rating improvement system for child care (SPARK), a requirement of home visiting programs, and is included in the MCH Strategic Plan as part of the policy and systems work related to cross system coordination to enhance screening and referral services.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, developmental screening was the least mentioned need of the five possible child health domain priority areas.

Partner survey

- In a statewide survey of partners, developmental screening was the second most selected of the five national priority areas in the child health population domain.
- It was rated third of five within the child health domain by partners in health impact, fourth in potential to effect health equity, and third in impact of applied resources.
- It was rated highest priority among partners who serve American Indian/Alaska Native communities and those who serve individuals with disabilities. It was rated second highest priority among partners who serve Asian, African American or Black, Native Hawaiian/Pacific Islander, immigrant, and LGBTQ+ communities.

Community voices

- Developmental screening was rated highest of the five child health priority areas among African American or Black, Latinx, immigrant/refugee, and rural families.

Priority Area: Injury

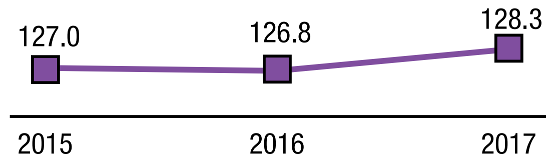
☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Significance of the issue

Unintentional injury is the leading cause of death for children ages 1 through 11. For those who survive severe injuries, many will have lasting challenges such as disability and chronic pain. Education, stronger laws, and safer environments can prevent and reduce serious injuries. Effective strategies, such as increasing knowledge and changing attitudes and behaviors, passing and enforcing legislation and policies that encourage safe behaviors, and changing the design of products and the environment, can prevent many injuries and improve the quality of life for children and adolescents, as well as their families.

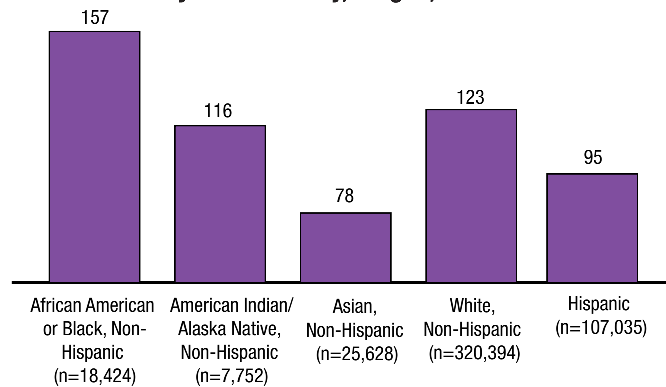
National performance measure

Figure 1. Rate of hospital admissions (per 100,000 population) with a primary diagnosis of unintentional or intentional injury among children, ages 0 through 9 (excludes in-hospital deaths), Oregon



Source: Oregon Hospitalization Data

Figure 2. Rate of hospital admissions (per 100,000 population) with a primary diagnosis of unintentional or intentional injury among children, ages 0 through 9, by race/ethnicity, Oregon, 2017

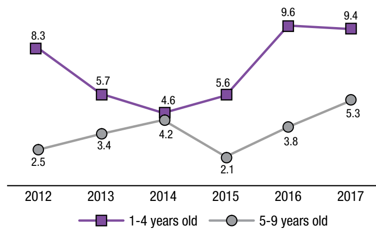


Source: Oregon Hospitalization Data

Health Status Data[1]

- In Oregon, from 2016-2018, the top five types of injuries requiring hospitalization among 1- to 11-year-olds were poisoning (1,139), falling (673), all transport-related injuries (347), natural/environmental (128), or being struck by or against a person or object (66).
- In Oregon in 2017, all transport-related injuries had the highest injury death rate for 1- to 4-year-olds (5.9) and 5- to 9-year-olds (3.2).

Figure 3. Unintentional death rate (per 100,000 population), by age, Oregon, 2012-2017



Source: Oregon Center for Health Statistics

[1] Oregon Health Authority. Oregon Hospitalization Data.

Context for the issue in Oregon

Child injury was not one of Oregon's selected Maternal, Child, and Adolescent Health (MCAH) Title V priorities for 2016-2020. However, work to reduce child injuries has continued to be a focus of state Maternal and Child Health (MCH) including home visiting programs, as well as other Oregon partners, during this period.

Successes

- Senate Bill 526 (2019), makes Oregon the first state in the country to offer a universal home visiting program for all

newborns and their families, including children who are adopted or fostered, serving families with public and private insurance coverage.

- House Bill 3273 (2019), provides easier ways to get rid of excess pharmaceuticals to prevent accidental poisonings.
- Senate Bill 52 (2019), Adi's Act, requires school districts to develop plans to prevent youth suicide.
- In 2019, Oregon MCH staff collaborated with Oregon Safe Kids to support state and local injury prevention through analysis and interpretation of child injury and death data.

Challenges

- Services and programs for school age and older children are limited statewide.
- Local and state child fatality review teams have limited capacity and resources.
- There is no designated funding to support prevention and health promotion in child care settings.

State and local efforts

- Oregon's home visiting programs offer parent education and support, assessments of the home environment and connections to resources and services for families with infants and toddlers.
- The MCH Section partners with Oregon Safe Kids to analyze hospital discharge and death data to identify trends and opportunities to reduce child injury and improve child health.
- The MCH Section partners with the Injury and Violence Prevention Program (IVPP) and the Department of Human Services to staff the State Child Fatality Review Team.
- While not one of Oregon's 2015-2020 selected priorities, several counties have elected to use their flexible Title V funds to address child injury topics such as safe sleep, car seat safety, and reducing infant mortality.

Partner alignment

- Oregon's child care rules have been updated to include much stronger safety requirements and training for providers to prevent sleep related deaths in child care settings.
- The MCH and IVPP sections have engaged key stakeholders from state education, early learning and emergency medical services to participate in the State Child Fatality Review Process.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, injury was the second least mentioned need of the five possible child health national priority areas.

Partner survey

- In a statewide survey of partners, child injury was the least selected of the five national priority areas in the child health population domain.
- It was rated lowest of five within the child health domain by partners in health impact, potential to effect health equity, and impact of applied resources.
- It was rated second lowest priority among partners who serve American Indian/Alaska Native, Asian, African American or Black, Native Hawaiian/Pacific Islander, immigrant, and LGBTQ+ communities. It was rated lowest priority among partners who serve individuals with disabilities.

Community voices

- Child injury was rated lowest of the five child health priority areas among African American or Black, Latinx, immigrant/refugee, and rural families.

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Priority Area: Physical Activity

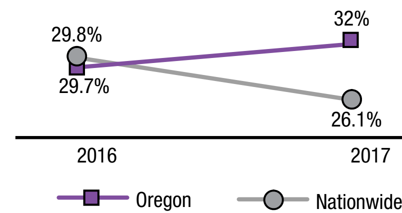
☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Significance of the issue

Regular physical activity can improve the health and quality of life of people of all ages, including those with chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, type II diabetes, and osteoporosis. Bone-strengthening activities are especially important for children and young adolescents because most peak bone mass is obtained by the end of adolescence.[1] Physical activity also contributes to healthy brain development, improved social and emotional health, ability to self-regulate and focus, as well as teaching social skills such as problem solving, sharing, communicating and decision making.

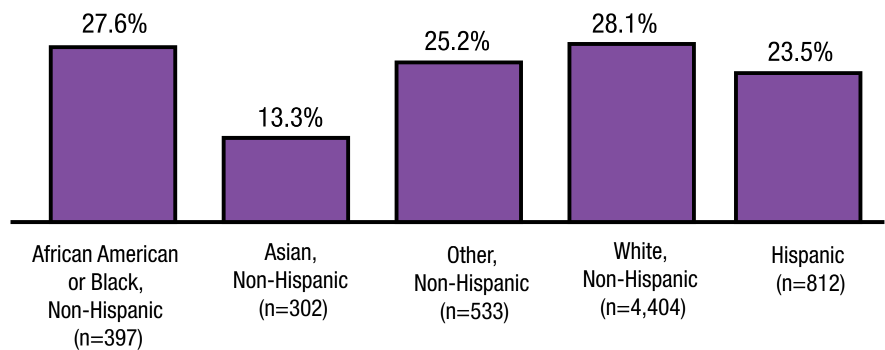
National performance measure

Figure 1. Percent of children, 6 to 11 years old, who are physically active at least 60 minutes per day, 2016-2017



Source: National Survey of Children's Health

Figure 2. Percent of children, 6 to 11 years old, who are physically active at least 60 minutes per day, by race/ethnicity, Nationwide, 2017



Source: National Survey of Children's Health

Notes: Oregon race/ethnicity data not available, using US data as a proxy.

Other, Non-Hispanic includes American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, and some other race.

Health Status Data

- In Oregon, schools are required to provide physical education instruction per week (150 minutes for grades K-5, 225 minutes for grades 6-8). However, the average number of minutes per week was only 74 for K-5 grade schools and only 152 minutes for 6-8 grade schools during the 2015–16 school year.[2]
- In Oregon, the proportion of schools that provided the required number of minutes of physical education instruction for the entire year to all students was only 7% for schools with K-5 grades and only 26% for schools with 6-8 grades during the 2015-16 school year.[3]

1 U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report.

2 Oregon Department of Education, 2017

3 Ibid

Context for the issue in Oregon

Child physical activity was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V priority for 2016-2020, as well as a priority for many partner agencies.

Legislative successes

- Senate Bill 4 (2017), updated physical education requirements: 150 minutes weekly for elementary school students, and 225 minutes for middle school students, of which 50% should be moderate to vigorous physical activity.
- House Bill 3427 (2019), Student Success Act, provides $200 million in additional support to schools to address student health and safety, reduce class size, and provide a well-rounded education, among many other purposes.
- House Bill 2017 (2017), Keep Oregon Moving, provides investment in public transportation, walking and biking, and other ways of moving goods and people.

State and local MCAH Title V efforts

- Oregon participates in the Children's Healthy Weight Collaborative Improvement & Innovation Networks (CoIIN) as a multi-sector team.
- Six counties and two tribes have selected physical activity for children as their Title V priority. Grantee activities include: Safe Routes to School programs, mapping tribal walking paths, yoga classes for children in schools, partnering with child care providers on center policies for physical activity, and collaborating with school districts to invest in physical activity equipment and resources.

Partner alignment

- The Oregon Department of Education (ODE) received the Centers for Disease Control and Prevention (CDC) "Improving Student Health and Academic Achievement through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools" 1801 grant.
- Other related initiatives and funding opportunities include Blue Zones, OEA Choice Trust School Wellness grants, Fuel Up to Play 60 grants, Safe Routes to School programming in communities, and Physical Education Expansion K-8 (PEEK-8) grants from the Department of Education.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, physical activity was the third most mentioned among the five possible child health national priority areas.

Partner survey

- In a statewide survey of partners, child physical activity was the most selected of the five national priority areas in the child health population domain.
- It was rated highest of five within the child health domain by partners in health impact, third in potential to effect health equity, and second in impact of applied resources.

Community voices

- Child physical activity was rated second highest of the five child health priority areas among African American or Black, Latinx, immigrant/refugee, and rural families.
- African American or Black and rural families reported a lack of safe environments as a barrier to physical activity among the children in their communities.
- Latinx families reported a lack of access to sports or recreational programs for their children, in addition to children having to stay home after school while parents worked, and video games, as reasons for child obesity in their communities.

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Priority Area: Oral Health

☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Significance of the issue

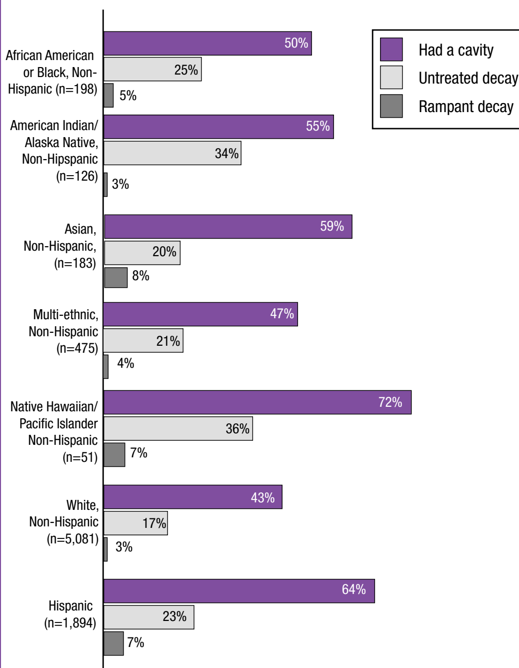
A healthy mouth is an important part of overall health and is especially important to child development. Despite being preventable, tooth decay (cavities) is one of the most common chronic diseases of childhood in the United States.[1] If left untreated, tooth decay can negatively affect a child's development and school performance. Poor oral health affects what we eat, how we communicate, the way we look, our ability to learn, and how we feel about ourselves.

Maintaining good oral health starts with a child's baby teeth. If baby teeth are kept cavity-free, then a child's adult teeth are more likely to be cavity-free. As recommended by the American Academy of Pediatric Dentistry (AAPD), every child should have a visit to a dentist as soon as the first tooth appears or by age one. Early dental visits teach children that oral health is important and makes them more comfortable visiting the dental clinic. Regular dental visits and good oral hygiene throughout childhood can help prevent cavities and most dental disease.

Health Status Data

- In Oregon, 49% of children, 6 to 9 years old, have had a cavity.[2]
- Statewide, cavity rates are higher in southeastern Oregon (68%) and northeastern Oregon (57%) than the statewide average (49%).[3]

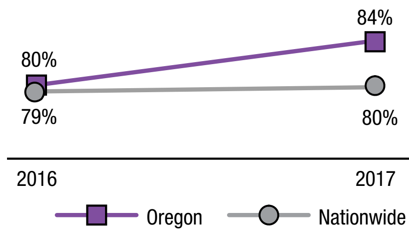
Figure 3. Percent of children, 6 to 9 years old, with cavities or decay, by race/ethnicity, Oregon, 2017



Source: Oregon Smile Survey, 2017

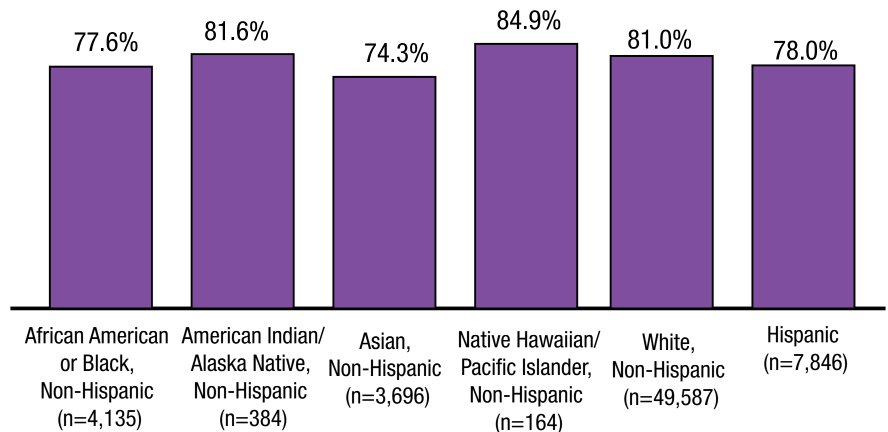
National performance measure

Figure 1. Percent of children, 1 to 17 years old, with a preventative dental visit in the last year, 2016-2017



Source: National Survey of Children's Health

Figure 2. Percent of children age 1 to 17 years with a preventive dental visit in the last year, by race/ethnicity, Nationwide, 2016-2017



Source: National Survey of Children's Health

Note: Nationwide data used since Oregon data is underrepresented

Context for the issue in Oregon

Children's oral health was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V priority for 2016-2020, as well as a priority for many partner agencies.

State level efforts

- Oregon takes a comprehensive approach to address oral health issues across the lifespan through building partnerships to support the integration of oral health in the Coordinated Care Organizations (CCOs), delivering school-based oral health programs, promoting oral health prevention during childhood, and continued surveillance of the oral health status of all Oregonians.

Local MCAH Title V implementation

- 15 local public health agencies and two tribes selected oral health as a Title V priority area for FY2020. Activities include providing oral health preventive services during nurse home and well-child visits as recommended by the American Academy of Pediatrics (AAP); increasing access to oral health services in schools; providing staff with the Oregon Oral Health Coalition's (OrOHC) First Tooth training; and educating children about oral health and the importance of dental visits.
- Local public health agencies are accountable for a developmental metric to increase dental visits for children 0 to 5 years old.

Partner alignment

- Strategies to promote oral health for children align with these strategic plans:
  - » Strategic Plan for Oral Health in Oregon 2014-2020
  - » State Health Improvement Plan (SHIP) 2020-2024 (access to equitable preventive health care)
  - » Raise Up Oregon: A Statewide Early Learning System Plan 2019 -2023
  - » OHA Oral Health Roadmap
  - » PHD Maternal & Child Health Section Strategic Plan
- In 2020, CCOs will be incentivized to increase preventive dental visits for children 1 to 14 years old.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, oral health was the second most mentioned among the five possible child health national priority areas.

Partner survey

- In a statewide survey of partners, child oral health was the third most selected of the five national priority areas in the child health population domain.
- It was rated second of five within the child health domain by partners in health impact, and highest in both potential to effect health equity and impact of applied resources.
- It was rated highest priority among partners who serve Asian and immigrant communities.

Community voices

- Child oral health was rated third of the five child health priority areas among African American or Black, Latinx, immigrant/refugee, and rural families.
- Rural families reported a lack of dental providers and affordable dental care as barriers to children receiving necessary oral health care.

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[1] Center for Disease Control and Prevention (2016). Hygiene-related Diseases: Dental Caries (Tooth Decay). Author: Center for Disease Control.

[2] Oregon Smile Survey, 2017

[3] Ibid

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Oregon's 2020 Title V Maternal, Child, and Adolescent Health Needs Assessment

Child Health

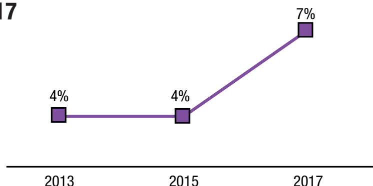
Priority Area: Exposure to Secondhand Tobacco Smoke

☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Health Status Data

- In 2017, 30% of Oregon 8th graders state they live with someone who smokes or vapes tobacco.[1]
- In 2017, 22% of Oregon 8th graders have seen someone smoking or vaping tobacco on school property.[2]
- Native Americans, people with household incomes under $15,000, people on Medicaid, and those with no high school diploma are significantly more likely to smoke in Oregon.[3]
- In Oregon, inequities in exposure to secondhand smoke exist, including a disparity between children aged 0 to 17 with and without special health care needs. 19.2% of children with special health care needs live in households where someone smokes, as opposed to only 13.2% of children without special health care needs.[4]

Figure 3. Percent of 8th graders who have someone living in their home who smokes or vapes tobacco inside the house, Oregon, 2013-2017



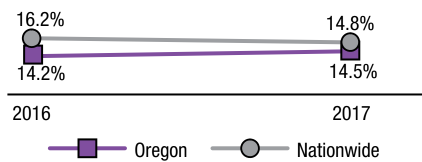
Source: Oregon Healthy Teens Survey

Significance of the issue

Adverse effects of parental smoking on children have been a clinical and public health concern for decades. Children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections; and Sudden Infant Death Syndrome (SIDS).[1]

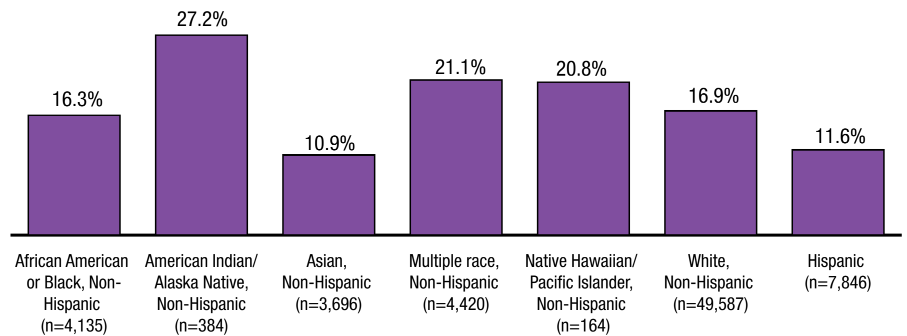
National performance measure

Figure 1. Percent of children, 0 to 17 years old, who live in a household with someone who smokes, 2016-2017



Source: National Survey of Children's Health

Figure 2. Percent of children, 0 to 17 years old, who live in a household with someone who smokes, by race/ethnicity, Nationwide, 2016-2017



Source: National Survey of Children's Health

Notes: Nationwide data used since Oregon data is underrepresented

Context for the issue in Oregon

Child secondhand smoke exposure was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V priority for 2016-2020, as well as a priority for many partner agencies.

Successes

- Smoking on the premises of certified licensed child care centers during business hours or while children are present was banned in 2018, adding to bans on the premises of public schools, colleges, and universities, and Head Start Child Care Centers.

- Smoking, aerosolizing, or vaporizing in motor vehicles while a person under 18 years of age is in the motor vehicle is a Class D traffic violation in Oregon for a first offence, and a Class C violation for subsequent offenses.
- House Bill 2270 (2019) will raise taxes on cigarettes and other tobacco products in 2020.

Challenges

- Unlike in certified licensed child care centers, many certified child care homes are not smoke-free and there are no regulations to protect children from secondhand smoke in these environments.

State Title V efforts

- Title V MCAH works with partners to analyze the impact of policy changes raising the legal age of purchase for tobacco and vaping products to measure success.
- Develop a policy agenda that decreases youth exposure to tobacco products and decreases likelihood for initiation and use.

Partner alignment

- Oregon's Medicaid Coordinated Care Organizations (CCOs) will be monetarily incentivized for reducing cigarette smoking prevalence among their members.
- Efforts continue to encourage the Oregon Department of Education (ODE) Office of Child Care to ban cigarette smoking on the premises of certified child care homes during business hours or when children are present.
- Partners include ODE Office of Child Care, Oregon's Tobacco Prevention and Education Program, and Local Title V Grantees.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, exposure to secondhand smoke was the most often mentioned among the five possible child health national priority areas.

Partner survey

- In a statewide survey of partners, childhood exposure to secondhand smoke was the second least selected of the five national priority areas in the child health population domain.
- It was rated third of five within the child health domain by partners in health impact, and fourth in both potential to effect health equity and impact of applied resources.
- It was rated lowest priority among partners who serve American Indian/Alaska Native, Asian, African American or Black, Native Hawaiian/Pacific Islander, immigrant, and LGBTQ+ communities.

Community voices

- Childhood exposure to secondhand smoke was rated fourth of the five child health priority areas among African American or Black, Latinx, immigrant/refugee, and rural families.

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[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report.

[2] 2017 Oregon Healthy Teens Survey

[3] 2018 Oregon Tobacco Facts

[4] National Survey of Children's Health, 2016-2017

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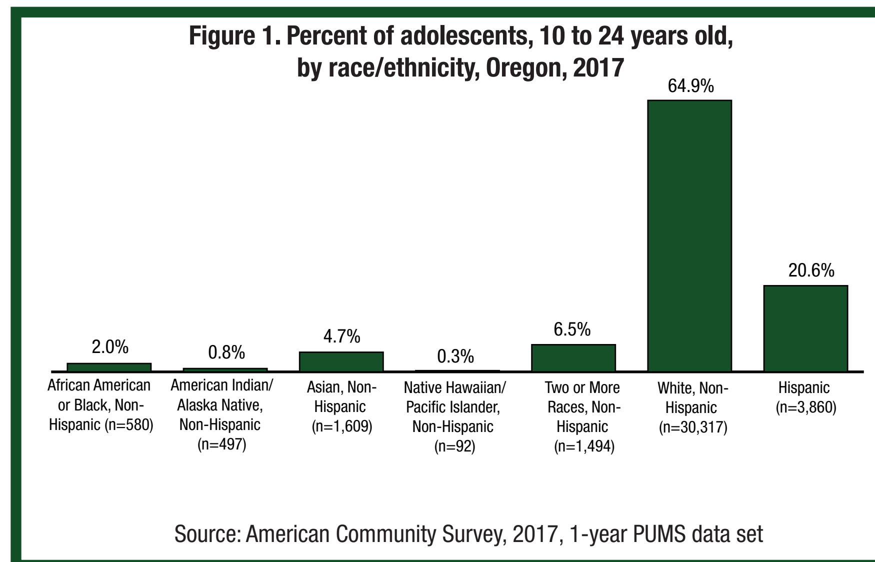
Population Domain: Adolescent Health

Oregon population profile

- Oregon's programming and approach to adolescence supports youth aged 10 to 24 years old. 19% of Oregon's population, over 760,000 people, are adolescents aged 10 to 24 years old.
- Among adolescents aged 10 to 24 years old, 19% lived in a household with income below the poverty line.[1]
- Fifty-one percent of households containing adolescents experienced rent burden, meaning more than 30% of income goes to housing costs.[2]



- Twenty-seven percent of households containing adolescents experienced extreme rent burden, meaning more than 50% of income goes to housing costs. Households spending this much of their budget on housing can have negative impacts on health and meeting other basic needs.[3]
- Ninety-seven percent of children under age 18 had health insurance.[4]

Key background & issues of concern for this population

Adolescence is a major period of development in the life course, second only to infancy.[5] While generally characterized by good health, adolescents are laying the foundation for wellness and health status that will persist into adulthood. Ensuring adolescents are healthy, educated, and engaged will support a healthy community now and in the future. Great strides have been made in adolescent health over the past few years – especially in terms of access to clinical preventive services and identification of mental and emotional health needs. However, issues such as systematic racism and oppression create barriers for adolescents of color, LGBTQ+ adolescents, and adolescents with disabilities, preventing them from sharing in the improvements gained across the population as a whole. Moreover, mental and emotional health continue to be an issue among all demographic groups, hindering youth's health and academic

outcomes. Work still needs to be done to support healthy adolescent development.

The Oregon Healthy Teens Survey of 2017 reports that among 11th graders:

- 18% report having an unmet physical health care need and 22% an unmet emotional health care need. These rates are higher for youth with disabilities, LGBTQ+ youth, and Native youth –symptomatic of a lack of or limited culturally competent services for these communities.
- 76% report having an adult at school who really cares about them.

The Positive Youth Development (PYD) benchmark is a six-item composite that measures research-based components of PYD including competence, confidence, support, service and health (emotional and physical). The PYD benchmark is associated with an array of positive health outcomes. Eleventh graders who met the PYD benchmark were less likely to: be depressed, miss school because it felt unsafe/be chronically absent, and engage in unhealthy coping behaviors (including use of alcohol, tobacco, and other drugs).[6] In 2017, 56% of 8th graders and 58% of 11th graders met the PYD benchmark.[7]

National priority area options (2021-2025)

- Injury
- Physical Activity
- Bullying
- Adolescent Well-Visit
- Oral Health
- Exposure to Secondhand Smoke

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, tobacco use ranked first among national priority options (not specifically to adolescent population). However, adolescent well-visit ranked a close second, and was mentioned in seven demographic/population specific needs assessments.

Partner survey

- In a statewide survey of partners, bullying was ranked as the number one national priority area in the adolescent domain. It was ranked first in terms of impact on the population, impact in terms of health equity, and impact relative to resource allocation. Partners who serve people with disabilities, communities of color, and LGBTQ+ individuals all ranked bullying highly. Secondhand tobacco exposure ranked last as a priority area.

Community voices

- Bullying was the highest rated priority area among families engaged in the community voices project, especially those representing immigrant refugee communities, rural communities, and African American or Black communities. Engagement of transgender youth revealed that behind adequacy of health insurance (especially for specialty care), bullying was the second highest priority. Mental health support was another priority concern of this population.

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1 US Census Bureau. American Community Survey 2017 1-year PUMS

2 Ibid.

3 Ibid.

4 Oregon Health Authority. Oregon Health Insurance Survey, 2017

5 Viner, R. M. et al. (2015). Life course epidemiology: recognizing the importance of adolescence. *J Epidemiol Community Health*, 69(8): 719-720.

6 Nystrom, R. J., Prata, A., & Knipper Ramowski, S. (2008). Measuring Positive Youth Development: The Development of a State Benchmark. *Journal of Youth Development*, 3(1).

7 2017 Oregon Healthy Teens Survey

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Priority Area: Well-Visit

☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Health Status Data[2]

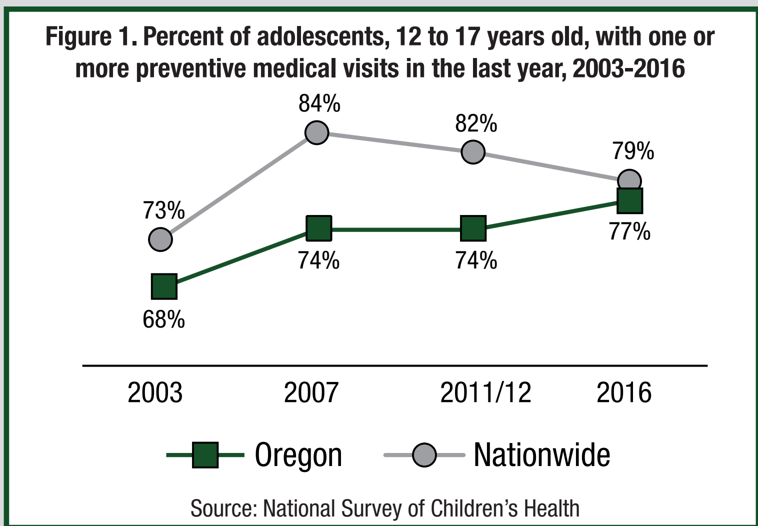
- According to 2017 Oregon Health Teens Survey (OHT), transgender and gender diverse 11th graders are less likely to have an annual well-visit (57%) than their cisgendered peers (63%).
- Only 58% of bisexual 11th grade students have an annual preventive care visit compared to 64% of straight 11th grade students. A lack of LGBTQ+ friendly clinic space and staff could create unwelcoming environments that create these inequities.
- Students reporting that they have unmet physical health need falls roughly in line with the proportion of youth in the National Survey of Children's Health (NSCH) data who have no preventative care - about 21% of 8th graders and 18% of 11th graders. This is also true for the proportion youth reporting unmet mental health need: 19% of 8th graders and 22% of 11th graders reported unmet mental health need. However, this rate has been increasing over time, even as the rate of well-visits has increased.

Significance of the issue

While most adolescents enjoy good health, significant physical, cognitive, social, and emotional changes during this period call for a unique approach to health care compared to adults or young children. Additionally, health behaviors established in adolescence tend to persist into adulthood and many chronic physical and mental health issues first emerge in this developmental timeframe. Comprehensive well-care visits aligned to Bright Futures guidelines are a vehicle to deliver evidence-based screening, services (such as immunizations) and health promoting messages.[1]

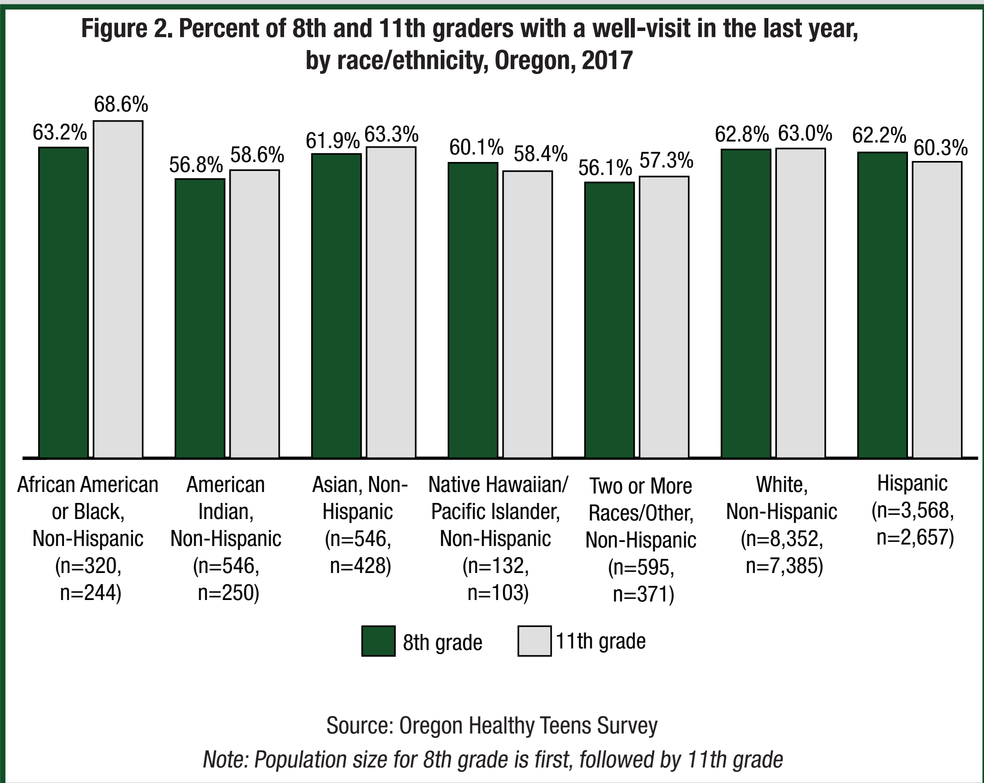
National performance measure

Figure 1. Percent of adolescents, 12 to 17 years old, with one or more preventive medical visits in the last year, 2003-2016



Source: National Survey of Children's Health

Figure 2. Percent of 8th and 11th graders with a well-visit in the last year, by race/ethnicity, Oregon, 2017



Source: Oregon Healthy Teens Survey

Note: Population size for 8th grade is first, followed by 11th grade

Context for the issue in Oregon

Adolescent well-visit was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V priority for 2016-2020, as well as a priority for many partner agencies.

Successes

- Oregon's adolescent well-visit rates benefitted from health systems transformation work including incentivizing Coordinated Care Organizations(CCOs) to increase well-visits among their members up until 2019. There are also robust partnerships between Medicaid, Title V, and the Oregon Pediatrics Society that have increased knowledge of the well-visit among providers. Moreover, the Affordable Care Act ensures access to the well-visit by mandating insurance coverage for this preventive care without cost sharing.
- Oregon has had success in creating and disseminating guidance documents for the well-visit.

Challenges

- Integrating health services, including the well-visit, into schools has been difficult in some communities due to a lack of providers and various funding streams/financial constraints for school-based health care.
- Beginning in January 2020, Oregon's CCOs will no longer have incentives to increase adolescent well-visit completion. This may limit resources available to promote the service.
- A lack of LGBTQ+ friendly clinic space and staff could create unwelcoming environments.

Needs assessment results

Environmental scan

- According to an environmental scan of community health needs assessments, access to health care (inclusive of the adolescent well-visit) came up the second most of any national priority area in the adolescent domain. It also came up among demographic and population specific assessments.

Partner survey

- In a statewide partner survey, the adolescent well-visit was the second highest priority area selected by partners. Among partners who served youth of color, youth with disabilities, and LGBTQ+ youth, the well-visit was ranked as the second highest (of seven) priority areas consistently. However, the adolescent well-visit ranked fifth out of seven other priority areas in terms of its impact on the adolescent population and health equity.

Community voices

- The adolescent well-visit ranked as the second lowest priority of families involved with the community voices engagement project. Likewise, transgender youth ranked it as the fourth highest priority with 76% of survey respondents reporting having a medical check up at least once a year. However, access to inclusive, affordable care (including coverage of specific services) that speaks to needs of gender diverse youth was cited as a major issue. Seventy-seven percent of transgender survey respondents have not sought specialty medical help, with cost and parental support being major barriers.

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[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report. Appendix of supporting documents. Rockville, MD: Author.

[2] 2017 Oregon Healthy Teens Survey

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Priority Area: Bullying

☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Significance of the issue

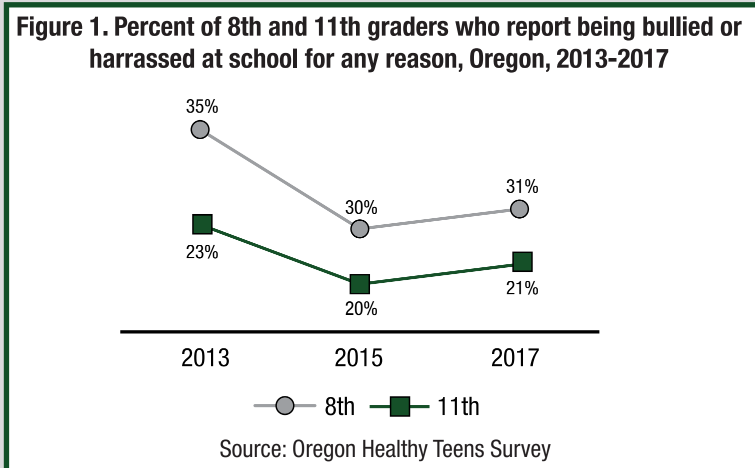
Bullying is unwanted, aggressive behavior among school-aged youth that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Youth who bully use their power—such as physical strength, access to embarrassing information, or popularity—to control or harm others. Bullying in school can often mirror systematic oppression in society at large. Power imbalances can change over time and in different situations, even if they involve the same people. There are negative outcomes for both victims and perpetrators of bullying including: poor academic achievement and school dropout, and negative physical and mental health outcomes. Youth who are the victims of bullying and who also perpetrate bullying may exhibit the poorest functioning, in comparison with either victims or bullies, with effects lasting into adulthood.[1]

Health Status Data[2]

- Almost one in three 8th graders and one in five 11th graders have been bullied in the last 30 days according to the (Figure 1). American Indian, Native Hawaiian/Pacific Islander, and LGBTQ+ students face higher rates of bullying – reflecting systematic oppression faced by these communities in and outside of schools (Figure 2). General bullying, cyber bullying, and bullying based on appearance were the most common forms of bullying reported.
- Since 2013, more students report missing school because they felt unsafe in the last month – about 9% of 8th graders and 7% of 11th graders.
- Youth who had a supportive adult at school were less likely to miss school because they felt unsafe.

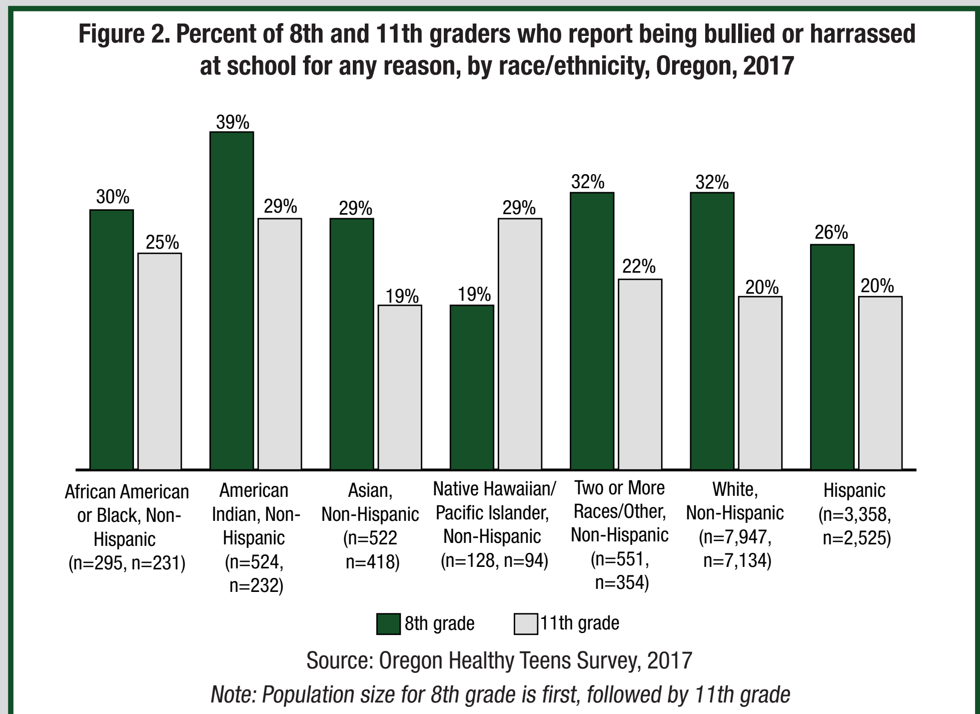
National performance measure

Figure 1. Percent of 8th and 11th graders who report being bullied or harrassed at school for any reason, Oregon, 2013-2017



Source: Oregon Healthy Teens Survey

Figure 2. Percent of 8th and 11th graders who report being bullied or harrassed at school for any reason, by race/ethnicity, Oregon, 2017



Source: Oregon Healthy Teens Survey, 2017

Note: Population size for 8th grade is first, followed by 11th grade

Context for the issue in Oregon

Bullying was not one of Oregon's selected Maternal, Child, and Adolescent Health (MCAH) Title V priorities for 2016-2020, although related work has been ongoing in the Oregon Health Authority (OHA) Adolescent and School Health programs and among partner agencies.

Successes and Challenges

- Oregon rates of bullying have slightly declined over the past four years,[2] but information provided to the Joint Committee on Student Success and other workgroups leading up to the 2019 Oregon Legislative Session suggest school climate and bullying remain significant issues in Oregon schools.

State level work

- The House Bill 2599, Oregon Safe Schools Act (2009) mandates that all schools have policies prohibiting bullying, harassment and cyber-bullying. In 2012, the law was amended to include reporting requirements for all school employees.
- The Student Success Act, House Bill 3427 (2019) establishes a statewide school safety and prevention system to help districts decrease acts of harassment, intimidation and bullying. The Legislature also passed a few bills related to school districts adopting procedures with respect to sexual harassment.
- In 2019, the OHA designed a youth health surveillance question to measure perpetuation of bullying.

Needs assessment results

Environmental scan

- According to an environmental scan of community health needs assessment, bullying came up the least of any of the six national priority areas for adolescents.

Partner survey

- Bullying was the highest priority area (of seven) selected by statewide partners. Bullying was the highest priority among partners who served youth of color, youth with disabilities, and LGBTQ+ youth. Bullying also ranked highest of the seven priority areas in terms of its impact on health equity and impact in relation to resource allocation.

Community voices

- Bullying ranked as the number one priority to families participating in community voices engagement project. This was especially true among African American or Black, immigrant/refugee, and rural families. Through community voices engagement directly with the LGBTQ+ community, transgender youth ranked bullying as second highest priority. About 30 percent of transgender youth surveyed experienced some bullying.

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[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017).Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report. Appendix of supporting documents. Rockville, MD: Author.

[2] 2017 Oregon Healthy Teens Survey

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Priority Area: Injury

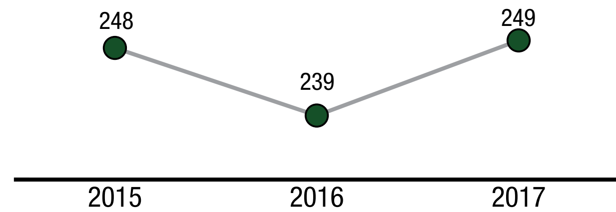
☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Significance of the issue

Injury, from both intentional and unintentional causes, is the leading cause of child mortality. For those who suffer non-fatal severe injuries, many will become adolescents with special health care needs.[1] Within injury, suicide was the second leading cause of death among youth 10 to 24 years old in Oregon in 2017. Overall, Oregon suicide deaths and rates among youth 10 to 24 years old have increased significantly since 2011. Effective interventions to reduce injury and suicide exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course of adolescents resulting in improved quality of life and cost savings.

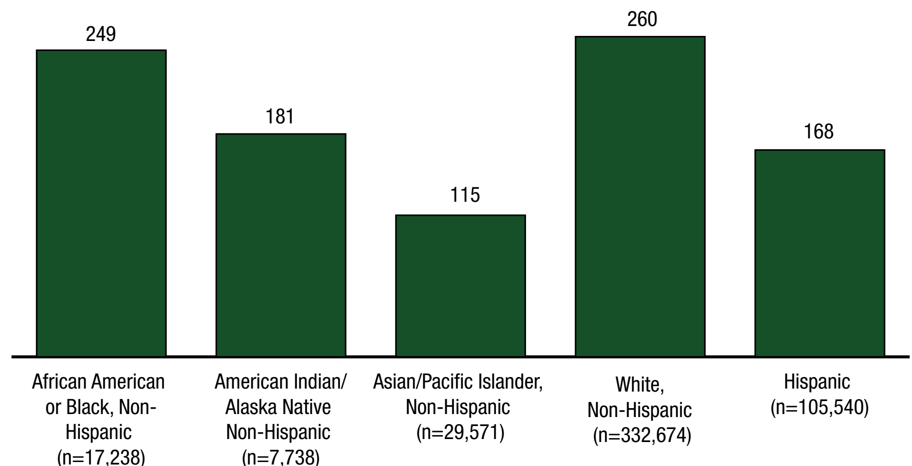
National performance measure

Figure 1. Rate of hospital admissions (per 100,000 population) with a primary diagnosis of unintentional or intentional injury among children, 10 to 19 years old (excludes in-hospital deaths), Oregon



Source: Oregon Hospitalization Data

Figure 2. Rate of hospital admissions (per 100,000 population) with a primary diagnosis of unintentional or intentional injury among children, 10 to 19 years old (excludes in-hospital deaths), by race/ethnicity, Oregon, 2017



Source: Oregon Hospitalization Data

Health Status Data

- In Oregon, from 2016 to 2018, the top five types of injuries requiring hospitalization among adolescents 12 to 17 years old were poisoning (2,306), all transport-related injuries (602), falling (264), being struck by or against a person or object (117), and firearms (42).[2]
- Unintentional injury is the leading cause of death among youth 10 to 24 years old.[3]
- Injury related to motor vehicles was the most common cause of unintentional injury death among youth 15 to 24 years old.[4]
- Increased risk for males for traumatic brain injury (especially with respect to motor vehicle and sports related injury) begins among youth 15 to 24 years old.[5]
- Suicide was the second leading cause of death among youth 10 to 24 years old in Oregon in 2017; there were 107 completed suicides by youths age 24 and younger. The Oregon rate of youth suicide ranked 17th among all states.[6]
- According to the 2017 Oregon Healthy Teens Survey, 9% of 8th graders and 7% of 11th graders reported attempting suicide in the past year. Almost one in five 8th and 11th graders report seriously considering suicide in the past year. These rates have increased since 2013 and higher among Native American youth, LGBTQ+ youth and youth with disabilities, reflecting a lack of resources and supports for these communities.

Context for the issue in Oregon

Adolescent injury was not one of Oregon's selected Maternal, Child, and Adolescent Health (MCAH) Title V priorities for 2016 – 2020. However, work to improve developmental screening rates has been a focus of Maternal and Child Health (MCH) home visiting programs, as well as other Oregon partners during this period.

- Oregon Health Authority (OHA) has focused youth brain injury prevention efforts on concussions sustained by sports activities, including evaluation of Oregon's Concussion Management Protocol post suspected concussion.
- In 2019, the Oregon legislature funded pieces of Youth Suicide Intervention and Prevention Plan to invest in effective prevention programs and statewide infrastructure, including: youth resources and resilience building in schools; postvention services and expertise; ongoing evaluation of program for effectiveness; and development of the 2021-26 plan. Moreover, Oregon adopted legislation to require school districts to adopt comprehensive planning and policies related to suicide prevention, intervention, and postvention.

Needs assessment results

Environmental scan

- According to an environmental scan of community health needs assessments, injury came up the sixth most of the seven national priority area for adolescents. It must be noted that suicide was separated from injury in terms of the scan.

Partner survey

- In a statewide partner survey, adolescent injury was the fifth highest priority area (of seven) selected by partners. Injury was not selected as a high priority among partners who served youth of color, youth with disabilities, and LGBTQ+ youth. Injury also ranked last in terms of impact on the adolescent population, impact on health equity, and impact relative to resource allocation. It must be noted injury was not explicitly defined in the partner survey to include suicide.

Community voices

- Adolescent injury ranked low among African American or Black, immigrant/refugee, rural, and Latinx families engaged with the community voices needs assessment. Transgender youth ranked unintentional injury as the third highest priority of the seven priorities.

[1] Title V Grant Guidance.
[2] Oregon Health Authority. Oregon Hospitalization Data.
[3] National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention.
[4] Oregon Health Authority. Oregon Vital Statistics Annual Report 2017.
[5] Oregon Health Authority. Injury in Oregon, Annual Data Report, 2014.
[6] Oregon Health Authority. Injury and Violence Prevention Section, Oregon Public Health Division.

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Priority Area: Physical Activity

☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Significance of the issue

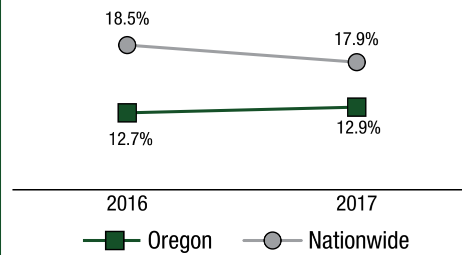
Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, type II diabetes, and osteoporosis. Physical activity also contributes to achieving a healthy weight, reduces anxiety and stress, and increases self-esteem. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for young adolescents because the majority of peak bone mass is obtained by the end of adolescence.[1]

Health Status Data

- One of Oregon's benchmarks of physical activity is 60 minutes or more for at least five days a week. According to the 2017 Oregon Health Teens Survey, 59% of 8th graders and 47% of 11th graders meet this threshold.
- Cis male 11th graders are more likely to have access to five days of physical activity (59%) compared to their cis female (37%) and gender diverse peers (35%). Likewise, lesbian and gay 11th graders (34%) and bisexual 11th graders (27%) have less access to physical activity than their straight peers. This could point to heterosexual and cis normative spaces/ norms within physical education and physically active extracurricular activities.[2]
- Finally, only 2% of schools have established, implemented, and/or evaluated a Comprehensive School Physical Activity Program according to the 2018 School Health Profiles Survey.

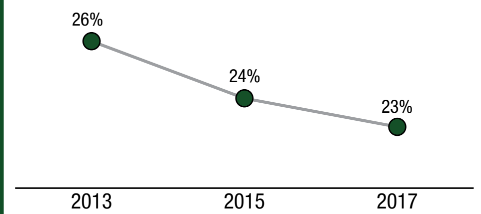
National performance measure

Figure 1. Percent of adolescents, 12 to 17 years old, who are reported by their parents to be physically active at least 60 minutes per day, 2016-2017



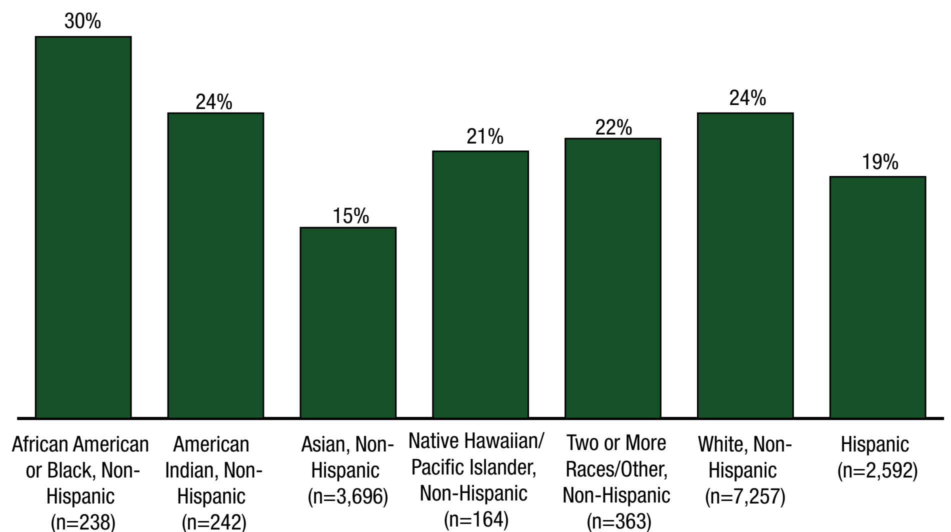
Source: National Survey of Children's Health

Figure 2. Percent of 11th graders who report exercising for at least 60 minutes everyday, 2013-2017



Source: Oregon Healthy Teen Survey

Figure 3. Percent of 11th graders who report exercising for at least 60 minutes everyday, by race/ethnicity, Oregon, 2017



Source: Oregon Healthy Teens Survey, 2017

Context for the issue in Oregon

Adolescent physical activity was not one of Oregon's selected Maternal, Child, and Adolescent Health (MCAH) Title V priorities for 2016-2020, although child physical activity was. However, child and adolescent physical activity was a focus of other Oregon partners during this period.

State level work

- With the passing of Senate Bill 4 (2017), Oregon began to implement required physical education (PE) minutes statewide in grades K-8 in 2019. House Bill 3141 (2007) provided a mechanism for data collection and Oregon currently has more than ten years' worth of statewide PE minute data for K-8 schools. Additionally, House Bill 2017 (2017), dedicates $10 million annually for Safe Routes to School infrastructure, increasing to $15 million annually in 2023.
- Oregon participated in a Children's Healthy Weight Collaborative Improvement & Innovation Network (CoINN) to accelerate progress in implementing new physical education standards, including focus groups with school administrators on PE and alignment of health and PE supplemental instructional materials with academic content standards.

Partner Alignment

- Oregon Department of Education and Oregon Health Authority partnered on the Centers for Disease Control and Prevention (CDC) 1801 grant to provide technical assistance and resources on physical education requirements.

Needs assessment results

Environmental scan

- According to an environmental scan of community health needs assessments, physical activity came up the fourth most often of the seven national priority options in the adolescent domain.

Partner survey

- In a statewide partner survey, physical activity was the third highest (of seven) priority areas selected by partners. Physical activity was ranked second in terms of impact on the adolescent population and ranked third in terms of impact on health equity and impact relative to investment.

Community voices

- According to community voices engagement project, physical activity ranked as the second highest collective priority (average ranking of three) among families engaged. However, rural, Latinx, and African American or Black families ranked the priority slightly higher. Transgender youth ranked physical activity as the fifth highest priority, and cited concerns of mockery in school-based locker rooms, fear of being outed and restrictions on participating in gender-based sports as barriers to physical activities.

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[1] U.S. Department of Health and Human Services, Health Resources and ServicesAdministration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report. Appendix of supporting documents. Rockville, MD: Author.

[2] 2017 Oregon Healthy Teens Survey

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Priority Area: Oral Health

☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Significance of the issue

Having a healthy mouth is an important part of overall health and is especially important in adolescence. Despite being preventable, tooth decay (cavities) is one of the most common chronic diseases affecting children and adolescents in the United States.[1] If left untreated, it can negatively affect school performance, social relationships, and health later in life.[2] Poor oral health affects what we eat, how we communicate, the way we look, our ability to learn, and how we feel about ourselves.

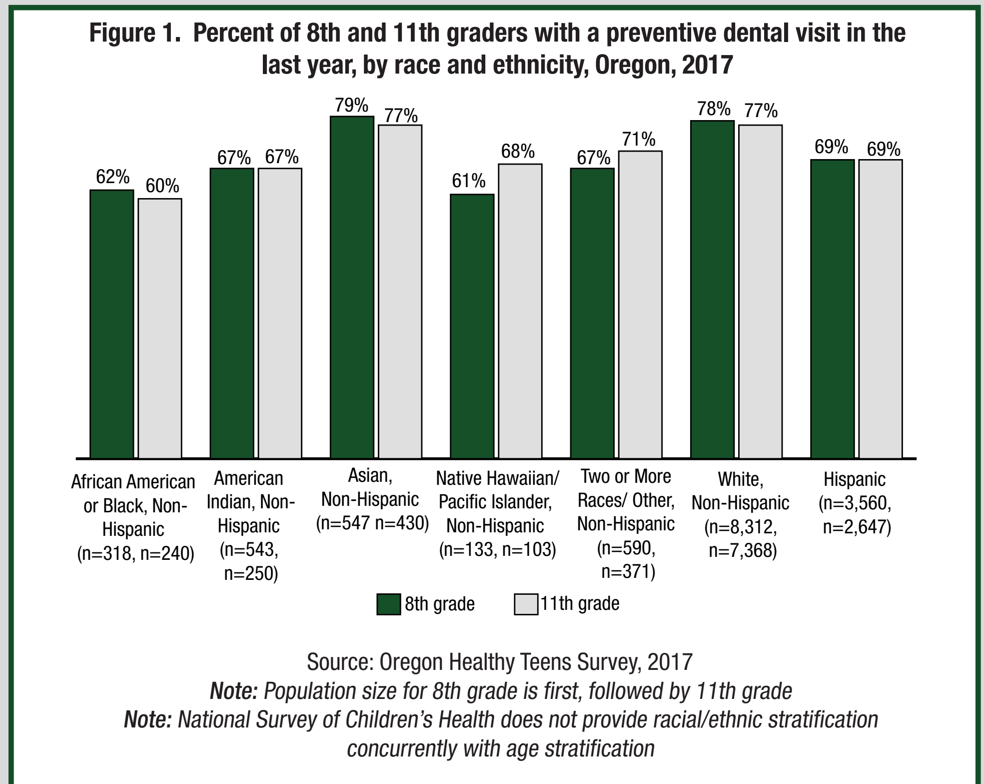
Adolescents have specific needs pertaining to oral health. Beyond preventing cavities, teens may need braces or to have their wisdom teeth removed. Adolescents need to know how sports injuries, oral piercings, smoking, drug usage, eating disorders, etc. can impact oral health. It is important that teens learn how to maintain a healthy mouth because lifelong health habits are created during these formative years. Regular preventive dental visits and good oral hygiene throughout adolescence can help prevent cavities and most dental disease.

Health Status Data

- According to 2017 Oregon Healthy Teens Survey, African American or Black 8th and 11th graders have less access to preventive dental care than their White peers, pointing to the need to alleviate barriers and provide greater levels of culturally competent access in communities of color (Figure 1).
- Sixty-nine percent of 8th graders and 75% of 11th graders report having ever had a cavity (2015 Oregon Healthy Teens Survey). This measure was not available in 2017, but the state will track cavities again beginning in 2019.

National performance measure

Figure 1. Percent of 8th and 11th graders with a preventive dental visit in the last year, by race and ethnicity, Oregon, 2017



Source: Oregon Healthy Teens Survey, 2017

***Note:** Population size for 8th grade is first, followed by 11th grade*

***Note:** National Survey of Children's Health does not provide racial/ethnic stratification concurrently with age stratification*

Context for the issue in Oregon

Oral health for children was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V priority for 2016-2020, although there was no specific Title V focus on oral health for adolescents.

Successes and state level efforts

- Oregon takes a comprehensive approach to address oral health issues across the lifespan through building partnerships to support the integration of oral health in the Coordinated Care Organizations (CCOs), delivering school-based oral health programs, promoting oral health prevention during adolescence, and continued surveillance of the oral health status of all Oregonians.
- In 2014, the Oregon School-Based Health Center (SBHC) Program expanded the list of providers meeting SBHC certification standards to include dental health professionals.
- As of 2018, 15 SBHCs had dental providers.
- The Oregon SBHC Program participates in the Oregon Oral Health Coalition's (OrOHC) K-12 subcommittee to inform the provision of technical assistance to school-based health centers for oral health services.

Partner Alignment

- Beginning in 2014, the Oregon CCOs were incentivized to increase dental sealants for children 10 to 14 years old. This incentive will retire beginning in 2020 and will be replaced by an incentive to increase preventive dental visits for children 1 to 14 years old.

Needs assessment results

Environmental scan

- According to an environmental scan of community health needs assessments, oral health came up the third most often of the seven of national priority areas for adolescents.

Partner survey

- In a statewide partner survey, adolescent oral health was the 6th highest priority area (of seven) selected by partners. Oral health was not selected as a high priority among partners who served youth of color, youth with disabilities, and LGBTQ+ youth. However, oral health ranked second highest of the seven priority areas in terms of its impact on health equity and impact in relation to resource allocation.

Community voices

- Adolescent oral health ranked relatively low among the priorities selected by families engaged in the community voices project. However, immigrant and refugee families ranked it the second highest priority. Oral health was ranked last among transgender youth, reflecting that almost 80% of survey respondents had seen a dentist at least once in the last year.

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[1] Center for Disease Control and Prevention (2016). Hygiene-related Diseases: Dental Caries (Tooth Decay). Author: Center for Disease Control.

[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report. Appendix of supporting documents. Rockville, MD: Author.

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Priority Area: Exposure to Secondhand Tobacco Smoke

☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Health Status Data

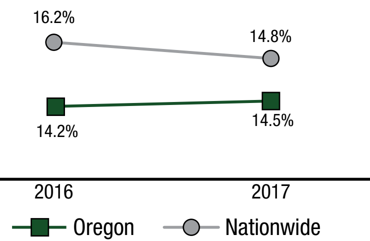
- In 2017, 30% of Oregon 8th graders, and 29% of 11th graders state they live with someone who smokes or vapes tobacco.[3]
- In 2017, 22% of 8th graders and 47% of 11th graders had seen someone smoking or vaping on school property.[4]
- Inequities in exposure to secondhand smoke exist, including a disparity between children 0 to 17 years old with and without special health care needs. 19.2% of children with special health care needs live in households where someone smokes, as opposed to only 13.2% of children without special health care needs.[5]

Significance of the issue

Adverse effects of parental smoking on children have been a clinical and public health concern for decades. Children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections; and Sudden Infant Death Syndrome (SIDS).[1] Tobacco smoke exposure among adolescents increases the risk of respiratory issues and utilization of emergency and urgent care facilities.[2]

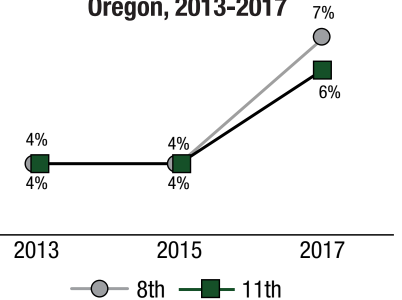
National performance measure

Figure 1. Percent of children, 0 to 17 years old, who live in a household with someone who smokes, 2016-2017



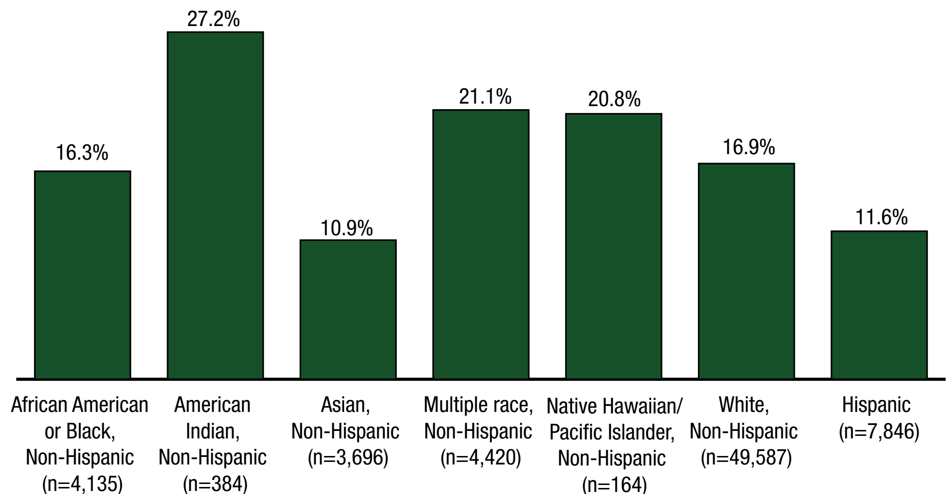
Source: Oregon Healthy Teen Survey

Figure 2. Percent of 8th and 11th graders who have someone living in their home who smokes or vapes inside the house, Oregon, 2013-2017



Source: Oregon Healthy Teen Survey

Figure 3. Percent of children, 0 to 17 years old, who live in a household with someone who smokes, by race/ethnicity, Nationwide, 2016-2017



Source: National Survey of Children's Health (NSCH)

Note: *Nationwide data used since Oregon data is underrepresented*

Context for the issue in Oregon

Secondhand smoke exposure for children was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V priority for 2016-2020, although there was not a specific Title V focus on smoking or secondhand smoke exposure for adolescents.

Successes and challenges

- According to Oregon Healthy Teens Survey, Oregon's smoking prevalence among youth has been declining over time, but adolescents still have exposure to secondhand smoke.
- In August 2017, Oregon raised the minimum age to buy, possess, or consume tobacco or inhalant delivery products from 18 to 21 years old.

Partner alignment

- Starting in 2019, Oregon's Coordinated Care Organizations (CCOs) will have an incentive to reduce cigarette smoking prevalence among their members.

Needs assessment results

Environmental scan

- According to an environmental scan of community health assessments, smoking was the most often cited among the national priority areas. However, smoking was inclusive of all populations and not specific to adolescents.

Partner survey

- In a statewide partner survey, adolescent secondhand smoke exposure was ranked the least important priority of the seven national priority areas. It was ranked next to last in terms of impact on adolescent health, impact on health equity, and impact relative to resource allocation. Partners who served communities of color, LGBTQ+ people, and people with disabilities did not rank secondhand smoke as a priority.

Community voices

- Secondhand smoke exposure ranked fourth highest of seven adolescent health priorities selected by families engaged in the community voices project. Transgender youth ranked secondhand smoke exposure next to last in terms of priority.

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[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report. Appendix of supporting documents. Rockville, MD: Author.

[2] Merianos, A.L., Jandraov, R.A., & Mahabee-Gittens, E. M. (2018). Adolescent Tobacco Exposure, Respirator Symptoms, and Emergency Department Use. *Pediatrics* 142(3).

[3] 2017 Oregon Healthy Teens Survey

[4] Ibid.

[5] National Survey of Children's Health, 2016-2017

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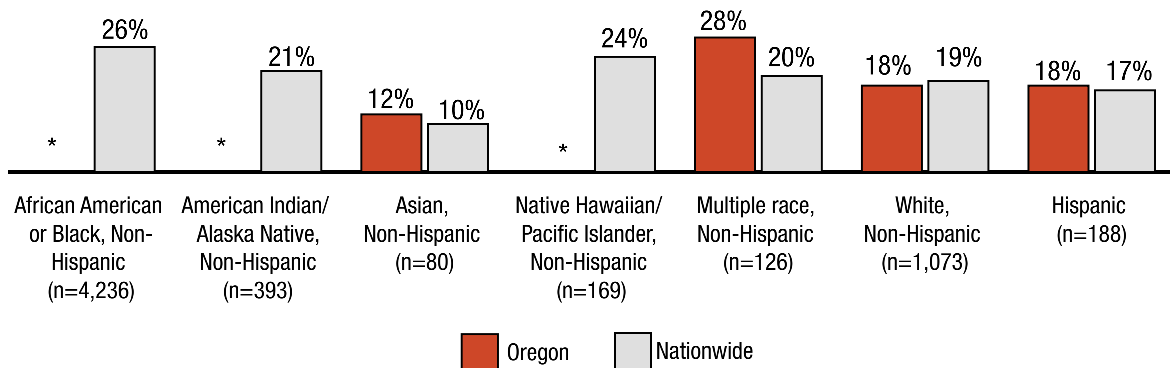
Population Domain: Children and Youth with Special Health Care Needs

Oregon population profile

The Maternal and Child Health Bureau defines children and youth with special health care needs (CYSHCN) as those who have, or who are at increased risk for, a chronic behavioral, developmental, emotional, or physical condition. CYSHCN require health and related services of a type or amount beyond that required by children generally.[1,2] In Oregon, nearly one in five (19%) children younger than 18 years has a special health care need.[3]

In Oregon, children who are younger than 18 years with a special health care need are Asian (12%), Hispanic (18%), White (18%), or multiple race (28%, Figure 1).

Figure 1. Percent of children and youth with special health care needs (CYSHCN), 0 through 17 years old, 2016-2017

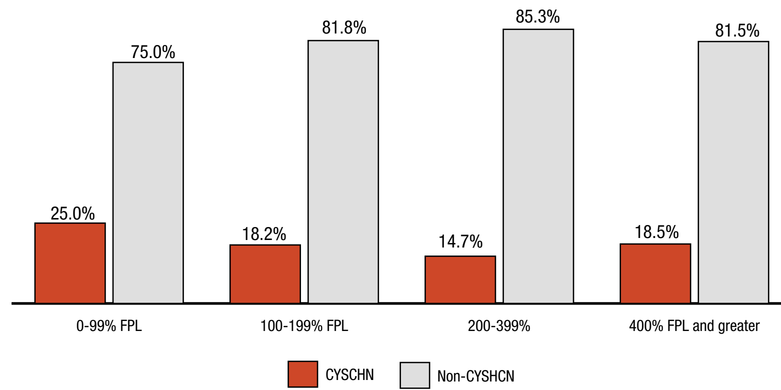


Source: National Survey of Children's Health, 2016-2017

Population listed is for Oregon.
**Oregon Non-Hispanic African American or Black, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander not included due to low sample size.*
Note: Use caution with Oregon Non-Hispanic Asian and Multiple race data; and with Nationwide Native Hawaiian/Pacific Islander data.

One-fourth (25%) of children and youth from families with annual household incomes 0-99% of the Federal Poverty Level (FPL) have a special health care need (Figure 2). Even though most Oregon CYSHCN have health insurance, 15% of their families reported having problems paying for their child's medical bills.[4] The percentage of families of CYSHCN who had out-of-pocket medical expenses of $1,000 or more in a year were twice that of families of non-CYSHCN.[5]

Figure 2. Percent of children, 0 through 17 years old, by annual household income, Oregon, 2016-2017



Source: National Survey of Children's Health
Note: FPL = Federal poverty level

Key background & issues of concern for this population

Oregon CYSHCN have unmet needs for mental and oral health care. Oregon CYSHCN have unmet needs for habilitative occupational, physical, and speech therapies, in part because of insurance caps on the number and duration of treatments. Habilitative care differs from rehabilitative care in that it helps patients improve or maintain current function, as opposed to regaining function lost due to illness or injury. Oregon CYSHCN are 2.5 times more likely than non-CYSHCN to have experienced two or more Adverse Childhood Experiences (ACEs).

National priority area options (2021-2025)

- CYSHCN younger than 18 years old with a medical home
- CYSHCN ages 12 through 17 who received services necessary to make transitions to adult health care

Needs assessment results

Environmental scan

- In an environmental scan, issues were not identified that explicitly related to CYSHCN and their families.

Partner survey

Nearly 170 partners responded to the CYSHCN survey section, of which most (43%) selected transition to adult healthcare as the priority to focus on for Oregon CYSHCN.

- Organizations that serve American Indian/Alaska Native, African American or Black, Native Hawaiian/Pacific Islander, immigrants, and LGBTQ+ most frequently identified medical home as the priority on which to focus.
- Respondents from organizations serving Asians most frequently identified medical home and insurance coverage as the highest priority.
- Respondents from organizations serving individuals with disabilities most frequently identified health care transition as the priority.

Community voices

- Community voices findings will be presented during the Stakeholder meeting.

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[1] McPherson, M., Arango, P., Fox, H., Lauver, C.,…Strickland, B. (1998). A new definition of children with special health care needs. *Pediatrics,* 102(1), 137-140.

[2] Children are identified as having a special health care need if they have any one of the following health conditions that has or is expected to last for 12 months or more: need or use prescription medication; need or use more medical care, mental health, or educational services than is usual for same-age children; limited or prevented in anyway in their ability to do things that most same-aged children can do; need or receive therapy (e.g., occupational, physical, speech); or has any kind of behavioral, developmental, or emotional condition for which they need treatment or counseling.

[3] National Survey of Children's Health (NSCH), 2016 - 2017.

[4] Ibid.

[5] Ibid.

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Priority Area: Medical Home

☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Health Status Data

- Only about four in every ten Oregon children and youth with special health care needs (CYSHCN) receive care in a medical home (Figure 1).
- Compared to children without special health needs, Oregon CYSHCN experience disparity receiving effective care coordination and getting referrals to physicians or receiving services (Figure 2), which are key medical home services for CYSHCN.

Significance of the issue

Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. The American Academy of Pediatrics (AAP) specify the following seven essential medical home qualities: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. The Maternal and Child Health Bureau uses the AAP definition of medical home.

Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.[1]

National performance measure

Figure 1. Percent of CYSHCN, 0 through 17 years old, who had a medical home, 2016-2017

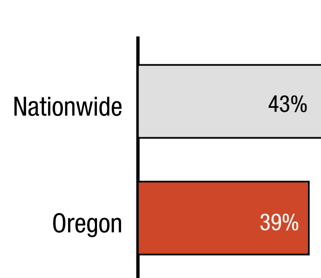
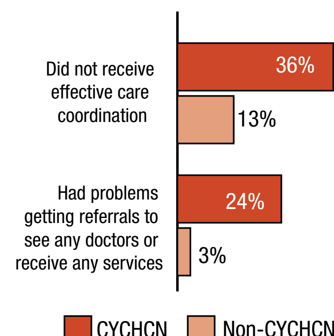


Figure 2. Percent of children, 0 through 17 years old, experiencing two medical home qualities, Oregon, 2016-2017



Source: National Survey of Children's Health (NSCH), 2016-2017

Note: We are unable to disaggregate NSCH data for Oregon CYSHCN by race/ethnicity, income, and other characteristics due to small sample size.

Context for the issue in Oregon

In 2011, Oregon launched the PCPCH program, the state effort to encourage primary care practices to implement clinical methods that align with the seven essential medical home qualities. Program standards do not differentiate pediatric and adult populations, and although the standards include examples of clinical methods for CYSHCN, there are no requirements specific to CYSHCN.

Medical home was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V priority for 2016-2020. The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) medical home block grant strategies with local public health authorities (LPHAs) seek to promote cross-systems care coordination for CYSHCN, including behavioral/mental health, oral and physical health, education and community-based services.

In 2018, LPHAs served 1,358 CYSHCN, under 21 years old, through the Care Coordination (CaCoon) public health nurse home visiting program.

- LPHAs facilitated cross-system team-based shared care planning for 101 CYSHCN and their families in 2017-2018.
- During the 2017-2018 block grant year, three Regional Approach to Child Health (REACH) teams implemented quality improvement strategies designed to address regional system barriers to shared care planning.

These strategies align with public health modernization guiding principles to address implementation of cross-sector collaboration, improving systems, applying evidence-based strategies to improve population health, and collaboration between health care and public health to address access and quality barriers. They also align with public health's accreditation efforts toward quality improvement, the PCPCH Program Standard 5.C. Complex Care Coordination, and the Early Learning Hubs' direction to ensure care is coordinated for children (0-5) through cross-sector collaboration.

OCCYSHN's infrastructure-building and policy efforts to promote medical home and cross-systems care coordination included the following in 2019:

- OCCYSHN's director sits on the PCPCH Standards Advisory Committee as of fall 2019.
- Clarified Targeted Case Management payments for CaCoon and shared care planning.
- Contracted with five LPHAs to develop or support cross-system teams of professionals who meet regularly to coordinate care for local CYSHCN.
- Provided written recommendations on CCO 2.0 contracts prior to awards.
- Provided verbal and written recommendations to the CCO 2.0 Rules Advisory Committee.

Needs assessment results

Environmental scan

- In an environmental scan, issues were not identified that explicitly related to medical home for CYSHCN.

Partner survey

Nearly 170 partners responded to the CYSHCN survey section. Of those, 31% selected medical home as the priority focus for Oregon CYSHCN.

- Respondents from organizations serving Asians most frequently identified medical home and insurance coverage as the highest priority.
- On average, respondents rated medical home as having a large impact on overall health of CYSHCN in their community. Similarly, respondents rated medical home on average as having a large impact on health equity among CYSHCN.
- Respondents on average rated Title V resource allocation, at both state and local levels, as having a large impact on medical home.

Community voices

- Community voices findings will be presented during the Stakeholder meeting.

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report. Rockville, MD: Author.

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Oregon's 2020 Title V Maternal, Child, and Adolescent Health Needs Assessment

Children and Youth with Special Health Care Needs

Priority Area: Transition to Adult Health Care

☑ National Priority Area ☐ State Priority Area ☐ Emerging State Topic

Health Status Data

- Oregon children generally, and CYSHCN specifically, do not receive transition to adult health care services (Figure 2).
- Eighty-six percent of CYSHCN receiving care in a medical home and 82% of CYSHCN with consistent insurance coverage did not receive transition services.
- CYSHCN with more complex needs (88%) and CYSHCN who experience emotional, developmental, and behavioral issues (86%) also did not receive transition services.* This is consistent with the Oregon Center for Children and Youth with Special Health Needs' findings from interviews with parents whose young adults are medically complex and 18 to 23 years old.
- These parents often reported that their behavioral health providers did not provide them with notice that care would cease once their child turned 18 years old. These parents were unable to find adult behavioral health providers within a reasonable period of time. Some parents were still looking for an adult behavioral health provider years after their child had to leave their pediatric behavioral health provider.

* Visit www.childhealthdata.org for more information about how the Child and Adolescent Health Measurement Initiative (CAHMI) determines complexity using NSCH data

Significance of the issue

The transition of youth to adulthood, including the movement from a child to an adult model of health care, has become a priority issue nationwide as evidenced by the 2011 clinical report and algorithm developed jointly by the American Academy of Pediatrics (AAP), American Academy of Family Physicians and American College of Physicians to improve health care transitions for all youth and families. Poor health has the potential to negatively impact the youth and young adults' academic and vocational outcomes. Over 90% of children and youth with special health care needs (CYSHCN) now live to adulthood but are less likely than their non-CYSHCN peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.[1]

National performance measure

Figure 1. Percent of CYSHCN, 12 through 17 years old, who received transition services, 2016-2017

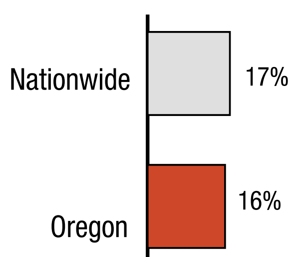
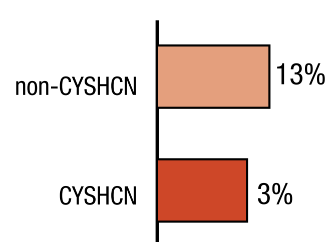


Figure 2. Percent of children, 12 through 17 years old, who received transition services, Oregon, 2016-2017



Source: National Survey of Children's Health (NSCH), 2016-2017

Note: We are unable to disaggregate NSCH data for Oregon CYSHCN by race/ethnicity, income, and other characteristics due to small sample size.

Context for the issue in Oregon

Transition to adult health care was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V priority for 2016-2020. In 2015, stakeholders encouraged OCCYSHN to select it as a priority, because, although there were state efforts to address education and employment transition for CYSHCN, no entities focused on transition from pediatric to adult health care. Neither the Patient-Centered Primary Care Home (PCPCH) Standards nor the Coordinated Care Organizations (CCO) 2.0 contracts address transition. The Health Plan Quality Metrics menu includes a transition metric option; however, the CCO Metrics and Scoring Committee has not selected it for the incentive metrics set.

Young adults who are medically complex are a subset of CYSHCN, and their families experience considerable challenges with transition to adult health care. These challenges stem, in part, from lack of attention to and awareness of health care transition needs, inadequate provider reimbursement, and a lack of providers who are prepared to care for these young adults.[2]

Since 2016-2017, OCCYSHN has included requirements for serving transition-aged youth in its contracts for shared care planning with local public health authorities (LPHA). The goal was for 20% of the CYSHCN served through LPHA-led shared care planning to be transition-aged (12 and older), and for those shared care plans to include at least one goal focused on the transition to adult health care (Table 1).

OCCYSHN leads Oregon's participation in the Health Resources and Services Administration (HRSA) funded, Boston University administered Children with Medical Complexity Collaborative Improvement and Innovation Network (CoIIN). The quality improvement project focuses on preparing young adults with medical complexity (17 years and older and cared for in Doernbecher Children's Hospital's Pediatrics and Adolescent Health Clinic) for the transition to an adult primary care provider. Since 2013, the Oregon Family to Family Health Information Center (OR F2F HIC) has conducted five to six trainings per year for CYSHCN families about health care transition planning.

Table 1. Transition Focus in LPHA-Led Shared Care Planning performance measures

	2016 - 2017	2017 - 2018
Percent of LPHA-led shared care plans serving transition-aged youth	25.5%	19.3%
Percent of shared care plans for transition-aged youth that address transition planning	45.7%	66.7%

OCCYSHN's infrastructure-building and policy efforts to promote transition to adult health care include:

- OCCYSHN's director sits on the PCPCH Standards Advisory Committee as of fall 2019.
- Clarified Targeted Case Management payments for Care Coordination (CaCoon) and shared care planning.
- Provided technical assistance to cross-systems care teams to support their care coordination for transition-aged CYSHCN and their families.
- Provided public comment to the Health Plan Quality Metrics on the importance of including a transition metric in its menu.
- Provided written recommendations on CCO 2.0 contracts prior to awards, and verbal and written recommendations to the CCO 2.0 Rules Advisory Committee.
- Received technical assistance from The National Alliance to Advance Adolescent Health to advance planning for payment strategies that support transfer of care activities.
- Contributed to the development of the Oregon Health & Science University (OHSU) evidence-based guidelines for transition planning and transfer of care from pediatric to adult providers.

Needs assessment results

Environmental scan

- An environmental scan did not identify transition issues generally or explicitly related to CYSHCN and their families.

Partner survey

Nearly 170 partners responded to the CYSHCN survey section, and most (43%) selected transition to adult health care as the priority on which to focus for Oregon CYSHCN.

- On average, respondents rated transition to adult health care as having a large impact on the overall health of CYSHCN in their community and having a large impact on health equity among CYSHCN.
- Respondents also rated that Title V resource allocation at both state and local level would have, on average, a large impact on transition to adult health care.

Community voices

- Community voices findings will be presented during the Stakeholder meeting.

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2017). Title V maternal and child health services block grant to states program. Guidance and forms for the Title V application/annual report. Rockville, MD: Author.

[2] Martin, AJ, Bakewell, T, Trejo, B, Valdez, A., Gallarde-Kim, S.,…Rumsey, D. (2019). *Inadequate preparation for transition from pediatric to adult healthcare for Oregon young adults with medical complexity: Root cause analysis.*

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Priority Area: Toxic Stress, Trauma, Adverse Childhood Experiences and Resilience

☐ National Priority Area ☑ State Priority Area ☐ Emerging State Topic

Significance of the issue

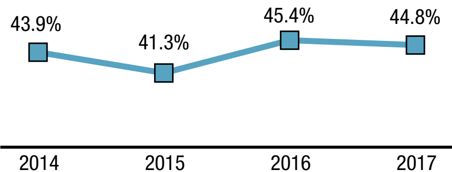
Trauma and adversity [including historical trauma, racism, adverse childhood experiences (ACEs), and adverse peer, school, and/or adult experiences] can create toxic stress. Toxic stress influences the biology of health and development, and may manifest in multiple mental, physical, relational, and productivity problems throughout the lifespan. Early childhood is a critical period when adversity and trauma can create toxic stress and interrupt normal brain development.

Individuals with multiple ACEs have higher rates of developmental delays and other problems in childhood, as well as adult health conditions such as smoking, alcoholism, depression, suicide, heart disease, cancer, diabetes, disability, and premature mortality.

Protective factors, at both the individual and community level, can build resilience and buffer the effects of adversity and trauma. Resilience can be enhanced by healthy relationships in early childhood, meaningful relationships for children and adolescents, and strong social support (i.e., connection to other people, community and culture) for adults. A public health response to trauma and adversity addresses systemic causes such as racism, discrimination, and structural inequities to prevent adversity and reduce toxic stress. It also promotes safe, stable, and nurturing relationships and environments that build resilience in individuals, families and communities.

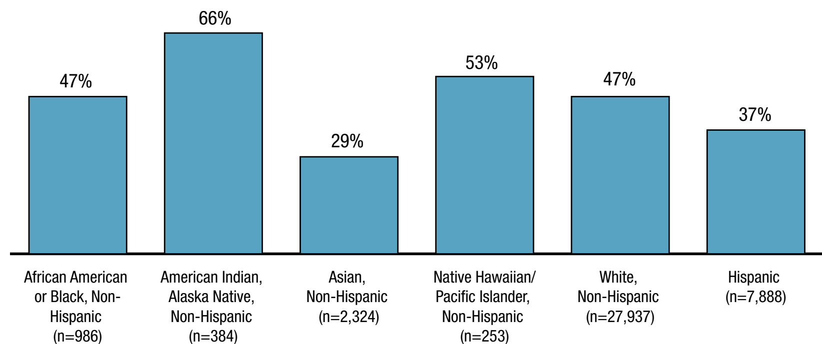
State performance measures

Figure 1. Percent of new mothers who experienced stressful life events before or during pregnancy, Oregon, 2014-2017



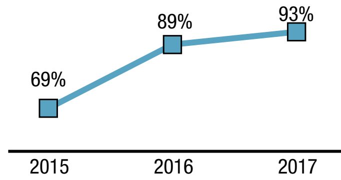
Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Figure 2. Percent of new mothers who experienced stressful life events before or during pregnancy, by race/ethnicity, Oregon, 2017



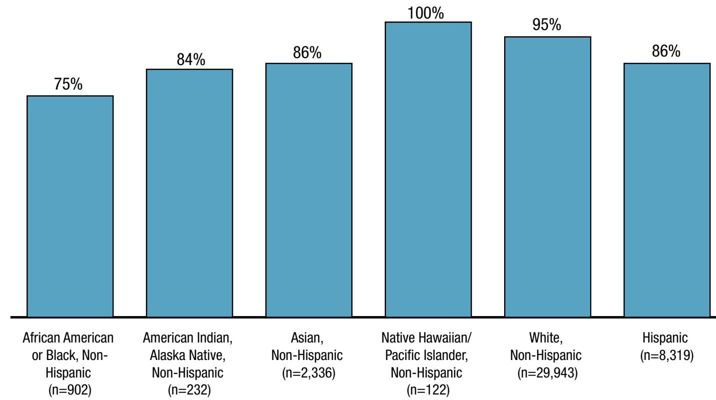
Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Figure 3. Percent of mothers of 2 year olds who have adequate social support, Oregon, 2015-2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

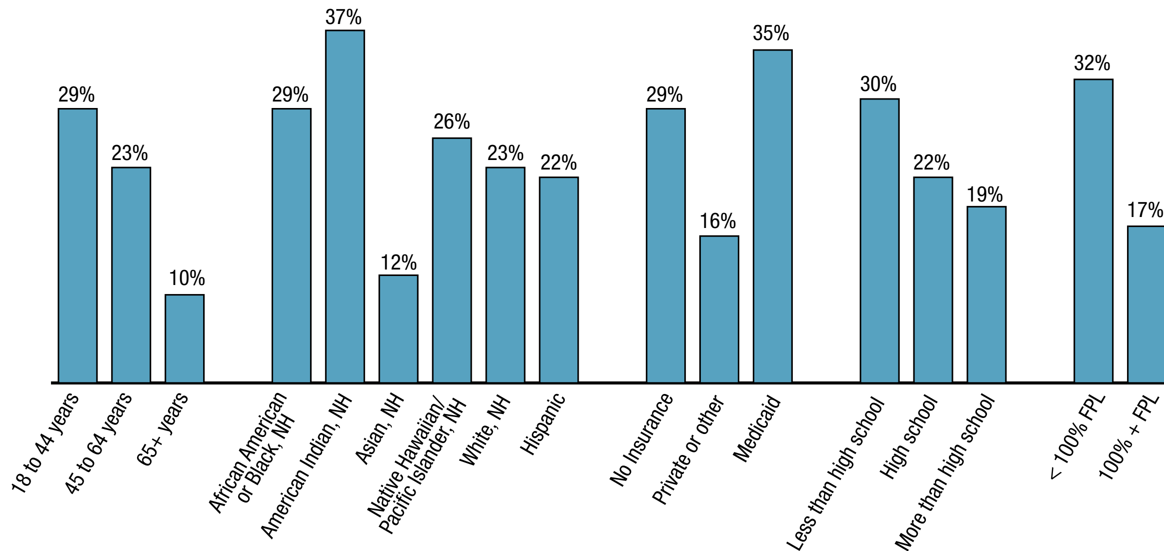
Figure 4. Percent of mothers of 2 year olds who have adequate social support, by race/ethnicity, Oregon, 2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Health status data[1]

Figure 5. Adults with high adverse childhood experiences (ACEs) score (4+), Oregon, 2015-2017



Note: NH = Non-Hispanic

Context for the issue in Oregon

State and local Maternal, Child, and Adolescent Health (MCAH) Title V implementation

Oregon's state Title V program and seven local grantees work with partners across the state to reduce exposure to trauma and adversity, and promote resilience among children, youth, families and communities. This is done through work on:

- Family friendly policies that decrease stress and adversity and increase economic stability
- Equitable, safe and connected communities
- Equitable and trauma informed workforce, systems, and services
- Strengthening protective factors for individuals and families
- Use of NEAR (neurobiology, epigenetics, ACEs and resilience) data and science to educate communities and inform policy makers

Partner alignment

Multiple partners around the state are focused on adversity and trauma, and their intersection with racial equity and social determinants of health. This is evidenced in alignment with:

- Oregon's State Health Improvement Plan priority on adversity, trauma and toxic stress
- Oregon Health Authority's trauma informed policy development
- State legislation (including Senate Bill 526 (2019) - universally offered home visiting; House Bill 2005 (2019) - paid family leave; and House Concurrent Resolution 33 (2017))
- Trauma Informed Oregon's work to create trauma informed system's statewide
- The Governor's Children's Cabinet Agenda
- The Early Learning Division's Raise up Oregon plan
- The Department of Education's Trauma Informed Schools initiative

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, toxic stress, trauma and ACEs were mentioned as needs in 17% (5 of 30) of county assessments and 36% (4 of 11) of special population assessments.

Partner survey

- In a statewide survey of partners, the toxic stress, trauma and ACEs priority area was the most commonly selected state priority option of the nine provided in the survey (both current state priority areas and emerging needs were provided as options).
- It was also rated highest of the state priority area options in terms of health impact, potential to effect health equity, and impact of applied resources.
- Toxic stress, trauma and ACEs were mentioned as emerging needs by seven partners who responded to the survey.

Title V grantee meeting

- In a meeting of county and Tribal Title V grantees, toxic stress, trauma and ACEs were mentioned by two grantees as an emerging need in the communities they serve, specifically children's involvement with child protective services.

Community voices

- Toxic stress, trauma and ACEs was rated the highest of the three current state priority areas among African American or Black, Latinx, immigrant/refugee, and rural families.
- Immigrant and refugee families reported that toxic stress was an issue that impacted the vast majority of families in their communities.
- Latinx families reported that stress and depression in their communities is related to factors including immigration status, including fear derived from the dominant political discourse on immigrants and Latinxs.

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[1] Behavioral Risk Factor Surveillance System, 2015-2017

Oregon's 2020 Title V Maternal, Child, and Adolescent Health Needs Assessment

State Priority Area

Priority Area: Food Insecurity

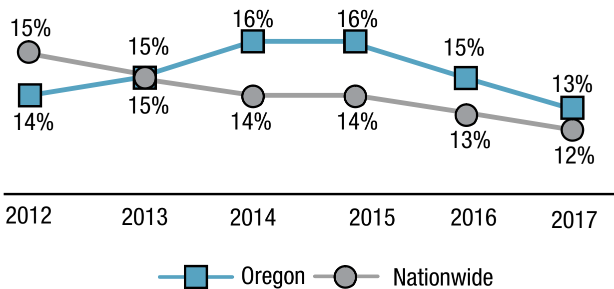
☐ National Priority Area ☑ State Priority Area ☐ Emerging State Topic

Significance of the issue

Food insecurity is defined as "limited or uncertain availability of nutritionally adequate and safe foods" or "limited or uncertain ability to acquire acceptable foods in socially acceptable ways." Food insecurity has significant impacts at all life stages, from infancy through elderly, and influences health status in several ways. Lack of access to adequate and nutritious food is related to being overweight or obese, hypertension, high cholesterol, and diabetes. In addition, food insecurity affects child development and readiness to learn, and has long-lasting impacts during pregnancy. Compared to children living in food secure households, those with inadequate access to food have higher rates of iron deficiency anemia, which may cause slow cognitive and social development, higher hospitalization rates, and increased psychosocial and academic problems. Screening and intervention for food insecurity have increasingly been incorporated into health clinic visits. Rural communities are often hit hard by food insecurity; and African American or Blacks, Hispanic, American Indians, and female-headed single parent families experience food insecurity at higher rates than the national average.

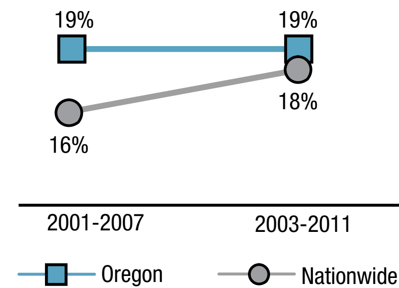
State performance measures

Figure 1. Percent of households experiencing food insecurity, 2001-2015



Source: United States Department of Agriculture (USDA)

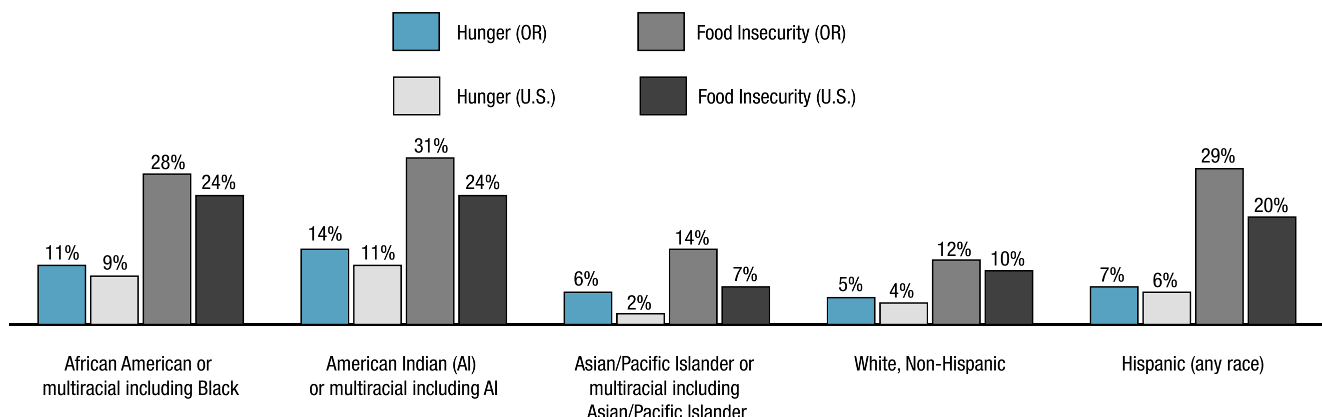
Figure 2. Percent of households with children <18 years experiencing food insecurity, 2001-2011



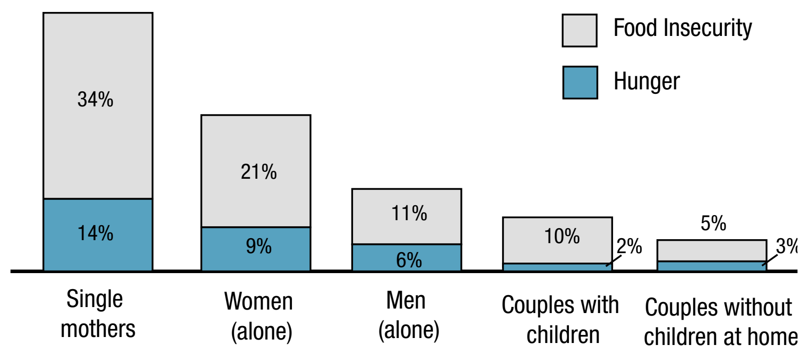
Source: United States Department of Agriculture (USDA)

Health status data

Figure 3. Hunger/Food insecurity rate, by race/ethnicity, Oregon vs. rest of U.S., 2013-2017



Source: Edward, 2018 [1]



- Half (52%) of Oregonian children are eligible for Free and Reduced-Price School Meals.[2]
- Thirteen percent of Oregonians are food insecure, which means there are approximately 500,000 Oregonians living in food insecure households.[3]
- One in five Oregon children are food insecure.[3]
- Significant disparities exist: single mothers (one in three households are food insecure), rural, and racial and ethnic minority residents experience higher rates of food insecurity. Female-headed households, with or without dependents, remain the most vulnerable to food insecurity.[3]

Context for the issue in Oregon

Food insecurity was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V state priority for 2016-2020, as well as a priority for many partner agencies.

Success and challenges

- Oregon's food security rates are improving with the economic recovery but have not recovered to pre-recession levels. Vulnerable populations remain at high risk for becoming food insecure whenever there is an economic downturn.

Local MCAH Title V implementation

- For 2019-2020, four Title V grantees are addressing food insecurity. All four grantees selected screening and referral for food insecurity as a strategy; each grantee has also selected an additional strategy.

Partner alignment

- 14 of 15 Coordinated Care Organizations (CCOs), representing 31 of 36 counties, are prioritizing nutrition and food security in their community health improvement plans.
- The 2020-2024 State Health Improvement Plan, addresses "economic drivers of health" (including food security) as a priority."
- The Oregon Student Success Act (2019) includes a Hunger Free Schools provision which invests in child nutrition programs at school, during summer and in child care settings. The Farm Direct Nutrition Program serving WIC families and seniors received funding for biennium.

Changes in federal rules

- Pending Federal changes which would add the Supplemental Nutrition Assistance Program (SNAP) to the Public Charge rule risk increasing food insecurity among legal immigrants.
- New federal regulation, Able-Bodied Adults Without Dependents (ABAWD) requirements for Supplemental Nutrition Assistance Program (SNAP), has tightened requirements and exemptions for receiving SNAP benefits increasing risk for food insecurity.
- New federal proposed rule for SNAP, undermines SNAP access by limiting broad-based categorical eligibility. Reduced access to SNAP can also impact families' access to WIC services through adjunctive eligibility. If proposed rule is adopted it is anticipated that food insecurity rates will increase.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, food insecurity was mentioned as a need in 63% (19 of 30) of county assessments and 27% (3 of 11) of special population assessments.

Partner survey

- In a statewide survey of partners, nutrition and food insecurity was the fifth most selected state priority option of the nine provided in the survey (both current state priority areas and emerging needs were provided as options).
- One partner mentioned food insecurity and nutrition as a significant concern in their community.

Community Voices

- Food insecurity was rated the lowest of the three current state priority areas among African American or Black, Latinx, immigrant/refugee, and rural families.
- Latinx families reported issues with eating well due to lack of time and money, such as being unable to buy fresh fruits and vegetables due to them being too expensive.
- Homeless families reported food insecurity as a major concern in their lives. "Food is a huge thing (worry) in our household, it's constant, other than a week and half or two out of the month, the rest of time…"
- African American or Black and rural families reported difficulties with accessing affordable fresh food, including living in food deserts.

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[1] Edward, Mark. Widespread Declines, Yet Persistent Inequalities: Food Insecurity in Oregon and the U.S. (2015-2017). Oregon State University School of Public Policy. December 2018

[2] Oregon Department of Education, 2018-19

[3] Status of Hunger in Oregon 2018

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Priority Area: Culturally and Linguistically Appropriate Services

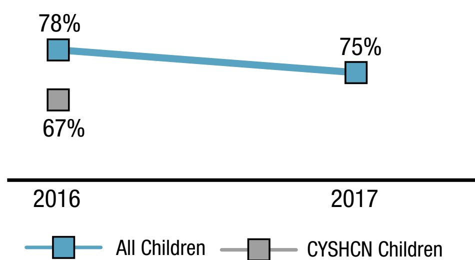
☐ National Priority Area ☑ State Priority Area ☐ Emerging State Topic

Significance of the issue

The field of Maternal and Child Health (MCH) is grounded in a life-course framework which recognizes the need to eliminate health inequities to improve the health of all women, adolescents and children, including those with special health care needs (CYSHCN). Health inequities are systemic, avoidable, and unfair. These differences in health status and mortality rates are sustained over generations and are beyond the control of individuals. Institutional changes, including implementing culturally and linguistically responsive MCH services and systems are essential in addressing health inequities. The principal national standard for culturally and linguistically appropriate services (CLAS) is to: Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

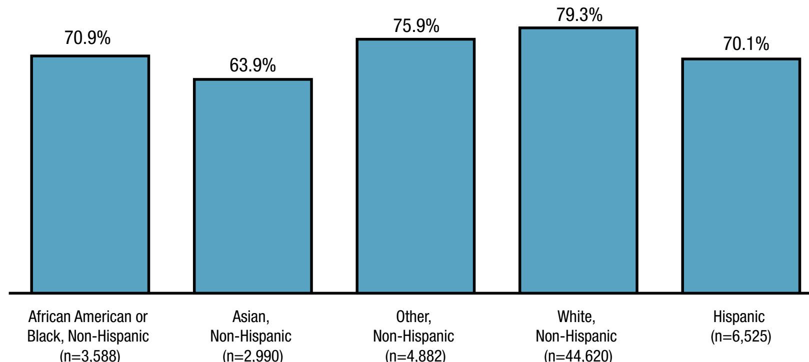
State performance measures

Figure 1. Percent of children age 0-17 years who have a healthcare provider who is sensitive to their family's values and customs, Oregon



Source: National Survey of Children's Health (NSCH). Note: In 2017, sample size too small to disaggregate by CYSHCN

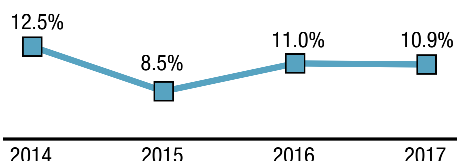
Figure 2. Percent of children age 0-17 years who have a healthcare provider who is sensitive to their family's values and customs, by race/ethnicity, Nationwide, 2016-2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

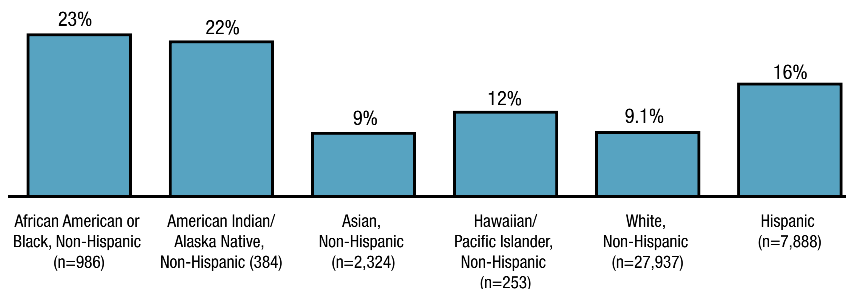
Note: Nationwide data used since Oregon data is underrepresented. "Other, Non-Hispanic" includes American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, and some other race.

Figure 3. Percent of new mothers who have ever experienced discrimination while getting any type of medical care, Oregon, 2014-2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Figure 4. Percent of new mothers who have ever experienced discrimination while getting any type of health or medical care, by race/ethnicity, Oregon, 2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS), 2017

Health status data

- Health disparities among race and ethnicity are substantial and persistent.[1]
- Research shows that 60 percent of deaths from pregnancy-related complications are potentially preventable through improvements to health before pregnancy and improved quality of medical care.[2]
- Across nearly every medical intervention in the U.S, Blacks and other minorities receive fewer procedures and poorer quality medical care than Whites.[3]
- Implicit bias is a major contributor to health inequities.[3]

There is a significant lack of data describing Oregon CYSHCN of color. However, a review of published literature reveals that among CYSHCN:

- Compared to White parents of children with developmental disabilities and Autism Spectrum Disorders (ASD), African American or Black and Latino parents were significantly less likely to report that their provider was sensitive to their family's values and spent enough time with their child.[4]
- African American or Black children were less likely to be diagnosed with attention deficit hyperactivity disorder (ADHD), despite exhibiting more ADHD symptoms than White children; had more emergency department visits and hospitalizations; had higher mortality rates associated with asthma; and survived less often with Down syndrome, type 1 diabetes, and traumatic brain injury compared to White children.[5]
- Latino children with ADHD were less likely to be diagnosed, had poorer glycemic control with type 1 diabetes, and survived less often with acute leukemia compared to White children.[5]
- Parents with limited English proficiency (LEP) were significantly less likely, than those with English proficiency, to report that: their child was insured; had a usual source of care or medical home; they experienced family-centered care or satisfaction with care.[6]
- When cared for in the perinatal infant care unit, families with LEP, less frequently reported that: they understood the content discussed on rounds, nurses spent enough time with them, or they could rely on their nurses for medical updates.[7]
- Children with ASD in Latino families with LEP experienced more diagnosis and service use barriers (related to knowledge about ASD and trust in providers), had more unmet therapy needs, and got fewer therapy hours than non-Latino White children with ASD.[8]

Context for the issue in Oregon

Culturally and Linguistically Appropriate Services was a selected Oregon Maternal, Child, and Adolescent Health (MCAH) Title V state priority for 2016-2020, as well as a priority for many partner agencies.

Local MCAH Title V implementation

- Tribal grantees continued their work with families on creating traditional native cradle boards, using this as a time to educate the younger generations on cultural history and parenting traditions. Positive Indian Parenting courses are also offered to increase knowledge of traditional parenting practices and to engage new parents in postpartum care.
- Community Health Workers are working with Portland area refugee and immigrant families.
- Several counties are working on improving internal operations through cultural responsiveness trainings and creating strategic plans to move this work forward across their agencies.
- Counties that are implementing Care Coordination (CaCoon) public nurse home visiting for CYSHCN are increasing their understanding of linking immigrant and refugee populations to services through training with the Oregon Law Center and Immigration and Counseling Services.
- Three counties have bilingual/bicultural public health workers on their staff who support CaCoon home visiting, shared care planning efforts, and other public health functions.
- Counties are increasing their implementation of shared care planning for CYSHCN who are racially and ethnically diverse. Staff participated in televideo training sessions that address health literacy and immigration status and access to services.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, CLAS was mentioned as a need in 30% (9 of 30) of county assessments and 55% (6 of 11) of special population assessments.
- The environmental scan revealed no discussion of culturally and linguistically appropriate services for CYSHCN.

Partner survey

- In a statewide survey of partners, CLAS was the sixth most selected state priority option of the nine provided in the survey (both current state priority areas and emerging needs were provided as options).
- The partner survey did not differentiate CLAS for CYSHCN separately from CLAS for MCAH populations broadly. Partners did not report this in the "other issues" section.

Community voices

- CLAS was rated second of the three current state priority areas among African American or Black, Latinx, immigrant/refugee, and rural families.
- Latinx families reported that interpretation services at health centers were very useful, and that when these services were not available, communication with doctors and staff was very difficult.
- African American or Black families reported that racism leads to their health issues being brushed aside by medical providers, therefore families do not seek help, which results in late diagnosis and death. "People feel that doctors don't believe them, so they don't go to the doctor."
- The community voices results for CYSHCN will be available during the Stakeholder meeting.

---

[1] Williams DR, Sternthal M. Understanding racial-ethnic disparities in health: sociological contributions. *J Health Soc Behav*. 2010;51 Suppl(Suppl):S15–S27

[2] Cynthia J. Berg et al. Preventability of Pregnancy-Related Deaths: Results of a State-Wide Review. *Obstetrics & Gynecology* 106, no. 6 (2005): 1228-34.

[3] Williams, David R., Cooper, Lisa A., Reducing Racial Inequities in Health: Using What We Already Know to Take Action, *International Journal of Environmental Research and Public Health*, February 2019

[4] Magaña, S., Parish, S.L., & Son, E. (2015). Have racial and ethnic disparities in the quality of health care relationships changed for children with developmental disabilities and ASD? *American Journal on Intellectual and Developmental Disabilities*, 120(6), 504-513.

[5] Berry, J.G., Bloom, S., Foley, S., & Palfrey, J.S. (2010). Health inequity in children and youth with chronic health conditions. *Pediatrics,* 126 (S3), S111-S119.

[6] Eneriz-Wiemer, M., Sanders, L.M., Barr, D.A., & Mendoza, F.S. (2014). Parental limited English proficiency and health outcomes for children with special health care needs: A systematic review. *Academic Pediatrics*, 14, 128-136.

[7] Zurca, A.D., Fisher, K.R., Flor, R.J., Gonzalez-Marques, C.D., Wang, J., Cheng, Y.I., & October, T.W. (2017). Communication with limited English-proficient families in the PICU. *Hospital Pediatrics,* 7(1), 9-15.

[8] Zuckerman, K.E., Lindly, O.J., Reyes, N.M., Chavez, A.E., Macias, K., Smith, K.N., & Reynolds, A. (2017). Disparities in diagnosisand treatment of Autism in Latino and non-Latino White families. *Pediatrics*, 139 (5), 1-10.

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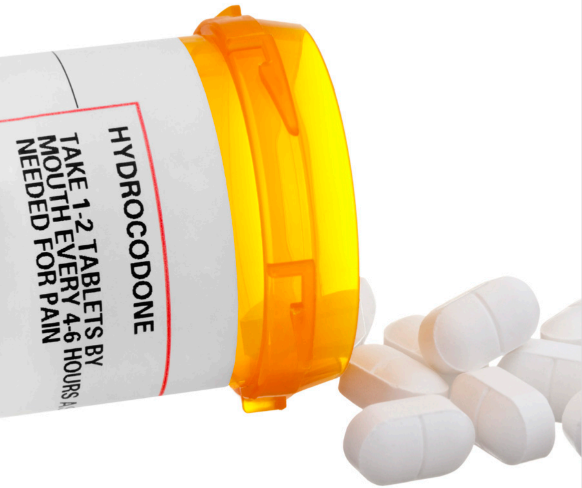
Oregon's 2020 Title V Maternal, Child, and Adolescent Health Needs Assessment

Emerging Issues

Drug Use and Misuse: Impact on Pregnant Women and Children

☐ National Priority Area ☐ State Priority Area ☑ Emerging State Topic



Significance of the issue

Substance use disorders are a problem that crosses all populations and ages. Consequences of drug misuse include overdose deaths and hospitalizations, lost income, lost productivity, unstable family relationships, and damaged communities. Marijuana, opioids and other drugs can have harmful effects on anyone's health. When a pregnant or nursing person uses these substances, the baby is exposed to them; as substances cross the placenta through the umbilical cord and enter the baby's bloodstream. Understanding substance use disorders in a public health context, including the impact on children, families and communities, opens the door to a maternal and child health prevention approach with potential to improve lifelong health and mitigate toxic stress and adverse childhood experiences.

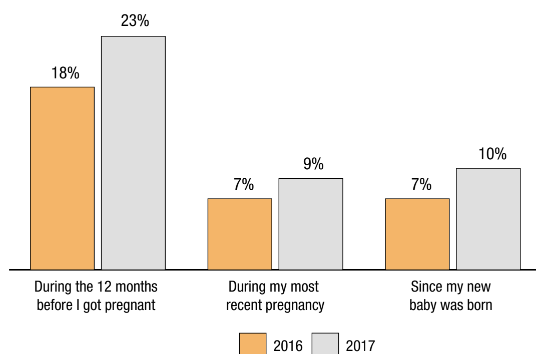
Prenatal substance use is a critical public health concern that is linked with several harmful maternal and fetal consequences. Polysubstance use, co-occurrence of substance use disorders and mental health disorders, environmental stressors, and limited and disrupted prenatal care, can all compound the impact of prenatal substance use and increase the risk for poor maternal and fetal outcomes.

Opioid use among pregnant and parenting people and neonatal abstinence syndrome (NAS) are complex public health issues. They cut across health and behavioral health providers, families, child welfare, the criminal justice system and other community organizations. A variety of life experiences can lead to opioid-exposed pregnancies. These include chronic pain or other conditions managed by medication, misuse of prescribed medication, recovery from opioid addiction and receiving medication-assisted treatment (MAT) and active abuse of heroin. Each of these experiences calls for differing prevention and intervention opportunities.

The Centers for Disease Control and Prevention (CDC) estimates that one-third of reproductive-age women enrolled in Medicaid and more than one-quarter of those with private insurance filled a prescription for an opioid pain medication each year between 2008 and 2012. The prevalence of opioid use disorder (OUD) during pregnancy more than quadrupled between 1999 and 2014 (from 1.5 per 1,000 delivery hospitalizations to 6.5).[1]

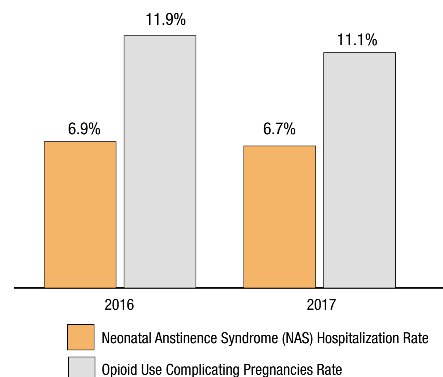
Health Status Data

Figure 1. Percent of women using marijuana before, during and after pregnancy, Oregon, 2016-2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Figure 2. Hospitalization rates for opioid use complicating pregnancy and NAS, Oregon, 2016-2017



Sources: Hospital Discharge Data, Health Analytics; Birth Certificate Data, Center for Health Statistics

Context for the issue in Oregon

State Title V MCAH and Public Health efforts

- The Oregon Health Authority (OHA) convened the Oregon Pregnancy and Opioids Workgroup (December 2017 – March 2018) to develop recommendations on opioid prescribing during pregnancy, identification and treatment of OUD during pregnancy, and care and treatment of prenatally exposed infants that can optimize the outcome for both mother and infant. The workgroup included experts from a variety of disciplines, including maternity and pediatric health care providers, public health, child welfare, and substance abuse treatment.
- The OHA Public Health Division is working to:
  - » Understand and minimize the negative public health impacts of cannabis use
  - » Educate the public about adverse health issues related to cannabis use
  - » Protect children and vulnerable populations from cannabis exposure
  - » Prevent youth cannabis use
  - » Monitor cannabis use, attitudes and health effects in Oregon

Partner alignment

- The Oregon Perinatal Collaborative recently received funding to increase screening with subsequent multidisciplinary referrals and treatment for women with an opioid use disorder.
- House Bill 2257 (2019) will establish pilot programs to provide comprehensive treatment for substance use disorders for perinatal women.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, drug use and misuse was mentioned as a need in 77% (23 of 30) of county assessments and 36% (4 of 11) of special population assessments.

Partner survey

- In a statewide survey of partners, drug use and misuse was the seventh selected state priority option of the nine provided in the survey (both current state priority areas and emerging needs were provided as options).
- In this survey, drug use was also mentioned by two partners as an emerging need; both partners specified the use of marijuana as a part of this emerging need.

Title V grantee meeting

- In a meeting of county and Tribal Title V grantees, three grantees mentioned drug use as an emerging need in their communities. One grantee specifically mentioned marijuana use, and two specifically mentioned use and misuse of opioids.

Community voices

- Drug use and misuse was mentioned as a concern during listening sessions with immigrant and refugee families. The main concern expressed was related to drug use by adolescent members of the community.

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[1] Opioid Use Disorder Documented at Delivery Hospitalization — United States, 1999–2014m CDC

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Oregon's 2020 Title V Maternal, Child, and Adolescent Health Needs Assessment

Emerging Issues

Adolescent Mental Health

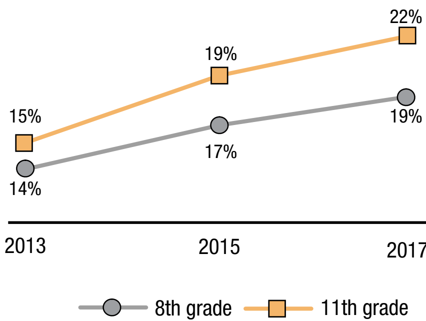
☐ National Priority Area ☐ State Priority Area ☑ Emerging State Topic

Significance of the issue

Mental health concerns and substance abuse are prevalent among children and adolescents. Mental health conditions often begin early in life and may become worse if left untreated. Childhood trauma has lifelong adverse effects on mental and physical health. Non-dominant groups, such as people of color, refugee/immigrant populations, the LGBTQ population, people living below the federal poverty level, and people without insurance/enrolled in Medicaid are more likely to experience complex childhood trauma. These groups are also less likely to have access to high quality culturally appropriate mental and preventive health services. Adolescence is also a significant time in brain development; this is an important time for developing positive behaviors that may last a lifetime. Promoting positive mental health and resiliency among children and adolescents can help prevent and/or mitigate negative mental and physical health outcomes.

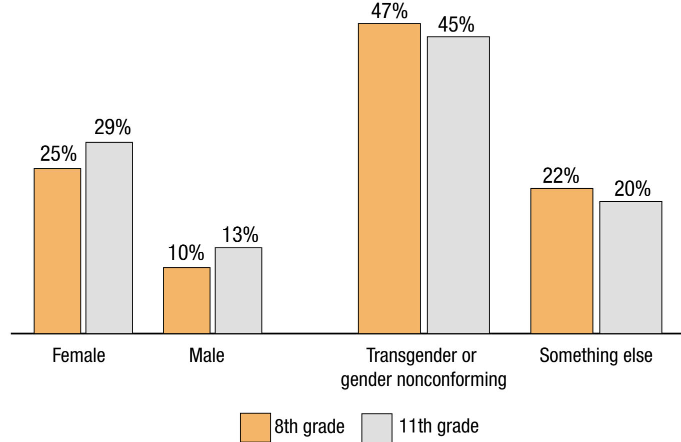
Health Status Data

Figure 1. Unmet Mental/Emotional health needs, by grade, Oregon, 2013-2017



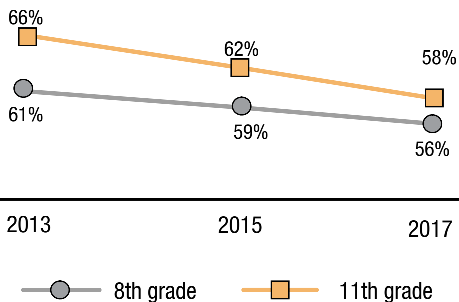
Sources: : Oregon Healthy Teens Survey, 2013, 2015, 2017

Figure 2. Unmet Mental/Emotional health needs, by gender, Oregon, 2017



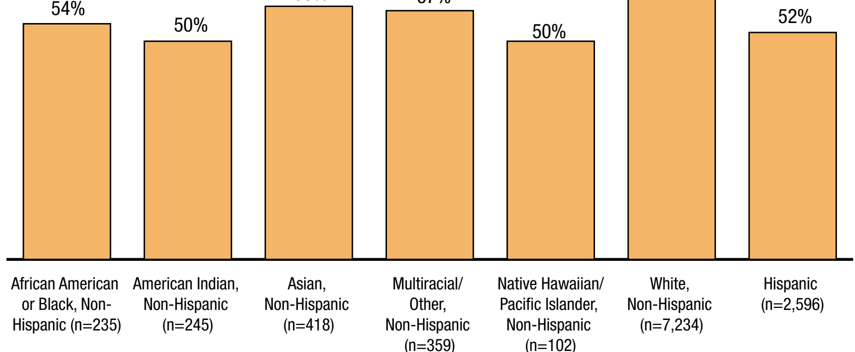
Source: 2017 Oregon Healthy Teens Survey

Figure 3. Positive Youth Development benchmark met, by grade, Oregon, 2013-2017



Sources: : Oregon Healthy Teens Survey, 2013, 2015, 2017

Figure 4. Positive Youth Development benchmark met, 11th graders, by race/ethnicity, Oregon, 2017



Source: 2017 Oregon Healthy Teens Survey

Note: Positive Youth Development (PYD) is a term used to describe empowering and promoting youth confidence, competence, and resilience in ways that benefit both youth and the society. The PYD Benchmark is based on six questions in the Oregon Healthy Teens Survey related to physical health status, mental health status, volunteerism, having a supportive adult, self-confidence and problem-solving capacity.

Health status data

- In the National Comorbidity Survey Adolescent Supplement, an estimated 49.5% of adolescents have experienced a mental health condition, such as anxiety or depression, at some point in their life.
- Over the past several years, Oregon Healthy Teens Survey data have indicated an increase in unmet mental health need (Figure 1).
- At the same time, youth are reporting progressively lower levels of resiliency, or the ability to recover from or adjust easily to change (Figure 3).
- Disparities in these measures exist among LGB and gender diverse youth, as well as among certain racial and ethnic groups (2017 Oregon Healthy Teens Survey). Gender diverse youth are far more likely to report an unmet health need than their cisgender peers (Figure 2). Youth of color, particularly Native American and Hawaiian/Pacific Islander 11th graders were less likely to meet the PYD Benchmark than their White peers in 2017 (Figure 4).

Context for the issue in Oregon

State Adolescent and School Health Program efforts

- The Oregon Adolescent & School Health Program currently provides grant funding to support mental health and prevention services through school-based health centers (SBHCs). The program also provides funding to 14 schools to support youth-led research efforts around mental health issues.
- The State Adolescent and School Health Program actively partners with community-based organizations, local public health authorities, federally qualified health centers, CCOs, other state agencies, and state-level coalitions to promote adolescent mental health and wellness.

Partner alignment

- Oregon's Coordinated Care Organizations (CCO's) will be pivoting their attention towards social determinants of health and healthcare integration over the next several years as Oregon Health Authority (OHA) embarks on CCO 2.0.
- Adolescent mental health is an emerging issue in Oregon. Recent state legislation, such as the Student Success Act, Adi's Act, and investments in child/young adult mental health and suicide prevention, are poised to contribute significant funding to support mental health services and prevention efforts statewide.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, mental health was mentioned as a need in 90% (27 of 30) of county assessments and 36% (4 of 11) of special population assessments.
- Adolescent mental health was specifically mentioned in 47% (14 of 30) of county assessments.

Partner survey

- In a statewide survey of partners, mental health was the second most selected state priority option of the nine provided in the survey (both current state priority areas and emerging needs were provided as options).
- Mental health was mentioned by 10 partners as an emerging need, including four specific mentions of mental health among children and youth.

Title V grantee meeting

- In a meeting of county and Tribal Title V grantees, mental health was mentioned by five grantees as an emerging need in the communities they serve.

Community voices

- Adolescent mental health was mentioned as a need among transgender and gender diverse youth.
- The following results from a survey of transgender youth were reported:
  - 88% report having their emotional state limit their activity
  - 85% report being anxious (all the time/frequently)
  - 67% report experiencing depression (all the time/frequently)
  - 14% have considered suicide (63% rarely or never think about suicide)

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Maternal Mental Health

☐ National Priority Area ☐ State Priority Area ☑ Emerging State Topic

Significance of the issue

Depression is the leading cause of disease-related disability in women, and the most common serious complication of childbirth. Maternal depression and anxiety affect a woman's ability to care for herself, relate to others, engage in healthy parenting behaviors, and bond with their newborn.

Children of depressed mothers are at risk for serious health, development, emotional, behavioral, and cognitive problems that can persist for many years. Maternal depression is highly treatable; however, many women are unaware that they have a treatable illness, or they fear being discriminated against, abandoned, isolated and blamed if they seek help.

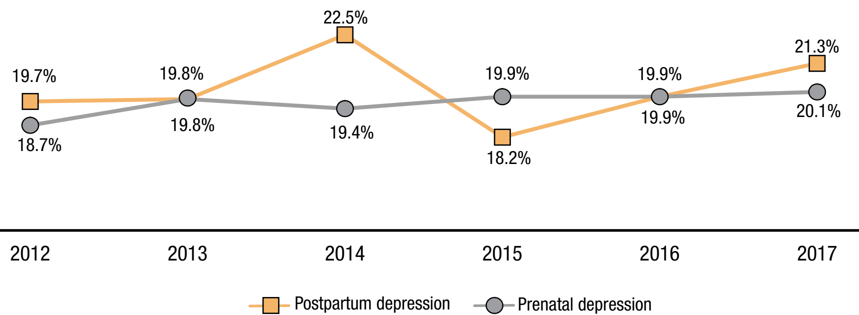
Structural inequities (including systemic discrimination and racism) exacerbate parental stress and maternal mental health problems, and contribute to disparities in incidence, screening, and access to treatment and support services.

Health Status Data

- Mothers who are young, single or have experienced traumatic or stressful situations such as intimate partner violence or homelessness are more likely to experience depression.[1]
- One study found that up to 51% of women who were socio-economically disadvantaged reported depressive symptoms during pregnancy.[1]

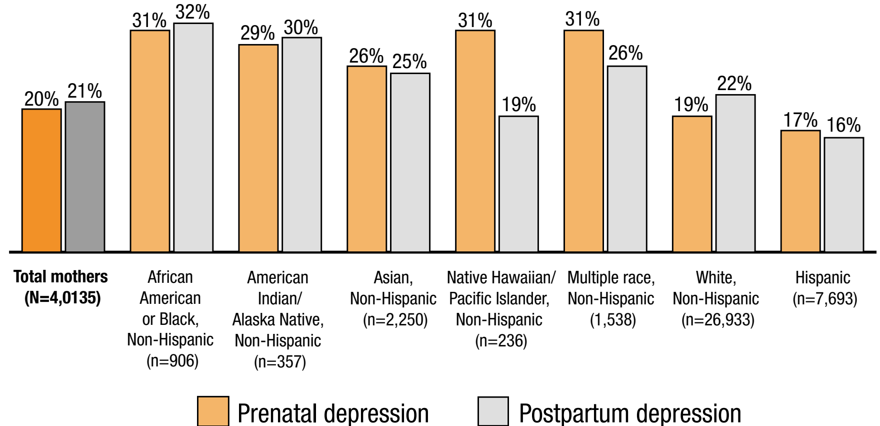
Health Status Data

Figure 1. Perinatal depression, Oregon, 2012-2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Figure 2. Perinatal depression, by race/ethnicity, Oregon, 2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Context for the issue in Oregon

State level Title V efforts

- Oregon's Title V program supports maternal mental health through development of policy; systems for screening, referral and treatment; and family and provider support and education.
- The Tile V program funds 211info to provide statewide information and referrals to anyone seeking support for maternal mental health or other maternal, child, and adolescent health (MCAH) concerns.

Partner alignment

- A variety of non-profit agencies including Postpartum Support International, Baby Blues Connection, Well Mama, and Compass Perinatal Peer Support provide information and services for families coping with perinatal depression and anxiety.
- Maternal mental health (and related issues of parental stress, trauma and adversity, and the impacts on children's health and development) have been priorities for Oregon's maternal and child health, early childhood education, health, and mental health sectors for many years. Alignment with these concerns is evidenced though:
  - » Investments to enhance mental and behavioral health through the Coordinated Care Organizations (CCOs) and the Oregon Health Authority (OHA) Health Systems Division.
  - » The State Health Improvement Plan focus on behavioral health, adversity and trauma, equitable access to preventive care, and social determinants of health.
  - » Governor Brown's Children's Agenda as well as The Early Learning Division's Raise up Oregon strategic plan.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, mental health was mentioned as a need in 90% (27 of 30) of county assessments and 36% (4 of 11) of special population assessments.

Partner survey

- In a statewide survey of partners, mental health was the second most selected state priority option of the nine provided in the survey (both current state priority areas and emerging needs were provided as options).
- Mental health was also mentioned by 10 partners as an emerging need.

Title V grantee meeting

- In a meeting of county and Tribal Title V grantees, mental health was mentioned by five grantees as an emerging need in the communities they serve.

Community voices

- Mental health was mentioned as a need among African American or Black, Latinx, and immigrant/refugee families.
- Maternal mental health was mentioned as a specific need among immigrant/refugee families.
- Latinx families mentioned that stress effects women in particular, including a cultural norm of living through depression; "Mothers care for their children, but not for themselves as much. So, they don't ask for help."

[1] Muzik M, Borovska S. Perinatal depression: implication for child mental health. Mental Health in Family Medicine 2010 [cited 2018 Jan 25].

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Oregon's 2020 Title V Maternal, Child, and Adolescent Health Needs Assessment

Emerging Issues

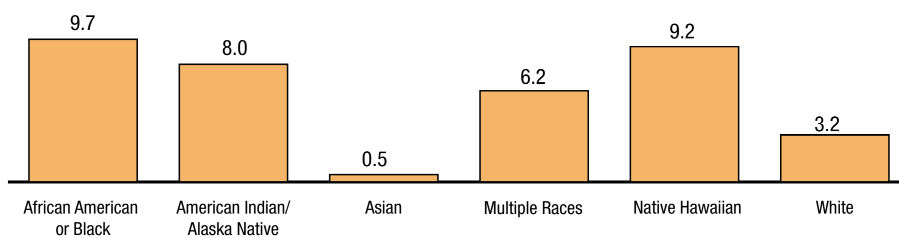
Social Determinants of Health and Equity

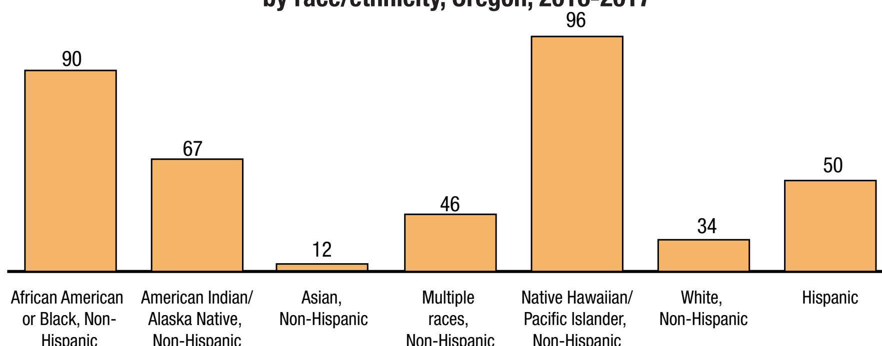
☐ National Priority Area ☐ State Priority Area ☑ Emerging State Topic

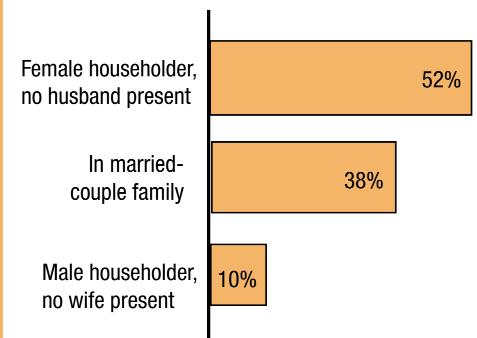
Significance of the issue

The social determinants of health (SDOH) refer to the social, economic, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities. The social determinants of equity refer to systemic or structural factors that shape the distribution of the SDOH in communities. Maternal, child, adolescent, and family health are determined in large part by these social determinants – including access to social and economic opportunities; resources and supports available in homes, neighborhoods and communities; quality of schooling; safety of workplaces; cleanliness of water, food, and air; and social interactions and relationships. Women and children are particularly vulnerable and over-represented among those impacted by poverty, homelessness, unhealthy housing, employment instability, family and community violence, and other social determinants. These factors amplify the impacts of adversity and inequity on women and children's health throughout the lifespan. Among SDOH, housing concerns consistently rank at or near the top of family and community concerns (including housing affordability and homelessness, health and safety of existing housing, and the neighborhood and physical environment). Recent studies show strong correlations between housing stability and child outcomes. Multiple aspects of housing quality and the social and physical environment of the home impact women and children's health. These include air quality, home safety, presence of mold, asbestos and lead. Poor-quality housing is associated with various negative health outcomes, including chronic disease and injury and poor mental health.[1]

Health status data







Health status data, continued

- In Oregon:[2]
  - » Almost two-thirds (64%) of children are living in low-income households (less than 200% of the FPL) where more than 30% of the monthly income is spent on rent, mortgage payments, taxes, insurance, and/or related expenses.
  - » Over one-fourth (27%) of children, under the age of 18, are living in families where no parent has regular, full-time employment.
  - » Almost one-third (30%) of female-headed families received child support during 2016-2018.
- Families who are homeless are more likely to be headed by young females while individuals who are homeless are more likely to be middle to late middle-aged men.[3]
- In 2017, Oregon had the second highest rate of homelessness among people in households with children in the United States.[4]
- According to the 2017 Point-in-Time Count, 25% (3,519) of the 13,953 Oregonians experiencing homelessness were families with children.[5]

Context for the issue in Oregon

State level efforts

- A focus on SDOH is increasingly recognized as essential to improving the health of families and communities, achieving successful health systems transformation, and improving health equity in Oregon.
- Social determinants of health and equity (SDOH-E) are a primary focus of Oregon's new State Health Improvement Plan priorities.

Partner alignment

- SDOH are a priority in Oregon's 2017-2022 Medicaid 115 Waiver.
- Addressing SDOH including housing, childcare, education, and parental job support, is a key priority of the Governor's Children's Agenda.
- Governor Brown identified the SDOH-E as one of the four priority areas of CCO 2.0. CCO 2.0 will require CCOs to: spend a portion of net income or reserves on SDOH-E; collaborate on shared community health assessments and community health improvement plan strategies and priorities; align with community-selected priorities as well as the State Health Improvement Plan; and to work on a statewide SDOH priority related to housing support.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, SDOH (including poverty, housing, employment, and transportation) were mentioned as a need in 83% (25 of 30) of county assessments and 82% (9 of 11) of special population assessments.

Partner survey

- In a statewide survey of partners, housing and poverty were the third and fourth most selected state priority options of the nine provided in the survey (both current state priority areas and emerging needs were provided as options).
- SDOH were also raised as emerging needs in this survey. Two partners raised the need for housing as an emerging need in the state, and two more partners listed employment as an emerging need.

Title V grantee meeting

- In a meeting of county and Tribal Title V grantees, housing was mentioned by three grantees as an emerging need in the communities they serve.

Community voices

- Housing was expressed as a need among African American or Black and rural families and among transgender youth.
- Poverty was raised as a concern by African American or Black, immigrant and refugee, and rural families,

and by transgender youth.

- Employment was expressed as a need among African American or Black, immigrant and refugee, and homeless families.
- Immigrant and refugee families specifically listed lack of employment and low wages as the issues that have the largest impact on the health of their communities.
- Homeless families reported experiencing discrimination while searching for stable housing, for example due to their appearance.

[1] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/quality-of-housing

[2] https://datacenter.kidscount.org/data/tables/10453-female-headed-families-receiving-child-support?loc=39&loct=2#detailed/2/39/false/1687/any/20156,20157

[3] https://www.hudexchange.info/onecpd/assets/File/2013-AHAR-Part-2.pdf

[4] https://oregonearlylearning.com/raise-up-oregon

[5] Ibid.

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Adult Alcohol Use

☐ National Priority Area ☐ State Priority Area ☑ Emerging State Topic

Health Status Data

- Alcohol use during pregnancy increases the risk of miscarriages, stillbirth and FASD. In 2009, annual health care expenses in Oregon associated with FASD were $82 million.[1]
- Age at first use of alcohol is highly correlated with subsequent alcohol dependence. The earlier a person begins using alcohol in their lives, the greater a chance that they will become alcohol-dependent during their lifetime.[2]
- Binge drinking (consumption of alcoholic drinks, 4+ drinks for females and 5+ drinks for males, in about two hours) is common among younger adults, 18 to 34 years old, who often fail to recognize their consumption as problematic.[3]
  - In 2016, more than one in five women, 18 to 24 years old, and more than one in six women, 25 to 34 years old, were binge drinkers.[4]
  - About 6.5% of Oregon women, 18 to 34 years old, were heavy drinkers (more than one drink per day every day).[3]
- In Oregon, an estimated 58% of women, 18 to 44 years old, report any alcohol use.[3]
- In Oregon 38.7% of new mothers reported drinking one or more alcoholic beverages per week in the three months prior to pregnancy.[5]
- Adverse childhood experiences (ACEs) are associated with heavy drinking and binge drinking in adults. In Oregon, adults with four or more ACEs are 1.7 times as likely to drink heavily, and 1.5 times as likely to binge drink.[6]

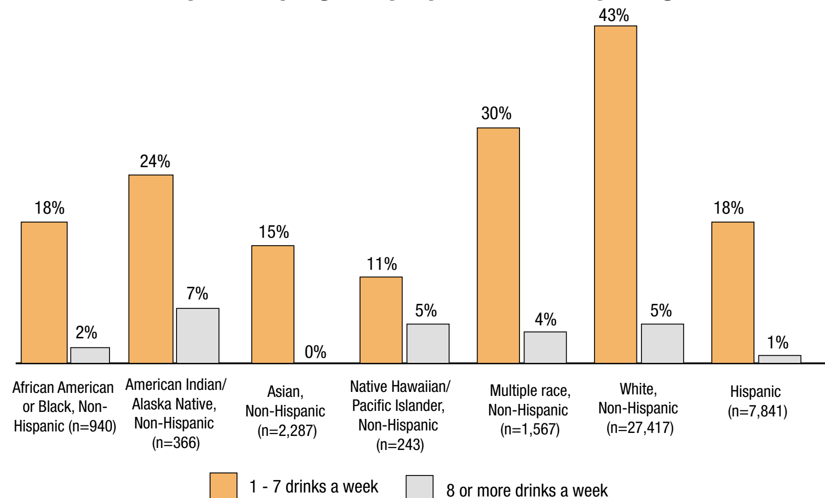
Significance of the issue

Excessive alcohol use has significant impacts on individual and family health and well-being. Problem drinking impacts broader social and economic issues such as public safety and ability to work. Alcohol use is a risk factor for injuries, violence, motor vehicle crashes, and unintended pregnancy. Excessive alcohol use at any age, can increase a person's risk of developing serious health problems such as brain and liver damage, heart disease, cancer, premature death, and fetal damage in pregnant women.

According to the Centers for Disease Control and Prevention (CDC) and the Journal of the American Medical Association (JAMA) Pediatrics no level of alcohol is safe to drink during pregnancy. Drinking alcohol can increase the risk of miscarriage, stillbirth, newborn death, and fetal alcohol spectrum disorder (FASD). Babies with FASD are more likely to experience low birth weight, heart defects, facial defects, learning problems and intellectual disability. It is important to note that alcohol misuse impacts not just the drinker but also those around them. Children affected by parental alcohol misuse are more likely to have physical, psychological, and behavioral problems. Parental alcohol misuse is strongly correlated with family conflict, intimate partner violence, and child abuse – posing both immediate risk and long-term negative consequences for children.

Health status data

Figure 1. Percent of women drinking once weekly or more during the 3 months prior to pregnancy, by race/ethnicity, Oregon, 2017



Source: Pregnancy Risk Assessment Monitoring System (PRAMS), 2017

Note: 3 months prior to pregnancy is considered a proxy for drinking during the first trimester of pregnancy.

Context for the issue in Oregon

- Several priorities of the Oregon Health Authority (OHA) Maternal and Child Health (MCH) Strategic Plan may address issues around alcohol and families including:
  - » Engage in cross-system coordination/integration at the state and local level to ensure quality screening, referral, and access to and utilization of preventive services for women, children and families.
  - » Promote programs that engage families and build parent capabilities, resilience, supportive/nurturing relationships–includes home visiting, parenting education, and culturally-specific evidence-based social support and mental health practices.
- Success in screening for alcohol use in pregnant women: Oregon PRAMS data show 97.4% of new mothers reported that a health care worker asked them about alcohol use during prenatal care.
- One of several CCO 2.0 behavioral health policies with potential to improve Children's Health is: "prioritize access to behavioral health services and early intervention for pregnant women, parents, families and young children to prevent poor long-term outcomes and reduce costs."
- Oregon's 2020 – 2024 State Health Improvement Plan has a priority related to behavioral health (including mental health and substance abuse) as well as one on adversity, trauma and toxic stress.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments, alcohol use was mentioned as a need in 60% (18 of 30) of county assessments and 36% (4 of 11) of special population assessments.

Partner survey

- In a statewide survey of partners, alcohol use was the least selected state priority option of the nine provided in the survey (both current state priority areas and emerging needs were provided as options).

Community voices

- The use of alcohol among adolescents was raised as a concern among immigrant and refugee families.

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[1] Oregon FAS Prevention Program, January 2, 2009.

[2] Liang, W., & Chikritzhs, T. (2013). Age at first use of alcohol and risk of heavy alcohol use: a population-based study. *BioMed research international*, 2013, 721761. doi:10.1155/2013/721761

[3] CDC Fact Sheet: Binge Drinking

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12/2019

Child Care

☐ National Priority Area ☐ State Priority Area ☑ Emerging State Topic

Significance of the issue

The first 2,000 days of a child's life are a critical window of both opportunity and vulnerability which sets a lifelong trajectory for health, growth, and brain development. Optimal nutrition, safe environments, and stable, responsive relationships with nurturing adult caregivers become the foundation for future learning, behavior, and health. A lack of nurturing relationships, nutrient deficiencies and adverse conditions can harm children's developing brains and limit their healthy development including their ability to establish critical attachments, communication, and self-regulation.

Families strive to meet their caregiving needs during the early childhood years in a variety of ways. These include parents providing care, licensed child care centers with professional staff serving many children, family-friend-and-neighbor (FFN) care, along with multiple alternatives in between. Many children spend a significant portion of their day in child care settings. Quality child care provides an opportunity for nutritious food, positive experiences, relationships, and interactions that can bolster child and family well-being. Unfortunately, too many families struggle to find high quality care that is affordable, culturally competent, meets their schedule needs, and is accessible – with potential long-term negative impacts. Parents' ability to work, their physical and mental health, family stability, and children's health and development, are all tied to having quality, affordable choices for infant care.

Health status data

- There is no state-supported child care system for young babies:
  - Children under 6 weeks old are not allowed in child care yet 25% of women must go back to work 2 weeks after delivering a baby.
  - In 2018, only 17% of US civilian workers had access to paid family leave; and women, people of color, single parents, and low-wage workers are far less likely to have access to it.[1]
- Oregon has an inadequate supply of child care. Statewide, only 12% of infants and toddlers, and 29% of preschool-age children have access to a regulated slot. Counties are considered child care deserts if fewer than 1/3 of the county's children have access to a regulated child care slot. Every county in Oregon is a child care desert for infants and toddlers, while only nine Oregon counties are not child care deserts for preschool-aged children.[2]
- Child care is expensive in Oregon. The annual cost of infant care in a center was $13,292, ranking Oregon as the third least affordable state for center-based infant care (2017). The annual cost of toddler care in a center was $12,442, ranking Oregon as the second least affordable state for center-based toddler care (2017).[3] These costs are more than the annual cost of in-state tuition at a public university (e.g., OSU $11,211 for 2018-19 school year).
- Child care is out of reach for low-wage workers. A minimum wage worker in Oregon pays 59.5% of their income on child care, whereas the federal definition of affordable child care states it should cost no more than 7% of a family's income.[4]
- Child care employs 14,000 Oregonians. They are a vulnerable resource that is predominantly white and female and often cannot afford care for their own children.[5]

- In 2018, the annual salary for child care workers in Oregon was $26,740.[6]
- In Oregon, annual turnover in the child care workforce is between 25-30%, harming quality. Staff turnover is primarily driven by low wages and the inability of providers to make ends meet.[7]

Context for the issue in Oregon

- Oregon recently released Raise Up Oregon, a statewide early learning system plan that engages with other agencies and partners towards better outcomes for Oregon's children (2019-2023).
- The Oregon Legislature passed a Paid Family Leave bill, House Bill 2005 (2019), that will provide up to 12 weeks of paid leave to eligible employees beginning in 2023.
- The Maternal and Child Health (MCH) Section partners with the Early Learning Division around topics related to health and safety in child care such as: safe sleep, lead prevention, nutrition and physical activity, and emergency preparedness.
- In Oregon, 211info serves as both the warm line for MCH information and referral, and as the child care referral resource for families.
- Oregon recently passed the Student Success Act, House Bill 3427 (2019), which includes funding to increase capacity of the early learning system.
- The Oregon Health Authority (OHA) and MCH leadership participate on the Early Learning Council, guiding the future of the early learning system.
- Oregon's 2020-2024 State Health Improvement Plan (SHIP) priorities include "economic drivers of health," of which child care is a critical factor. Stressors related to child care are also closely tied to the SHIP priorities of adversity, trauma, toxic stress, and behavioral health.
- Oregon's Social Determinants of Health Collaborative Improvement & Innovation Network (CoIIN), *Oregon Infant Care: Parent Voices for Change,* has focused on engaging parents to tell how challenges with finding quality and accessible infant care impacted the health of their children and families.
- In September 2019, the Northwest Health Foundation and other Health & Education Fund Partners granted $1 million to a coalition of six community agencies to seed a community-led campaign to build a new child care system in Oregon.

Needs assessment results

Environmental scan

- 17% (5 of 30) of county assessments and 13% (1 of 11) of special special population assessments.

Partner survey

- In a statewide survey of partners, child care tied for second most often mentioned among 17 emerging needs. One partner stated "Child care, especially for infants and toddlers under three, is almost impossible to find and pay for. The quality of child care and the amount of transitions affects development the most during those ages, yet good affordable and reliable child care is hardest to find at those ages."

Title V grantee meeting

- In a meeting of county and Tribal Title V grantees, child care was mentioned by two grantees as an emerging need in the communities they serve.

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[1] Access to paid and unpaid family leave in 2018

[2] Oregon's Child Care Deserts, Mapping Supply by Age Group, Metropolitan Status, and Percentage of Publicly Funded Slots

[3] The US and the High Cost of Child Care: A Review of Prices and Proposed Solutions for a Broken System, 2018.

[4] The Cost of Child Care in Oregon

[5] Oregon's Care Economy, the Case for Public Care Investment

[6] Oregon's unmet child care needs, it's time to invest: our future depends on it

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Oregon's 2020 Title V Maternal, Child, and Adolescent Health Needs Assessment

Emerging Issues

Social Connectedness

☐ National Priority Area ☐ State Priority Area ✓ Emerging State Topic

Significance of the issue

Social connectedness can include both individual social connection (the subjective experience of feeling close to and a sense of belonging with others)[1] and community social cohesion (the strength of relationships and sense of solidarity among members of a community).[2] Social connection improves physical, mental and emotional health, and decreases mortality and morbidity.[3] One landmark study showed that lack of social connection may be a greater detriment to health than obesity, smoking and high blood pressure. Strong social connection leads to increased longevity, strengthened immune function, and lower levels of depression and anxiety.[4] Parent-child bonding and social support for parents have long-term positive effects on both maternal and child outcomes; and connections to school and to supportive adults are tied to positive youth outcomes including school attendance and academic achievement.

Social connectedness is known to be protective against the emotional and health effects that individuals and communities experience as a result of violence, isolation, marginalization, and trauma. High social connectedness can protect against the negative impact of family violence that encompasses a continuum of violence and abuse including child abuse, sexual assault, reproductive coercion, stalking, sexual harassment, and elder abuse. At the community level, solid community ties – including trust in institutions and within neighborhoods – are associated with economic growth, higher academic achievement, and lower crime rates.

Fostering resilient, connected, and thriving communities can support healing from community trauma while contributing to greater community resilience. A systems level approach to thriving and connected communities promotes equitable opportunity, social networks, community norms and culture, safe parks and neighborhoods, opportunities for cultural expression, and quality housing.[5]

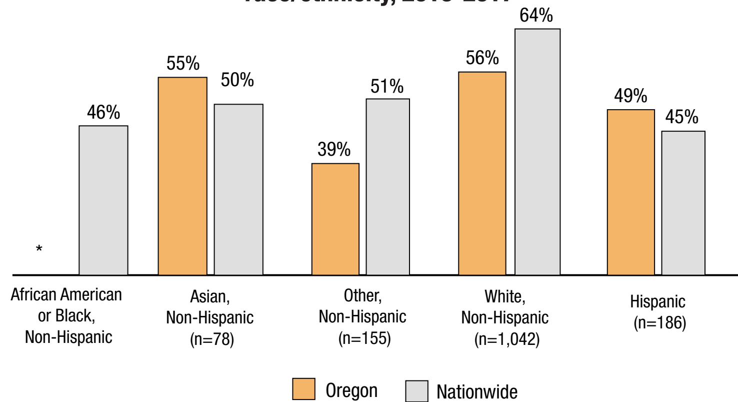
Many disciplines (including public health, psychology, violence prevention, education, early childhood development, and climate health) recognize social connectedness as protective across all stages of the life cycle and have developed interventions to strengthen social connectedness at the individual, relationship, and community levels. The cross-cutting nature of social connectedness as a protective factor makes it particularly powerful, both for its potential to improve the lives of women, children, youth, and families in Oregon and as a topic for collaboration and collective impact with multiple maternal child and adolescent health (MCAH) partners statewide.

Health status data

- More than a fifth of adults in the Unites States (22%) say they often or always feel "lonely, that they lack companionship, feel left out, or are isolated from others" – frequently with physical, mental, and financial consequences.[6]
- Neighborhoods where there is low social cohesion or where residents don't support or trust each other are more likely to have residents that also experience child maltreatment, intimate partner violence, and youth violence.[7]
- Research indicates that the number one protective factor in helping children heal from the experience of exposure to family violence is the presence of a consistent, supportive, and loving adult.[8]

- Among people with four or more adverse childhood experiences (ACEs), positive childhood experiences (Counter-ACES) – including having good friends and neighbors, liking school, teachers who care, and having a caregiver whom you feel safe – lessened the negative effect of ACEs on adult health.[9]
- Youth who report having a caring adult at school are less likely to be chronically absent or to miss school because they felt unsafe than youth who do not.[10]

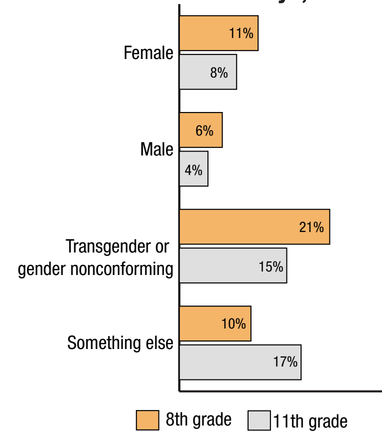
Figure 1. Percent of children who live in neighborhoods that are supportive, by race/ethnicity, 2016-2017



Source: National Survey of Children's Health, 2016-2017.

**Sample sizes included for Oregon, however no data for African American or Black, Non-Hispanic in Oregon*

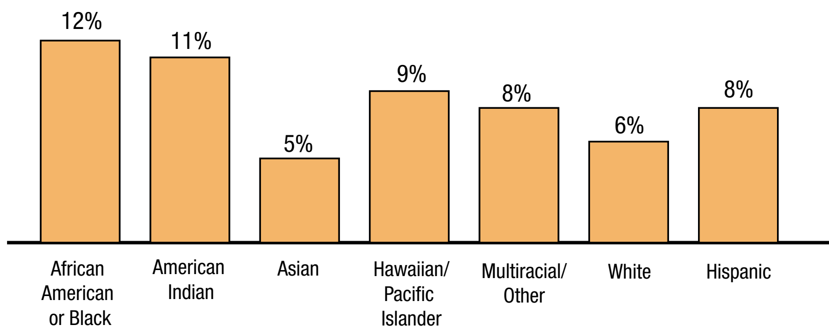
Figure 2. Missed school because felt unsafe in last 30 days, 2017



Source: 2017 Oregon Healthy Teens Survey.

Note: "Transgender or gender..." includes those who identified as transgender, gender fluid, genderqueer, gender non–conforming, intersex/intergender, multiple responses, and "not sure of gender."

Figure 3. Missed school because felt unsafe in last 30 days (11th Grade), by race/ethnicity, Oregon, 2017



Source: 2017 Oregon Healthy Teens Survey

Context for the issue in Oregon

Oregon's work to promote social connectedness spans a wide range of partners and agencies both within and outside public health. Much of the work in MCAH has focused on violence prevention and promoting safe, nurturing, and healthy relationships through the Rape Prevention and Education (RPE) grant, adolescent health programs that promote healthy sexuality education, and home visiting programs that provide parenting support and education. In addition, the Oregon Sexual Assault Task Force has directed a review of healthy relationships curricula since 2015, and the Campus Prevention Work Group produced the Campus Climate Survey Toolkit in 2017.

Opportunities to address these issues include:

- Additional funding and support from the Centers for Disease Control and Prevention (CDC) to implement the STOP SV: A Technical Package to Prevent Sexual Violence at the community level (2019-2024).
- Legislation and guidance that support sexual violence prevention in K-12 schools, including: Comprehensive Sexuality Education (2009), The Healthy Teen Relationships Act (2013), and Erin's Law: Child Sex Abuse Prevention (2015).[11]

- An interactive mapping tool so communities can see the risk and protective factors for sexual and intimate partner violence and healthy sexuality education resources that exist in their communities.
- In 2020, the Oregon Climate Health program will be funding mini-grants to Oregon communities focused on building community social cohesion.

Partner alignment

- Promoting social connectedness and supporting safe, nurturing relationships and environments aligns with the work of other state agencies including the Oregon Department of Justice, Education, Human Services, and departments across the Oregon Health Authority. A goal of the new Raise Up Oregon Early Learning System Plan is that "all families with infants have opportunities for connection." Social connectedness aligns with the work of other Oregon Public Health Division programs including Injury, Climate Health, and Women's and Reproductive Health. The topic also aligns with the MCH Strategic Plan and State Health Improvement Plan's (SHIP) focus on social determinants of health, trauma and resilience, and equity. Other important statewide partners with shared commitment to this work include the Oregon Sexual Assault Task Force, the Oregon Coalition Against Domestic and Sexual Violence, business, college campuses, and policy makers.

Needs assessment results

Environmental scan

- In an environmental scan of community health needs assessments social connection was mentioned as a need in 37% (11 of 30) of county assessments and 36% (4 of 11) of special population assessments.
- In an environmental scan of community health needs assessments violence and crime were mentioned as a need in 30% (9 of 30) of county assessments and 18% (2 of 11) of special population assessments.

Partner survey

- In a statewide survey of partners, social connection was mentioned as an emerging need by 3 partners.

Title V grantee meeting

- In a meeting of county and Tribal Title V grantees, social connection and violence were mentioned by one grantee each, as an emerging need in the communities they serve.

Community voices

- Social connection was mentioned as a need among rural and immigrant and refugee families, as well as by transgender youth.
- Transgender youth also raised the experience of violence as a pressing issue in their community, with 32% of survey respondents answering that what they feared most were death, being murdered, and public physical violence.

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[3] Advancing Social Connection as a Public Health Priority in the United States. American Psychologist ©2017 American Psychological Association 2017, Vol. 72, No. 6, 517–530

[4] Connectedness & Health: The Science of Social Connection

[5] Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma

[6] Loneliness and Social Isolation in the United States, the United Kingdom, and Japan: An International Survey

[7] Connecting the Dots: An overview of the Links among Multiple Forms of Violence.

[8] Promoting Resiliency Infographic, Futures Without Violence

[9] ACEs and counter-ACEs: How positive and negative childhood experiences influence adult health. Child Abuse & Neglect, Volume 96, October 2019, 104089

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