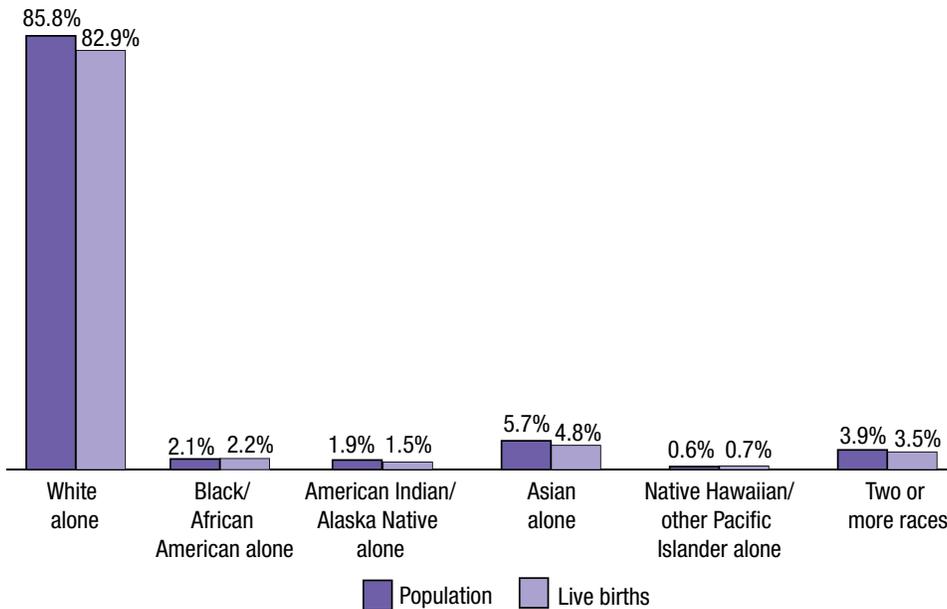
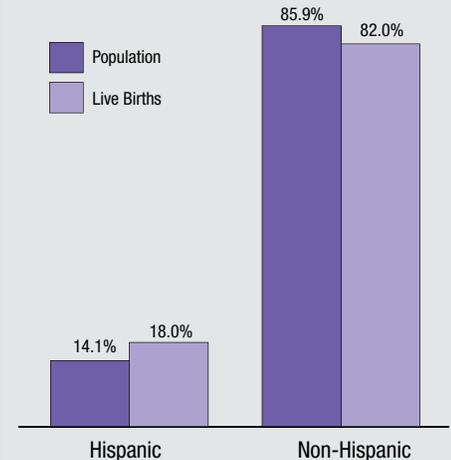


**Races of Oregon Women 18-44**



Source: American Fact Finder, United States Census Bureau

**Ethnicities of Oregon women 18-44**



**Key background & issues of concern for this population**

**Healthy weight:** In 2011, 46.3% of Oregon women were overweight or obese just before getting pregnant.

**Nutrition and food insecurity:** Periods of low or very low food security are usually recurrent and episodic rather than chronic. Nonetheless, nutritional risk due to poor dietary quality can persist across periods of food insecurity, and may increase the risk of nutritional deficiencies and diet sensitive conditions. At least one-quarter of Oregon women of reproductive age are food insecure.

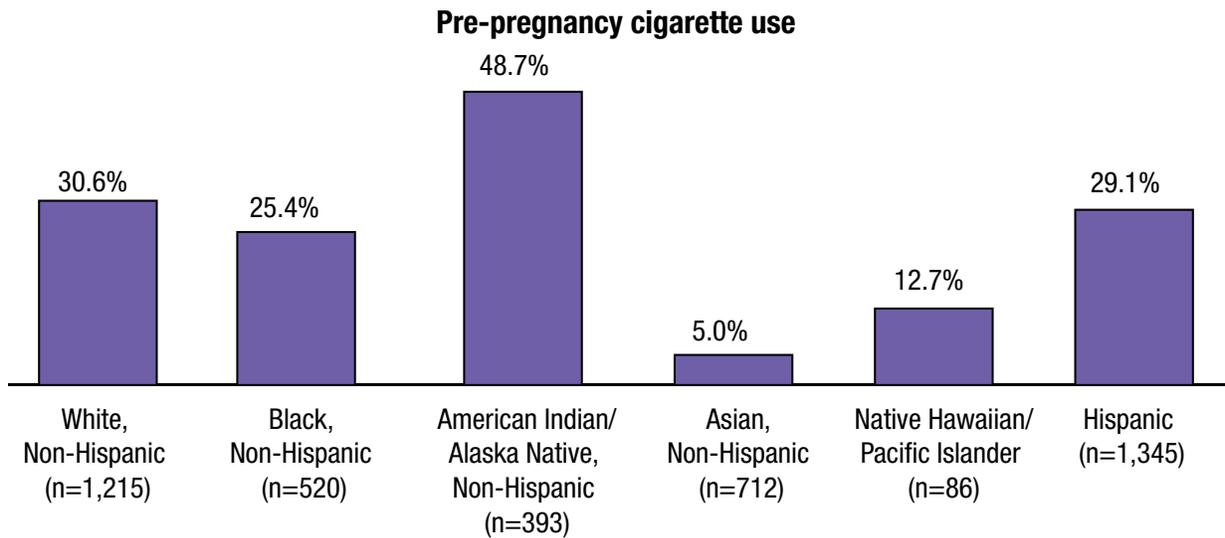
**Stress and depression:** In 2011, 28.4% of pregnant women in Oregon reported depressive symptoms. Stress is significantly associated with self-reported depression. Common stressors among pregnant women in Oregon (2011) were: moving to a new address (37.4%), problems paying bills (26.1%), arguing with spouse or partner more than usual (22%), and having a close family member who was very sick (21.6%).

**Tobacco use:** Prenatal cigarette smoking is the greatest known risk factor for low birthweight births. In 2011, 25.2% of Oregon's women reported smoking cigarettes in the 3 months before getting pregnant.

**Intimate partner violence:** In 2010, 35.6% of adult women aged 18 years and older reported having experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.

## Health Status Data

- The US Census Bureau estimated the population of women ages 18-44 in Oregon in 2013 to be 698,813.
- 45,136 births in Oregon in 2013, 18,184 (40.3%) of which were first births.
- 5.8% teen births (10-19 years of age)
- 15% of female Oregon residents age 17-44 receive Medicaid benefits
- Mean household income: \$50,251 Median household income: \$67,500
- 14.9 % of women age 18-44 live in poverty. 25% have no health insurance.



*Source: Oregon Health Authority, Center for Health Statistics*

### Proposed National Priority Areas (2017-2021)

- Well woman care
- Low-risk cesarean deliveries

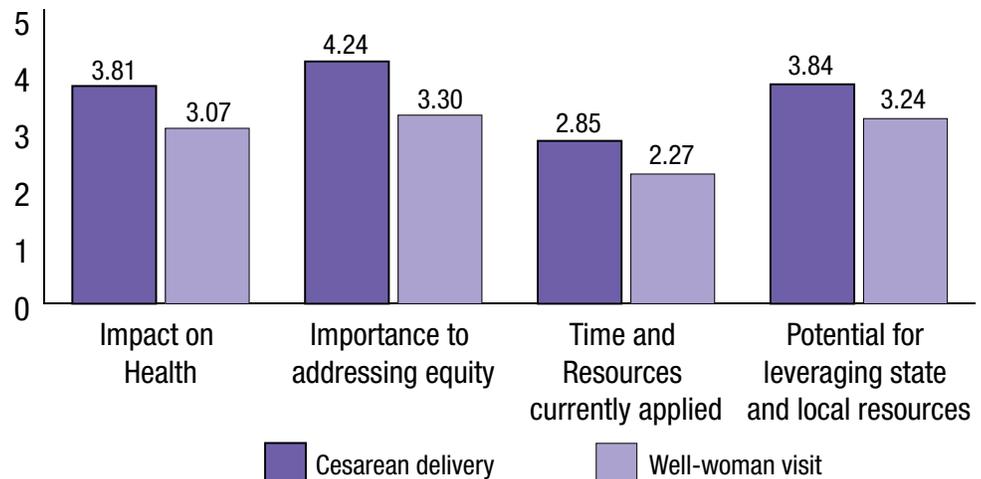
### Current State Priority Areas (2011-2016)

- Maternal mental health

## Partner Survey:

### Women's/Maternal Health

Providers and agencies that serve women, infants, children, adolescents and children/youth with special health needs were asked about maternal and child health priority areas. Each topic was rated in on 4 scales. The results for the two proposed national maternal and women's health priority areas are shown to the right.



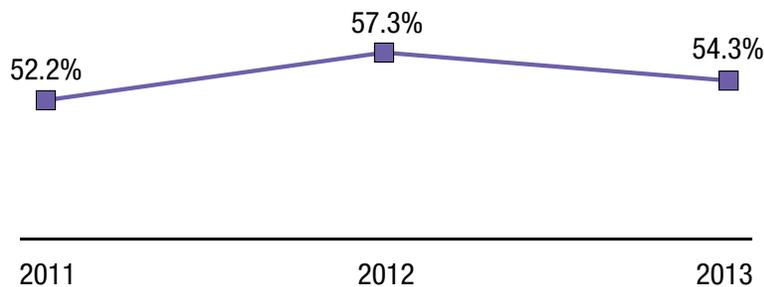
**Population Domain: Maternal and Women's Health**  
**Priority Area: Well Woman Care**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**National performance measure:**

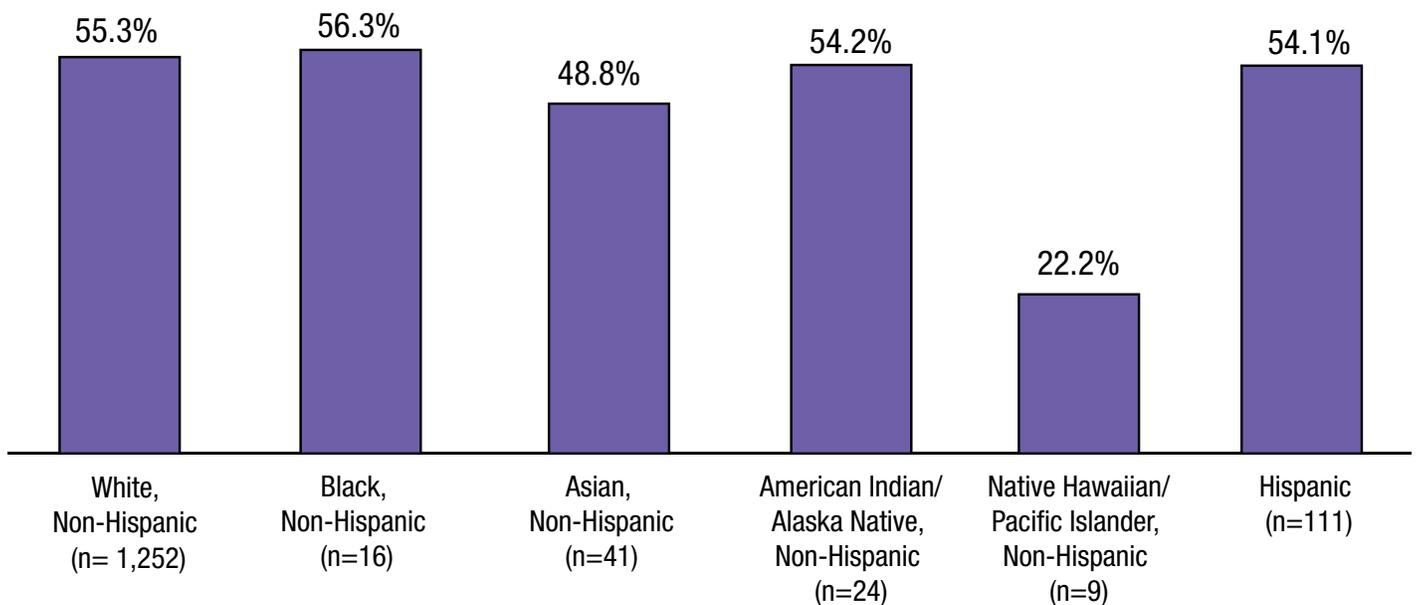
Percentage of women with a past year preventive visit

**Percent of women ages 18-44 who had a routine checkup within the past year, Oregon, 2011 - 2013**



*Data source: Behavioral Risk Factor Surveillance System*  
*Note: Trend data over time is not available at the national level*

**Percent of women ages 18-44 who had a routine checkup within the past year, by race/ethnicity, Oregon, 2011**



*Source: Behavioral Risk Factor Surveillance System*

## 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 appropriate 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, counseling to achieve a healthy weight, and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.

## Context for the issue in Oregon

A well woman care visit is supported in Oregon and nationally as a chance to screen for diseases and risk factors, and promote health before and between pregnancies. Access and insurance coverage have been barriers. With the Affordable Care Act, Oregon's health care transformation, and the well woman care visit coverage requirement, new opportunities to promote the well woman care visit exist. It is becoming increasingly important with the reduction in annual reproductive health visits due to an increase in Long Acting Reversible Contraceptives (LARC) in Oregon.

The Public Health Division's Maternal and Child Health and Reproductive Health Sections are working on providing guidelines for preconception health visits for the Coordinated Care Organizations (CCOs) as part of the Oregon Reproductive Health Advisory Council (ORHAC), an organization formed in 2014 to prepare guidance and standards for providers and CCOs on services provided in preconception care visits and reproductive health visits for women. Preconception care visits are now covered under the well woman care (WWC) visit. This priority area could be addressed by increasing the percentage of women with health insurance who access a WWC visit. Options for this include:

- Exploring strategies of promoting WWC exam services for women who do not have health insurance.
- Increasing the percentage of women of reproductive age who have health insurance.

CCOs in Oregon now have a new incentive measure: "Effective use of contraceptives for women at risk of an unintended pregnancy". This new measure may be another opportunity to provide guidance to CCOs around WCC visit.

## Stakeholder input

- Well woman care ranked eleventh out of fifteen national priority areas (in terms of the number of times it was referenced) in the statewide scan of community health assessments, the highest of the two priority areas in this domain.
- Well woman care has the highest level of disparities of the two priority areas in this domain.
- Well woman care has both the largest percentage at risk in Oregon and the largest percentage at risk above the US percentage of the two priority areas in this domain.
- In a survey of partners and providers, well woman care had an average rating in terms of impact on health, importance for addressing equity, current time and resources applied to the issue, and potential for leveraging state resources.

## Alignment with partners

This measure is aligned with the Collaborative Improvement & Innovation Network (CollIN) to Reduce Infant Mortality. It is also aligned with the CCO Incentive measure for 2015: "Effective contraceptive use among women at risk of unintended pregnancy"

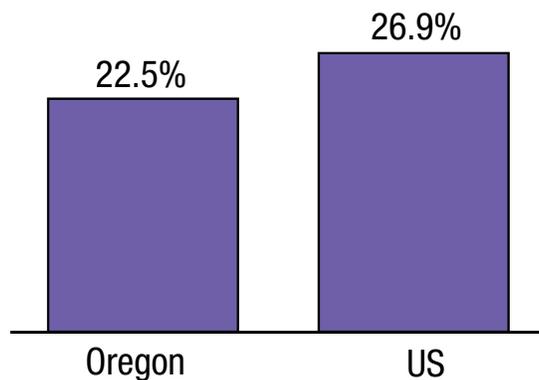
**Population Domain: Maternal and Women's Health**  
**Priority Area: Low Risk Cesarean Deliveries**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

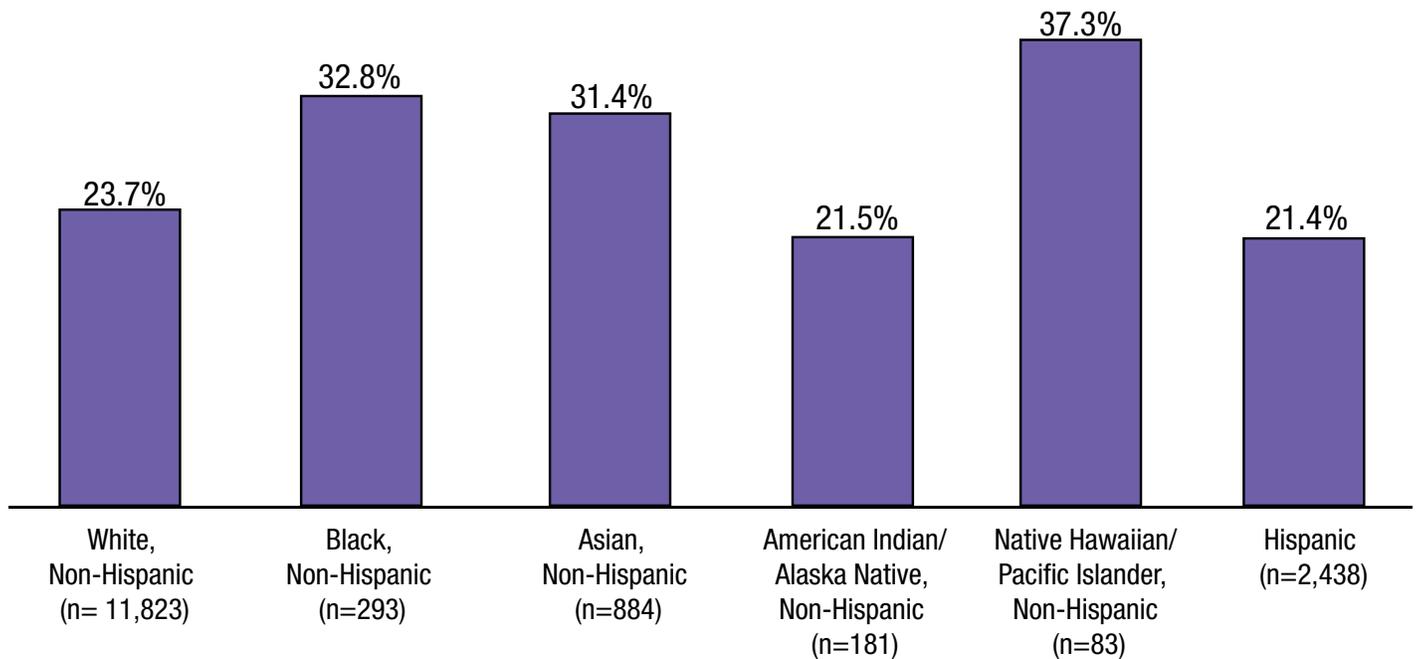
**National performance measure:**

Percentage of cesarean deliveries among low-risk first births

**Percent of low-risk Cesarean deliveries, 2013**



**Percent of low-risk Cesarean deliveries, by race/ethnicity, Oregon, 2013**



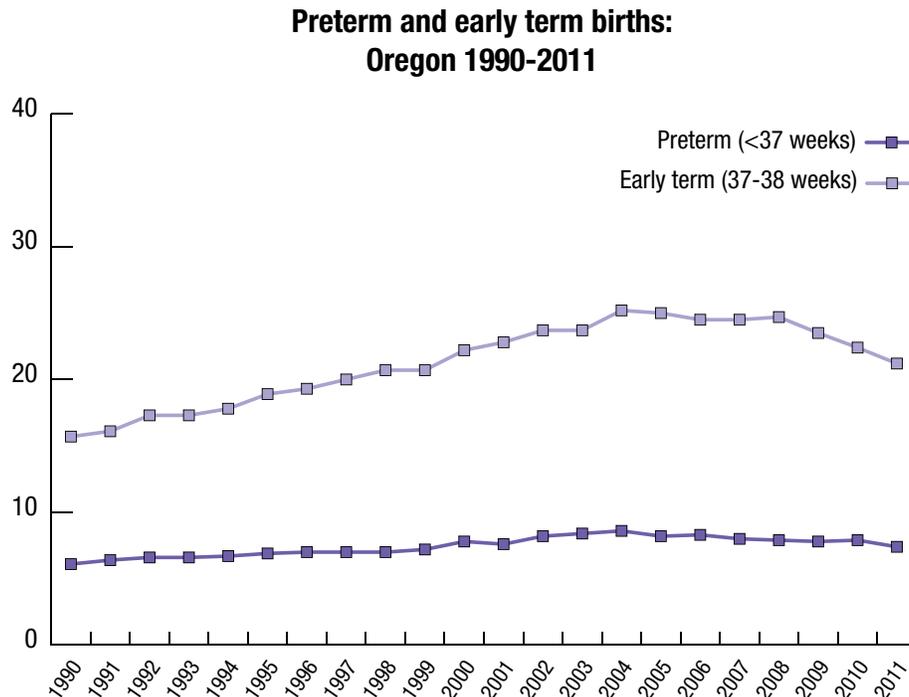
Source: OHA Center for Health Statistics

*Low risk is defined as 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.*

## 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.

## Health status data



## Context for the issue in Oregon

The preterm birth rate in Oregon has fallen from 8.6% in 2004 to 7.4% in 2011 (See Figure 1). The early term births increased from 15.7% in 1990 to 25.2% in 2004 but have been on the decline since (21.2% in 2011) (see Figure 1). The upward trend from 1990-2006 was associated, in part, with more frequent use of obstetrical intervention (induction of labor and cesarean delivery). The recent decline in early term births may be associated with efforts to reduce scheduled, non-medically indicated inductions and cesareans (early elective deliveries).

Many Oregon hospitals have started to implement practices and quality improvement efforts aimed at reducing cesarean rates. Oregon's success in decreasing early elective deliveries through a "hard stop" campaign led by the Oregon Perinatal Collaborative offers a model for a reduction in cesarean deliveries among low-risk women.

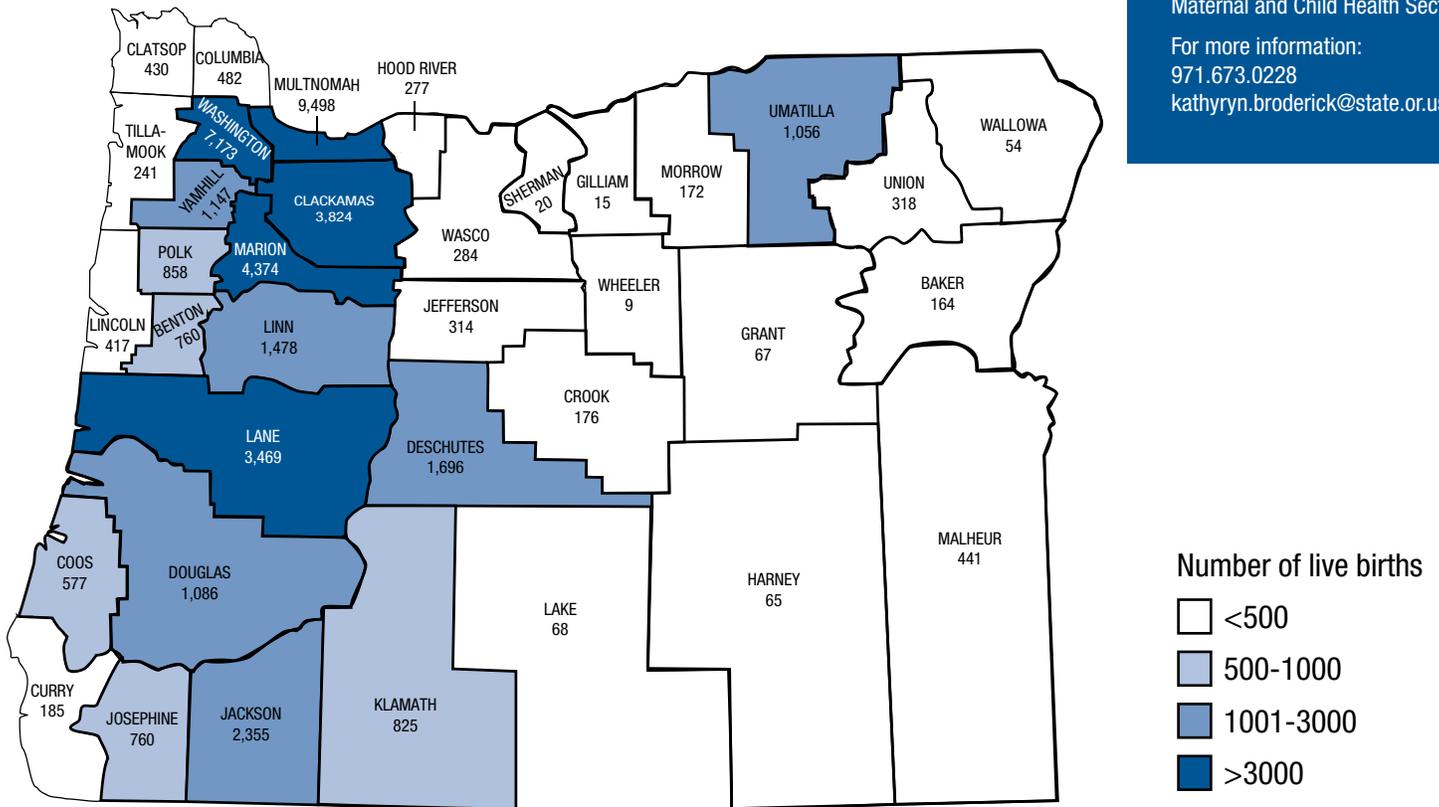
## Stakeholder input

- Low-risk cesarean deliveries ranked fourteenth out of fifteen national priority areas (in terms of the number of times it was referenced) in the statewide scan of community health assessments.

## Alignment with partners

This low-risk cesarean measure, also known as nulliparous term singleton vertex (NTSV) cesarean, is endorsed by the American College of Obstetricians and Gynecologists (ACOG), the Joint Commission (PC-02), National Quality Forum (#0471), Center for Medicaid and Medicare Services (CMS) – CHIPRA Child Core Set of Maternity Measures, and the American Medical Association-Physician Consortium for Patient Improvement.

# Population/Domain Overview: Perinatal/Infant Health



In 2011, there were 45,136 live births in Oregon.  
Three-fourths of all live births occurred along the I-5 corridor.

## Key background & issues of concern for this population

**Insurance coverage.** Women who have no insurance coverage often experience delays in accessing prenatal care.

**Cigarette smoking** is the greatest known risk factor for low birth weight births and is associated with infant mortality, preterm delivery, miscarriages, and newborn respiratory problems.

**Depression,** anxiety, stress, and other psychosocial factors affect the health of women and their pregnancy outcomes. Depression is widespread, particularly among low-income women.

**Oral health** is key to overall health and well-being. Many Oregon women face barriers to receiving oral health care during pregnancy.

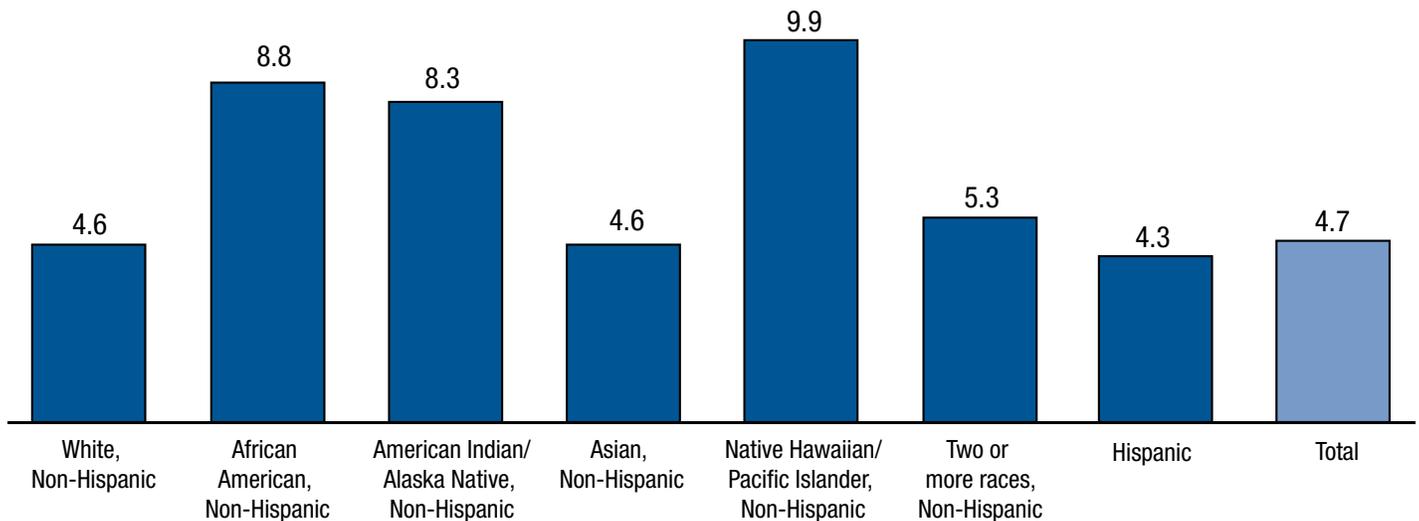
**Gestational diabetes.** Each year in Oregon, approximately 7% of births are to women who have gestational diabetes. The consequences of gestational diabetes are immediate and long-term for both the mother and the child.

**Pre-pregnancy overweight or obesity** and **excessive weight gain during pregnancy** are often accompanied by chronic disease, and present health risks for the mother and child. In 2011, 46.3% of Oregon women were overweight or obese just before getting pregnant.

## Health status data

Preterm-related mortality is the leading cause of infant death followed by congenital anomalies, other perinatal conditions and Sudden Unexplained Infant Death (SUID).

Infant mortality rate; 2009 - 2011 birth cohort (per 1,000 births)



Source: Oregon Health Authority, Center for Health Statistics

### Proposed National Priority Areas (2016-2021)

- Perinatal regionalization
- Breastfeeding
- Safe sleep

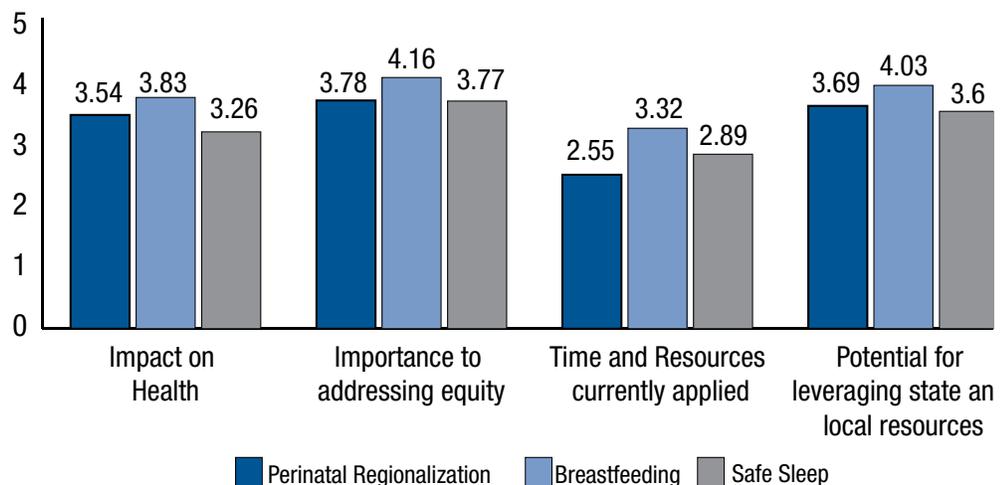
### Existing State Priority Areas (2011-2016)

- Alcohol and drug use prevention
- Resources for parent education and skills

## Partner Survey:

### Perinatal/Infant Health

In a survey, service providers that serve women, pregnant women, mothers, infants, adolescents and children and agencies that receive Title V funds were asked to rate 29 areas in terms of their impact on health, the time and resources currently applied, importance to addressing equity and potential for leveraging state resources on a scale of 0 to 5. The results for the two national perinatal/ infant health priority areas are shown to the right.



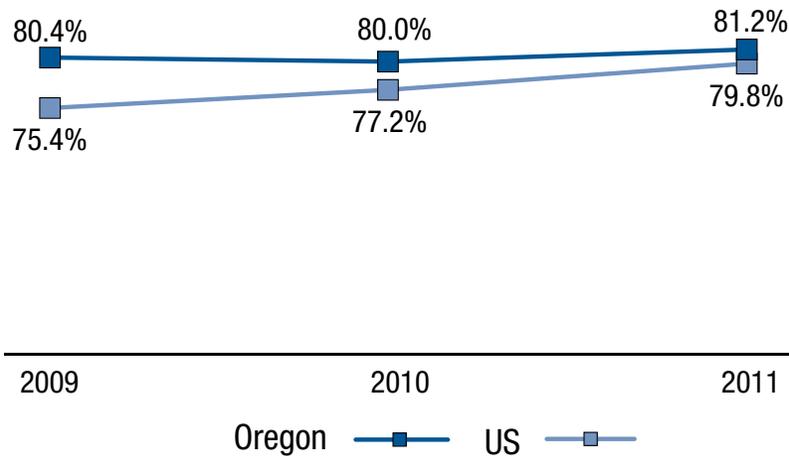
**Population Domain: Perinatal/infant Health**  
**Priority Area: Safe Sleep**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**National performance measure:**

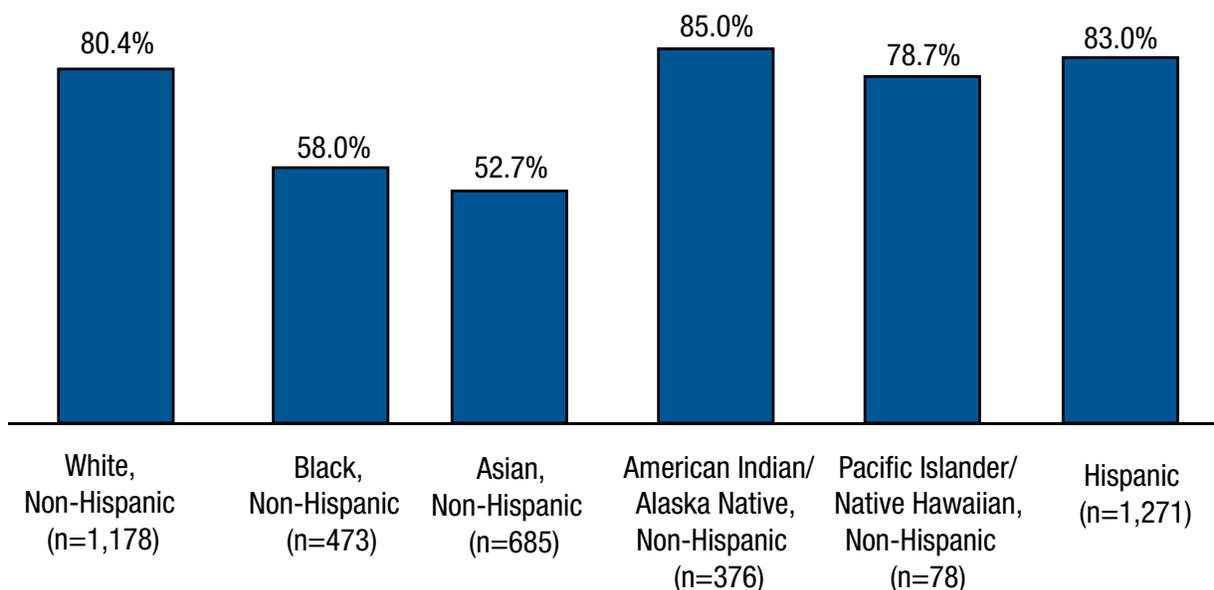
Percentage of infants placed to sleep on their backs

**Percent of mothers who most often place their baby to sleep on their back, 2009 - 2011**



Source: Pregnancy Risk Assessment Monitoring System

**Percent of mothers who most often place their baby to sleep on their back, by race/ethnicity, Oregon 2009 - 2011**

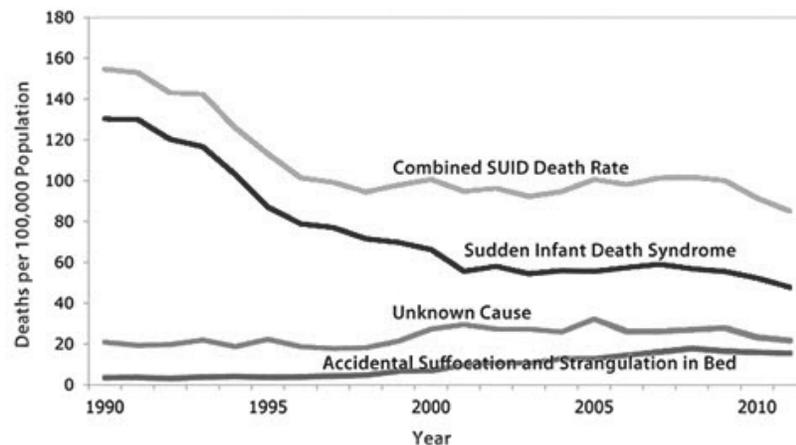


Source: Pregnancy Risk Assessment Monitoring System

## Significance of the issue

Sleep-related infant deaths, 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. The most frequently reported causes of SUID include: Sudden Infant Death Syndrome (SIDS), Accidental Suffocation and Strangulation in Bed (ASSB) and unknown cause. 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 and rates of SIDS have declined considerably. Accidental suffocation and strangulation in bed (ASSB) mortality rates remained unchanged until the late 1990s. Rates started to increase beginning in 1998 and reached the highest rate at 17.8 deaths per 100,000 live births in 2008.

Trends in Sudden Unexpected Infant Death Rates by Cause, 1990-2011



*National Vital Statistics System, Compressed Mortality File.*

## Context for the issue in Oregon

In 2011, the AAP expanded its guidelines with additional information for parents on creating a safe environment for their babies to sleep. Oregon's Public Health Division partners with child fatality review teams, home visiting programs, WIC, hospitals, primary care, early care and education to provide consistent, clear, evidence-based safe sleep messages that can reduce the risk of all sleep-related infant deaths. We know that quitting smoking and breastfeeding reduce the risk of SIDS. Parents are also advised to sleep in the room where the baby sleeps, remove soft fluffy bedding, stuffed toys and bumper pads from sleep areas and avoid placing babies to sleep on soft things like couches, upholstered chairs and waterbeds. Oregon Public Health provides a Safe Sleep brochure and information on safe sleep in the Prenatal and Newborn Resource Guide.

## Stakeholder Input:

- Safe sleep ranked tenth out of fifteen national priority areas (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- In a survey of partners and providers, safe sleep was rated lower than average in terms of its impact on health, importance to addressing equity and potential for leveraging state resources.

## Alignment with partners

This measure is aligned with the Collaborative Improvement & Innovation Network (CollIN) to Reduce Infant Mortality.

# Population Domain: Perinatal/infant Health

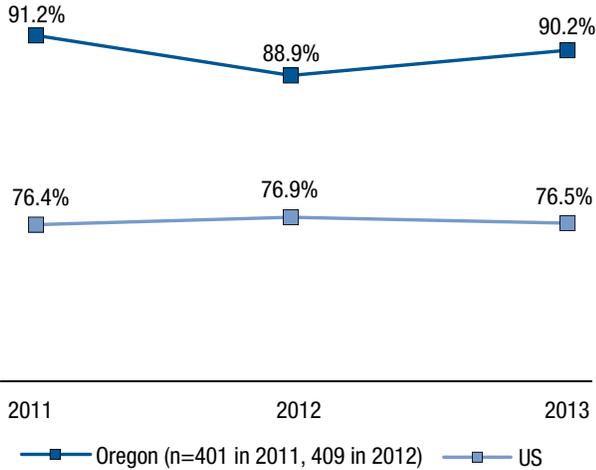
## Priority Area: Breastfeeding

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**National performance measure:**

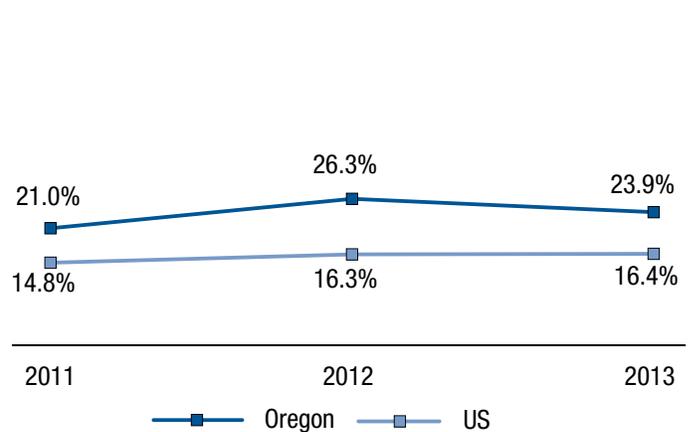
A) Percentage of infants who are ever breastfed, and B) percentage of infants breastfed exclusively through 6 months.

**Percent of infants ever breastfed, 2011-2013**



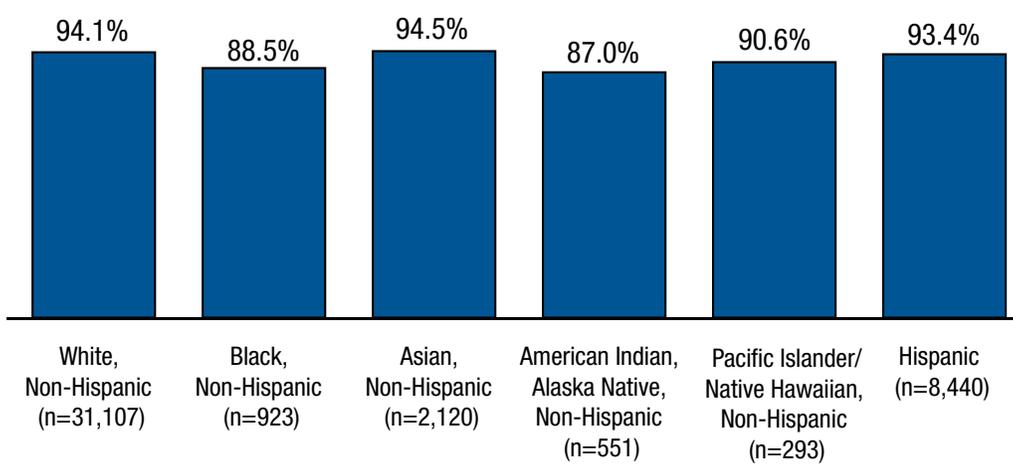
Source: National Immunization Survey

**Percent of infants breastfed exclusively at 6 months, 2011-2013**



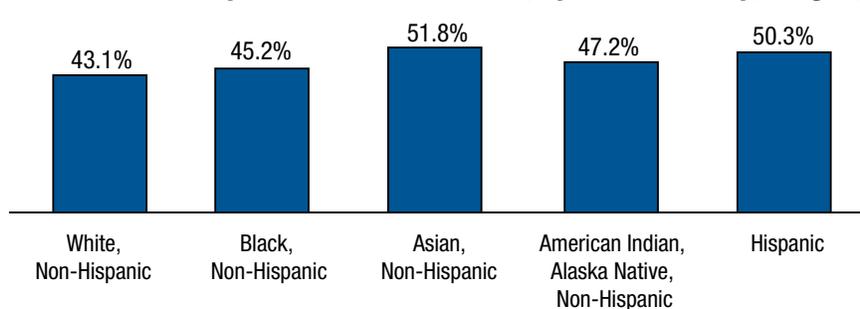
Source: National Immunization Survey

**Percent of infants ever breastfed, by race/ethnicity, Oregon, 2013**



Source: OHA Center for Health Statistics

**Percent of infants exclusively breastfed at 6 months, by race/ethnicity, Oregon, 2009 births**



Source: Pregnancy Risk Assessment Monitoring System-2

## Significance of the issue

The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Children who are not breastfed or fed human milk have an increased risk for a number of health conditions including infections, allergies, asthma, diabetes, sudden infant death syndrome (SIDS), childhood cancers and childhood obesity. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and postnatal depression. Increased release of oxytocin while breastfeeding leads to a reduction in postpartum hemorrhage and quicker return to a normal sized uterus over time. Mothers who do not breastfeed have higher rates of breast, uterine and ovarian cancer, diabetes, heart disease and osteoporosis.

## Context for the issue in Oregon

Oregon has many supports in place to encourage women to initiate and continue breastfeeding, however sustaining breastfeeding remains the primary challenge in Oregon. Also, there is great variability of breastfeeding among different groups by race and ethnicity. Oregon had a workplace lactation accommodation law preceding the federal Affordable Care Act. Almost all Oregon women have legal protection for lactation accommodation at work, however many women are unable to access its benefits due to lack of awareness and employer non-compliance. Recent data indicate that less than 50% of employers are complying with the law. Low income women in Oregon (WIC data) initiate and sustain breastfeeding at a rate comparable to more affluent Oregon women, whereas in most states there is a wide gap between these two groups.

Oregon has among the highest breastfeeding rates in the US; most Oregon mothers initiate breastfeeding. Since data has been collected by CDC NIS (2000), Oregon has met all HP 2010 / 2020 breastfeeding objectives with the exception of 6 months exclusive breastfeeding (2011 and 2013), and 6 months any breastfeeding (2002). Overall trends for any breastfeeding at all time periods appear to be slowly increasing; exclusive breastfeeding, especially at 6 months, appears to remain stagnant over time, indicating that there are many barriers that prevent women from continuing to breastfeed.

- WIC provides breastfeeding support both prenatally and postpartum at all 34 local agencies, including staff training, breastfeeding education and provision of breast pumps for women returning to work or school. In addition, WIC provides breastfeeding peer counselors at 10 local agencies statewide.
- Oregon hospitals have better than the national average of maternity care practices that support breastfeeding. The Maternity Practices in Infant Nutrition and Care (mPINC) survey measures breastfeeding related policies and practices. Oregon's overall mPINC score is higher than national average (Oregon score = 85; US score = 75). However, the three areas needing most improvement are hospital policies, appropriate use of breastfeeding supplements and hospital discharge planning.
- There are five Baby Friendly Hospitals in Oregon, representing 9.21% live births, and many more are working towards designation. The Baby-friendly Hospital Initiative (BFHI) was launched by the World Health Organization and the United Nations Children's Fund (UNICEF) in 1991, following the Innocenti Declaration of 1990. The initiative is a global effort to implement practices that protect, promote and support breastfeeding.

## Stakeholder input:

- Breastfeeding ranked sixth out of fifteen national priority areas (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- Breastfeeding has the highest level of disparities of the three Perinatal/Infant Health priority areas.
- In a survey of partners and providers, breastfeeding visit was rated lower than average in terms of its impact on health, importance to addressing equity and potential for leveraging state resources.

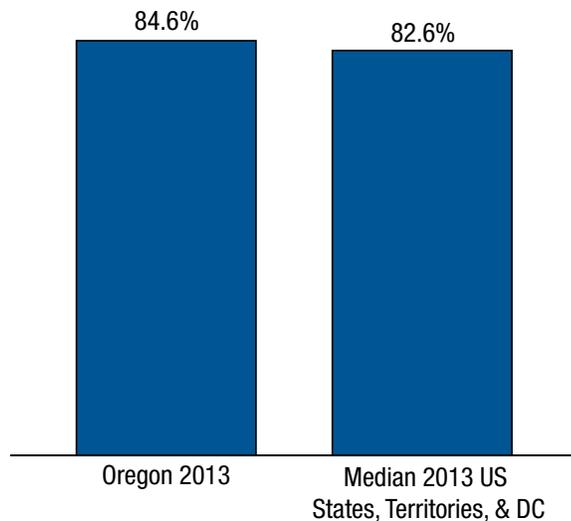
**Population Domain: Perinatal/infant Health**  
**Priority Area: Perinatal Regionalization**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**National performance measure:**

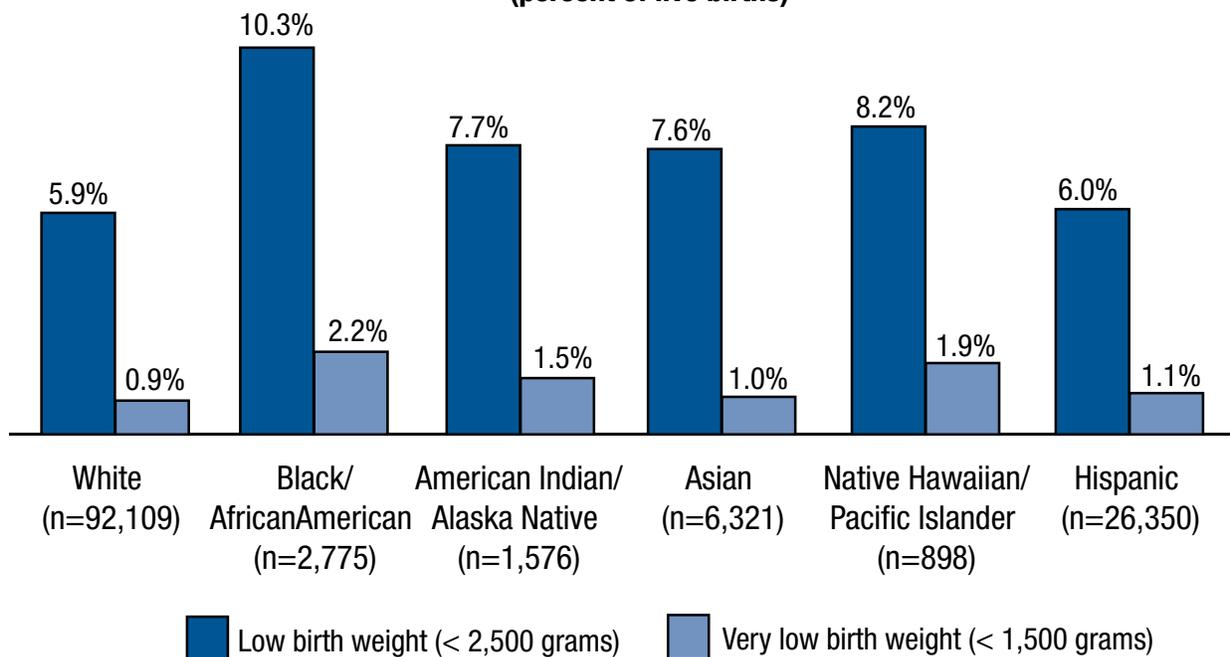
Percentage of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

**Percent of very low birth weight infants born at facilities with a Level III neonatal intensive care unit**



Source: Pregnancy Risk Assessment Monitoring System

**Low birth weight and very low birth weight births by race, 2010-2012 (percent of live births)**



Sources: OHA Center for Health Statistics, US Department of Health and Human Services, Maternal & Child Health Bureau. Title V Information System

## Significance of the issue

Very low birth weight infants (or VLBW) (<1,500 grams or 3.25 pounds) are the most fragile newborns. Although they represented less than 2% of all births in 2010 in the U.S., VLBW infants accounted for 53% of all infant deaths, with a risk of death over 100 times higher than that of normal birth weight infants ( $\geq 2,500$  grams or 5.5 pounds). VLBW infants are significantly more likely to survive and thrive when born in a facility with a level-III Neonatal Intensive Care Unit (NICU), a subspecialty facility equipped to handle high-risk neonates. In 2012, the AAP provided updated guidelines on the definitions of neonatal levels of care to include Level I (basic care), Level II (specialty care), and Levels III and IV (subspecialty intensive care) based on the availability of appropriate personnel, physical space, equipment, and organization. Given overwhelming evidence of improved outcomes, the AAP recommends that VLBW and/or very preterm infants (<32 weeks' gestation) be born in only level III or IV facilities. This measure is endorsed by the National Quality Forum (#0477).

## Context for the issue in Oregon

Oregon has a slightly higher percentage of very low birth weight infants who were born at a facility with a Level III NICU than the median percentage for 59 states, territories, and the District of Columbia. Caution must be used in interpreting these data, however, because states may have different levels of data quality and different methods of calculation. In Oregon, there is no regulated designation for a Neonatal Intensive Care Units (NICUs). Although little debate exists on the need for advanced neonatal services for the most immature and surgically complex neonates, ongoing controversies exist regarding which facilities are qualified to provide these services and what is the most appropriate measure for such qualification.

There are nine neonatal intensive care units (NICUs) in Oregon. Five are in the Portland Metro area. The NICUs in the rest of Oregon include Salem Hospital in Salem, Sacred Heart Medical Center in Eugene, Rogue Valley Medical Center in Medford, and St. Charles Medical Center in Bend. There are no NICUs in Oregon's eastern rural and frontier areas.

In collaboration with the state's Center for Health Statistics, the Maternal and Child Health Section monitors VLBW births where they occur. However, there are a number of measurement challenges such as the need to capture births to state residents that occur in other states and the lack of a formal level designation for NICUs.

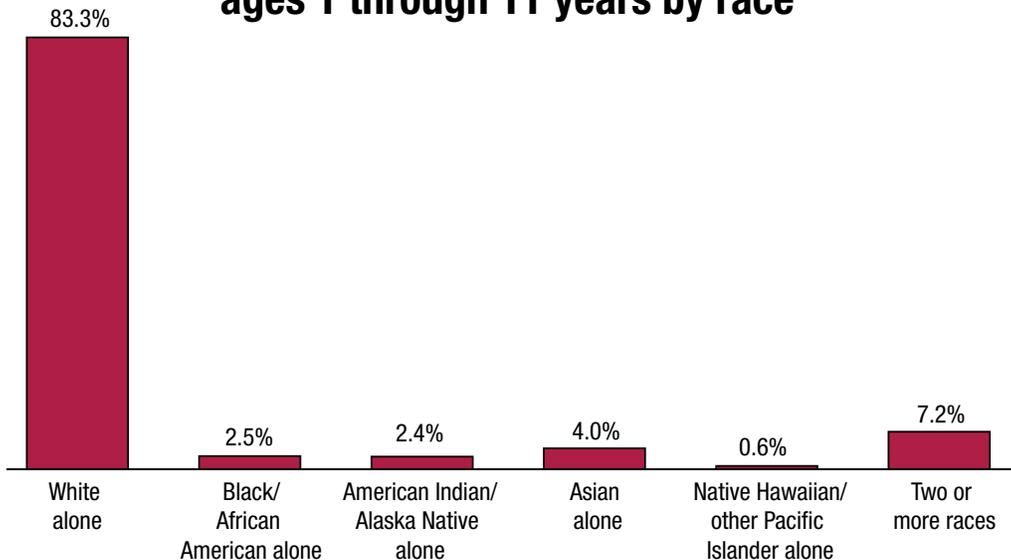
## Stakeholder Input:

- Perinatal regionalization ranked fifteenth out of fifteen national priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- In a survey of partners and providers, perinatal regionalization was rated lower than average in terms of its impact on health, importance to addressing equity and potential for leveraging state resources.

## Alignment with partners

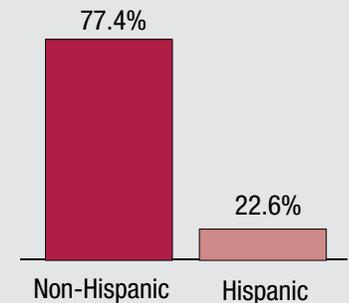
Perinatal Regionalization is considered important for Oregon's Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality but was not chosen as a topic in a recent prioritization discussion.

**Percent of children in Oregon  
 ages 1 through 11 years by race**



Source: American Fact Finder, United States Census Bureau

**Percent of children in Oregon  
 ages 1 through 11 years by  
 ethnicity**



Source: American Fact Finder, United States Census Bureau

**Key background & issues of concern for this population**

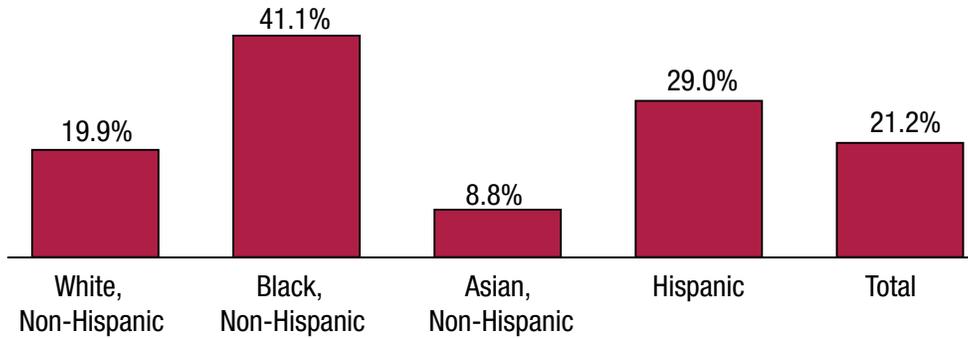
**Poverty:** The future and prosperity of Oregon state lies in the hands of our youngest children. The breakfasts they eat, the homes where they live, and the classrooms where they learn are all factors that determine whether they will be able to lead us towards progress and prosperity. For those of our children living in poverty, that crucial foundation, including nutrition, a nurturing home, a safe neighborhood, and access to a good education are often missing. This is the daily reality for the one in four children in Oregon who lives in poverty. Childhood poverty stifles human potential with its devastating effects on health, learning and development. Serious racial/ethnic disparities in poverty persist in Oregon, resulting in children of color to be disproportionately impacted by it. Among Oregon's communities of color, children have fewer opportunities for success than their white peers in all parts of the state.<sup>1</sup>

**Developmental screening:** Research indicates that as many as 1 in 4 children, ages 0-5, are at moderate or high risk for developmental, behavioral, or social delay.<sup>2</sup> Early identification of developmental disorders is critical to the well-being of children and their families. The percentage of children with a developmental disorder has been increasing, yet overall screening rates have remained low. Oregon is transforming health care and early education service delivery specific to developmental screening. Work is occurring at multiple levels, including state legislative directives, government policy makers, medical providers, home visiting programs and child care quality improvement programs. Developmental screening is currently a focus for CCO's and for Early Learning Division efforts with many initiatives underway to increase the screening rate. Early identification of developmental delay allows for early intervention and offers the greatest promise for ensuring children reach their maximum potential. Intervention in the preschool years is effective and less expensive than special education services in the school years.

**Childhood obesity:** Early childhood is a critical time for obesity prevention as children are primed to mimic healthy and unhealthy eating and physical activity behaviors. Children who are overweight or obese are at risk for becoming overweight or obese adults; being overweight or obese increases the risk for chronic disease, poor emotional wellbeing and depression.

<sup>1</sup> Children First for Oregon, County Data Book, 2014

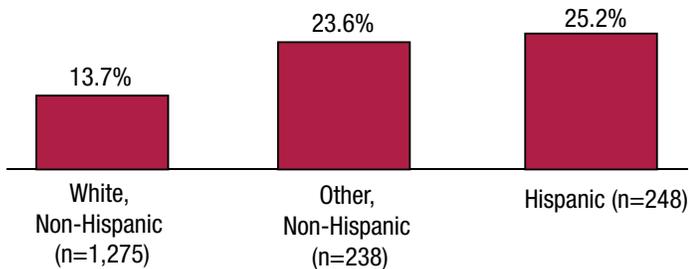
**Percent of families living under the federal poverty level, with related children under 5 years of age, by race/ethnicity, Oregon, 2013**



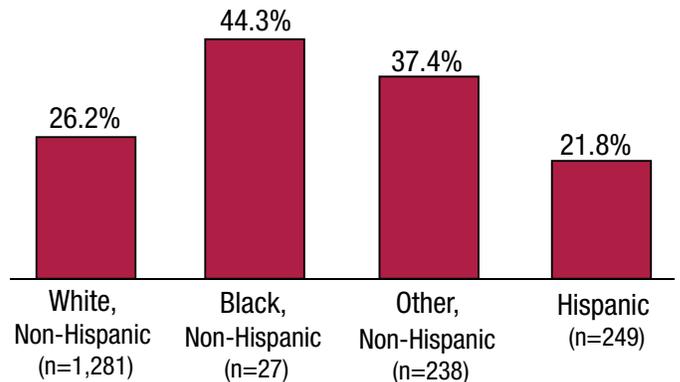
Source: American Fact Finder, United States Census Bureau

Note: American Indian/Alaska Native, Non-Hispanic not included due to small sample size

**Percent of children aged 0 to 17 who do not live in supportive neighborhoods, by race/ethnicity, Oregon, 2011/12**



**Percent of children age 0 to 17 years who have experienced two or more adverse family experiences, Oregon, by race/ethnicity, 2011/12**



Source: National Survey of Children's Health; Note: Black, Non-Hispanic not included due to low sample size; Note: Supportive neighborhood defined as agreement with  $\geq 3$  of the following: "People in my neighborhood help each other out"; "We watch out for each other's children in this neighborhood"; "There are people I can count on in this neighborhood"; and "If my child were outside playing and got hurt or scared, there are adults nearby who I trust to help my child".

**Proposed National Priority Areas (2017-2021)**

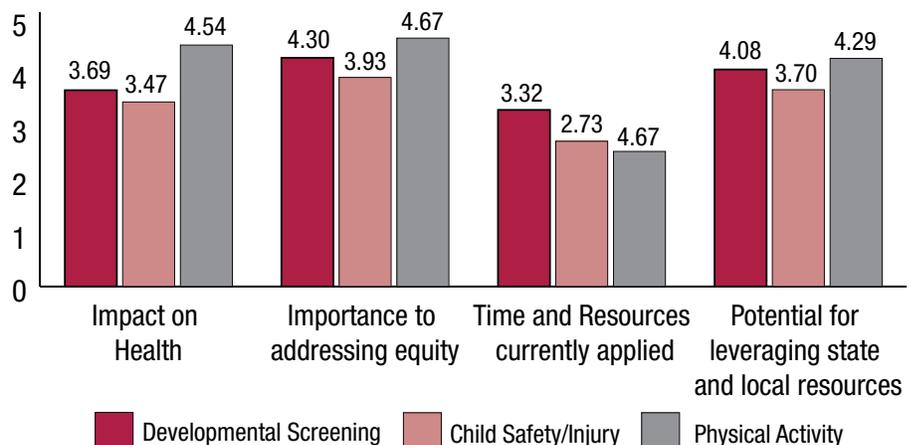
- Developmental screening
- Child safety/injury
- Physical activity

**Current State Priority Areas (2011-2016)**

- Oral health
- Parent Resources and Support

**Partner Survey: National Child Health Priority Areas**

In a survey, service providers that serve women, pregnant women, mothers, infants, adolescents and children and agencies that receive Title V funds were asked to rate 29 areas in terms of their impact on health, the time and resources currently applied, importance to addressing equity and potential for leveraging state resources on a scale of 0 to 5. The results for the three national child health priority areas are shown to the right.



# Population Domain: Child Health

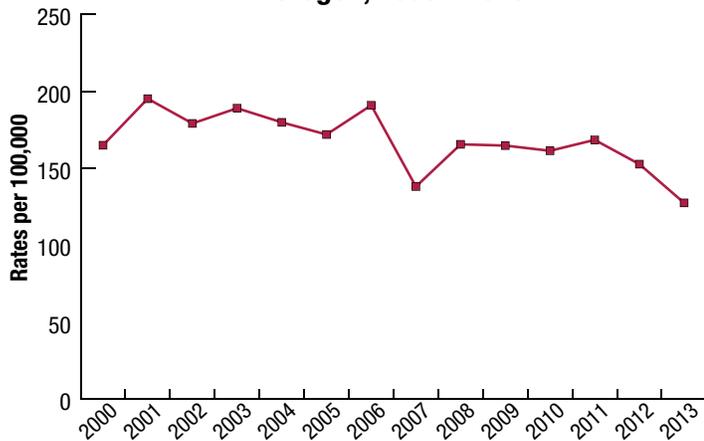
## Priority Area: Child Safety/Injury

- National Priority Area
- Current State Priority Area
- Emerging State Topic

### National performance measure:

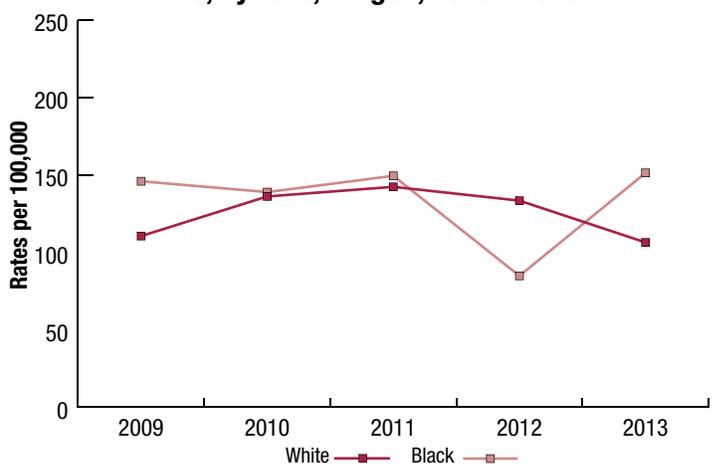
Rate of injury-related hospital admissions per population ages 0 through 19 years  
(Only 0 – 9 shown for this population domain)

**Injury hospitalization rate among 0 to 9 year olds, Oregon, 2000 - 2013**



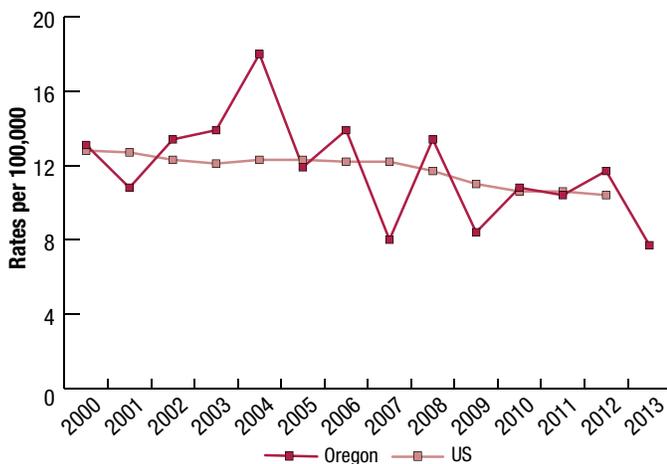
Source: Oregon hospitalization data

**Injury hospitalization rate among 0 to 9 year olds, by race, Oregon, 2009 - 2013**



Source: Oregon hospitalization data

**Injury related fatality rate among 0 to 9 year olds, 2000 - 2013**



Source: National Vital Statistics and Oregon Center for Health Statistics  
Note: Injury hospitalization data not available at national level

### Significance of the issue

Injury is the leading cause of child mortality. For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury 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 trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.

### Context for the issue in Oregon

Since 2000, injury has been the leading cause of mortality for Oregon children ages 1-19. For children under age 1, injury was the 4th leading cause of death from 2011-2013, with suffocation (62%), undetermined (14%) and homicide (10%) as top

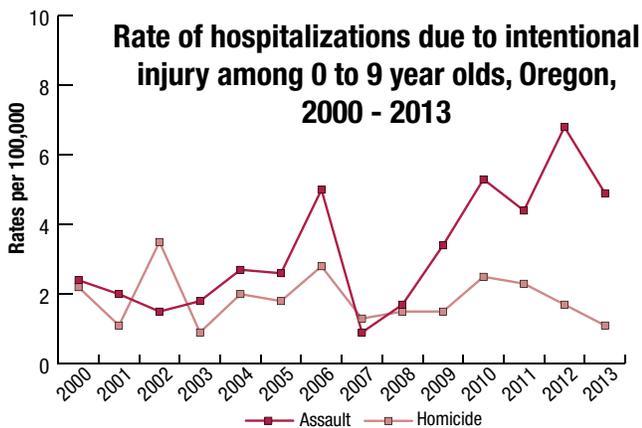
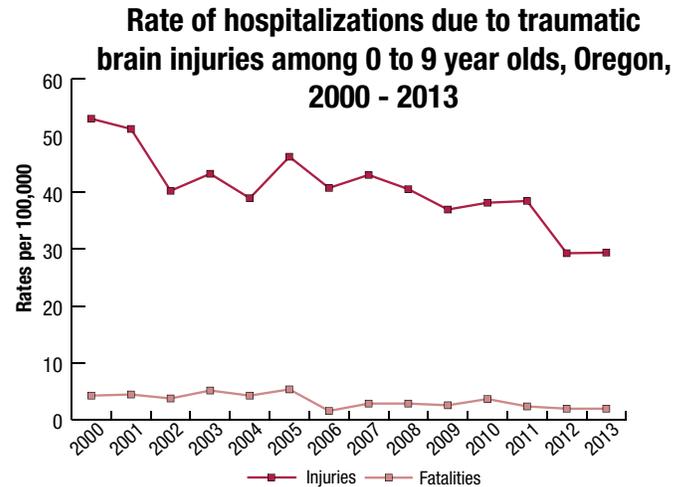
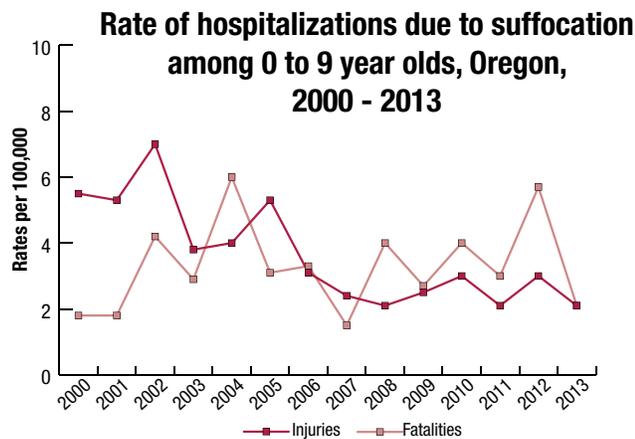
causes of infant injury death. For children ages 0-9, suffocation, traumatic brain injury and homicide are leading causes of death. Non-fatal injuries are included in hospitalization data. Children ages 0-9 were hospitalized most often for traumatic brain injuries followed by motor vehicle traffic injuries. The 5 leading causes of traumatic brain injury among children are falls, motor vehicle injuries, "Struck by or against" (such as in a sports-related injury), "other" transport (i.e. non-public roadway transport, such as ATVs and off-road motorcycles), and bicycle injuries not involving motor vehicles (such as falling from a bike). Those suffering non-fatal severe injuries may have life-long special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and

adolescents resulting in improved quality of life and cost savings. Since 2000, motor vehicle traffic deaths and injuries to children under 15 have steadily declined. However, other child injury issues such as suffocation, suicide, traumatic brain injury and homicide have not had the same success.

## Stakeholder input

- Child injury ranked fourth out of fifteen national priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- In a survey of partners and providers, child injury was rated lower than average in terms of its impact on health, importance to addressing equity and potential for leveraging state resources.

## Health status data



Source for all graphs: Oregon hospitalization data

## Alignment with partners

- Oregon Public Health Division's 2015 Strategic Plan includes strategies for reduction and prevention of family violence, suicide and child maltreatment
- Oregon Injury and Violence Prevention (IVP)'s Pedestrian Safety Policy and Systems Change Strategies 2012 – 2015 implementation plan
- Public Health Division's development of Safe and Nurturing Environments integrated framework.
- CCO metric to increase the percentage of Medicaid patients served by a CCO, ages 6 and older, who received follow-up care with a health care provider within 7 days of being discharged from the hospital for mental illness
- MIECHV measure to decrease the rate of reported ED or urgent care visits per child-year in the home visiting program; decrease the rate of injury hospitalizations to children (unintentional, undetermined and assault); and decrease the percentage of abuse/neglect assessments founded for abuse/neglect reported to Child Protective Services; and increase the percentage of families utilizing services due to Nurse-Family Partnership (NFP) home visit referrals for domestic, substance use/abuse and maternal mental health in Umatilla, Morrow, Jefferson, Lincoln and Lane counties through NFP efforts.
- Injury and violence prevention (IVP) measure to increase the Child Death Review (CDR) cases that are reviewed by a local CDR team statewide.

# Population Domain: Child Health

## Priority Area: Developmental Screening

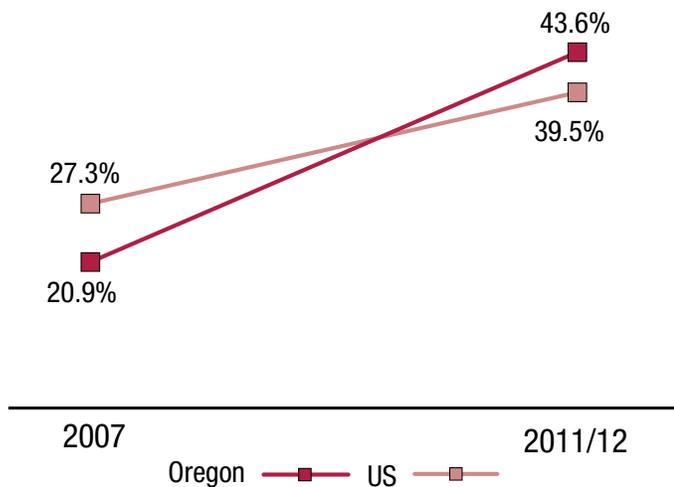
- National Priority Area
- Current State Priority Area
- Emerging State Topic

### National performance measure:

Percentage of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool

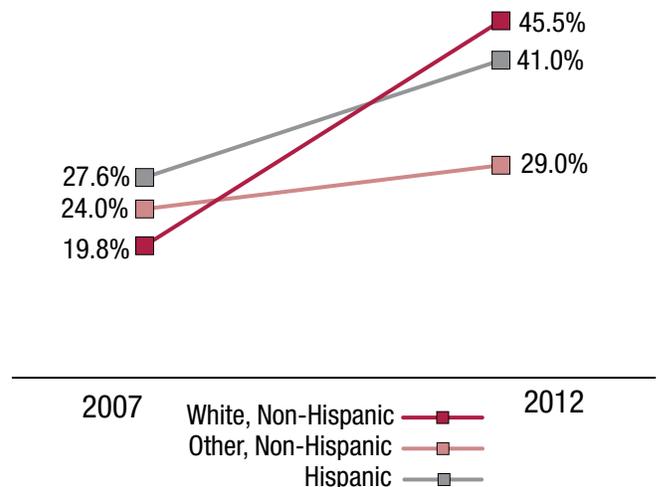
*(Note: These are current American Academy of Pediatrics recommendations. However, an emerging issue in Oregon is that the Ages and Stages Questionnaire-3 (ASQ-3) can be completed as young as 4 weeks of age.)*

**Percent of children, ages 10 months through 5 years, receiving a developmental screening using a parent-completed screening tool, 2007 - 2011/12**



Source: National Survey of Children's Health

**Percent of children, ages 10 months through 5 years, receiving a developmental screening using a parent-completed screening tool, by race/ethnicity, Oregon, 2007 - 2011/12**



Source: Oregon Healthy Teens

Note: Black, Non-Hispanic, not included due to small sample size

### Significance of the issue

Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percentage of children with a developmental disorder has been increasing, yet overall screening rates have remained low.

There is concentrated national promotion of developmental screening. The American Academy of Pediatrics recommends screening tests begin at the nine month visit. Initiatives span federal government, professional organizations, child advocacy groups and the Centers for Disease Control and Prevention (CDC).

Examples of national efforts include:

- Affordable Care Act (ACA)
- Maternal Infant and Early Childhood Home Visiting Grant (MIECHV)
- American Academy of Pediatrics Developmental Screening Guidelines alignment with Bright Futures
- The CDC has developed a website and resources (English and Spanish) promoting attention to early childhood development, monitoring and screening, which aligns with "Healthy People 2020" goals.

## Context for the issue in Oregon

There is widespread acknowledgement of the value of developmental screening in Oregon, and developmental screening has been conducted in public health, home visiting, and some early childhood and pediatric settings across the state for many years. In addition, the Robert Wood Johnson-funded ABCD initiative supported a collaboration of Maternal and Child Health, Medicaid, Early Intervention, Early Childhood Special Education, and Oregon pediatric providers to develop screening and referral partnerships for developmental assessment in Oregon in 2011-2012. Currently, Oregon is transforming health care and early education service delivery specific to developmental screening. Work is occurring at multiple levels, including state legislative directives, government policy makers, medical providers, home visiting programs and child care quality improvement programs. In Oregon, initiatives to promote developmental screening include a focus on:

- Coordination of developmental screening results across providers.
- Reduction of screening process burden for families (e.g. multiple service providers conducting the same screenings)

## Stakeholder input

- Developmental screening ranked seventh out of fifteen national priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- Developmental screening was the priority area mentioned most often in the stakeholder phase of the needs assessment, and ranked second in terms of unmet needs in that phase.
- In a survey of partners and providers, developmental screening was rated as having a relatively lower than average impact on health and importance to addressing equity, and a moderate rating for its potential for leveraging state resources.

## Alignment with partners

Examples of state wide efforts with a focus or objective of developmental screening include:

- Early Learning Legislation in Oregon: SB909 and HB 2013
- Early Learning Council adoption of ASQ-3/Oregon Health Authority
- Public Health Nurse Home Visiting Programs (e.g. Nurse Family Partnership (NFP), Babies First! and CaCoon). Provide multiple screening tools. Adopted ASQ-3 in 2010 as primary developmental screening tool.
- Home Visiting Programs (e.g. Early Head Start (EHS), Head Start, Healthy Families Oregon (HFO), EI) all utilize ASQ-3
- Maternal Infant and Early Childhood Home Visiting Grant (MIECHV) in Oregon that support EHS, HFO and NFP program.
- Patient Centered Primary Care medical home quality care measure (Calls for routine developmental Screening.
- CCOs – Developmental Screening is a quality metric requirement.
- Early Learning Hubs metrics includes incentive for developmental screening
- Oregon's Race to the Top Early Learning Challenge
- State Improvement Model Grant (SIM) Eastern Oregon CCO (EOCCO) – focus on increasing the number of developmental screenings conducted is a primary goal objective. SIM grant covers 11 Eastern Oregon counties.
- Quality Rating Improvement System (QRIS), calls for developmental screening in child care starting at 3-Star level.

# Population Domain: Child Health

## Priority Area: Physical Activity

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**National performance measure:**

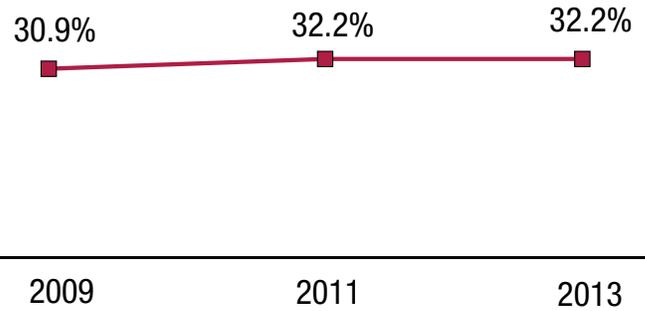
Percentage of children ages 6 through 11 years who are physically active at least 60 minutes per day, 2003 – 2011/12.

**Percent of children ages 6 through 11 years who are physically active at least 20 minutes per day, 2003 - 2011/12**



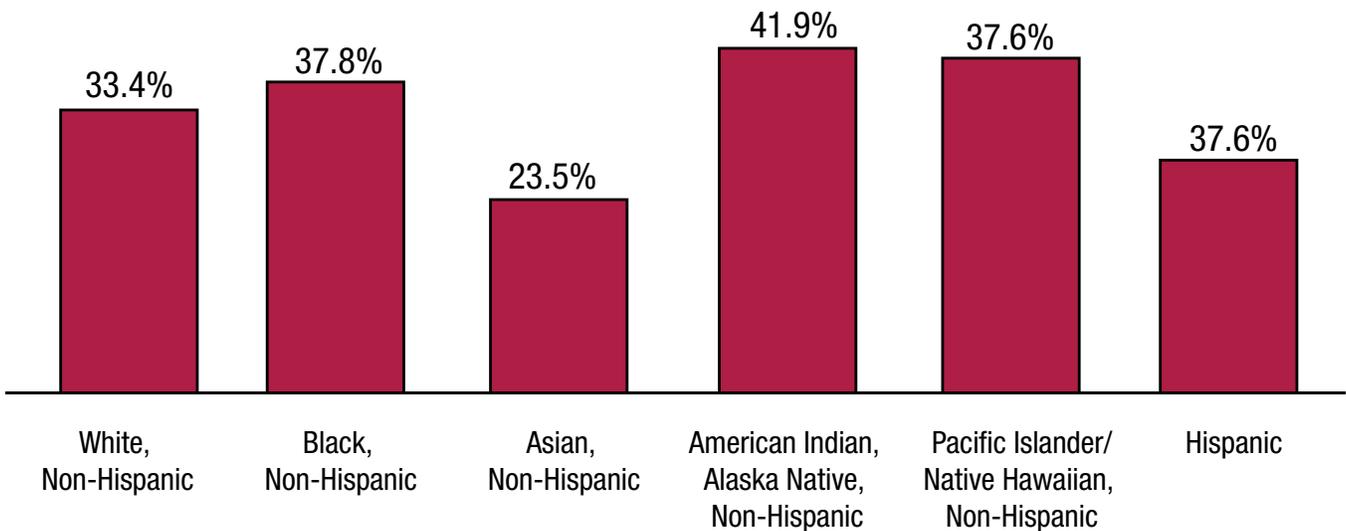
Source: National Survey of Children's Health  
 Note: NSCH reports 20 minutes of physical activity, and racial/ethnic stratification not available

**Percent of 8th graders who report exercising for at least 60 minutes everyday, Oregon, 2009 - 2013**



Source: Oregon Healthy Teens  
 Note: US data not available for 8th graders

**Percent of 8th graders who report exercising for at least 60 minutes a day, by race/ethnicity, Oregon, 2013**



Source: Oregon Healthy Teens

## 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 children 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 children in order to build peak bone mass.

## Context for the issue in Oregon

Children spend a significant portion of their day in school, making schools a critical setting for addressing physical activity. In 2007 the Oregon Legislature passed physical education standards for public schools, specifying that by 2017 all elementary and middle schools will be required to ensure that K-5 students receive 150 minutes per week of physical education and that students in grades 6-8 receive 225 minutes per week. The number of schools that meet requirements for PE has actually declined 54% from the 2008-2009 school year to the 2009-2010 school year.

Oregon is working towards implementation of Comprehensive School Physical Activity Program (CSPAP) through its work via the CDC 1305 basic and enhanced obesity prevention grant. CSPAP is an approach to use all opportunities for students to be physically active in order to meet physical activity recommendations and develop skills for lifelong activity. This includes addressing activity before and after school (e.g. Walk and Bike to School), during school (recess) and physical education. Oregon Safe Routes to School program is predominantly along the I-5 corridor although all schools are encouraged to participate. Oregon Healthy Teens data show that 21% of 8th graders walk to school 5 days per week. There are currently limited Quality Rating and Improvement System standards for physical activity for both family-based and center-based child care in Oregon.

School Based Health Centers across the state perform BMI screening and counseling about physical activity.

## Stakeholder input

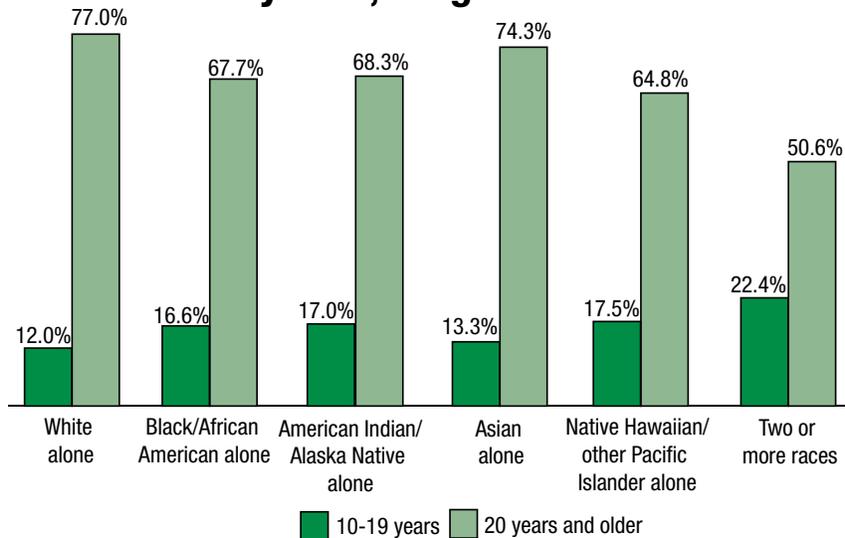
- Physical activity ranked first out of fifteen national priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- In a survey of partners and providers, physical activity was rated higher than average in terms of its impact on health, importance to addressing equity and potential for leveraging state resources.

## Alignment with partners

- Increasing physical activity, along with improving nutrition, is a focus of the Oregon Public Health Division's Strategic Plan, as a part of an objective to reduce obesity
- Diabetes measures, which are directly related to physical activity, are both incentive and performance measures for Oregon CCOs.
- Physical activity priority areas are identified in CCO Community Health Improvement Plans (CHIPs)
- Physical activity is a priority of a CDC grant; "State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health"

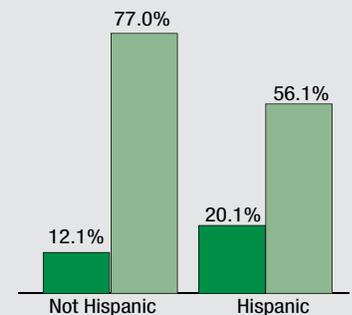
# Population/Domain Overview: Adolescent Health

## Adolescent and adult population, by race, Oregon 2010



Source: American Fact Finder, United States Census Bureau

## Adolescent and adult population, by ethnicity, Oregon, 2010



## Key background & issues of concern for this population

Adolescence is the greatest period of development in the lifecourse, second only to infancy. While generally characterized by good health, adolescents are laying the foundation for health behaviors 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. For example, teen pregnancy rates among Oregon females aged 15–17 years have declined almost by half over the past five years, from 25.8 per 1,000 in 2008 to 13.9 in 2013. Racial and ethnic disparities still exist, but all racial and ethnic groups experienced declines. Even with great improvements in teen pregnancy rates, work still needs to be done to support healthy adolescent development. Among 11th graders in 2013:

- 11% report having an unmet physical health care need; 9% an unmet emotional health care need; and 6% report having both. Girls were twice as likely to report having unmet emotional health care needs.
- 1 out of 3 (33.7%) girls and 1 out of 5 (20%) of boys reported being depressed in the past year.
- Suicide is the 2nd leading cause of death among Oregon youth. Approximately 15% of 11th graders reported seriously considering suicide in the last year.
- While alcohol use is on the decline statewide, it is still the most commonly used substance. 31% of 11th graders report using alcohol in the past month.
- Almost half (45%) have ever had intercourse; of those, 36% did not use a condom at last intercourse.

The Positive Youth Development (PYD) 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 health outcomes. 11th graders who met the PYD Benchmark were:

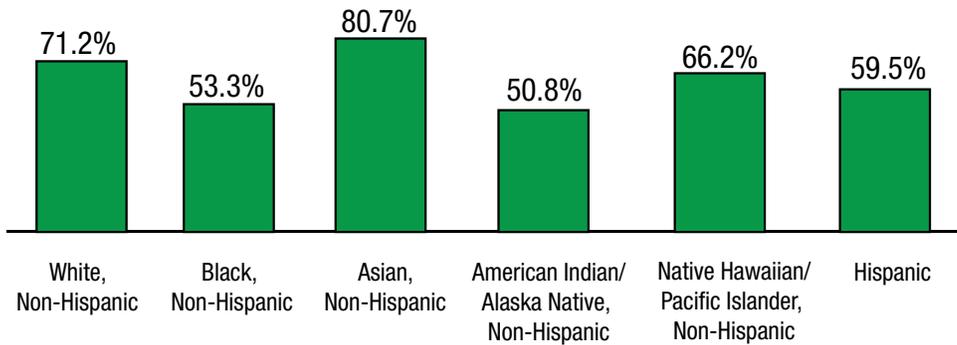
### More likely to:

- Get 60 minutes of physical activity per day
- Eat 5 servings of fruits and veggies
- Get A or B grades
- Never have had sex

### Less likely to:

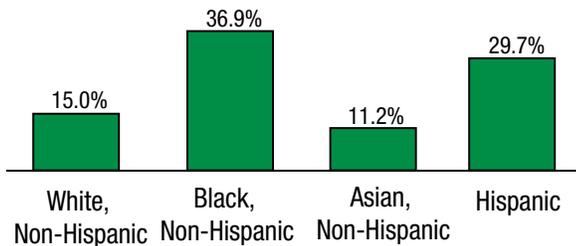
- Be depressed
- Use alcohol, tobacco, and other drugs
- Miss school because it was unsafe

### Oregon four year cohort graduation rate, by race/ethnicity, 2011-12



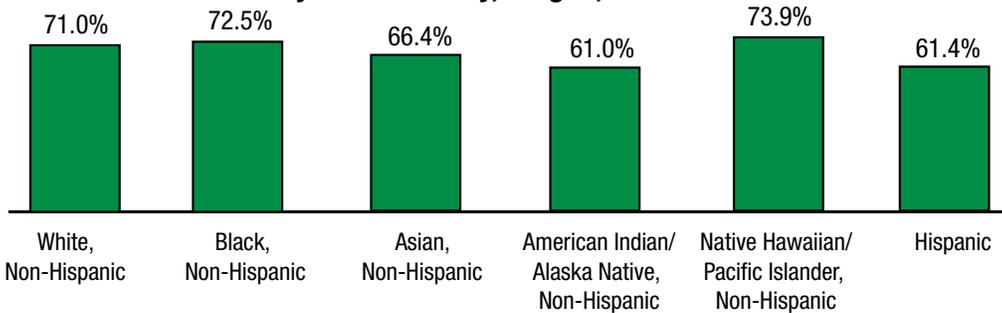
Source: Oregon Department of Education

### Percent of families with related children <18 years old living in poverty, by race/ethnicity, Oregon, 2013

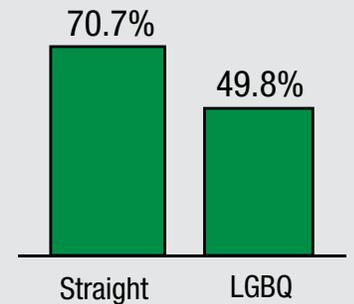


Source: American Fact Finder, United States Census Bureau

### Percent of 11th graders who meet the PYD benchmark, by race/ethnicity, Oregon, 2006-2011



### Percent of 11th graders who meet the PYD benchmark, by sexual orientation, Oregon, 2006-2011



### Proposed National Priority Areas (2017-2021)

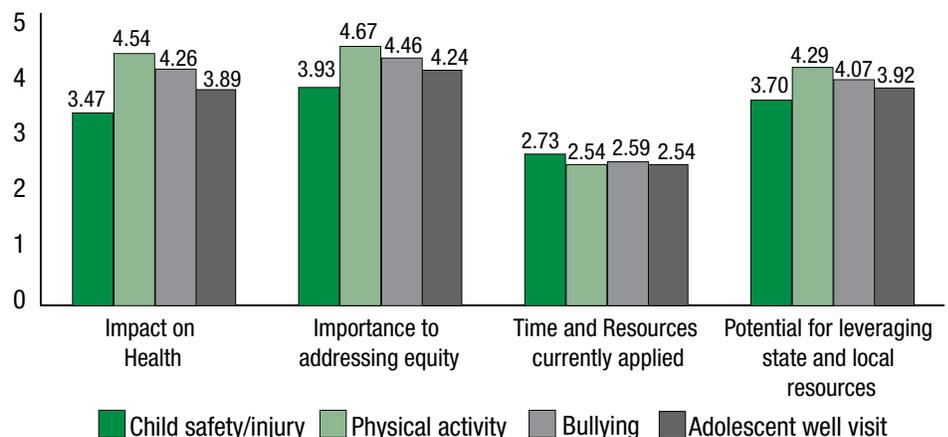
- Adolescent safety/injury
- Adolescent physical activity
- Bullying
- Adolescent well visit

### Current State Priority Areas (2011-2016)

- Overweight and obesity
- Adolescent well visit

### Partner Survey: National Adolescent Health Priority Areas

In a survey, service providers that serve women, pregnant women, mothers, infants, adolescents and children and agencies that receive Title V funds were asked to rate 29 areas in terms of their impact on health, the time and resources currently applied, importance to addressing equity and potential for leveraging state resources on a scale of 0 to 5. The results for the four national adolescent health priority areas are shown to the right.



# Population Domain: Adolescent Health

## Priority Area: Physical Activity

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**National performance measure:**

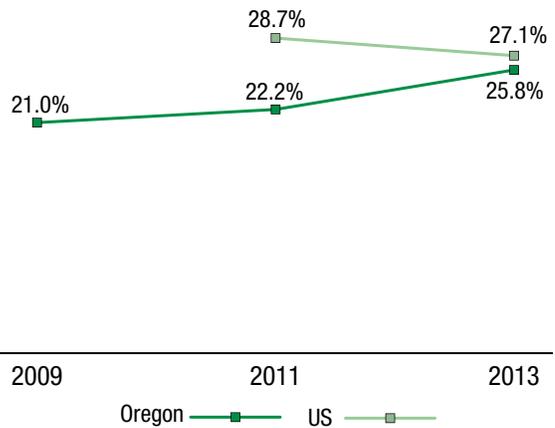
Percentage of adolescents ages 12 through 17 years who are physically active at least 60 minutes per day.

**Percent of adolescents ages 12 through 17 years who are physically active at least 20 minutes per day, 2003 - 2011/12**



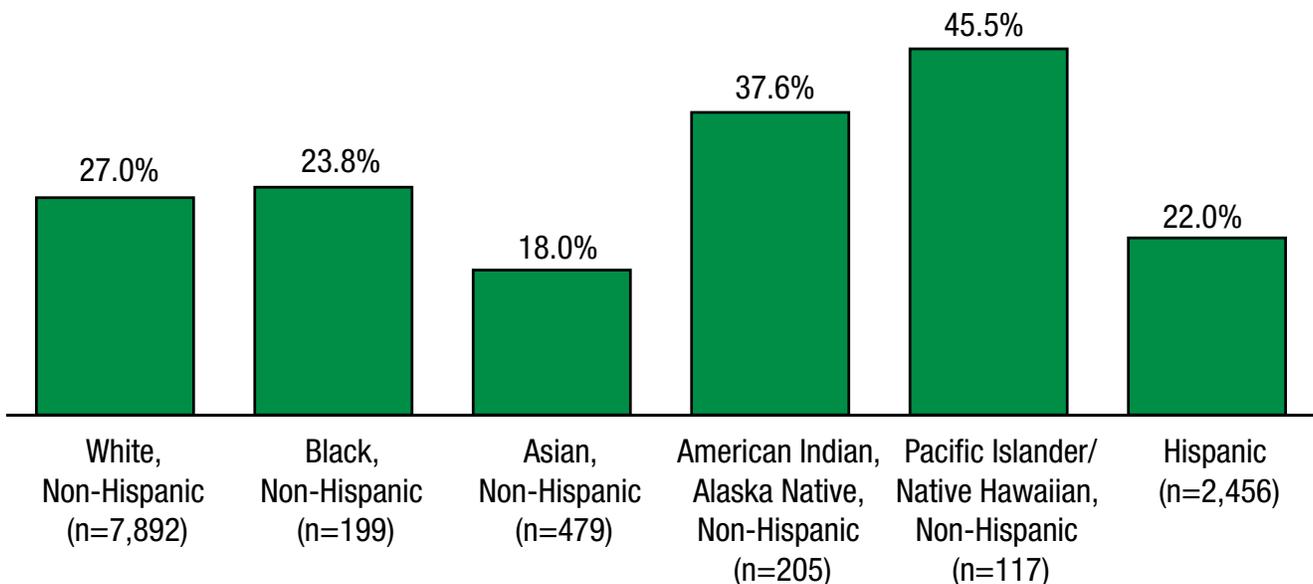
Source: National Survey of Children's Health  
 Note: NSCH reports 20 minutes of physical activity, and racial/ethnic stratification not available

**Percent of 11th graders who report exercising for at least 60 minutes everyday, 2009 - 2013**



Source: Oregon Healthy Teens and Youth Risk Behavior Surveillance System

**Percent of 11th graders who report exercising for at least 60 minutes a day, by race/ethnicity, Oregon, 2013**



Source: Oregon Healthy Teens

## 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.

## Context for the issue in Oregon

Adolescents spend a significant portion of their day in school, making schools a critical setting for addressing physical activity. In 2007 the Oregon Legislature passed physical education standards for public schools, specifying that by 2017 all elementary and middle schools will be required to ensure that K-5 students receive 150 minutes per week of physical education and that students in grades 6-8 receive 225 minutes per week. The number of schools that meet requirements for PE has actually declined 54% from the 2008-2009 school year to the 2009-2010 school year.

Oregon is working towards implementation of Comprehensive School Physical Activity Program (CSPAP) through its work via the CDC 1305 basic and enhanced obesity prevention grant. CSPAP is an approach to use all opportunities for students to be physically active in order to meet physical activity recommendations and develop skills for lifelong activity. This includes addressing activity before and after school (e.g. Walk and Bike to School), during school (recess) and physical education. Oregon Safe Routes to School program is predominantly along the I-5 corridor, although all schools are encouraged to participate. OHT data show that 16% of 11th graders walk to school 5 days per week.

School Based Health Centers across the state perform BMI screening and counseling about physical activity.

## Stakeholder input

- Physical activity ranked highest out of fifteen national priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- In a survey of partners and providers, physical activity had the third highest rating for impact on health and the fourth highest for importance for addressing equity. Respondents indicated that there is a strong potential for leveraging state resources in this area.

## Alignment with partners

- Increasing physical activity, along with improving nutrition, is a focus of the Oregon Public Health Division's Strategic Plan, as a part of an objective to reduce obesity
- Diabetes is both an incentive and performance measure of Oregon CCOs, which is directly related to physical activity
- Physical activity priority areas are identified in CCO Community Health Improvement Plans (CHIPs)
- Physical activity is a priority of a CDC grant; "State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health

# Population Domain: Adolescent Health

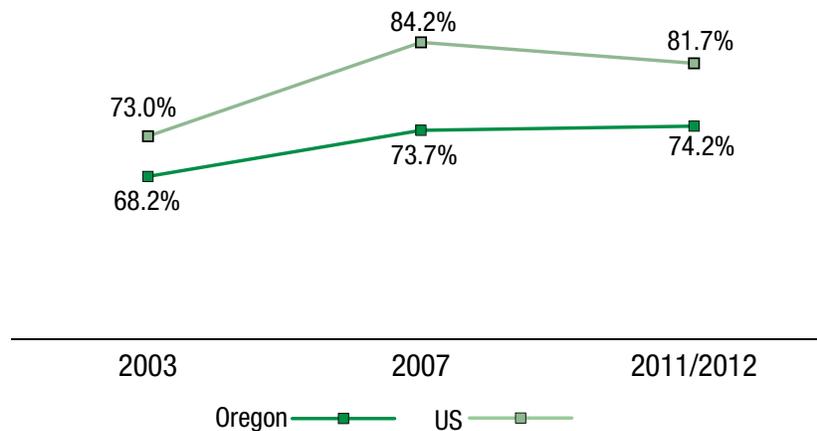
## Priority Area: Adolescent Well Visit

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**National performance measure:**

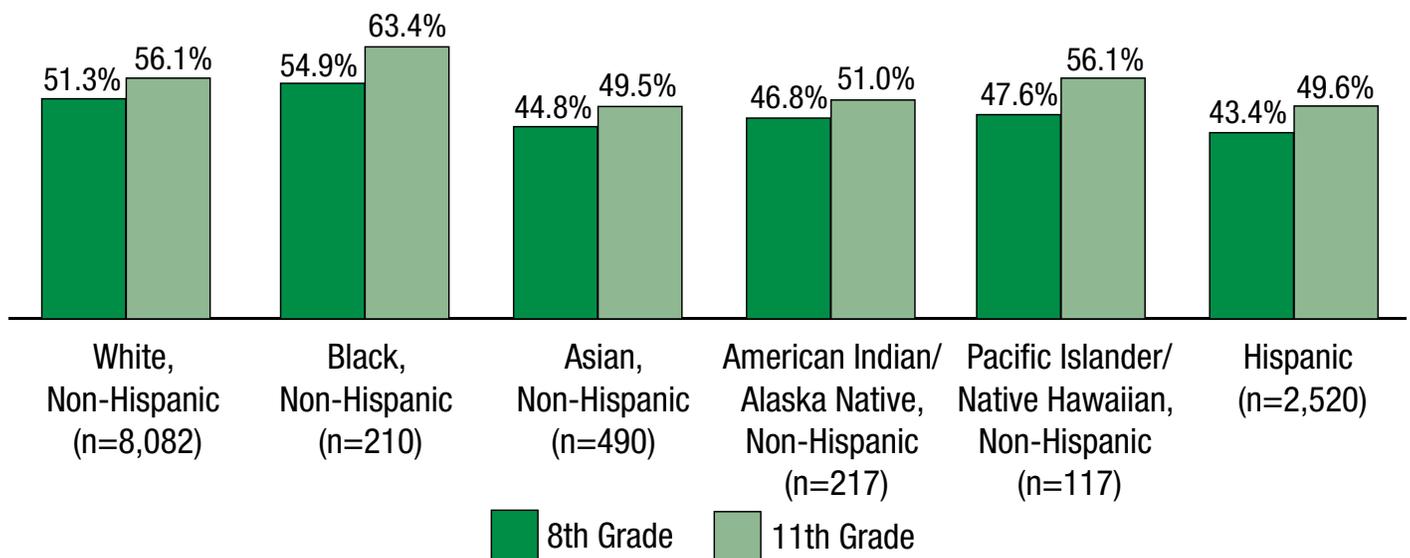
Percentage of adolescents with a preventive services visit in the last year.

**Percent of adolescents age 12 to 17 years with one or more preventive medical visits in the last year, 2003 - 2011/12**



Source: National Survey of Children's Health

**Percent of 8th and 11th graders with a well-visit in the last year, by race/ethnicity, Oregon, 2011**



Source: Oregon Healthy Teens

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

### Significance of the issue

While generally characterized by good health, adolescence is a key transition period in the life course that requires a unique set of health care services. Adolescents are establishing health behaviors that lay the foundation for their health in adulthood, which carry implications for lifelong health outcomes, health care spending and economic stability. Furthermore, adolescence is a critical time to empower, educate and engage youth as they begin to transition to independent consumers of health care services. The Bright Futures guidelines recommend that adolescents (11-24) have

annual well-visits. The visit should cover a comprehensive set of preventive services, such as a physical examination, immunizations and discussion of health-related behaviors including: healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.

Nationally, only about half (46%) of adolescents on Medicaid aged 12–21 years received a well-visit in the past year, the lowest utilization of primary care compared to any other age group. The adolescent well-visit rate for the Oregon Health Plan is significantly lower, with 29.2% of Medicaid enrollees aged 12–21 years having a well-care visit in the past 12 months.

## **Context for the issue in Oregon**

Increasing the number of youth receiving a preventive visit in the past year has been a Title V state-selected priority since 2010. The adolescent well-visit was selected as an incentive measure for Coordinated Care Organizations (CCOs), which greatly elevated the focus on the adolescent population. The well-visit has been included as a key performance measure for certified school-based health centers (SBHCs) since 2008. During the 2013–14 school year, 32% of youth aged 12–21 years seen in an SBHC received a well-visit.

Though it is a clinical measure, the adolescent well-visit shines a light on the unique needs of adolescents in accessing health services, such as physical access points (i.e. SBHCs), confidentiality in the provision of care to adolescents, and the availability of culturally relevant, and developmentally appropriate care. The Adolescent and School Health Program is currently working with the OHA Child Health Director, Insurance Division, and partners across OHA to assess policy opportunities to strengthen confidentiality protections in health care. Additionally, the emphasis on the adolescent well-visit has brought together partners from the Oregon Pediatric Society and Oregon Pediatric Improvement Partnership to improve the quality of adolescent well-visits and increase screening and follow-up for substance use and depression (also CCO incentive measures). SBHCs have been identified as key partners to improve the adolescent well-visit rate.

There is growing realization that young people must be actively engaged in their communities to increase the proportion that access preventive services. There is increased interest in using public health tools and strategies to improve this measure.

## **Stakeholder input**

- Statewide review of county assessments: In a review of 53 county needs assessments, adolescent well-visit ranked eighth out of fifteen national priority measures (in terms of the number of times it was referenced)
- Partner survey: Of 29 health topics, adolescent preventive health ranked 19th in terms of impact on health, 19th in terms of importance for addressing equity, 22nd in terms of the time and resources currently being applied and 22nd in terms of potential for leveraging state resources.

## **Health status data**

Many Oregon youth could benefit from increased access to screening and anticipatory guidance. According to 11th graders in 2013:

- 1 in 4 girls and 1 in 10 boys reported having an unmet physical or emotional health care need in the past year;
- Over a quarter (27%) were at risk for depression in the past year;
- Approximately 15% contemplated suicide in the past year;
- 31% used alcohol; 13% used tobacco; 14% used drugs in the past month;
- Almost half (45%) report ever having had intercourse; of those, 36% did not use a condom at last intercourse.

## **Alignment with partners**

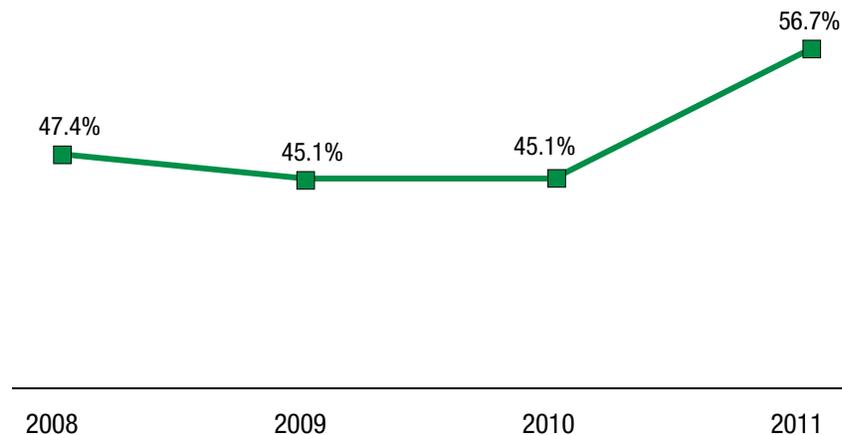
- Health System Transformation efforts: CCO Incentive Measure, and demonstrates the integration of public health and primary care.
- The adolescent well-visit provides a clear example of “upstream” focus on the Triple Aim of better health, better care, and lower costs.
- Adolescent and School Health Program and SBHC Program have prioritized adolescent well-visits for years.

# Current State Priority Area: Adolescent Well Visit

**Oregon Title V goal:** Increase access to preventive physical and mental health services.

**State performance measure:** Percent of 8th grade students who went to a doctor or nurse practitioner for a check-up or physical exam when they were not sick or injured during the past 12 months.

**Percentage of 8th grade students who went to a doctor or nurse practitioner for a check-up or physical exam when they were not sick or injured during the past 12 months, Oregon, 2008 - 2011**



Source: Oregon Healthy Teens

## Work in progress

- Staff in Adolescent Health and Reproductive Health are spearheading a group focused on confidentiality policies for sensitive services. The group includes the OHA Child Health Director and representatives from Health Analytics, OHPR, Addictions and Mental Health, HIV/STD Program, OHA Privacy Office, Office of Health IT, and the Insurance Division. PHD staff and the OHA Child Health Director will meet with representatives from health insurance carriers to further understand HIPPA regulations.
- A Youth Action Research Curriculum has been finalized and published. Grants have been released for communities to pilot the curriculum. One community will be focused on access to mental health services.
- Public Health and Addictions and Mental Health Divisions are partnering with the Oregon Pediatric Society and Oregon Pediatric Improvement Partnership to train adolescent providers in screening for alcohol/substance use and follow-up (SBIRT) during adolescent well care visits. There are nine current planning grants in eight counties.
- The SBHC State Program Office continues to support 68 certified SBHCs across the state in a dynamic health care landscape.
- SBHC mental health expansion funds were released to 16 counties to support enhanced provider time and/or implementation of a targeted mental health project. There are now 57 SBHCs with a mental health provider on-site.

# Population Domain: Adolescent Health

## Priority Area: Adolescent Safety/Injury

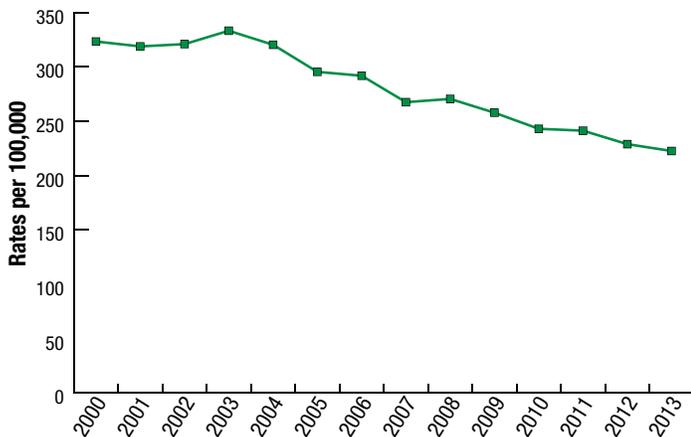
- National Priority Area
- State Priority Area
- Emerging State Topic

### National performance measure:

Rate of injury-related hospital admissions per population ages 0 through 19 years.

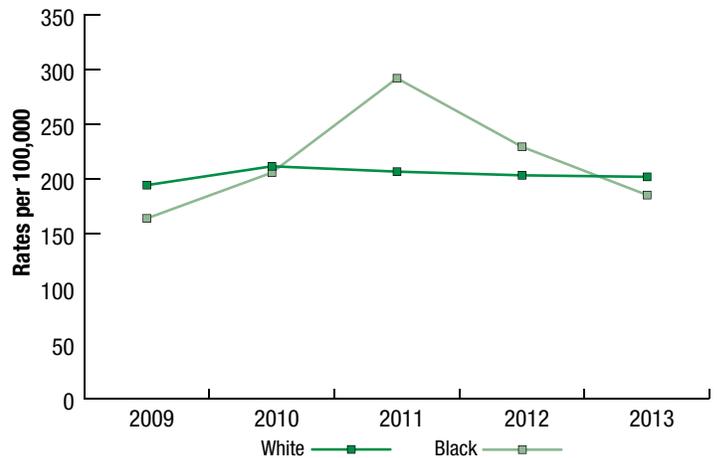
Note: Only ages 10 – 19 years shown for this population domain

**Injury hospitalization rate among 10 to 19 year olds, Oregon, 2000 - 2013**



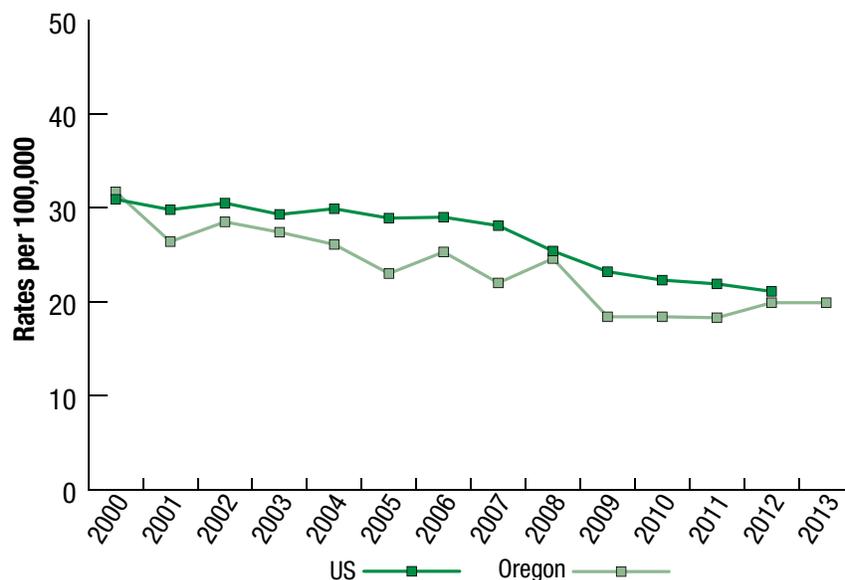
Source: Oregon hospitalization data

**Injury hospitalization rate among 10 to 19 year olds, by race, Oregon, 2000 - 2013**



Source: Oregon hospitalization data

**Injury related fatality rate among 10 to 19 year olds, 2000 - 2013**



Source: National Vital Statistics and Oregon Center for Health Statistics

Note: Injury hospitalization data not available at national level

### Significance of the issue

Injury is the leading cause of child mortality. For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury 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 trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.

## Context for the issue in Oregon

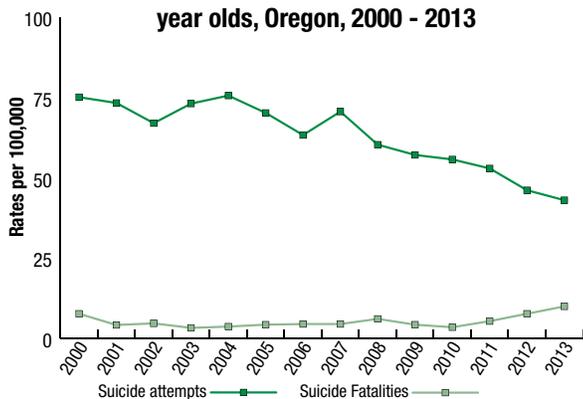
Since 2000, injury has been the leading cause of mortality for Oregon children ages 1-19. For children ages 10-19, traumatic brain injury, suicide and motor vehicle traffic are leading causes of death. The 5 leading causes of traumatic brain injury among children are falls, motor vehicle injuries, “Struck by or against” (such as in a sports-related injury), “other” transport (i.e. non-public roadway transport, such as ATVs and off-road motorcycles), and bicycle injuries not involving motor vehicles (such as falling from a bike). Non-fatal injuries are included in hospitalization data. Children and adolescents ages 10-19 were hospitalized most often for suicide attempts, followed by traumatic brain injuries and motor vehicle traffic injuries. Those suffering non-fatal severe injuries may have life-long special health care needs. Since 2000, motor vehicle traffic deaths and injuries to children under 19 have steadily declined. However, other child injury issues such as suicide, traumatic brain injury and homicide have not had the same success.

## Stakeholder input

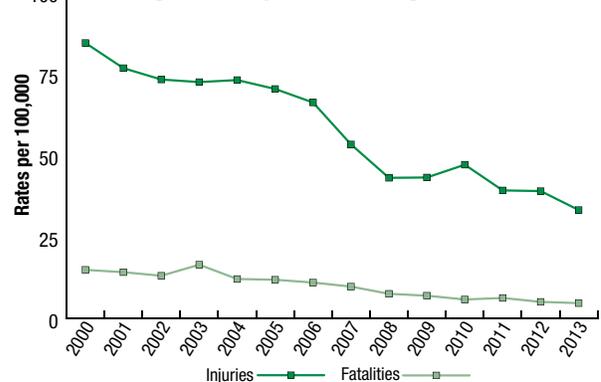
- Injury ranked fourth out of fifteen national priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- In a survey of partners and providers, injury was rated lower than average in terms of its impact on health, importance to addressing equity and potential for leveraging state resources.

## Health status data (Source: Oregon hospitalization data)

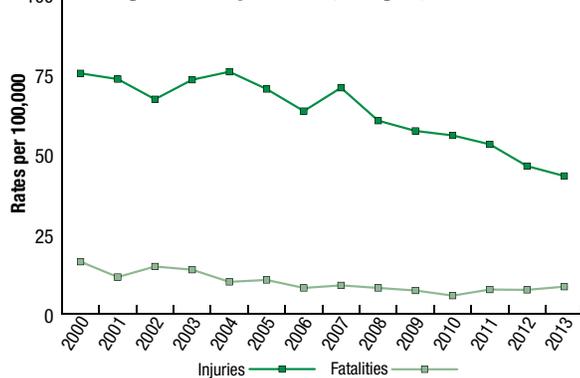
**Suicide-related hospitalization and death rate among 10 to 19 year olds, Oregon, 2000 - 2013**



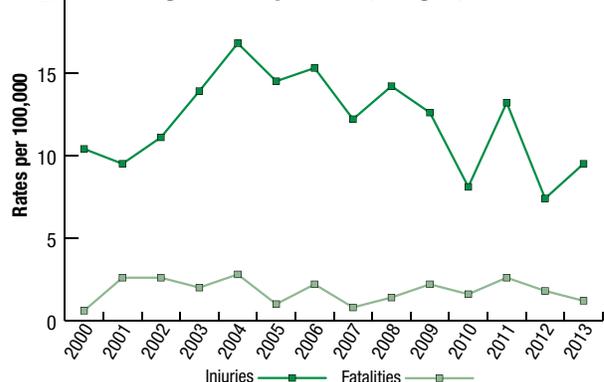
**Rate of hospitalizations and death due to motor vehicle accidents among 10 to 19 year olds, Oregon, 2000 - 2013**



**Rate of hospitalizations and deaths due to traumatic brain injury among 10 to 19 year olds, Oregon, 2000 - 2013**



**Rate of hospitalizations and deaths due to intentional injury among 10 to 19 year olds, Oregon, 2000 - 2013**



## Alignment with partners

- Oregon Public Health Division’s 2015 Strategic Plan includes strategies for reduction and prevention of family violence, suicide and child maltreatment
- Oregon IVP’s Pedestrian Safety Policy and Systems Change Strategies 2012 – 2015 implementation plan
- CCO metric to increase the percentage of Medicaid patients served , ages 6 and older, who received follow-up care with a health care provider after being discharged from the hospital for mental illness
- IVP measure to increase the Child Death Review cases that are reviewed by a local CDR team statewide
- CCO metric on adolescent well care visits

# Population Domain: Adolescent Health

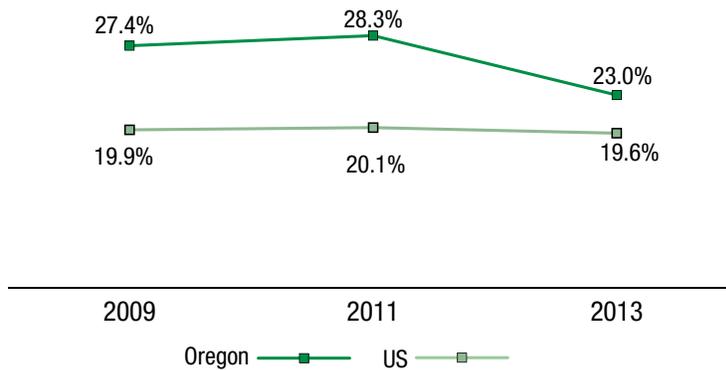
## Priority Area: Bullying

- National Priority Area
- Current State Priority Area
- Emerging State Topic

### National performance measure:

Percentage of adolescents, ages 12 through 17 years, who are bullied.

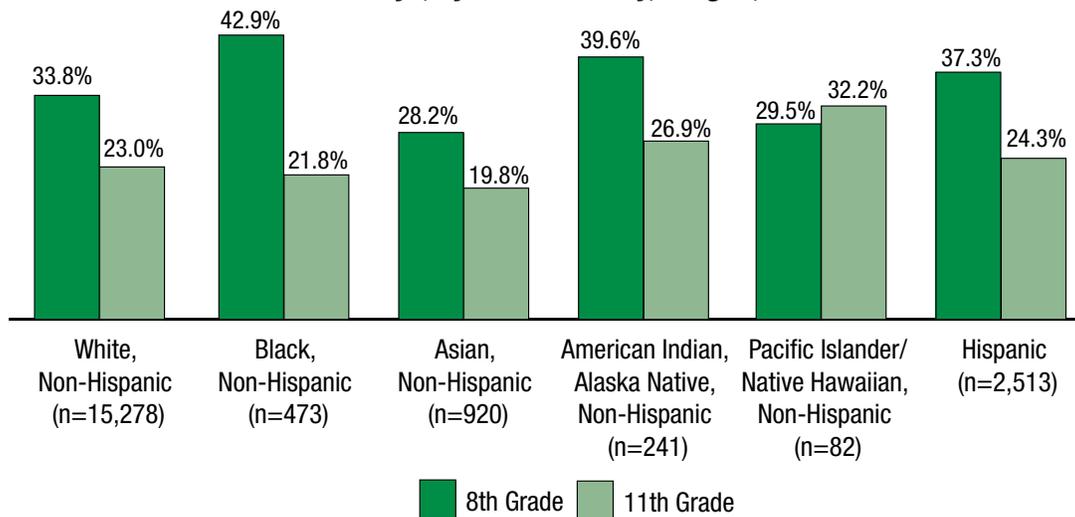
#### Percent of 11th graders who report being bullied or harrassed at school within the last 30 days, 2009 - 2013



Source: Oregon Healthy Teens

Note: 8th graders were not included, as US data is not available.

#### Percent of 8th graders and 11th graders who report being bullied/harrassed at school within the last 30 days, by race/ethnicity, Oregon, 2011



Source: Oregon Healthy Teens

### Significance of the issue

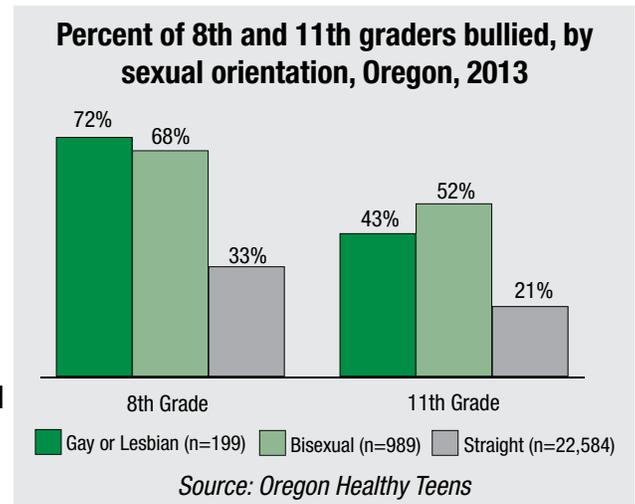
Bullying is unwanted, aggressive behavior among school aged youth that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Youth who bully use their power—such as physical strength, access to embarrassing information, or popularity—to control or harm others. Power imbalances can change over time and in different situations, even if they involve the same people. Types of bullying include verbal (teasing, name calling); relational (spreading rumors, leaving someone out); physical (hitting, kicking, pinching); and cyber-bullying.<sup>1</sup>

Nationally, 13% of adolescents reported being a bully, 11% reported being a victim of bullying, and 6% reported being both a bully and a victim. 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 (i.e., bully-victims) may exhibit the poorest functioning, in comparison with either victims or bullies, with effects lasting into adulthood.

<sup>1</sup> [www.stopbullying.gov/what-is-bullying/definition/](http://www.stopbullying.gov/what-is-bullying/definition/)

## Health status data

- Bullying appears to be declining in Oregon. From 2007-2013 8th grade bullying dropped from 42% to 35% and 11th grade bullying dropped from 27% to 23%. Cyber-bullying is not represented in these data, but a related question is being added to the 2015 OHT Survey.
- 8th graders are more likely to report being bullied than 11th graders (35% vs. 23% respectively)
- Girls are more likely to report being bullied compared to boys (39% vs. 30% among 8th graders; 25% vs 21% among 11th graders).
- Youth who met the Positive Youth Development (PYD) Benchmark (a six-item composite that measures research-based components of PYD including competence, confidence, support, service and health, both emotional and physical) are nearly half as likely to have reported being bullied or harassed in the past 30 days.<sup>2</sup>
- More than twice as many youth who identify as gay/lesbian or bisexual (LGB) report being bullied compared to youth who identify as straight.



## Context for the issue in Oregon

The Oregon Safe Schools Act mandates that all schools have policies prohibiting bullying, harassment and cyber-bullying. Anti-bullying policies must: enumerate protected classes; describe uniform procedures on reporting, investigating and responding to incidents; and specify that the policy applies to behavior on school grounds, as well as all school-sponsored activities, school-provided transportation, and official school bus stops. In 2012, the law was amended to include reporting requirements for all school employees, and that bullying prevention must be included in existing programs for students and employees. There was no funding directed to this mandate.

In 2013, the Oregon Public Health Division, Program Design and Evaluation Services, worked with partners to evaluate the policies against the statute. 66% of school district policies were found to be “substantially compliant” with the law.<sup>3</sup> However, there is question on the extent to which the policies have impacted behaviors and outcomes in the school environment. A 2013 report found that 60% of LGBT students who were harassed or assaulted in school never reported it to school staff. Among students who did report incidents to school authorities, only 40% said that reporting resulted in effective intervention by staff.<sup>4</sup>

The most effective anti-bullying interventions focus on improving the whole-school environment (such as Positive Behavior Intervention and Support, or PBIS).

## Stakeholder input

- Bullying ranked ninth out of fifteen national priority areas (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- In a survey of partners and providers, bullying was rated as having a relatively lower than average impact on health and importance to addressing equity, and was seen as relatively low in its potential for leveraging state resources.

## Alignment with partners

- PHD strategic plan objective around promoting safe and nurturing environments to reduce violence.
- Adolescent and School Health Program focus on Positive Youth Development and building resiliency.
- The Oregon Public Health Division and the Oregon Department of Education are both focusing on reducing bullying as a priority.
- Governor’s goal for 100% high school graduation by 2025.

<sup>2</sup> 8th grade OR: 0.53; 11th grade OR: 0.58

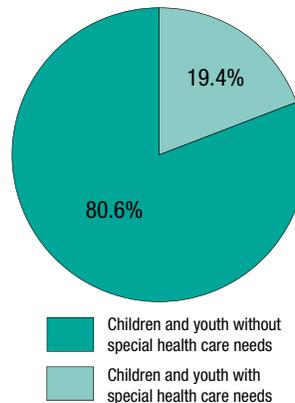
<sup>3</sup> State of the Safe Schools Act. May, 2013. [http://www.oregonsafeschools.org/wp-content/uploads/SafeSchoolsReport\\_2013\\_pages\\_v5.pdf](http://www.oregonsafeschools.org/wp-content/uploads/SafeSchoolsReport_2013_pages_v5.pdf)

<sup>4</sup> GLSEN 2013 Oregon State Snapshot.

# Population/Domain Overview: Children and Youth with Special Health Care Needs

The Maternal and Child Health Bureau define Children and youth with special health care needs (CYSHCN) as “those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally.”<sup>1</sup> CYSHCN experience complex health problems, chronic illnesses, and disabilities. Results of the 2011/12 National Survey of Children’s Health (NSCH) estimated the population of Oregon CYSHCN (ages 0-17 years) to be 166,596, or 19.4%, of Oregon children.

Percent of children and youth in Oregon with special health care needs, 2011/12



## Key background & issues of concern for this population

**Care Coordination:** CYSHCN face more inadequacies in healthcare, education, health of family, and maintaining a healthy lifestyle, when compared to children without special health care needs.<sup>2</sup> The need for care coordination for CYSHCN is related to medical complexity, use of multiple providers and services, and family-based social stressors.<sup>3</sup> Effective care coordination has been seen to foster communication among health care providers, improve satisfaction, and decrease barriers to effective care.<sup>4</sup>

**Health Care Costs:** CYSHCN account for 45.4% of the total health care costs for children excluding dental care, long term care, educational, and institutional care costs. CYSHCN make more than twice as many physician visits, have 1.5 times as many emergency department visits, have more than 3 times as many hospitalizations, and spend about 7 times as many days in hospitals as children without special health care needs.<sup>5</sup>

**Family Stress:** 25% of parents of CYSHCN reported feeling stress from parenting during the past month compared to 7% of parents of non-CYSHCN. About 21% of families of Oregon CYSHCN had problems paying or were unable to pay for their child’s medical bills.<sup>6</sup> Average out of pocket health expenses for families of CYSHCN are twice those for other families.<sup>5</sup> Families participating in Oregon Family to Family Health Information Center report that health care reform has confused many families and caused some temporary disruption in coverage. Many families lack knowledge of their rights and protections.

**Geographic Challenges:** Oregon frontier counties have about 3% of the state’s population but 1% of Oregon’s physicians. 2009 data show that almost no pediatricians practice in eastern Oregon.<sup>7</sup> Family and service providers report that families of CYSHCN living in rural areas experience difficulty obtaining the services that their children need.

<sup>1</sup> McPherson, M., Arango, P., Fox, H., Lauver, C., McManus, M., Newacheck, P.W., Perrin, J.M., Shonkoff, J.P., & Strickland, B. (1998). A new definition of children with special health care needs. *Pediatrics*, 102, 137-140.

<sup>2</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2011). *Children with special health care needs in context: a portrait of states and the nation 2007*. Rockville, Maryland: U.S. Department of Health and Human Services.

<sup>3</sup> Antonelli RC, Stille CJ, Antonelli DM (2008). Care coordination for children and youth with special health care needs: a descriptive, multisite study of activities, personnel costs, and outcomes. *Pediatrics*, 122(1).

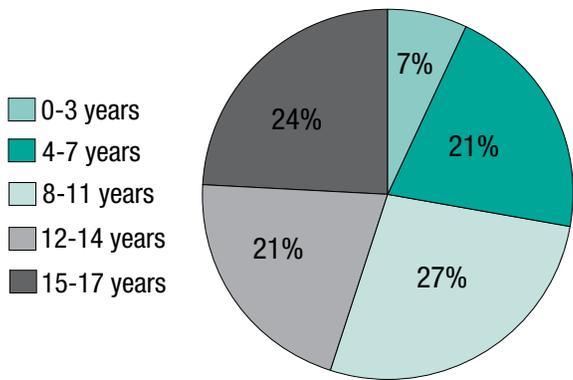
<sup>4</sup> Wood D, Winterbauer N, Sloyer P, et al. (2009). A longitudinal study of a pediatric practice- based versus an agency-based model of care coordination for children and youth with special health care needs. *Matern Child Health J.*, 13(5), 667–676.

<sup>5</sup> Newacheck, P.W., & Kim, S.E. (2005). A national profile of health care utilization and expenditures for children with special health care needs. *Archives of Pediatric and Adolescent Medicine*, 159, 10-17.

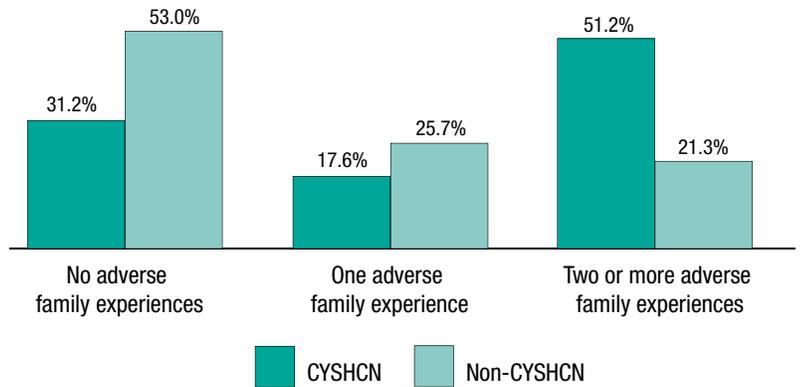
<sup>6</sup> National Survey of Children’s Health, 2011-12.

<sup>7</sup> Oregon Office of Rural Health. (2010). *Number of pediatricians by city and number of children 0-14 by service area in Oregon*. Retrieved on February 3, 2015 from <http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/publications/upload/Pediatricians-2010-Map.pdf>.

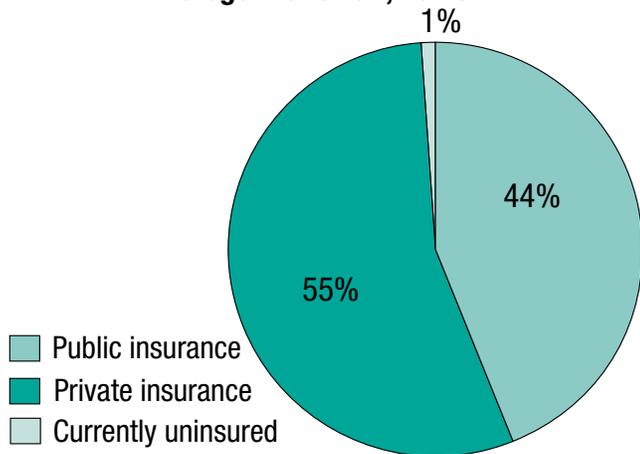
### Age Distribution of Oregon CYSHCN, 2011/2012



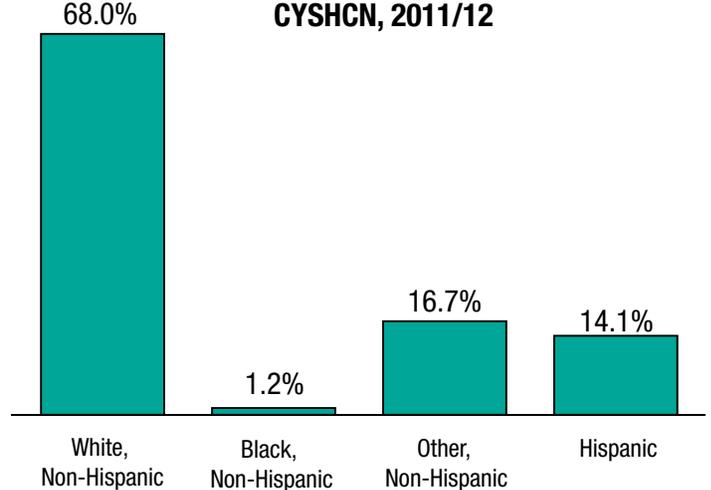
### Oregon CYSHCN with adverse childhood experiences (ACEs), Oregon, 2011/12



### Type of health insurance coverage for Oregon CYSHCN, 2011/12



### Race and ethnicity distribution of Oregon CYSHCN, 2011/12



Source for all figures: National Survey of Children's Health

#### Proposed National Priority Areas (2017-2021)

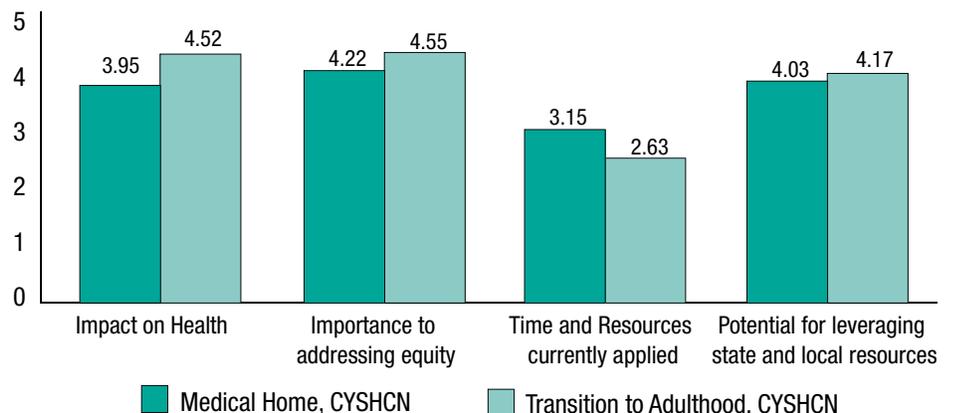
- Medical home
- Transition

#### Current State Priority Areas (2011-2016)

- Linkages for CYSHCN to mental health services
- Access to specialized services
- Access to family support services

### Partner Survey: Children and Youth with Special Health Care Needs Priority Areas

In a survey, service providers that serve women, pregnant women, mothers, infants, adolescents and children and agencies that receive Title V funds were asked to rate 29 areas in terms of their impact on health, the time and resources currently applied, importance to addressing equity and potential for leveraging state resources on a scale of 0 to 5. The results for the two national CYSHCN priority areas are shown to the right.



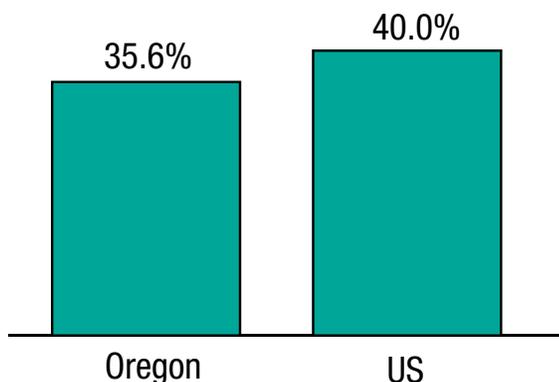
**Population Domain: Children and Youth with Special Health Needs**  
**Priority Area: Transition to Adulthood**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

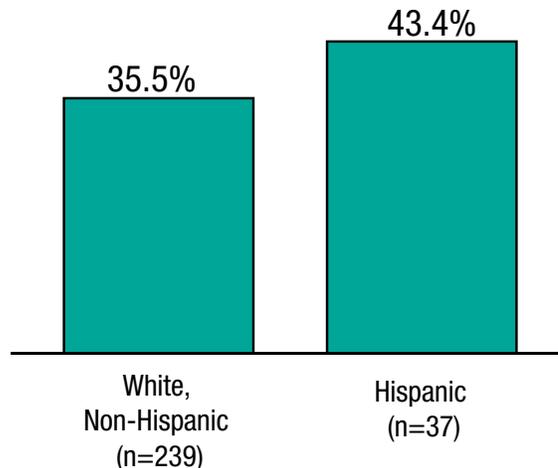
**National performance measure:**

Percentage of children and youth with special health care needs, ages 12 through 17, who received the services necessary to transition to adult health care.

**Percent of children with special health care needs who received necessary transition services, 2009/2010**



**Percent of children with special health care needs who received necessary transition services, by race/ethnicity, 2009/2010**



Source: National Survey of Children with Special Health Care Needs

Note: The sample for other racial/ethnic groups was sample too small to meet standard for reliability or precision.

**Significance of the issue**

The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians to improve healthcare transitions for all youth and families.<sup>1</sup> Healthy People 2020 established a CYSHCN-specific objective for transition: “increase the proportion of youth with special health care needs (YSHCN) whose health care provider has discussed transition planning from pediatric to adult health care.”<sup>2</sup> Most CYSHCN experience the same transition stages as children without special health care needs, and life course theory identifies transition from high school into adulthood as one of two critical transition stages that bear substantial influence on children’s life course.<sup>3</sup> Over 90% of CYSHCN now live to adulthood, but are less likely than their non-disabled 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. Improved outcomes, such as reduced medical complications, better patient-reported outcomes, greater adherence to care, improved continuity of care, and lower costs, have been associated with transition planning.<sup>4</sup> In addition, research has shown that CYSHCN ages 12 to 17 who received transition services were half as likely to have a family who cut back or stopped working because of their child’s health needs.<sup>3</sup>

1 Health Resources and Services Administration (HRSA). (2014, November 13). 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: U.S. Department of Health and Human Services, HRSA.  
 2 <http://www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health/objectives>  
 3 These stages may be reached at older ages depending on whether the child’s condition naturally affects her or his developmental trajectory. Bethell, C., Newacheck, P.W., Fine, A., et al. (2014). Optimizing health and health care systems for children with special health care needs using the life course perspective. *Maternal and Child Health Journal*, 18(2), 467-477.  
 4 <http://www.gottransition.org/news/index.cfm>

## Health status data

Based on their analysis of 2009/2010 National Survey of Children with Special Health Care Needs, researchers concluded that most CYSHCN do not receive the needed preparatory information to transition from pediatric to adult models of care.<sup>1</sup> The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) found similar results from its survey of a convenience sample of Oregon young adults (12 to 26 years old) with special health care needs and families and medical providers of CYSHCN. Only 12 percent of CYSHCN reported that their health care provider talked with them about how their relationship with their health care provider will change when they turn 18. About half of CYSHCN reported that their provider gives them “a lot of” or “some” help learning how to manage their own health and health care. These findings mirror the conclusions of CYSHCN transition experts who stated that health care providers encourage CYSHCN to assume greater responsibility for their health care, but less frequently discuss moving to an adult model of care.<sup>1</sup>

Less than one-third of families reported that their child’s primary care provider talked with the family member about how their child’s care may change after the child turns 18. Of the 25 medical providers that reported their practice serves YSHCN who are 14 years or older,

- 10 reported that their practice assesses readiness for transition to adult care, typically between 15 and 20 years of age;
- 5 reported that their practice has a written policy addressing YSHCN transition; and
- 0 had a program to foster the development of desirable self-management skills or knowledge for transition.

## Context for the issue in Oregon

OCCYSHN key stakeholder panelists reported that Oregon health care providers are not current on transition practices, and thus not prepared to provide transition direction for CYSHCN. In addition, transition efforts need to focus on both CYSHCN who will have some independence and those who will not have any degree of independence. The stakeholder panel advocated for including both medical home and transition as state priorities. Panelists stated that if the number of priorities was constrained due to resource availability, the state should focus on youth transition as medical home efforts are occurring elsewhere in the state.

## Alignment with partners

- OCCYSHN stakeholders reported that currently efforts are underway to address transition for education and employment for CYSHCN who will have some independence; however these efforts are not focused on health. The Governor’s Executive Order No. 13-04 focuses on improving employment services to individuals with intellectual and developmental disabilities (I/DD). This executive order is realized through the Oregon Department of Human Services’ Employment First, which presumes that working age adults and youth with I/DD can work in integrated jobs, i.e., those located typical workplaces in the community with opportunities to interact with colleagues and customers without I/DD. In addition to DHS Vocational Rehabilitation and Office of Developmental Disability Services, the Oregon Department of Education and Oregon Council on Developmental Disabilities participate in implementing the executive order.<sup>2</sup>
- The Oregon Consortium of Family Networks has a Reaching Our Community Combining Our Strengths (ROCCOS) Family Network website. One of the website’s goals is to facilitate college students with disabilities obtaining needed information and support to succeed in their academic career.
- Some families have served as mentors for others through the Oregon Family to Family (F2F) Health Information Center Transition Stories, which are health-focused “vignettes” about strategies to improve the transition process for CYSHCN and their families.

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<sup>1</sup> McManus, M.A., Pollack, L.R., Cooley, W.C., et al. (2013). Current status of transition preparation among youth with special needs in the United States. *Pediatrics*, 131, 1090-1097.

<sup>2</sup> <http://www.oregon.gov/dhs/employment/employment-first/Pages/about.aspx>

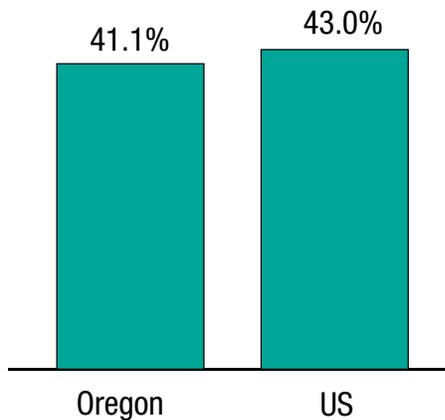
**Population Domain: Children and Youth with Special Health Needs**  
**Priority Area: Medical Home**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

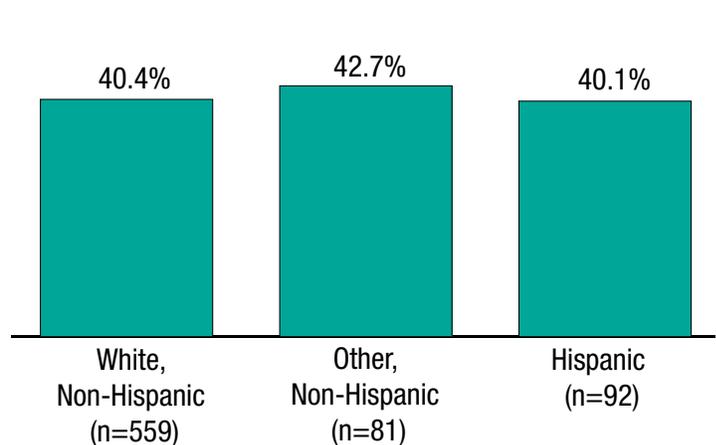
**National performance measure:**

Percentage of children with special health care needs having a medical home

**Percent of CYSHCN Who Receive Coordinated, Ongoing, Comprehensive Care within a Medical Home, 2009/10**



**Percent of CYSHCN Who Receive Coordinated, Ongoing, Comprehensive Care within a Medical Home, 2009/10**



Source: National Survey of Children with Special Health Care  
 Note: The sample for "Black, Non-Hispanic" only included 7 individuals, which was insufficient to report results.

**Significance of the issue**

In 1967 the American Academy of Pediatrics introduced the medical home model as a standard of primary care provision for CYSHCN.<sup>1</sup> Research suggests that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations; less likely to be hospitalized for preventable conditions; and more likely to be diagnosed early for chronic or disabling conditions. For families of CYSHCN a lack of medical home has been associated with increased out-of-pocket health-related costs and fewer referrals to needed specialty care.<sup>2</sup>

Healthy People 2020 established objectives to increase the proportion of CYSHCN who have access to a medical home.<sup>3</sup> The National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs Project proposed medical home as 1 of 10 standards for systems that serve CYSHCN. The standard includes specification that a primary care provider and/or a pediatric specialist participate in an integrated care team to provide care coordination and develop care plans.<sup>4</sup> Care coordination is particularly important because it might be a means of reducing unmet specialty care needs for CYSCHN families.

<sup>1</sup> [http://www.medicalhomeinfo.org/how/care\\_delivery/cyshcn.aspx](http://www.medicalhomeinfo.org/how/care_delivery/cyshcn.aspx)

<sup>2</sup> Boudreau, A.A., Goodman, E., Kurovski, D., et al. (2014). Care coordination and unmet specialty care among children with special health care needs. *Pediatrics*, 133, 1046-1053.

<sup>3</sup> <http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives>

<sup>4</sup> VanLandeghem, K., Sloyer, P., Gabor, V., & Helms, V. (2014). *Standards for systems of care for children and youth with special health care needs. A product of the National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs project.* Washington, DC: Association of Maternal & Child Health.

## Health status data

According to the National Survey of Children's Health, 2011/12:

- 37% of Oregon families of CYSHCN did not receive family centered care
- 34% did not meet one or more elements of care coordination
- 20% had one or more unmet needs for care during the past 12 months

OCCYSHN's survey results showed that:

- 47% of families "rarely" or "never" receive as much help as they want arranging or coordinating their child's care
- 37% of parents reported that someone helped them arrange or coordinate their child's care in the past month
- Less than one-third of parents reported that their child has a care plan; of those, half reported that their child's care plan had been given to all of his or her health care providers.
- Only 14 out of 26 care providers reported that their practices routinely complete care plans for CYSHCN

## Context for the issue in Oregon

Patient-Centered Primary Care Homes (PCPCH) are not equally distributed around the state. As of December 2014, 532 practices were recognized as PCPCHs, and the majority are clustered along the I-5 corridor between Portland and Eugene. PCPCHs are particularly sparse in central and eastern Oregon, and nearly non-existent in Southeastern Oregon.

Communication and information sharing among providers and family was identified as a barriers to effective care coordination by county public health nurses and key stakeholders. Key stakeholders also reported that:

- Efforts to promote medical home need to include a CYSHCN-specific focus.
- Primary care, education, and mental health providers in particular need to be talking with each other when caring for CYSHCN.
- Not all practices that develop care plans actually use them.
- Families do not expect their child's providers to supply or initiate a care plan.
- Youth transition for CYSHCN should be a part of medical home implementation.
- If Title V resources were only available for one of the two priorities, the state should focus on transition as other existing efforts are likely to address medical home for CYSHCN.

## Alignment with partners

- The PCPCH seeks to develop strategies to identify and measure what a primary care home does, promote their development, and encourage Oregonians to seek care through PCPCHs. No standards explicitly require address caring for CYSHCN; however, CYSHCN are one example of how a practice could meet Standard 5.C, Complex Care Coordination.<sup>1</sup>
- The foci of the Oregon Pediatric Improvement Partnership (OPIP) include implementation and enhancement of patient-centered primary care medical homes and use of practice-level findings to improve policy.<sup>2</sup>
- OCCYSHN received 1 of 12 State Implementation Grants for Enhancing the System of Services for CYSHCN through Systems Integration. The 3 year grant is funded through the Federal Maternal and Child Health Bureau. The program goal is to achieve a comprehensive, coordinated, and integrated state and community system of services and supports for CYSHCN. Its objective is to increase by 20% the proportion of CYSHCN who receive care through a medical home by 2017. OCCYSHN and OPIP will collaborate with state partners to implement the grant.

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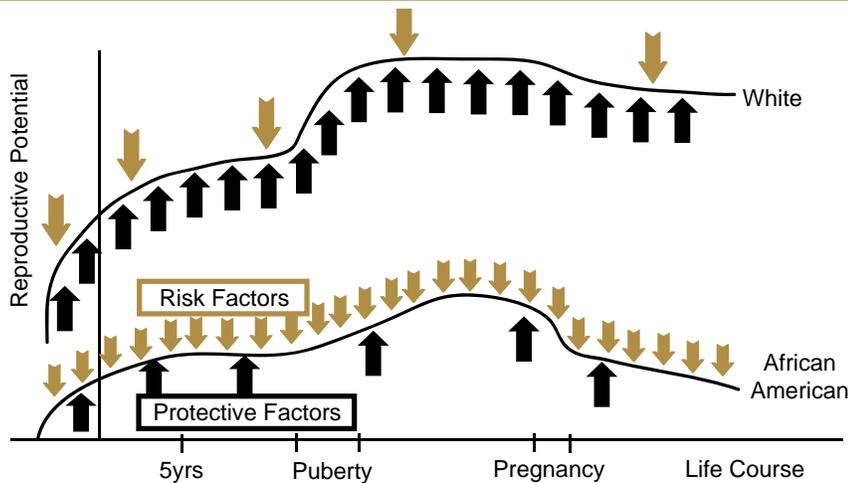
<sup>1</sup> Oregon Health Authority. (2013). *Patient-centered primary care home program 2014 recognition criteria. Technical specifications and reporting guide*. Retrieved on December 16, 2014, from <http://www.oregon.gov/oha/pcpch/Documents/2014%20Technical%20Assistance%20and%20Reporting%20Guide.pdf>.

<sup>2</sup> <http://www.oregon-pip.org/about/mission.html#>

# Population/Domain Overview: Cross-cutting/Life Course

PUBLIC HEALTH DIVISION  
CENTER FOR PREVENTION &  
HEALTH PROMOTION  
Maternal and Child Health Section

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The Life Course Perspective integrates a focus on critical periods and early life events with an emphasis on the wear and tear a person experiences over time. The figure above illustrates a disparity in reproductive potential, which is how one's health status at any given age may influence reproductive health and future birth outcomes. It demonstrates that there are differences in risk factors and protective factors over the life course of White and African American women, which in turn affects their health and development and contributes to disparities in birth outcomes.

## Key background & issues of concern for this population

Life Course theory explores the impact of early events on later health outcomes. For example, the children of pregnant women exposed to famine (in the Dutch famine of 1944) were more susceptible to diabetes, obesity, cardiovascular disease and schizophrenia as adults.

The Maternal and Child Health Bureau (MCHB) is using the lifecourse approach to promote optimal health and healthy development across the lifespan, as well as across generations, which promotes equity in health across communities and populations.

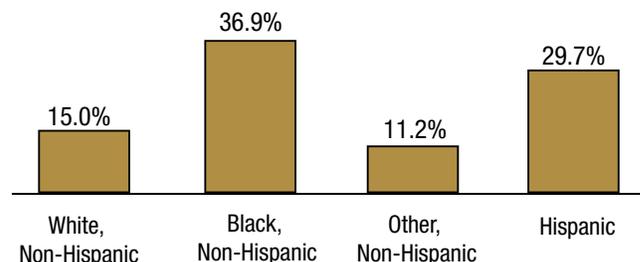
Key concepts of Life Course theory:

- Today's experiences and exposures influence tomorrow's health. (Timeline)
- Health trajectories are particularly affected during critical or sensitive periods. (Timing)
- The broader community environment—biologic, physical, and social—strongly affects the capacity to be healthy. (Environment)
- While genetic make-up offers both protective and risk factors for disease conditions, inequality in health reflects more than genetics and personal choice. (Equity)

A Life Course approach to maternal and child health interventions focuses on changes that can be made at early and sensitive periods to improve long-term health effects. Examples include the long-term effects of smoking, obesity and breastfeeding on the health of children and their descendants.

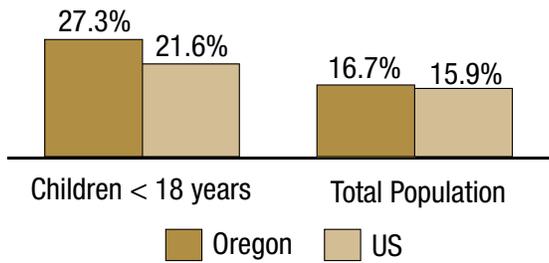
### Health status data:

Percent of families with children < 18 years old living in poverty, by race/ethnicity, Oregon, 2013



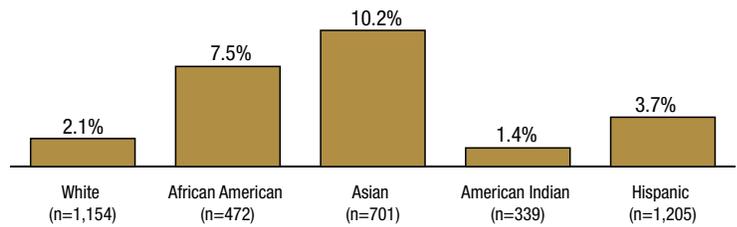
Source: American Fact Finder, United States Census Bureau  
Note: American Indian/Alaska Native and Native Hawaiian/Pacific Islander not included due to small sample size

### Food insecurity among total population and children < 18 years, 2012



Source: Map the Meal Gap, Feeding America, 2012

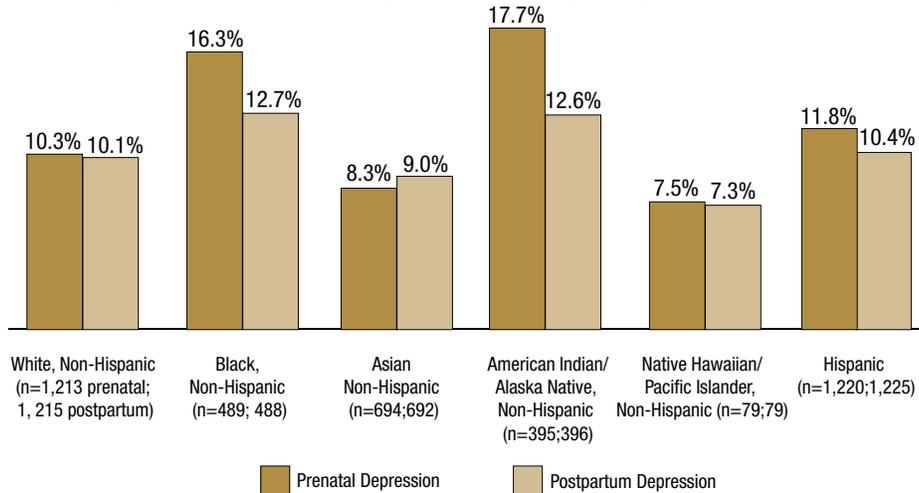
### Percent of women who experienced intimate partner violence in the last 12 months prior to pregnancy, by race/ethnicity, in Oregon, 2011



Source: Pregnancy Risk Assessment Monitoring System

Note: Native Hawaiian/ Pacific Islander not included due to small sample size

### Percent of women who self-report experiencing prenatal and postpartum depressive symptoms, by race/ethnicity, Oregon. 2009-2011 births



Source: Pregnancy Risk Assessment Monitoring System

#### Proposed National Priority Areas (2017-2021)

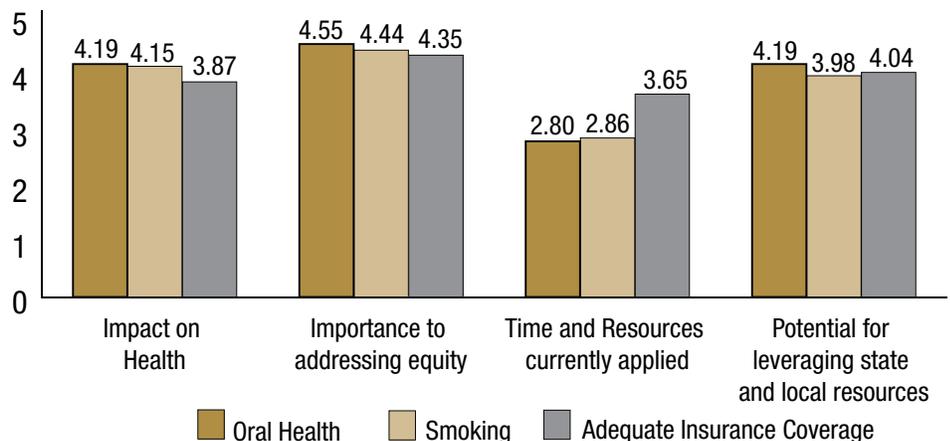
- Oral health
- Smoking
- Adequate insurance coverage

#### Current State Priority Areas (2011-2016)

- Oral health

### Partner Survey: Cross-cutting/ Life Course National Priority Areas

In a survey, service providers that serve women, pregnant women, mothers, infants, adolescents and children and agencies that receive Title V funds were asked to rate 29 areas in terms of their impact on health, the time and resources currently applied, importance to addressing equity and potential for leveraging state resources on a scale of 0 to 5. The results for the three national cross-cutting/life course priority areas are shown to the right.



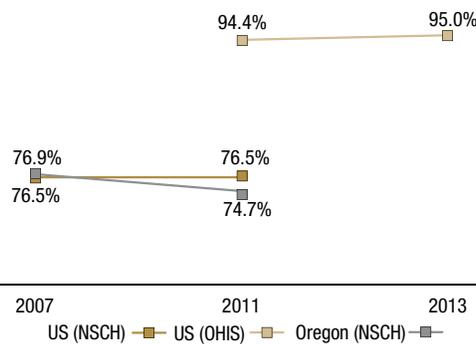
**Population Domain: Cross-cutting/Life Course**  
**Priority Area: Adequate Insurance Coverage**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**National performance measure:**

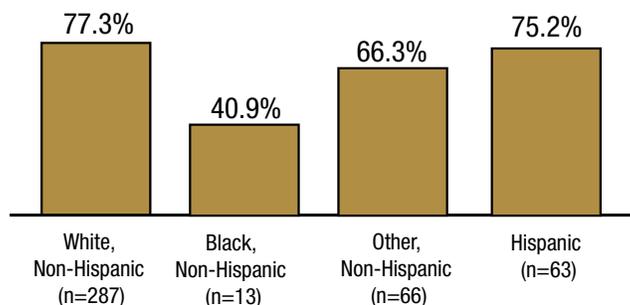
Percentage of children 0 through 17 years who are adequately insured

**Percent of children 0 to 17 years of age who are adequately insured, 2007 - 2013**



Sources: NSCH = National Survey of Children's Health  
 OHIS = Oregon Health Insurance Survey

**Percentage of children 0 to 17 years of age who are adequately insured, by race/ethnicity, Oregon, 2011**



Source: National Survey of Children's Health

**Significance of the issue**

Almost one-quarter of American children with continuous insurance coverage are not adequately insured. Inadequately insured children are more likely to have delayed or forgone care, to lack a medical home, are less likely to receive needed referrals and care coordination, and to receive family-centered care. The American Academy of Pediatrics highlighted the importance of this issue with a policy statement. The major problems cited were cost-sharing requirements that are too high, benefit limitations, and inadequate coverage of needed services.

**Context for the issue in Oregon**

In 2009, the Oregon Legislature expanded access to the Oregon Health Plan by creating the Healthy Kids Program. The program expanded eligibility for state-covered health insurance to 300 percentage of the Federal Poverty Level, streamlined the application process for children, and conducted outreach and enrollment to parents of children. By 2013, only 5% of Oregon children were uninsured.

Until October, 2013, undocumented pregnant women in only a few select Oregon counties had access to health insurance. However, with the implementation of the Affordable Care Act, CAWEM-Plus (Covered Alien Worker Emergency Medical) became available throughout the state, resulting in full pregnancy coverage for all undocumented pregnant women.

In addition to racial and ethnic disparities in health insurance coverage, there are disparities based on other characteristics, resulting in pockets of children in Oregon that are more likely to be uninsured. They include those whose families have financial and educational vulnerabilities, as well as those families that don't speak English in the home.

Insurance rates have received attention and are a quantifiable performance measure, however, the ability to access services once insured has received less attention and is becoming a larger issue for both children and pregnant women. Because of a large push to insure children in Oregon through the Healthy Kids Program, and the subsequent Medicaid Expansion through the Affordable Care Act, rates of uninsurance among children are low. However, insurance inadequacy as reported by parents may point to a different problem. Newly pregnant women remain a group more likely to be uninsured, and this impacts their timely access to prenatal care and their babies' health.

## Stakeholder input

- Adequate insurance coverage ranked third out of fifteen national priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- In a survey of partners and providers, adequate insurance coverage was rated higher than average in terms of its impact on health, importance to addressing equity and potential for leveraging state resources.

## Health status data

- In 2011, according to the Oregon Health Insurance Survey, 5.6 percent of children age 18 and under were uninsured in Oregon. However according to National Survey of Children's Health, for that same year, 24.5% of parents reported that their children were inadequately insured.
- In 2013, the Oregon Health Insurance Survey reported the uninsured percent as 5%. They reported higher percentages for children who experienced uninsurance at some time within a 12 month period at 11.8% in 2011 and 9.1% in 2013 (Oregon Health Insurance Survey, 2013), indicating that more children tend to "churn" (go on and off of insurance). This is significantly lower than the rates reported by parents on PRAMS.
- Pregnancy becomes an important motivator for women to get health insurance, which then allows for subsequent coverage of their child in utero and at birth. In 2011, 27% of women reported being uninsured in the month prior to pregnancy. However, between conception and prenatal care many more women became insured; 97.4% of pregnant women received coverage to pay for prenatal care. By the time of delivery, only 1.5% reported having no health insurance. (Oregon PRAMS, 2011)
- According to data from the National Survey of Children's Health (2011/2012), Oregon has lower uninsurance rates than the nationwide average for children with special health care needs; 0.9% vs. 3.2%.
- Children with parents who have less than a high school education are uninsured at a rate of 12.3%, compared to 6.3% for children of parents who are high school graduates and 2.6% for children of parents with more than a high school education. Of families under 200% of the Federal Poverty Level, 15% had uninsured children in 2011, compared to 3.1% of families at 200% FPL and over. And in homes in which Spanish is the primary language, 14% of children are uninsured compared to only 3% of Non-Hispanic and Hispanic English-speaking families (National Survey of Children's Health, 2011/2012).

## Alignment with partners

- Large push for insured children in Oregon through the Healthy Kids Program
- Medicaid Expansion through the Affordable Care Act
- CAWEM-Plus (Covered Alien Worker Emergency Medical) resulted in full pregnancy coverage for all undocumented pregnant women
- The Oregon Health Insurance Exchange collaborating with partners to not only expand access to care, but also to improve its quality and value

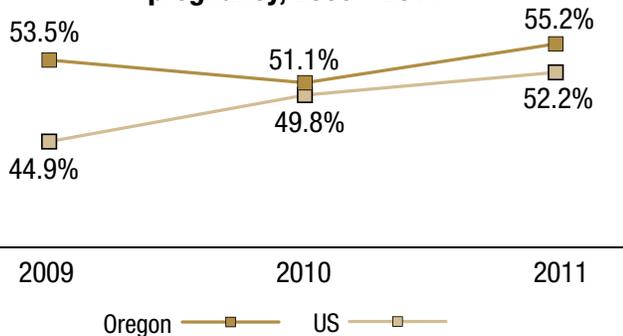
**Population Domain: Cross-cutting/Life Course**  
**Priority Area: Oral Health**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**National performance measure:**

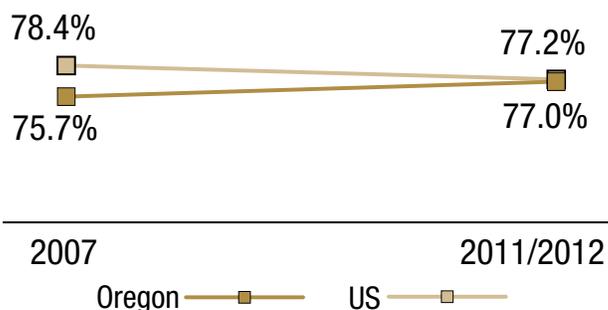
A) Percentage of women who had a dental visit during pregnancy and B) percentage of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year.

**Percent of women who had a dental visit during pregnancy, 2009 - 2011**



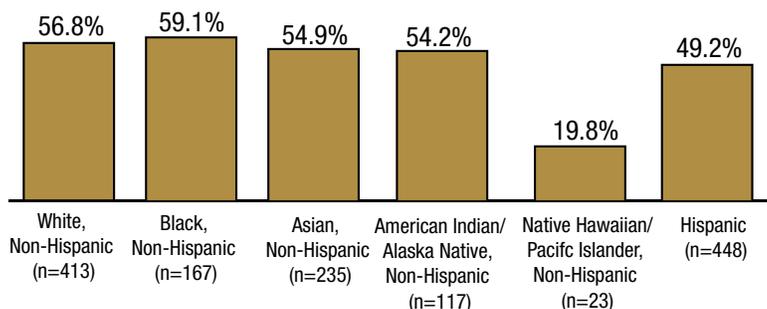
Source: Pregnancy Risk Assessment Monitoring System

**Percent of children age 1 to 17 years with a preventive dental visit in the last year, 2007 - 2011/12**



Source: National Survey of Children's Health

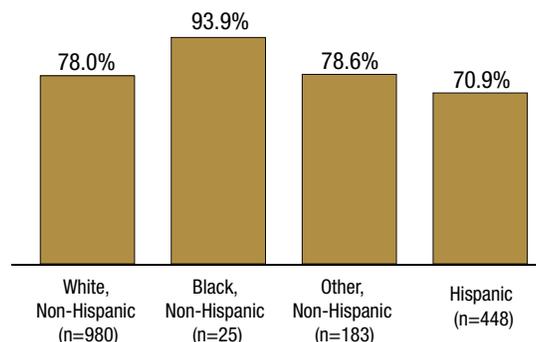
**Percent of women who had a dental visit during their pregnancy, by race/ethnicity, Oregon, 2011**



Source: Pregnancy Risk Assessment Monitoring System

NH = Non Hispanic, AI/AN = American Indian/Alaska Native, NH/PI = Native Hawaiian/Pacific Islander

**Percent of children age 1 to 17 years with a preventive dental visit in the last year, by race/ethnicity, Oregon 2011/12**



Source: National Survey of Children's Health

**Significance of the issue**

Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential components of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral

health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care.

State Title V Maternal and Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.

## **Context for the issue in Oregon**

Oregon has a comprehensive state-based oral health surveillance system, a nationally recognized best practice school-based dental sealant program, a robust statewide oral health coalition, a successful early childhood cavities prevention program (First Tooth), and integration of dental services in the Coordinated Care Model.

Despite these:

- the majority of children in Oregon have decay,
- non-traumatic dental needs are one of the most common reasons for emergency department visits,
- the statewide fluoridation rate remains around 22%, and
- children residing in rural and frontier areas have less access to care and higher rates of decay.

## **Stakeholder input**

- Oral health ranked fifth out of fifteen national priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- Oral health was the second most frequently mentioned priority area in the stakeholder phase of the needs assessment, and ranked highest in terms of unmet needs in that phase.
- In a survey of partners and providers, oral health was given an average rating in terms of its impact on health, and above average ratings in terms of its importance to addressing equity and potential for leveraging state resources.

## **Health status data**

48% of first graders have had a cavity. This rate jumps to 57.5% by third grade, to 70.1% in 8th grade and 74% in 11th grade. Cavities are almost entirely preventable.

## **Alignment with partners**

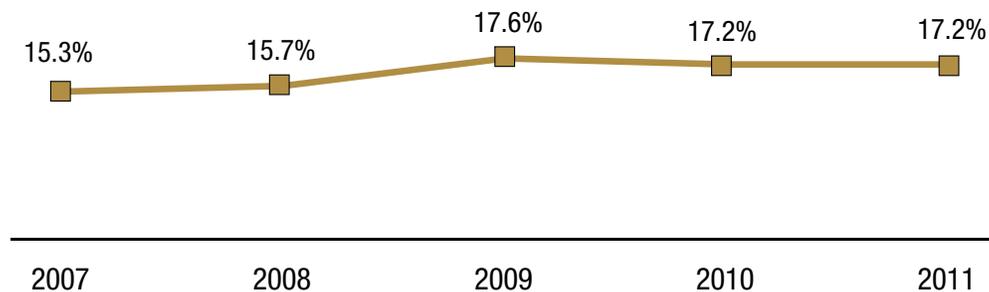
- Oral health is one of the six priority areas in the State Health Improvement Plan
- Oregon just released the Oral Health Strategic Plan that comprehensively outlines the priorities for improving oral health across the lifespan
- The Oregon Oral Health Coalition has recently been awarded two grants: expansion of the First Tooth Program and improving oral health for older adults
- Oregon Coordinated Care Organizations have a dental sealant performance metric
- SB 738 allows for Oregon to test various types of new and expanded workforce models to improve access and outcomes for the most vulnerable populations.
- Legislation is being developed to expand oral health preventive services for children.

## Current State Priority Area: Oral Health

**Oregon Title V goal:** Increase the percentage of children aged 4 years and under who have a preventive dental visit each year.

**State performance measure:** Percentage of children less than 4 years of age on Medicaid who received preventive dental services from a dental provider in the year.

**Percent of children less than 4 years of age on Medicaid who received preventive dental services from a dental provider within the last year, Oregon, 2007 - 2011**



*Source: Division of Medical Assistance Programs - Medicaid/Oregon Health Plan Claims*

### Work in progress

- In 2014, the Oral Health Unit served 159 schools, and local programs served 226 schools. Although the number of eligible schools in the state is increasing, the program was able to serve 77.7% of the eligible schools in Oregon in 2014. Continuous quality improvement has increased the parent permission return rates to 62% and improved the retention rate to 91% retention program-wide.
- The Oral Health Program has begun the implementation of the HRSA workforce grant to utilize Expanded Practice Dental Hygienists (EPDHs) to provide additional preventive services in a select number of schools. Results of this effort will guide program development in the future.
- The Oral Health Program is working to establish a reimbursement mechanism that will provide sustainability and enable us to expand the program to serve more children.

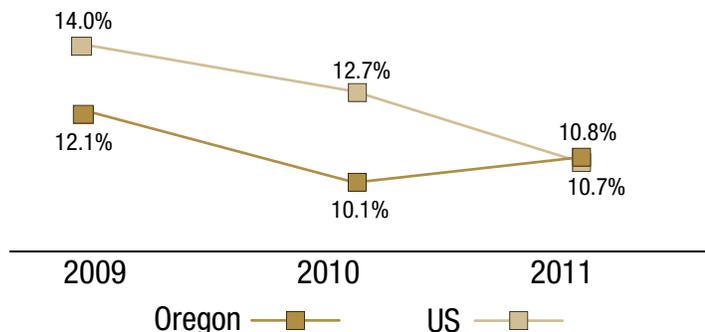
**Population Domain: Cross-cutting/Life Course**  
**Priority Area: Smoking**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**National performance measure:**

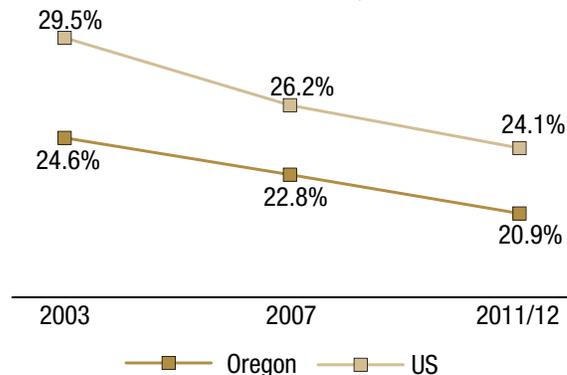
A) Percentage of women who smoke during pregnancy, and B) percentage of children who live in households where someone smokes

**Percent of women who smoked during the last 3 months of their pregnancy, 2009 - 2011**



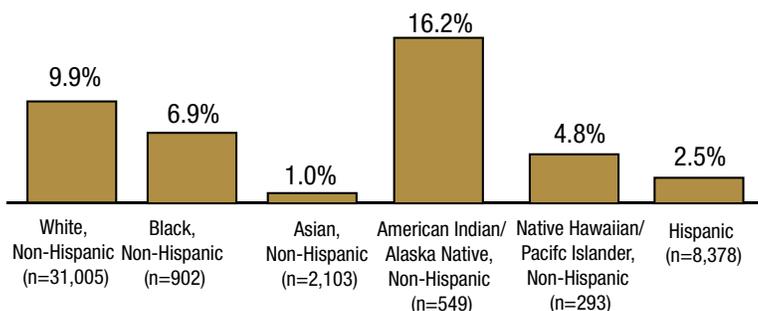
Source: Pregnancy Risk Assessment Monitoring System

**Percent of children who live in a household with someone who smokes, 2003 - 2007**



Source: National Survey of Children's Health

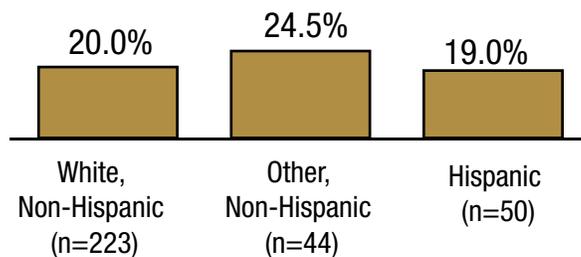
**Percent of women who who smoked during the last 3 months of their pregnancy, by race/ethnicity, Oregon, 2011 Births**



Source: Pregnancy Risk Assessment Monitoring System

NH = Non Hispanic, AI/AN = American Indian/ Alaska Native, NH/PI = Native Hawaiian/Pacific Islander

**Percent of children who live in a household with someone who smokes, by race/ethnicity, Oregon, 2011/12**



Source: National Survey of Children's Health

Note: Black, Non-Hispanic not included due to small sample size

**Significance of the issue**

Tobacco use during pregnancy is a special concern because of the effects of smoking on the mother and to the fetus. 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. Adverse effects of parental smoking on children have been a clinical and public health concern for decades and were documented in the 1986 U.S. Surgeon General Report.

## Context for the issue in Oregon

**Community programs:** Tobacco Prevention and Education Program (TPEP) has collaborated with MCH and WIC to present a webinar to county and tribal TPEP grantees on tobacco use and pregnant women. The webinar summarized Oregon data related to pregnant women and tobacco; described opportunities to collaborate with local partners such as WIC, Oregon MothersCare, public health nurses and home visiting programs; and outlined a framework for addressing smoking and pregnancy among American Indian and Alaska Native communities.

In December 2014, TPEP established a workgroup led by local grantees on the topic of tobacco use and pregnant women. The workgroup convenes bimonthly to share successful strategies and learn from guest speakers regarding pregnant women and tobacco use using policy and systems change approaches. Activities among the workgroup members include partnering with Coordinated Care Organizations (CCO's) to establish electronic health record documentation of tobacco use by pregnant women, setting up referral systems to the Tobacco Quit Line and other evidence based cessation services, and strengthening policies on tobacco cessation intervention protocols in local WIC offices.

**Cessation:** Beginning in January 2015, the Oregon Tobacco Quit Line will offer enhanced services to smokers who are pregnant. The "pregnancy program" offers pregnant smokers increased support; pregnant women will receive 10 outbound consultation calls, up to six months post-partum. This pregnancy program is grounded in existing scientific evidence, and will provide pregnant smokers the resources they need to be successful in quitting tobacco use.

## Stakeholder input

- Smoking ranked second out of fifteen national priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- In a survey of partners and providers, smoking was rated higher than average in terms of its impact on health, importance to addressing equity and potential for leveraging state resources.

## Health status data

- Oregon's rate of smoking during pregnancy has always been above the national average. An estimated 4,795 infants in Oregon were born in 2011 to mothers who used tobacco during pregnancy, resulting in an estimated \$1.9 million in extra health costs.
- Pregnant women who are younger, have a low level of education, and are unmarried are more likely to smoke during pregnancy.
- Most pregnant women make quit attempts during pregnancy; according to Oregon PRAMS (2011), 71% of women attempted to quit. And smoking rates decrease during pregnancy from 23.2 to 10.8% in the last trimester.
- Rates however increase after a baby is born to 13.8% (PRAMS, 2011). Smoking rates by pregnant women are not consistent across race and ethnicity, with the highest rates among American Indian/Alaska Native and White mothers.
- The Public Health Division (PHD) will continue to follow smoking in the household as Oregon legalizes marijuana to see if these percentages change.

## Alignment with partners

- Addressing tobacco use for the entire population is a primary priority of the PHD's Strategic Plan
- Tobacco use is a performance measure for Oregon's CCO's
- A variety of strategies are used by the PHD, which works to protect all Oregonians from secondhand smoke in their homes, workplaces and communities, and also help smokers, including those who are pregnant, to quit
- The PHD Strategic Plan includes five evidence-based strategies for tobacco prevention towards the goal of improved quality of life and increased years of healthy life
- PHD's Maternal and Child Health Program works closely with TPEP on tobacco prevention and cessation efforts

**Population Domain: Maternal and Women's Health**  
**Priority Area: Family Violence**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

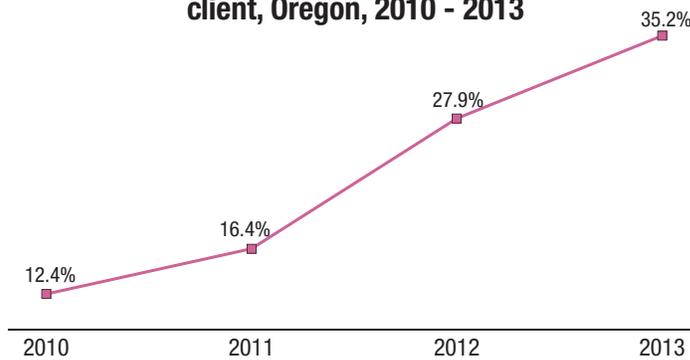
**Oregon Title V Goal:**

Improve Oregon's systems and services for screening women for domestic and sexual violence (DSV) and for linking those affected by DSV to adequate services.

**State performance measure:**

Percentage of family planning clinic encounters in which relationship safety was discussed with the client.

**Percentage of family planning clinic encounters in which relationship safety was discussed with the client, Oregon, 2010 - 2013**



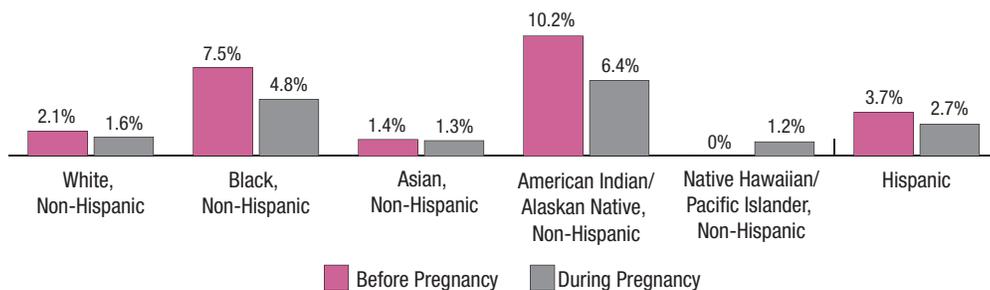
Source: Ahlers Family Planning Client Data-Clinic Visit Record, Oregon Reproductive Health Program

**Significance of the issue**

Family violence encompasses a continuum of violence and abuse, including child abuse (physical, sexual and observing adult abuse); sexual assault; reproductive coercion; stalking; sexual harassment; and elder abuse. Domestic and sexual violence (DSV) is a serious public health problem with grave consequences for women, children, families, and communities. The Adverse Childhood Events (ACEs) Study, demonstrates that exposure to DSV or family violence can result in serious lifelong physical and mental health problems including depression, self-destructive behavior, anxiety, toxic stress, and substance abuse. People experiencing violence have difficulty maintaining health and children experiencing violence have challenges with developing and learning because their immediate safety is their priority. Public health is now using emerging evidence-based interventions to help implement primary prevention strategies that address the root causes and prevent the violence before it occurs. Health care providers and public health and social service programs play an important role in screening their clients, referring them on for services, and creating a strong service network for victims.

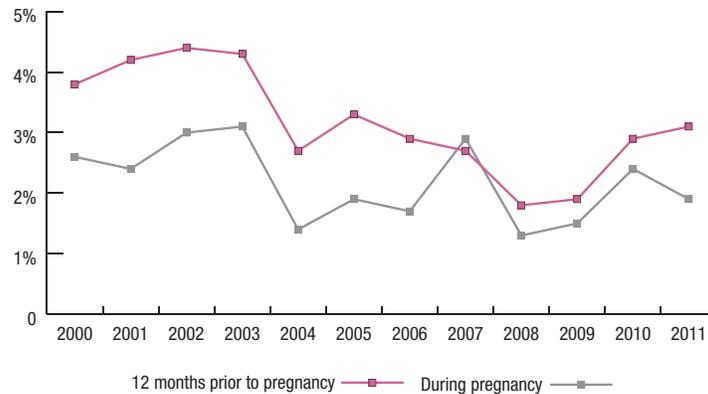
**Health status data**

**Percentage of women who experienced intimate partner violence before and during pregnancy, by race/ethnicity, Oregon, 2011 births**



Source: Oregon Pregnancy Risk Assessment Monitoring System

## Percentage of women who experienced intimate partner violence before pregnancy, during pregnancy, Oregon, 2000 - 2011 births



Source: Oregon Pregnancy Risk Assessment Monitoring System

## Stakeholder input

### Statewide review of county assessments

A review was conducted of 53 community health assessments, including those from counties, community health agencies, and communities that experience health disparities, such as African American, American Indian, and Hispanic communities. Family violence was cited in 24 of these assessments. Domestic violence/child abuse was the 31st most frequently cited out of 32 unmet maternal and child health needs.

### Partner Survey

Of 29 health topics, family violence ranked 15th in terms of impact on health, 4th in terms of importance for addressing equity, 11th in terms of the time and resources currently being applied and 11th in terms of potential for leveraging state resources.

## Work in progress

Beginning in January of 2013, Oregon Public Health Division was awarded funds from Futures without Violence and the Federal Office of Women's Health to implement Project Connect. The three year grant implemented a clinic-based intensive screening and referral intervention at three family planning sites (North Central Public Health District, Washington County, and Deschutes County). The grant also required the creation of an enhanced referral network with the DSV services agencies. Since Project Connect began, 75 providers and over 150 DSV advocates have been trained. Twenty-three providers also attended a train-the-trainer session on screening and DSV. The third and final year of the grant is now focused on sustainability and moving the screening and referral system beyond family planning providers. Project Connect is starting to focus on training OB-GYNs, primary care providers, and home visitors in implementing the screening intervention.

The results have been encouraging, showing a dramatic increase from 2010 to 2013 in the proportion of visits that included counseling on relationship safety (12.4% in 2010, 16.4% in 2011, 27.9% in 2012, and 35.2% in 2013) in public family planning clinics in Oregon. In addition the percentage of Oregon's family planning providers reporting they are screening for IPV has gone up significantly since addressing IPV became a Title V priority.

## Alignment with partners

The Futures without Violence/Project Connect grant has allowed Oregon to move forward with the promotion of screening in the health care setting with a number of key partners. A formal collaboration with the Oregon Coalition against Domestic and Sexual Violence (OCADSV) has been forged. They now have staff who are able to assist providers and clinics statewide on screening and support issues. Partners include the Department of Justice Safer Futures program, local Department of Human Services programs, local health departments, family planning providers, CCOs, innovator agents, legal advocates, and tribes. The Department of Justice, Safer Futures grant allowed the formation of the IPV and Health Care policy work group, which has been meeting monthly for the past two years. The OCADSV statewide conference in June 2015 will focus on the integration of DV services and screening with health care.

**Population Domain: Maternal and Women's Health**  
**Priority Area: Drug and Alcohol Use**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**Oregon Title V Goal:**

Decrease the risk of lifetime dependence on alcohol for teens and adults.

**State performance measure:**

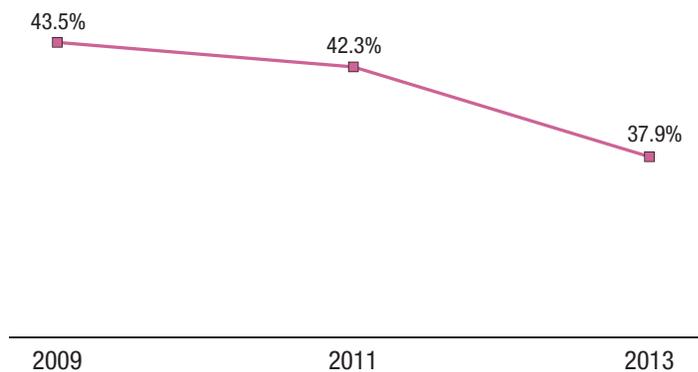
Percent of 11th grade students who were 14 years old or younger when they had more than a sip or two of beer, wine, or hard liquor for the first time.

**Significance of the issue**

- Age at first use of alcohol is highly correlated with 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.
- People in their child-bearing years, between the ages of 18 – 34, are the most likely to binge drink but don't recognize their consumption as problematic.
- More than half (51.7 percent) of new mothers reported drinking alcohol before they knew they were pregnant and 8.7 percent consumed alcoholic beverages during their last trimester.<sup>1</sup>
- Alcohol is a teratogen (an agent that can disturb the development of an embryo or fetus) and can cause Fetal Alcohol Spectrum Disorders (FASD) in infants exposed prior to birth. In Oregon, annual health care expenses associated with FASD totaled \$78 million.<sup>2</sup>

**Health status data**

**Percent of 11th grade students who were 14 years old or younger when they had more than a sip or two of alcohol for the first time, Oregon, 2009 - 2013**



Data source: Oregon Healthy Teens

Note: Available US data is 12 years or younger, not 14, so not directly comparable.

<sup>1</sup> 2007 Oregon PRAMS, the Pregnancy Risk Assessment Monitoring System, is a project of the Office of Family Health with support from the national Centers for Disease Control and Prevention (CDC).

<sup>2</sup> Department of Human Services, Public Health Division. (2009.) *Gaining Knowledge About Fetal Alcohol Syndrome: Results from Oregon's FAS Prevention Program, 2005–2009.* Retrieved from [http://public.health.oregon.gov/HealthyPeopleFamilies/Women/PreconceptionHealth/FetalAlcoholSyndrome/Documents/fas\\_final\\_report.pdf](http://public.health.oregon.gov/HealthyPeopleFamilies/Women/PreconceptionHealth/FetalAlcoholSyndrome/Documents/fas_final_report.pdf).

## **Stakeholder input**

### **Statewide review of county assessments**

In a review of 53 community health assessments, alcohol abuse was cited in 16 assessments and ranked 9th out of 33 unmet maternal and child health needs.

### **Partner Survey**

Of 29 health topics, adolescent alcohol use ranked 9th in terms of impact on health, 16th in terms of importance for addressing equity, 26th in terms of the time and resources currently being applied, and 19th in terms of potential for leveraging state resources.

## **Work in progress**

A contract was executed with the Sanction, Treatment, Assessment, Revocation, and Transition (START) Program in the Oregon Pediatric Society (OPS) with the goal of implementing a performance improvement project with adolescent providers to increase utilization of Screening, Brief Intervention, and Referral to Treatment (SBIRT) framework for substance use, within the context of the adolescent well visit. Oregon's MCH Program and Adolescent Health Program participated with Oregon's Addiction and Mental Health Division on an advisory group for their Strategic Prevention Framework – State Incentive Grant (SPF-SIG). Many of their activities align with the Public Health and MCH priorities regarding the reduction of binge drinking in young adults and youth. Oregon's Coordinated Care Organizations (CCOs) have, as an incentivized performance measure, the responsibility to ensure annual SBIRT screenings for their members.

For the past 4 years, the MCH Section has participated with OHA's Addictions and Mental Health Division on their Strategic Prevention Framework – State Incentive Grant (SPF-SIG), providing consultation regarding population-based interventions, social marketing, and recommendations for sustainability and dissemination. The goals of the grant are to prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking, reduce substance abuse-related problems in communities, and build prevention capacity and infrastructure at the state/tribal and community levels.

## **Alignment with partners**

The MCH Program has been collaborating with Oregon's Addictions and Mental Health Division in the statewide effort to integrate SBIRT screening into the CCOs. In addition, the MCH and Adolescent Health Programs have worked together to ensure implementation of the START Program's performance improvement project with adolescent providers. Oregon's Adolescent Health Section is working with partners to inform strategies that address policy implications around SBIRT screening of adolescents. It is necessary that this same work is conducted with prenatal care providers to prevent alcohol use during pregnancy.

**Population Domain: Maternal and Women's Health**  
**Priority Area: Maternal Mental Health**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**Oregon Title V Goal:**

Prevent the negative consequences of maternal mental health (MMH) disorders for women, infants, children and families by improving Oregon's systems and services to identify, treat, and support women with perinatal mental health disorders.

**State performance measure:**

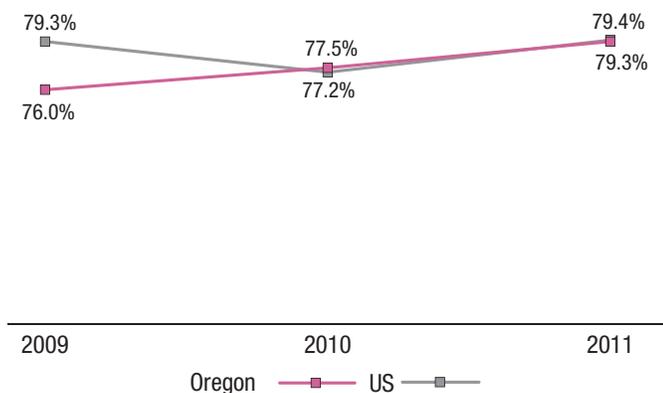
Percent of women who reported that they received education about depression during their most recent pregnancy from a prenatal care provider.

**Significance of the issue**

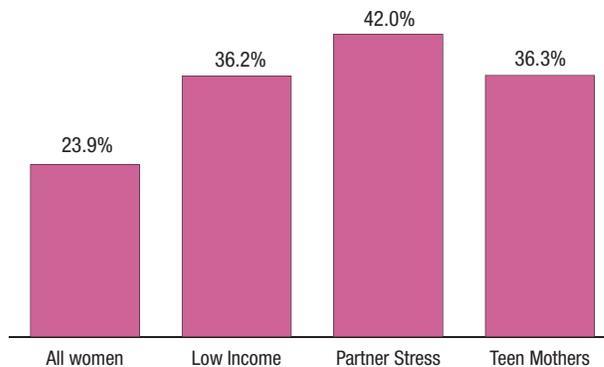
- Depression is the leading cause of disease-related disability in women, and the most common serious complication of childbirth.
- Maternal depression and anxiety affect a woman's ability to care for herself, relate to others, engage in healthy parenting behaviors, and bond with newborns.
- Children of depressed mothers are at risk for serious health, development, emotional, behavioral, and cognitive problems that can persist for many years.

**Health status data**

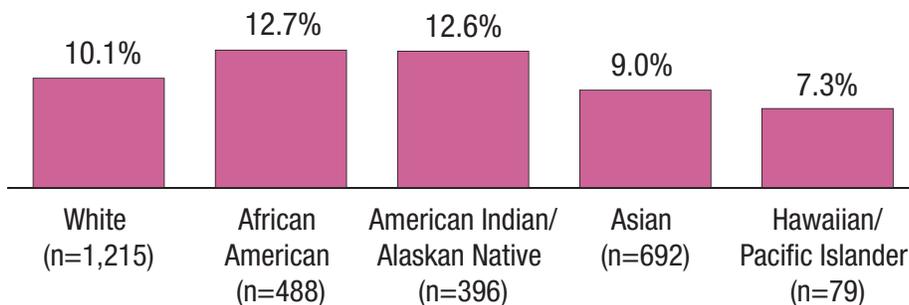
**Percent of women who received education about depression during prenatal care, 2009 - 2011**



**Self-reported maternal depression in Oregon by selected maternal characteristics, 2004 - 2008**



**Percentage of women who self-report experiencing postpartum depression symptoms, by race/ethnicity, Oregon, 2009 - 2011 births**



Source: Pregnancy Risk Assessment Monitoring System

Note: The self-reported depression questions in PRAMS were different in 2004-2008 and 2009-2011, so statistics across these two time periods should not be compared.

## **Stakeholder input**

### **Statewide review of county assessments**

In a review of 53 community health assessments, maternal mental health was cited in 22 assessments. It ranked 2nd out of 32 unmet maternal and child health needs.

### **Partner Survey**

Of 29 health topics, maternal mental health ranked 6th in terms of impact on health, 1st in terms of importance for addressing equity, 19th in terms of the time and resources currently being applied, and 1st in terms of potential for leveraging state resources.

## **Work in progress**

From 2009 to 2011, 10.8% of women in Oregon self-reported depressive symptoms prior to pregnancy, and 10.2% self-reported depressive symptoms after giving birth (Oregon PRAMS). Title V is convening and collaborating with public, private, and non-profit partners around the state to strengthen Oregon's systems, services, and supports for perinatal and postpartum families. Specific activities included:

- Working with 211Info to improve the database, protocols, and training of 211 staff in MMH and assure the quality of information and referrals for maternal mental health issues.
- Providing technical assistance to communities to assess community needs and resources for maternal mental health; mobilize community partners; and implement screening, assessment, referral, treatment, and support systems for maternal mental health in their communities.
- Working with state agency partners to integrate MMH screening, assessment, treatment, and support into Oregon's new CCOs and the Early Learning Hubs.
- Maintaining and improving the MMH patient and provider education website and supporting materials.
- Increasing the MCH Section's capacity to provide consultation for perinatal mental health through Postpartum Support International and NCAST training of public health nursing and MIECHV staff.
- Training of statewide home visiting and WIC staff.
- Ongoing surveillance of MMH status and needs through Oregon PRAMS and PRAMS-2.

## **Alignment with partners**

- Screening and referral for depression in adults is an incentive measure for Oregon's CCOs.
- The Oregon Pediatric Society has developed and is implementing training for pediatric and primary care providers in screening and referral for perinatal depression and anxiety.
- The Early Learning Division recognizes maternal mental health as a critical component to achieving their goal of stable and attached families.
- Oregon's Maternal, Infant and Early Childhood Home Visiting (MIECV) programs focus on anticipatory guidance, screening, referral, and support for maternal depression and anxiety.

**Population Domain: Child Health**  
**Priority Area: Parent Resources and Support**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

**Oregon Title V Goal:**

Improve the state's capacity for supporting parents in building parent skills and for linking parents to resources.

**State performance measure:**

Using benchmarks, to develop a Public Health Action Plan for improving parenting skills and education within the maternal and child health policies, programs, and outcomes.

**Significance of the issue**

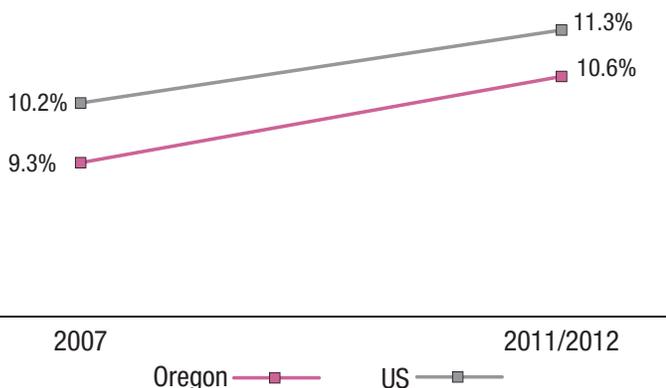
- Children experience better health outcomes when they live in safe, nurturing relationships and environments.
- Building parenting skills and education improves their capacity for providing safe, nurturing relationships and environments.
- The more Adverse Childhood Experiences (ACEs) a child experiences, the greater the risk for negative long-term health consequences over the life course.
- Parents who experienced many ACEs may have not developed executive function and may need additional supports for parenting skills and resources.
- Parents who are currently experiencing trauma and/or high levels of stress may need additional supports for parenting skills and resources.

<http://developingchild.harvard.edu/>

[http://www.cdc.gov/ViolencePrevention/pub/healthy\\_infants.html](http://www.cdc.gov/ViolencePrevention/pub/healthy_infants.html)

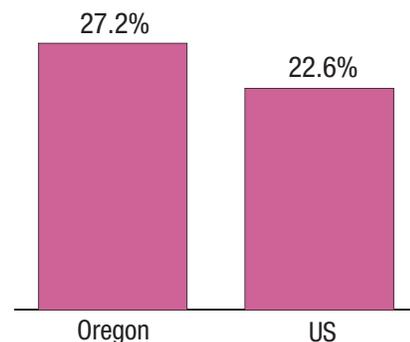
**Health status data**

**Percentage of parents of children 0 to 17 years who usually or always feel stress from parenting, 2007 - 2011/12**



Source: National Survey of Children's Health

**Percentage of families with children aged 0 to 17 in which a child has experienced two or more adverse childhood experiences, 2011/12**



Source: National Survey of Children's Health

## **Stakeholder input**

### **Statewide review of county assessments**

In a review of 53 community needs assessments, parent resources and support was cited in 19 assessments and as an unmet need in 5 assessments. It ranked 18th out of 32 unmet maternal and child health needs.

### **Partner Survey**

Of 29 health topics, parent resources and support ranked 8th in terms of impact on health, 10th in terms of importance for addressing equity, 5th in terms of the time and resources currently being applied, and 5th in terms of potential for leveraging state resources.

## **Work in progress**

- Partnering with and fostering collaborative relationships with the many partners that focus on improving parenting skills and education.
- Identifying a continuum of evidence-informed parenting programs including home visiting programs, embedded parenting education within programs, parenting education classes, parenting workshops, parenting cafes, parenting supports within childcare, and therapeutic parenting interventions that are culturally and linguistically sensitive.
- Working with parenting education partners to identify common language and practices around parent/family involvement, parent/family engagement, parenting education, parent leadership and parent partnership.
- Working with the 211Info staff to improve the database, protocols, and training of 211 staff about the needs of parents and families and assure the quality of information and referrals for parenting skills and education.
- Researching emerging programs and policies that strengthen families and parents.

## **Alignment with partners**

- The Maternal Infant Early Childhood Home Visiting (MIECHV) Expansion Grant included a parent engagement and leadership component.
- The Oregon Parenting Education/Program Consortium is working on defining parenting terms and identifying new and emerging parenting education and resources across the state.
- The Oregon Parenting Education Collaborative funds and supports evidence-based parenting education to communities across the state.
- The Teen Parent Family Resources Consortium Meeting meets quarterly to identify the needs and resources for teen parents.
- The Early Learning Division recognizes parenting skills and education as a critical component to achieving their goal of ensuring that children live in stable and attached families.
- The 211 Information and Referral System supports parents and families by connecting them to available resources.

**Population Domain: Adolescent Health**  
**Priority Area: Overweight and Obesity**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

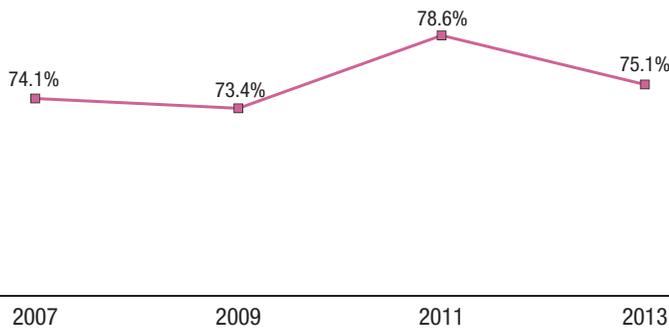
**Oregon Title V Goal:**

Increase the percent of children/adolescents with a healthy body weight.

**State performance measure:**

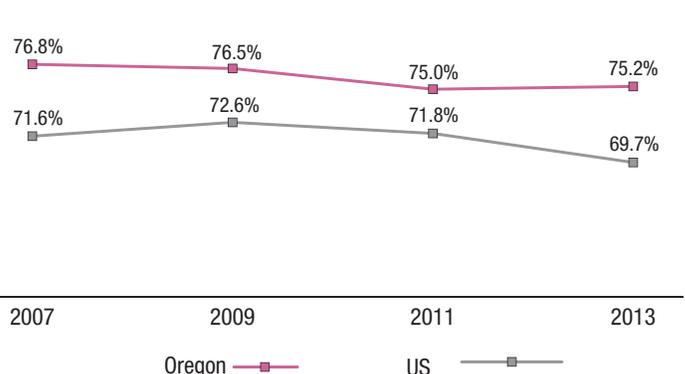
Percent of 8th grade students with a BMI below the 85th percentile.

**Percentage of 8th grade students with a BMI below the 85th percentile, Oregon, 2007 - 2013**



*Data source: Oregon Health Teens*  
*Note: US data is not available for 8th graders*

**Percentage of 11th grade students with a BMI below the 85th percentile, 2007 - 2013**



*Data source: Oregon Health Teens and Youth Risk Behavior Surveillance System*

**Significance of the issue**

Obesity is the second leading cause of preventable death in Oregon. Obesity is a major risk factor for current and future health risks in children and youth including: high blood pressure, high cholesterol, diabetes, heart disease, cancer, and social and psychological problems like discrimination and poor self-esteem. Between 2001 and 2013, obesity increased 38% among Oregon eighth-graders, from 7.3% to 10.1%. If Oregon remains on the 2001 to 2013 trajectory, medical care costs to treat obesity-related diseases will rise, and children born today will have shorter lives, on average, than their parents.

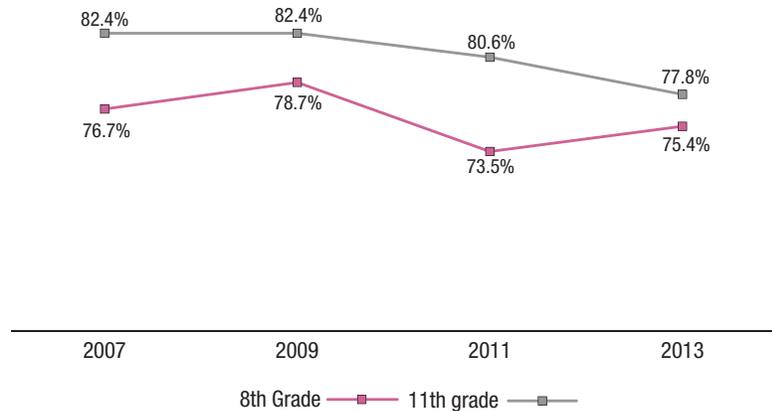
Comprehensive strategies designed to improve diets and increase physical activity among Oregon's population are urgently needed to address this problem. The dietary and physical activity behaviors of children and adolescents are influenced by many sectors of society, including: families, communities, schools, child care settings, medical care providers, faith-based institutions, government agencies, the media, food and beverage industries and entertainment industries. Schools play a particularly critical role by establishing a safe and supportive environment with policies and practices that support healthy behaviors. Schools also provide opportunities for students to learn about and practice healthy eating and physical activity behaviors.

**Health status data**

- Eating five or more servings of fruits and vegetables a day and drinking sugar-sweetened beverages are used as markers of healthy and unhealthy diets respectively. During 2009, Oregon eighth-graders (one in five) were less likely than adults to consume five or more servings a day of fruits and vegetables. Consumption of fruits and vegetables by eighth-graders does not vary by weight and has declined by 24% from 2001 to 2009. Overall, during 2009, 20.6% of Oregon eighth-graders (25.1% of boys and 16.4% of girls) reported drinking  $\geq 7$  more soft drinks per week.

- For teens, being physically active for at least 60 minutes per day on most days of the week is recommended by CDC. Nearly 60% of Oregon eighth-graders meet these recommendations (2013). Boys were 35% more likely to achieve minimum physical activity recommendations than girls. (Note: Detailed physical activity data can be found on the Child and Adolescent Physical Activity National Priority Area data tools)

**Percentage of 8th and 11th grade students who consume fewer than 5 servings of fruit and vegetables per day, Oregon, 2007 - 2013**



Source: Oregon Health Teens

## Stakeholder input

### Statewide review of county assessments

In a review of 53 community health assessments, overweight and obesity was cited in 17 assessments. It ranked 8th out of 32 unmet maternal and child health needs.

### Partner Survey

Of 29 health topics, overweight and obesity (not limited to adolescents) ranked 7th in terms of impact on health, 6th in terms of importance for addressing equity, 25th in terms of the time and resources currently being applied, and 6th in terms of potential for leveraging state resources.

## Work in progress

The Oregon Health Promotion and Chronic Disease Prevention Program received both the basic and enhanced funding for a five-year CDC 1305 grant (State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health) with multiple strategies including early care and education and schools, and partner engagement with programs across the Public Health Division. The Healthy Growth Survey, a statewide survey of the BMI of early-elementary age students was conducted and published. The Promoting Healthy Weight and Development in Early Childhood framework continues to be promoted with partners. The statewide shared meals initiative, **Cook Together. Eat together. Talk together. Make meal time a shared time**, was launched in 2013 and is continuing to increase awareness about shared meals across the lifespan. This is a collaborative effort between many state-level partners and health care systems.

## Alignment with partners

- Improving the nutrition and increasing the physical activity of children and adolescents is a focus of the Oregon Public Health Division’s Strategic Plan, with the ultimate goal of reducing childhood and adolescent overweight and obesity.
- CCO Community Health Improvement Plans (CHIPs) are tasked with identifying strategies to address childhood and adolescent obesity.
- Reducing childhood and adolescent overweight and obesity is a priority of a CDC grant “State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.”

*Population Domain: Children and Youth with Special Health Care Needs*  
*Priority Area: Family support for children and youth with special health care needs*

- National Priority Area
- Current State Priority Area
- Emerging State Topic

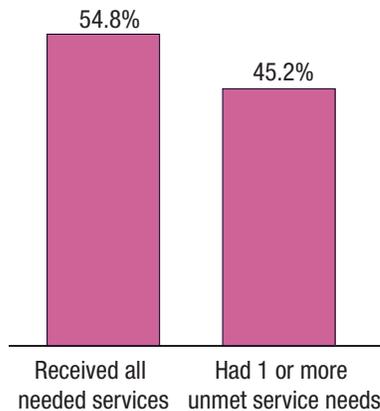
**Oregon Title V Goal:**

Increase access to family support services among families of children and youth with special health needs (CYSHCN).

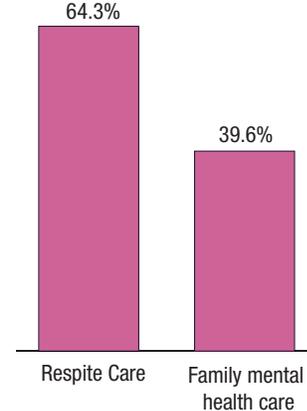
**State performance measure:**

Progress in developing an action plan to improve access to family support services for families of CYSHCN.

**Percent of CYSHCN Families With One or More Unmet Service Needs, 2009/10**



**Percent of CYSHCN Families Who Did Not Receive All Needed Care in Past 12 Months, 2009/10**



Source: National Survey of Children with Special Health Care Needs

Note: The survey asked about 3 family support services: respite care, mental health counseling, and genetic counseling.

Genetic counseling was not included in the second graph because the sample was too small to meet standards for reliability or precision.

**Significance of the issue**

Services that help families of CYSHCN cope with the challenges of their child’s condition may benefit these families. Examples of these services are family counseling/mental health care, genetic counseling (for advice on inherited conditions related to the child), and respite care (another caregiver watches the child to provide a break for parents or other family members).<sup>1</sup> The Association of Maternal and Child Health Programs asserted a standard for systems serving CYSHCN that CYSHCN and their families are provided access to comprehensive home and community-based supports, provided by their health plan and/or in partnership with other community agencies including family organizations, public health, education, Early Intervention, Special Education, child welfare, mental health, and home health care organizations. The standard specifically draws attention to the accessibility of respite, palliative, and hospice care.<sup>2</sup>

**Health Status Data:**

According to the 2011-12 National Survey of Children’s Health, 25% of parents of CYSHCN reported feeling stress from parenting during the past month, compared to 7% of parents of non-CYSHCN. Results of the Child Family Survey (part of the National Core Indicators Project) indicated that 74% of Oregon families of children with developmental disabilities do not have access to needed respite services; 65% of these families reported that there are other services that their family needs that are not currently offered or available.<sup>3</sup> Results of the Oregon Home Visiting Needs Assessment showed that the following were among the top 10 services that parents of young children with special health care needs identified as

<sup>1</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *The National Survey of Children with Special Health Care Needs Chartbook 2009-2010*. Rockville, MD: Author.

<sup>2</sup> VanLandeghem, K., Sloyer, P., Gabor, V., & Helms, V. (2014). *Standards for systems of care for children and youth with special health care needs*. A product of the National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs project. Washington, DC: Association of Maternal & Child Health Programs.

<sup>3</sup> Human Services Research Institute (HSRI) and National Associate of State Directors of Developmental Disabilities Services. (2014). *Child family survey 2012-13 final report*. Cambridge, MA: HSRI.

most difficult to obtain: housing assistance, job search help, job training/education help, child care, transportation help, adult dental care, adult mental/behavioral health services, domestic violence/sexual violence help, health insurance/medical care, and cash assistance.<sup>4</sup>

## **Stakeholder Input**

### **Statewide review of county assessments**

In a review of 53 county health assessments, CYSHCN family support was cited in 22 assessments.

### **Partner survey**

Of 29 health topics, CYSHCN family support ranked 4th in terms of impact on health, 12th in terms of importance for addressing equity, 21st in terms of the time and resources currently being applied, and 9th in terms of potential for leveraging state resources.

### **OCCYSHN data collections**

Family, care coordinator, and medical provider survey respondents identified respite care as challenging for families of CYSHCN to access. In addition, 24% of family survey respondents identified quality respite care as 1 of 3 things that their family most needs but has difficulty obtaining. Respite care was the third most popular priority area when CaCoon staff voted on issues to address within their community. Key stakeholder panel members agreed that respite care is challenging for families to access.

CaCoon public health nurses and key stakeholder panel members also identified child care as a key challenge for families of CYSHCN. Two-thirds of family survey respondents who needed child care indicated that it was difficult to obtain. CaCoon nurses in some Eastern Oregon counties identified access to quality child care as nearly impossible to obtain for all families, especially those of CYSHCN.

Twenty percent of family survey respondents also reported that supports, such as activities with other families that have children with disabilities, coaching on how to get around on buses, help shopping, housing and homelessness services, parent or sibling support groups, sleep, and time to relax, were 1 of 3 things that their family most needed but was difficult to obtain. Medical providers reported that obtaining supports (e.g., income support, peer support, parenting resource supports) was difficult for families of CYSHCN to obtain. Coordinators also reported that families of CYSHCN experience challenges accessing other families of CYSHCN with similar diagnoses. Key stakeholder panel members agreed that families of CYSHCN need support and assistance in identifying resources to support their child and family. Members also noted that families need support in learning how to access various services that their child needs, and importantly, need to learn how to self-advocate for their needs.

## **Work in Progress**

- The Oregon Family to Family Health Information Center employs parents of CYSHCN to provide information to families navigating the complexities of meeting their child's special health care needs.

## **Alignment with partners**

- 211info provides free information on over 50,000 programs in Oregon and southwest Washington.
- OCCYSHN key stakeholders observed that the Early Learning Hubs are increasing the availability of parenting classes and supports for all families, including those of CYSHCN.
- The Statewide Family Training Outreach Committee (SFTOC) was formed in 2013. It is a coalition of family groups, all of which conduct family training and outreach throughout the state. The coalition has made progress toward bringing more, and better-attended, family support activities to communities throughout Oregon.
- Swindells Resource Center provides resources, information, and education to parents and caregivers of children with special needs, developmental delays, or disabilities in Oregon and southwest Washington.
- Six family networks have been funded by the Oregon Council on Developmental Disabilities. Their purpose is to link families to the natural and supportive environments that exist within their communities.

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<sup>4</sup> Oregon Health Authority, Public Health Division, Office of Family Health. (2012). *Oregon home visiting needs assessment report*. Portland, OR: Author.

*Population Domain: Children and Youth with Special Health Care Needs*  
*Priority Area: Access to mental health services for children and youth with special health care needs*

- National Priority Area
- Current State Priority Area
- Emerging State Topic

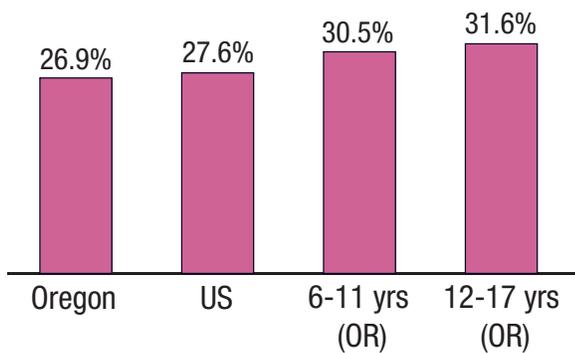
**Oregon Title V Goal:**

Increase linkages to mental health services for children and youth with special health needs (CYSHCN).

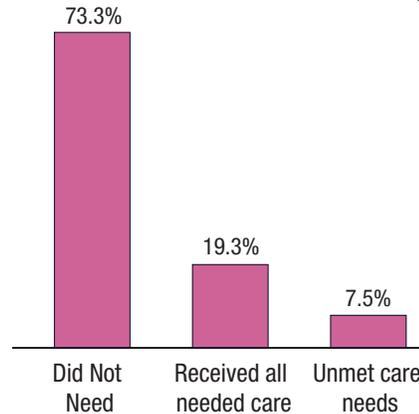
**State performance measure:**

Among CYSHCN who needed mental health care or counseling in the past 12 months, percent of CYSHCN who received all needed care.

**Percent of CYSHCN Who Needed Mental Health Care in The Past 12 Months, 2009/10**



**Percent of Oregon CYSHCN Who Needed and Received Mental Health Care in The Past 12 Months, 2009/10**



*Data source: National Survey of Children with Special Health Care Needs*

*Note: The sample for CYSHCN ages birth to 5 years was too small to meet standards for reliability or precision.*

**Significance of the issue**

The Association for Maternal and Child Health Programs (AMCHP) issued standards for the systems serving CYSHCN. The Access to Care Standard asserts that the system has the capacity to ensure CYSHCN geographical and timely access to appropriate primary and specialty services, including mental health services.<sup>1</sup> Nationally, the most commonly reported service that was needed for CYSHCN but not received was mental health care or counseling.<sup>2</sup> A study found that 38% of families of CYSHCN that were enrolled in Medicaid had a child with a mental health problem in need of treatment.<sup>3</sup>

**Health Status Data:**

Results of the 2012 Oregon Home Visiting Needs Assessment showed that getting child mental/behavioral health services was one of the top 10 most difficult services for families of young children with special health care needs.<sup>4</sup>

**Stakeholder Input**

**Partner survey**

Of 29 health topics, CYSHCN mental health ranked 5th in terms of impact on health, 5th in terms of importance for addressing equity, 24th in terms of the time and resources currently being applied, and 2nd in terms of potential for leveraging state resources.

<sup>1</sup> VanLandeghem, K., Sloyer, P., Gabor, V., & Helms, V. (2014). *Standards for systems of care for children and youth with special health care needs. A product of the National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs project.* Washington, DC: Association of Maternal & Child Health Programs.

<sup>2</sup> U.S. Department of Health and Human Services, health Resources and Services Administration, Maternal and Child Health Bureau. (2013). *The National Survey of Children with Special Health Care Needs chartbook 2009-2010.* Rockville, MD: Author.

<sup>3</sup> Agency for Healthcare Research and Quality. (2009). *Mental health needs of low-income children with special health care needs. Issue brief no. 9.* Retrieved on December 16, 2014, from <http://www.ahrq.gov/cpi/initiatives/chiri/Briefs/brief9/brief9.pdf>.

<sup>4</sup> Oregon Health Authority, Public Health Division, Office of Family Health. (2012). *Oregon home visiting needs assessment report.* Portland, OR: Author.

## **OCCYSHN data collections**

A majority of both families of CYSHCN and care coordinators survey respondents identified that behavioral and mental health services were challenging for families to access. In addition, 24% of families reported that mental or behavioral health services (e.g., autism counseling or services, behavior support, specialized counseling for children who are deaf and developmentally disabled, psychiatrists) were 1 of 3 things that their child or family most needed but had a hard time obtaining. CaCoon public health nurses voted Non-acute Behavioral/Mental Health Care for CYSHCN as the second most popular priority area to address within their communities.

Key stakeholder panel members agreed that access to mental and behavioral health services is challenging for families of CYSHCN. Panelists reported that behavioral or mental health diagnoses often co-occur with other SHCN diagnoses, such as developmental disabilities, and parents are unsure of what information or services to ask for or where to find services. Panelists identified that youth that have diagnoses like Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder usually do not have a care plan and do not qualify for an Individual Educational Plan (IEP) because they do not meet eligibility thresholds; however, their behaviors result in chaos for the family. Panelists noted that these youth do not qualify for either the mental health or developmental disability systems, which results in a “gaping hole of services” for these youth.

A majority of both care coordinators and medical providers responding to the surveys identified shortages of counselors/therapists, psychologists, and psychiatrists in the communities in which they work. Key stakeholder panelists agreed that there are not enough providers to fill the need for services, particularly in rural and frontier areas. An example of this workforce deficit will be evident as families seek a Board Certified Applied Behavior Analyst. In addition, panel members asserted that integrating behavioral health into primary health care is challenging and work needs to occur to break down the silos between these systems to better serve CYSHCN, particularly within the commercial insurance population. When considering what Oregon’s state priorities should be for CYSHCN, OCCYSHN’s key stakeholder panel members most frequently identified addressing lack of reimbursement, disparities in access to services, access to mental health services, and care coordination.

## **Work in Progress**

The Assuring Comprehensive Care through Enhanced Service Systems for Children with Autism Spectrum Disorder (ASD) and other Developmental Disabilities (DD) Project supports building local medical-educational ASD Identification Teams to improve medical home practices’ delivery of comprehensive, coordinated health care and related community-based services for children with ASD/DD and their families. These teams work in alignment with the Oregon Commission on ASD, Subcommittee on Screening, Identification, and Assessment. Mental health providers work with some Community Connection Networks teams.

## **Alignment with partners**

- In 2009 the Governor created the Oregon Commission on Autism Spectrum Disorders (OCASD). In 2010, OCASD made 4 recommendations to the Governor that include early identification and immediate provision of services; service integration; and training of personnel statewide.
- In August 2013 Oregon passed SB365, the state’s autism reform bill, which establishes requirements for state-regulated health plans to approve and manage autism treatment, including Applied Behavior Analysis (ABA). An ABA Regulatory Board has been established within the Oregon Health Licensing Agency.
- The same legislation also funded the Early Assessment and Support Alliance (EASA), which provides information and support to Oregon youth who are experiencing symptoms of psychosis for the first time.
- In 2013, Oregon funded the Oregon Psychiatric Access Line about Kids (OPAL-K). This collaboration between OHSU’s Division of Child/Adolescent Psychiatry, the Oregon Pediatric Society, and the Oregon Council of Child and Adolescent Psychiatry provides free, same-day psychiatric phone consultation to Oregon primary care clinicians. The goal is to reduce delays in diagnosis and treatment and enhance capacity for primary care practices to treat children with mental health conditions.

**Population Domain: Children and Youth with Special Health Care Needs**  
**Priority Area: Access to specialized health and related services for children and youth with special health care needs**

- National Priority Area
- Current State Priority Area
- Emerging State Topic

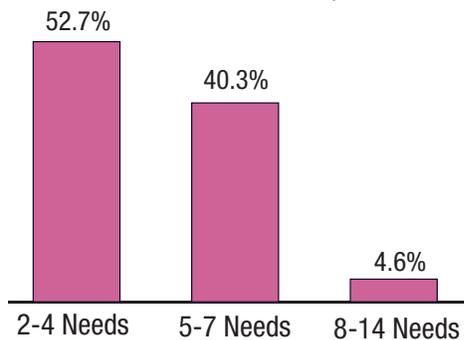
**Oregon Title V Goal:**

Increase access to specialized health and related services for underserved populations of children and youth with special health care needs (CYSHCN).

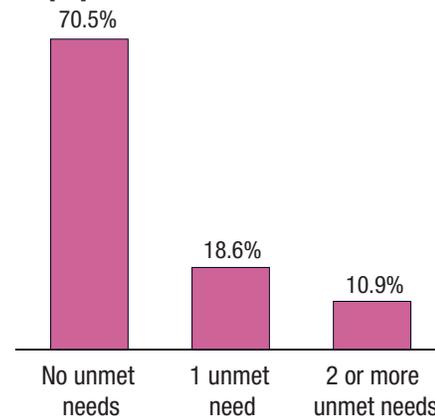
**State performance measure:**

Among CYSHCN who needed specialized services, percent of CYSHCN who received all needed care.

**Percent of Families of CYSHCN With Numbers of Specific Health Care Services or Equipment Needs in the Past 12 Months, 2009/10**



**Percent of Families of CYSHCN With Unmet Needs for Services or Equipment in the Past 12 Months, 2009/10**



Data source: National Survey of Children with Special Health Care Needs

Note: The survey asked about 14 types of health services or equipment (preventive medical, specialty care, preventive dental, other dental, prescription medications, physical/occupational/speech therapy, mental health, substance abuse treatment or counseling, home health care, eyeglasses/vision care, hearing aids/hearing care, mobility aids/devices, communication aids/devices, and durable medical equipment). The sample for 0-1 needs was too small for inclusion in the first graph.

**Significance of the issue**

This population requires a type or level of service for chronic physical, developmental, behavioral, or emotional conditions beyond that required by children generally by definition.<sup>1</sup> Standards for systems serving CYSHCN assert that systems should have the capacity to ensure CYSHCN geographical and timely access to appropriate primary and specialty services.<sup>2</sup> Results of our 2010 Title V needs assessment revealed that many specialized services for CYSHCN were located primarily in metropolitan areas, presenting families of CYSHCN living in rural areas with challenges in obtaining needed specialty services.<sup>3</sup>

**Stakeholder Input**

**Partner survey**

Of 29 health topics, specialized services for CYSHCN was ranked 12th in terms of impact on health, 14th in terms of importance for addressing equity, 14th in terms of the time and resources currently being applied, and 12th in terms of potential for leveraging state resources.

<sup>1</sup> McPherson, M., Arango, P., Fox, H., Lauer, C., McManus, M., Newacheck, P.W., Perrin, J.M., Shonkoff, J.P., & Strickland, B. (1998). A new definition of children with special health care needs. *Pediatrics*, 102, 137-140.  
<sup>2</sup> Office of Family Health, Oregon Health Authority, and Oregon Center for Children and Youth with Special Health Needs. (2010). *Oregon Title V maternal and child health five-year needs assessment, 2011*. Portland, OR: Oregon Health Authority.  
<sup>3</sup> VanLandeghem, K., Sloyer, P., Gabor, V., & Helms, V. (2014). *Standards for systems of care for children and youth with special health care needs. A product of the National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs project*. Washington, DC: Association of Maternal & Child Health.

## OCCYSHN data collections

Family survey respondents reported experiencing difficulties accessing specialized health and related services. The types of care identified as challenging for families to access were: behavioral and mental health services, durable medical equipment, mobility aids, home health care, palliative care, and specialty dental care. Of the 3 things their child or family most needs but has a hard time obtaining, 39% of families reported specialty medical care for physical health (e.g., audiology care; chiropractic care; genetic testing; occupational, physical, and speech therapy).

Key stakeholder panel members and CaCoon public health nurses resoundingly agreed that access to specialty providers and related services is challenging for Oregon families of CYSHCN. Myriad factors contribute to families' inability to access services: living in rural Oregon, falling outside of the threshold to qualify for financial assistance, and a child lacking a diagnosis or a qualifying diagnosis limits service accessibility. In addition,

- The type of insurance that a family has may influence their ease of accessing a service. CaCoon nurses described that families' ability to access a dentist in a timely manner, or at all, is made more difficult if the family has Oregon Health Plan (OHP) insurance, because fewer providers accept OHP. With the increased access to dental care by virtue of OHP, fewer appointments are available from providers that do accept OHP. Some mental health services are available to CYSHCN covered by OHP that are not available to those with private insurance.
- Reimbursements rates do not fully cover providers' bills, which inhibits providers from serving families covered by OHP.
- Disparities exist in the services that are available regionally because CCOs have the latitude to determine what services are covered for their members. This impacts the relative "adequacy" of health care coverage for families of CYSHCN.
- Families may not be aware of available services. This may result from providers not communicating well to families what services are available or families not understanding services due to language barriers or the lack of an up-to-date central repository identifying available services.
- Some practices drop families who miss appointments. Practices use this approach because they have waiting lists; if a family misses multiple appointments, providers want to ensure that the appointments are available to other families. However, some families miss appointments for reasons beyond their control.

CaCoon public health nurses across the state consistently identified transportation, as an issue of access to needed health and health related services, as a priority that needs to be addressed. Key stakeholders agreed. When available, public bus transportation is challenging for families traveling with a CYSHCN and other siblings or multiple CYSHCN, particularly when rides are long and require transfers. According to key stakeholders, although OHP provides transportation services to families insured by OHP, their use is difficult for these families because

- Making a request can take over an hour by phone and requires a significant amount of information that not all families can manage.
- Only 1 parent and the child with the appointment can travel; siblings and other parents cannot.
- Parents must request translation services, which requires that they know how to request the service.
- Parents can wait at home for an hour to be picked up, which then results in their child missing their appointment.
- Parents can wait for hours at the clinic to return home because taxis would prefer a typical fare.

## Work in Progress

The HRSA/MCHB funded State Implementation Grant for Enhancing Oregon's System of Services for CYSHCN aims to achieve a comprehensive, coordinated, and integrated state and community system of services for CYSHCN. The grant is a collaborative effort among state partners. The Community Connections Network (CCN) has 9 teams composed of education, health, and community services representatives that seek to improve local systems of care and ensure receipt of care. CaCoon is a statewide public health nurse home visiting program for CYSHCN that includes the provision of care coordination. The HRSA/MCHB funded Assuring Comprehensive Care through Enhanced Service Systems for Children with ASD/DDs grant project supports building local medical-educational ASD Identification Teams to improve medical home practices' delivery of comprehensive, coordinated health care and related services for children with ASD/DD.

# Topic Area: Adolescent mental health, depression and suicide

- National Priority Area
- Current State Priority Area
- Emerging State Topic

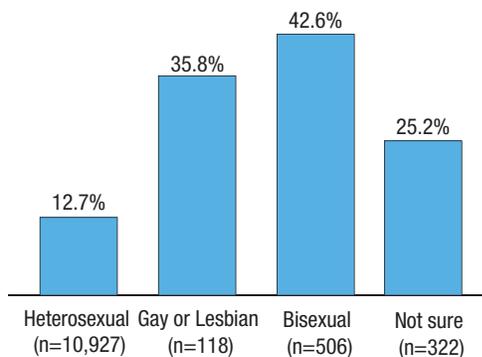
## Significance of the issue

Mental health is a vital component of overall health for adolescents. Depression and suicide represent two important public health priority areas that are complex in etiology, and require comprehensive and ecological prevention strategies that reduce factors that increase risk and increase factors that promote resilience.

## Context for Oregon

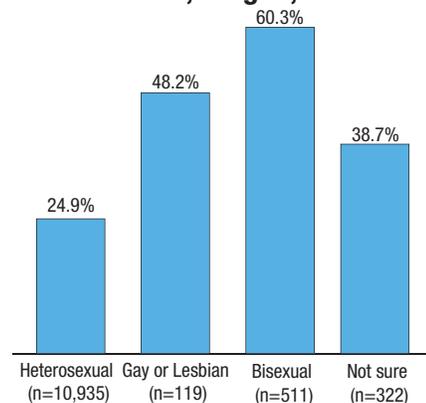
- Suicide, which can result from the interaction of mental disorders and other factors, was the second leading cause of death among children aged 10–19 years in Oregon in 2013. In 2013, 15% of 11th graders seriously considering suicide in the past 12 months.<sup>1</sup>
- Major contributors to suicide include mental health challenges (such as depression), a crisis within two weeks, interpersonal relationship problems and trouble at school. Nearly eight of 10 youth who attempted suicide in 2012 had at least one mental health condition.<sup>2</sup>
- Data from the Adolescent Suicide Attempt Data System show that youth attempted suicide by using prescription or over-the-counter drugs more than by any other method. Most attempts were in the youths' own home. 66 percent of the youth who attempted suicide were females - however, three times more males than females died by suicide. Over half of youth suicides were from firearms.
- Approximately 9% of 11th graders reported having an unmet emotional health care need.
- 1 out of 3 girls (33.7%) and 1 out of 5 boys (20%) reported being depressed in the past year. Before adolescence, depression occurs in equal numbers of boys and girls.. Once children reach adolescence, a shift occurs and more than twice as many girls as boys are depressed, regardless of racial or ethnic background.
- Risk factors for adolescent depression include low self-esteem and social support, negative body image and cognitive style, and ineffective coping.<sup>3</sup>
- Youth who identify as gay/lesbian, bisexual or questioning (LGBQ) are more likely to report being depressed and to contemplate suicide.

**Percent of 11th graders who considered suicide in the past 12 months, by sexual orientation, Oregon, 2013**



Source: Oregon Healthy Teens

**Percent of 11th graders with self-reported depressive symptoms in the last 12 months, by sexual orientation, Oregon, 2013**



Source: Oregon Healthy Teens

1 Oregon Healthy Teens Survey, 2013

2 Adolescent Suicide Attempt Data System. 2012. <http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/Suicide,suicide%20Attempts,%20and%20ideation%20among%20Adolescents%20in%20Oregon%202010.pdf>

3 National Research Council, Institute of Medicine. *Depression in parents, parenting, and children*. Washington DC: National Academies Press; 2009. *The etiology of depression*; p. 73-118.

## **Stakeholder input**

- In a review of 53 community health assessments conducted in Oregon over the past 3 years: mental health, depression and suicide (among all ages) was the 2nd most mentioned unmet maternal and child health need.
- Mental health was the most frequently referenced non-system emerging topic in the MCH Needs Assessment listening sessions conducted with Regional Health Equity Coalitions, the Oregon Parenting Education Collaborative, and Oregon's tribal MCH partners.

## **Alignment with partners**

- In 2013, the Oregon State Legislature increased funding to the 2013–15 budget of the Addictions and Mental Health Division (AMHD) to support and enhance Oregon's community mental health system. A portion of this funding was specifically allocated for children's mental health at SBHCs. There are now 57 SBHCs with a mental health provider on-site.
- The Adolescent and School Health Program is partnering with AMHD, the Oregon Pediatric Society and Oregon Pediatric Improvement Partnership to increase depression screening and follow-up within the context of an adolescent well visit.
- Oregon's Coordinated Care Organizations have an incentive measure for depression screening and follow-up, that is inclusive of youth 12 to 17 years old.
- Injury and Violence Prevention Program recently received a SAMSHA grant that includes work in preventing youth suicide.
- The Oregon Public Health Division's Strategic Plan includes an objective to reduce violence and suicide rates through prevention efforts.

## Topic Area: Toxic stress and trauma

- National Priority Area
- Current State Priority Area
- Emerging State Topic

### Significance of the issue

National surveillance from 1994–2011 has shown an increasing prevalence of mental health disorders among children. The brain develops in response to experiences in all domains (physical, social, emotional, linguistic, and cognitive) beginning prenatally and continuing over the lifecourse. The experiences of the first three years of life lay down the neurological pathways and connections which create procedural memories and responses, including positive or negative lifelong expectations, physiological stress responses, emotional regulation, the development of attachment and bonding, and style of relating to others.

Behavioral health problems, whether originating in childhood or adulthood, are often the first visible consequences of stress and trauma. Toxic stress results from intense adverse childhood experiences that may be sustained over a long period of time.<sup>1</sup> Without identification and treatment, children who are exposed to toxic stress and trauma are at increased risk for mental and addictive disorders as well as learning deficits, which in turn can contribute to academic failure, compromised occupational achievement, lower socioeconomic status, and health problems. Adults who experience violence and trauma are also at increased risk for a variety of poor health and social outcomes. Without effective support and intervention, the risk increases for inter-generational exposure to toxic stress and trauma, creating a “vicious circle” of self-reinforcing mechanisms that undermine population health and well-being.<sup>2</sup>

A public health approach to reducing toxic stress includes strategies for preventing or reducing extreme stress and trauma, building resilience, and providing effective care and treatment for people who have been exposed to trauma.<sup>3</sup>

Adverse childhood experiences (ACEs) is a term used to describe neglect, abuse, violence, and/or distressed family environments that children under the age of 18 may experience. The cumulative effect of ACEs can be traumatic, especially if experienced repeatedly at a young age.<sup>4</sup> ACEs are associated with negative health outcomes in adults including depression, obesity, diabetes, cardiovascular disease, asthma and others.

### Context for Oregon

- Oregon has invested \$2,380,000 this biennium to expand mental health-related evidence based practices to children under 8 yrs. old, increase the expertise of service providers in the area of early childhood mental health, and increase the number of mental health service providers to underserved areas of the state.
- Adults in Oregon were surveyed about their childhood exposure to ACEs in 2011 and 2013 through the Behavioral Risk Factor Surveillance System Survey (BRFSS). The results below demonstrate the relationship between the number of ACEs Oregonians experienced and their adult health outcomes.

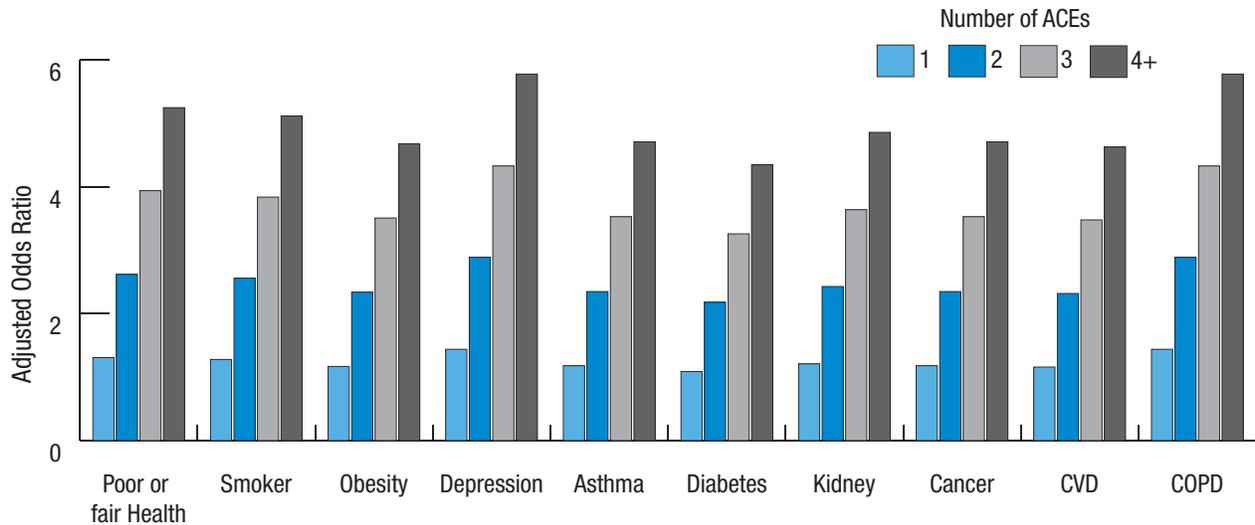
<sup>1</sup> Middlebrooks, Jennifer S. and Audage, Natalie C. “The Effects of Childhood Stress on Health Across the Lifespan” available at [http://www.cdc.gov/ncipc/pub-res/pdf/Childhood\\_Stress.pdf](http://www.cdc.gov/ncipc/pub-res/pdf/Childhood_Stress.pdf)

<sup>2</sup> Blanch, Shern, and Steverman. “Toxic Stress, Behavioral Health, and the Next Major Era in Public Health”. Mental Health America. 2014.

<sup>3</sup> Blanch, Shern, and Steverman. “Toxic Stress, Behavioral Health, and the Next Major Era in Public Health”. Mental Health America. 2014.

<sup>4</sup> Schonkoff, Jack, *The Foundations of Lifelong Health are Built in Early Childhood*, Center for the Developing Child, Harvard University [http://developingchild.harvard.edu/resources/reports\\_and\\_working\\_papers/foundations-of-lifelong-health/](http://developingchild.harvard.edu/resources/reports_and_working_papers/foundations-of-lifelong-health/)

## The association between ACEs and adult health outcomes, Oregon, 2013



Note: Odds ratios adjusted for age, sex, education, poverty, race and ethnicity and smoking for COPD and CVD

## Stakeholder input

- In a review of 53 community health assessments conducted in Oregon over the past 3 years: mental health, depression and suicide was the 2nd most mentioned unmet maternal and child health need.
- Among 29 priority areas included in the MCH needs assessment's provider and partner survey, respondents ranked toxic stress/ACEs 1st in terms of its impact on health (4.59 on a scale of 1 to 5 with 5 being the highest degree of need), 2nd in terms of its importance to addressing equity (4.68), last in terms of the amount of time and effort currently applied (2.16), and 3rd in terms of its potential for leveraging state resources (4.30).
- Mental health was the most frequently referenced non-system emerging topic in the MCH Needs Assessment listening sessions conducted with Regional Health Equity Coalitions, the Oregon Parenting Education Collaborative, and Oregon's tribal MCH partners.

## Alignment with partners

- The Addictions and Mental Health Division of the Oregon Health Authority included a goal in their Behavioral Health Strategic Plan for 2015-2018 to develop and enhance programs that emphasize prevention, early identification, and intervention for at-risk children and families.
- The Oregon Youth Authority, OHA Addictions and Mental and Public Health Division, Children First for Oregon, Oregon Health Sciences University, Portland State University, and the Oregon Pediatric Society are partnering through the Trauma Informed Leadership team to develop a framework and action plan for Trauma informed care.
- Oregon's Maternal, Infant, and Early Childhood Home Visiting program and the OHA Transformation Center have convened an Infant Mental Health Work Group to establish an Infant Mental Health Endorsement for Oregon.
- Oregon's community of early childhood professionals is working to integrate the emerging science of toxic stress and ACEs with practice and systems of care. Development of strategies to address ACEs and support parents is a focus of:
  - the Child Health Policy Team (a subcommittee of: the Joint Policy Steering Committee (JPSC) of OHA/DHS);
  - Trauma Informed Oregon;
  - Multnomah County Project Launch; and
  - Maternal, Infant, and Early Childhood Home Visiting (MIECHV).

## Topic Area: Nutrition and food insecurity

- National Priority Area
- Current State Priority Area
- Emerging State Topic

### Significance of the issue

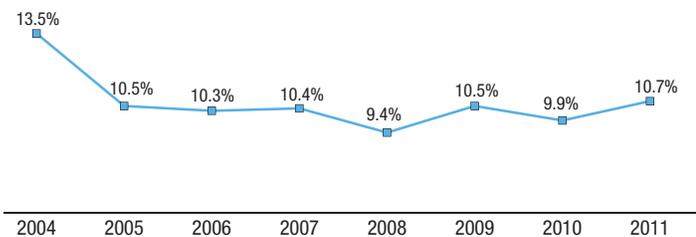
Food insecurity is defined as limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.

Food insecurity influences health status in several ways. Level of access to adequate and nutritious food is related to overweight and obesity, 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 for food insecurity is rarely done. Parents, caregivers and others are reluctant to admit that they are unable to provide adequate food for their families and themselves, but when asked directly will reveal that they often run out of food or cannot provide a meal that day.

Rural communities are hit hard by food insecurity; and some populations experience hunger at higher rates. African-Americans, Latinos, and female-headed single parent families experience food insecurity at higher rates than the national average.

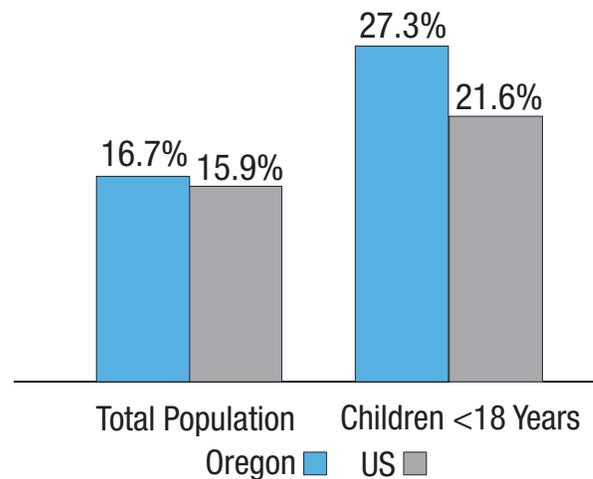
### Context for Oregon

**Percent of mothers who reported food insecurity in the 12 months before giving birth, Oregon, 2004-2011**



Source: Pregnancy Risk Assessment Monitoring System

**Food insecurity among total population and children <18 years, Oregon and U.S., 2012**



Source: Oregon State Health Profile

- In 2012 over 16% of Oregon households were food insecure.<sup>1</sup> This is slightly higher than the overall US rate. Children in Oregon have much higher rates of food insecurity than the total population, and rates in Oregon are higher than in the US. Oregon rates remain higher than before the recession.
- Since 2000, Oregon has made a number of changes to reduce hunger and poverty, such as expanding the earned income tax credit, getting more people enrolled up for SNAP benefits, and opening new food pantries.
- The Nutrition and Health Screening (WIC) Program cultivates a strong regional food system in Oregon through expansion of Farm Direct Voucher program for seniors and WIC participants and strengthening healthy food choices in grocery stores across the state.

<sup>1</sup> <http://www.ers.usda.gov/media/1565415/err173.pdf> ; <http://www.feedingamerica.org/hunger-in-america/our-research/map-the-meal-gap/>

## Stakeholder input

- In a review of 53 Oregon community needs assessments, nutrition/food insecurity ranked 7th out of 33 unmet maternal and child health needs.
- In the MCH needs assessment's partner and provider survey, nutrition/food insecurity was the 4th most frequent response to an open-ended question about topics that should be added to Oregon's maternal, child and adolescent health priorities (after mental health, reproductive care and education, and substance abuse).
- Nutrition/ food insecurity was the second most frequently referenced of five emerging topics in listening sessions with the Regional Health Equity Coalitions, the Oregon Parenting Education Collaborative and a webinar with tribal maternal and child health partners.

## Alignment with partners

- Partners with a focus on addressing nutrition and food insecurity include:
  - Oregon Hunger Task Force, Partners for a Hunger-Free Oregon, the Nutrition and Health Screening (WIC) Program, the Supplemental Nutrition Assistance Program (SNAP), Oregon State University Extension (SNAP\_Ed), the Oregon Department of Education Child and Adult Care Food Program, and the Oregon Food Bank.
- Oregon's Nutrition and Health Screening (WIC) Program's work to address food insecurity will include:
  - Strengthening coordination and collaboration with partners to improve access to and use/preparation of healthy foods by WIC participants;
  - Support for local agency outreach to increase access to WIC services for the highest risk, most vulnerable populations and families of color; and
  - Expansion of screening for hunger and food insecurity in select WIC agencies.
- Partners for a Hunger-Free Oregon have a strategic plan for addressing food insecurity in Oregon, Ending Hunger Before It Begins, Oregon's Call to Action 2010-2015 (<https://oregonhunger.org/oregon-hunger-plan>)
- The Public Health Division's draft 2015-2019 Strategic Plan identified food insecurity as a long term indicator. The Division has a goal of decreasing the rate of food insecurity from 15.9% (in 2012) to 13.2% by 2019 (USDA ERS, Household Food Security) with identified strategies and actions to achieve this goal.

## Topic Area: Drug abuse/misuse

- National Priority Area
- Current State Priority Area
- Emerging State Topic

### Significance of the issue

Drug abuse is a problem for adolescents, pregnant women, and parents. Overdose deaths and hospitalizations are only the tip of the iceberg when it comes to drug use, misuse, and overdose. Lost income, lost productivity, unstable family relationships, and damaged communities are just a few of the other consequences. For adolescents, any drug use can interfere with normal cognitive, emotional, and social development, as well as increase risk of motor vehicle crashes and risky health behaviors. Drug use by pregnant women creates problems not only for the woman, but for her unborn child. Fetal addiction and maternal avoidance of preventive prenatal care are common concerns, and prenatal developmental delays may also occur. Parents who use drugs face more than the problems that come with addiction; they may also become unable to parent effectively, being more likely to use poor judgment in their parenting. Parental drug abuse also has effects on children, such as increased future substance abuse risk, experiences of neglect, isolation, and family instability. Understanding drug abuse 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.

### Context for Oregon

#### Marijuana

- Marijuana will become a legal drug in Oregon on July 1, 2015. Little is known about its health impacts during pregnancy, postpartum and throughout the life course.
- Maternal and child health concerns related to legalization of retail marijuana in Oregon include: protection of children from unintentional poisoning from edible marijuana products, prevention of youth initiation, and potential health effects on pregnancy and infant development.
- Unlike alcohol and tobacco, marijuana surveillance that captures use, misuse, abuse, and addiction has not been conducted in Oregon or the US.

#### Opioids (including heroin and prescription opioids)

- Oregon is the state with the highest rate of non-medical use of opioids (pain relievers), with a prevalence 6.27% in Oregon, and 4.41% in the US.<sup>1</sup> In 2013, almost 1 in 4 Oregonians received a prescription for opioid medications. The increased use of opioids is paralleled by increases in overdose hospitalizations and deaths, and need for treatment.<sup>2</sup>
- In Oregon, as in the rest of the country the rise in the availability and prescriptions of controlled substances over the past decade has contributed to an increase in overdose.<sup>3</sup>
- In 2013, nearly half (44.7%) of all founded child abuse cases in Oregon had parental alcohol or drug use as a risk factor. Parent drug abuse was listed as the reason for children entering foster care in 49.1% of cases in 2013. This number may be artificially low compared to previous years due to changes in the data collection method

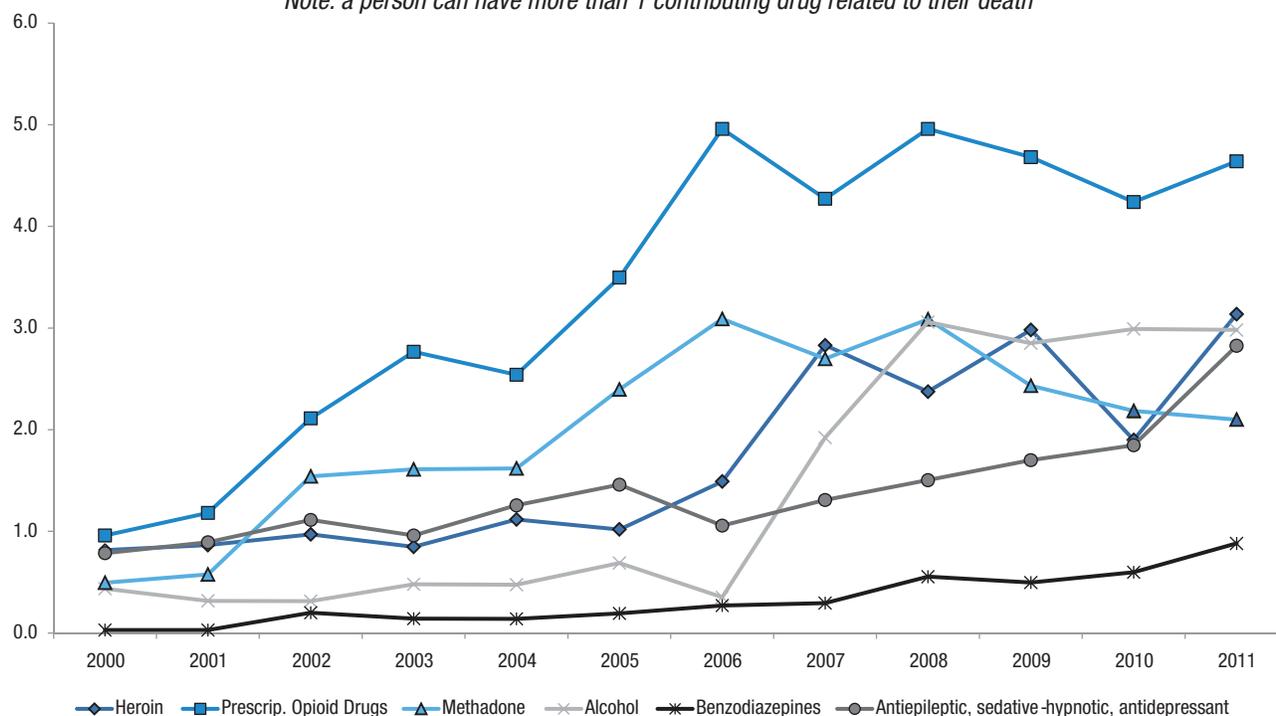
<sup>1</sup> <http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2011-2012/AdultTabs/Web/NSDUHsaeAdultTabs2012.pdf>

<sup>2</sup> Oregon Public Health Division, Oregon Health Authority, CD Summary: Drug Overdose In Oregon, Vol. 63, No. 18, 9/9/14, available at <https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/CDSummaryNewsletter/Documents/2014/ohd6318.pdf>

<sup>3</sup> Oregon Public Health Division, Oregon Health Authority, CD Summary: Drug Overdose In Oregon, Vol. 63, No. 18, 9/9/14, available at <https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/CDSummaryNewsletter/Documents/2014/ohd6318.pdf>

## Overdose death rate by drug type per 100,000, OR, 2000-2011<sup>4</sup>

Note: a person can have more than 1 contributing drug related to their death



## Stakeholder input

- In a review of 53 community health assessments:
  - Drug abuse (excluding alcohol use) ranked 3rd out of 33 unmet maternal and child health needs.
  - Alcohol abuse was ranked 9th out of 33 unmet maternal and child health needs.
- In the MCH needs assessment partner and provider survey:
  - Substance abuse was the 3rd most frequently mentioned issue in an open-ended question that asked about what “should be added to Oregon’s maternal, child and adolescent health priorities”.
  - Opioid use was asked about specifically as a potential emerging issue and was ranked 16th out of 29 health topics in terms of impact on health, but 9th in terms of importance for addressing equity

## Alignment with partners

- The Oregon Health Authority’s Addictions and Mental Health Division, Public Health Division, Medicaid Assistance Programs, Adult and Family Services, and the Early Learning Division are all partners in preventing and addressing the impact of drug use on Oregon’s families.
- Development of policy, surveillance, and research on health effects and prevention strategies related to marijuana legalization will be a focus for DHS, OHA and other state agencies as marijuana legalization is implemented in the coming years.
- Issues related to substance abuse have been identified as a focus in 11 of Oregon’s CCO Community Health Improvement Plans.
- The Oregon Alcohol and Drug Policy Commission coordinates Oregon’s priorities and policies related to alcohol and other drug prevention and treatment services.

<sup>4</sup> [http://www.orpdmp.com/orpdmpfiles/PDF\\_Files/Reports/NGA-overdose-presentation\\_Millet\\_12-05-2012.pdf](http://www.orpdmp.com/orpdmpfiles/PDF_Files/Reports/NGA-overdose-presentation_Millet_12-05-2012.pdf)

## *Topic Area: Culturally and linguistically responsive services*

- National Priority Area
- Current State Priority Area
- Emerging State Topic

### **Significance of the issue**

The field of maternal and child health is grounded in a lifecourse framework which recognizes the need to eliminate health inequities in order to improve the health of all women, children, and families. Health inequities are systemic, avoidable, unfair and unjust differences in health status and mortality rates that are sustained over generations and beyond the control of individuals. Institutional changes, including the development of culturally and linguistically responsive maternal and child health (MCH) services and systems are needed to address health inequities.

The principal national standard for culturally and linguistically appropriate services (CLAS) is: 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.

### **Context for Oregon**

- As Oregon's population has become increasingly diverse, the need for culturally and linguistically responsive MCH services has become more urgent than ever.
- Oregon's geography, with large rural and frontier areas as well as concentrations of new immigrants in various communities, poses unique challenges for the delivery of culturally and linguistically responsive MCH services.

### **Stakeholder input**

- In a review of 53 community needs assessments, the need for culturally and linguistically accessible services was the 11th most commonly referenced unmet maternal and child health need.
- In the MCH needs assessment's provider and partner survey, respondents were asked to rate the level of need for Oregon's MCH system to build capacity for linguistically competent approaches to MCH service delivery rated the need as 3.9 out of 5 (with 5 being the highest degree of need).
- Challenges to delivery of coordinated MCH services and recommendations for improving culturally competent approaches to MCH services were discussed in an online discussion forum and listening sessions held with health equity coalitions, parent educators, tribal MCH leads, and local health departments. The need for culturally relevant services and services for non-English speakers were among the top concerns raised across all of these forums.

### **Oregon Center for Children & Youth with Special Health Needs**

- Key stakeholder panel members underscored the importance of families being able to communicate with their child's health providers in their primary language. Panelists also stated that culturally responsive services includes education and socioeconomic status in addition to race and ethnicity as norms and expectations can also differ by these social characteristics.
- Public health nurses attending the CaCoon regional meeting in Bend identified a need for culturally responsive services in areas of the state that employ seasonal migrant workers

### **Alignment with partners**

- Health equity and cultural responsiveness is one of the foundational capabilities in the modernization of Public Health Framework currently being proposed in the current Oregon Legislative Session.
- The delivery of culturally and linguistically responsive services is a core value for both the health and early learning systems transformation efforts in Oregon.

- Ensuring culturally and linguistically responsive MCH services is a key component of the newly revised Title V MCH Block Grant.
- Oregon's Tribal MCH grantees focus on delivery of culturally relevant MCH services in 5 of Oregon's 9 federally recognized tribes.
- CaCoon is a statewide public health nurse home visiting program for children and youth with special health care needs that includes the provision of care coordination. Promotoras work with CaCoon programs in 4 counties with high concentrations of Spanish-speaking families.

## Topic Area: Cross-system coordination

- National Priority Area
- Current State Priority Area
- Emerging State Topic

### Significance of the issue

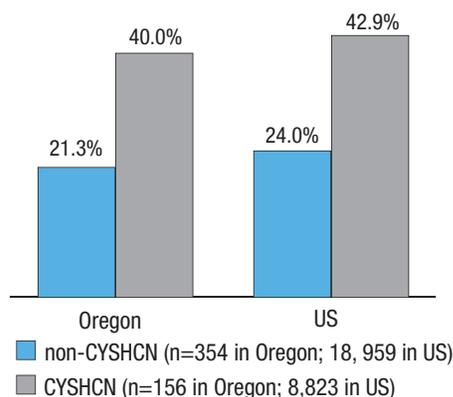
Leaders in health, education and social services have long-acknowledged the need for cross-system collaboration to effectively meet maternal, child and adolescent health and development goals. The MCH Title V Block Grant requires MCH and CYSHCN programs to take steps to ensure a statewide system of services which reflect the principles of comprehensive, community-based, coordinated, and family-centered care.

The Association of Maternal & Child Health Programs (AMCHP) recommends bringing together agencies, advocacy organizations, and experts to define state-level strategies to build comprehensive systems including:

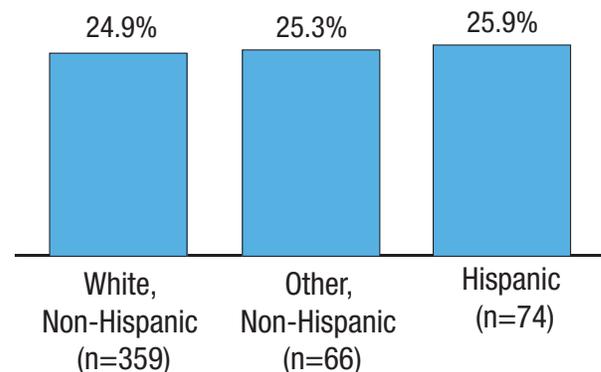
- Identifying gaps in services and funding which serve as barriers to systems building;
- Defining specific outcomes that the comprehensive systems approach aims to achieve;
- Creating monitoring and evaluation tools to help track progress and assess efficiency and effectiveness to show impact;
- Developing additional resources, tools, and technical assistance for conducting environmental scans which assess existing funding and services potentially available for coordinated comprehensive system development; and
- Developing evidence-based tools and strategies for capacity building that include promoting collaborative efforts and developing systems.

### Context for Oregon

**Received all needed components of care coordination, children 0-17 years**



**Received all needed components of care coordination, children 0-17 years**



Source: 2011/12 National Survey of Children's Health

The following system improvements have been identified as necessary to strengthen service coordination to achieve better outcomes for all children and youth, including those with special health care needs:

- Identification and adoption of a common tool to screen for family strengths and risk factors
- Establishment of protocols for referral feedback loops and case management/care coordination
- Integration of early childhood data to monitor child and early learning system outcomes; improved data system functionality (such as secure information exchange), and improved data collection capability
- Identification of approaches to shared accountability across health, early learning and education systems

Current transformation of Oregon's health and education systems are aimed at improving the manner in which services are delivered with an emphasis on efficiency, value and outcomes.

The Legislature created the Patient Centered Primary Care Home (PCPCH) Program in 2009. The PCPCH Standards Advisory Committee informed the development of 6 standards for PCPCH recognition: access to care, accountability, comprehensive whole person care, continuity, coordination and integration, and person & family centered care. No standards explicitly require addressing care for CYSHCN; however, CYSHCN are one example of how a practice could meet Standard 5.C, Complex Care Coordination.

OCCYSHN's Enhancing Oregon's System of Services for CYSHCN state implementation grant will seek to address integration and coordination of systems of care serving CYSHCN. A cross-systems state leadership committee and cross systems stakeholders group are partnering with OCCYSHN to achieve this objective

## **Stakeholder input**

- In listening sessions with Oregon's Regional Health Equity Coalitions and the Oregon Parenting Education Collaborative, coordination and integration of MCH services was the most frequently mentioned category of response to the question: "What challenges do you see to working with partner agencies to ensure a coordinated system of services to improve maternal, child, adolescent and family health in your community?"
- The need for coordination of services was the most frequently cited emerging need in interviews with key informants from partner agencies.
- Listening sessions with CaCoon public health nurses identified fragmentation of care coordination in their communities and lack of effective communication and information sharing among providers and families as inhibiting care coordination.
- OCCYSHN key stakeholder panelists stated that education and primary care and mental health providers, in particular, need to be talking with each other when caring for CYSHCN.

## **Alignment with partners**

- Early Learning and Health Transformation: The Joint ELC/Oregon Health Policy Board (OHPB) Subcommittee: key areas of focus for their efforts include care coordination, and data/metrics sharing and alignment.
- Early Learning Hubs: A key goal of the hubs is to support coordinated systems to meet the needs of children and families
- MIECHV: The grant efforts include strengthening systems that serve early childhood such as workforce development and training, a cross-agency data system and shared outcomes.
- Oregon's State Innovation Model (SIM) grant: efforts to coordinate and integrate across health care delivery and early learning.
- The Coordinated School Health model: focus on coordination of preventive and health services, which includes School-based Health Centers.
- Addictions and Mental Health Services and Child Welfare's wraparound services: aimed at comprehensive, coordinated care.