

National Priority Area: Adolescent well-care visit

National performance measure: Percentage of adolescents with a preventive services visit in the last year.

Title V MCH Block Grant in Oregon

The Title V Maternal and Child Health (MCH) Block Grant is a federal program that provides funding to states to improve the health of all women, children, adolescents, and families, including children with special health care needs (CYSHCN). Oregon's Title V MCH priorities for 2016-2020 include: well-woman care, breastfeeding, physical activity for children, adolescent well-care visits, oral health, smoking, toxic stress and trauma, nutrition and food insecurity, culturally and linguistically responsive services, and medical homes and services for the transition to adulthood for children and youth with special health care needs.

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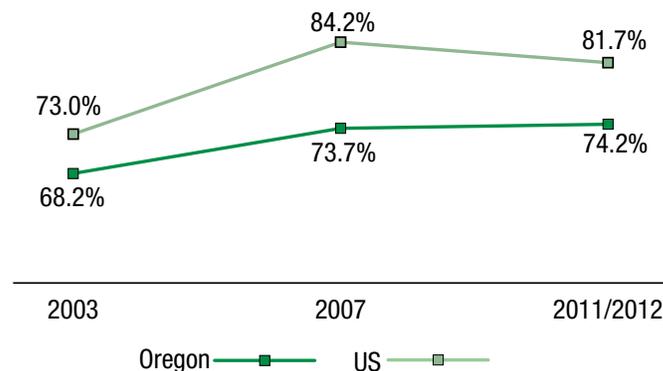
Significance of the issue

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 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 32% of Medicaid enrollees aged 12–21 years having a well-care visit in the past 12 months in 2014.¹

Health Status Data

Percent of adolescents age 12-17 years with one or more preventative medical visits in the last year, 2003-2011/12
Source: National Survey of Children's Health

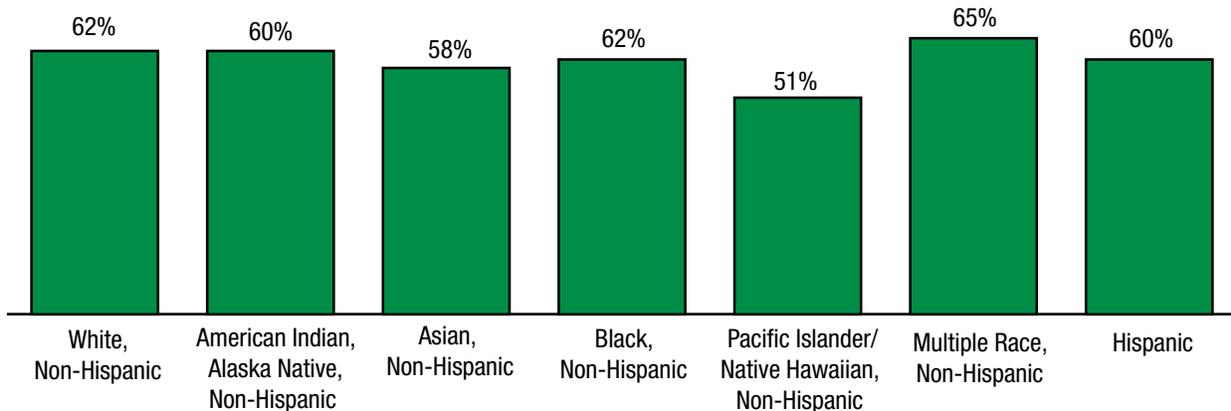


¹ CCO administrative (billing) data. <http://www.oregon.gov/oha/Metrics/Pages/measure-adolescent.aspx>

National Priority Area: Adolescent well-care visit

11th grade- Saw doctor or nurse in the past 12 months, not for sickness or injury, Oregon 2015

Source: Oregon Healthy Teens



Many Oregon youth could benefit from increased access to screening and anticipatory guidance. According to 11th graders in 2015:

- 29% felt depressed in the past 12 months
- 16% seriously considered suicide in the past 12 months
- 41% have ever had sex
- Among those who have ever had sex 38% did not use a condom at last intercourse
- 29% drank alcohol in the past month
- 20% used marijuana in the past month

Context for the Issue in Oregon

The Patient Protection and Affordable Care Act (ACA) elevated the importance of preventive care for children and youth by ensuring access to the gold standard preventing care – screenings and services recommended by the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents—without cost sharing. Bright Futures recommends annual well-care visits for adolescents from ages 11-21. 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. There is a general lack of awareness that youth should see doctor for a preventive visit every year, and many youth do not view a well visit as a priority. There is growing acknowledgment that young people must be actively engaged as partners in the delivery of health care to increase the proportion that access preventive services. There is increased interest in using public health tools and strategies to shift the culture and raise awareness of the importance of adolescent well-care.

National Priority Area: Breastfeeding

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

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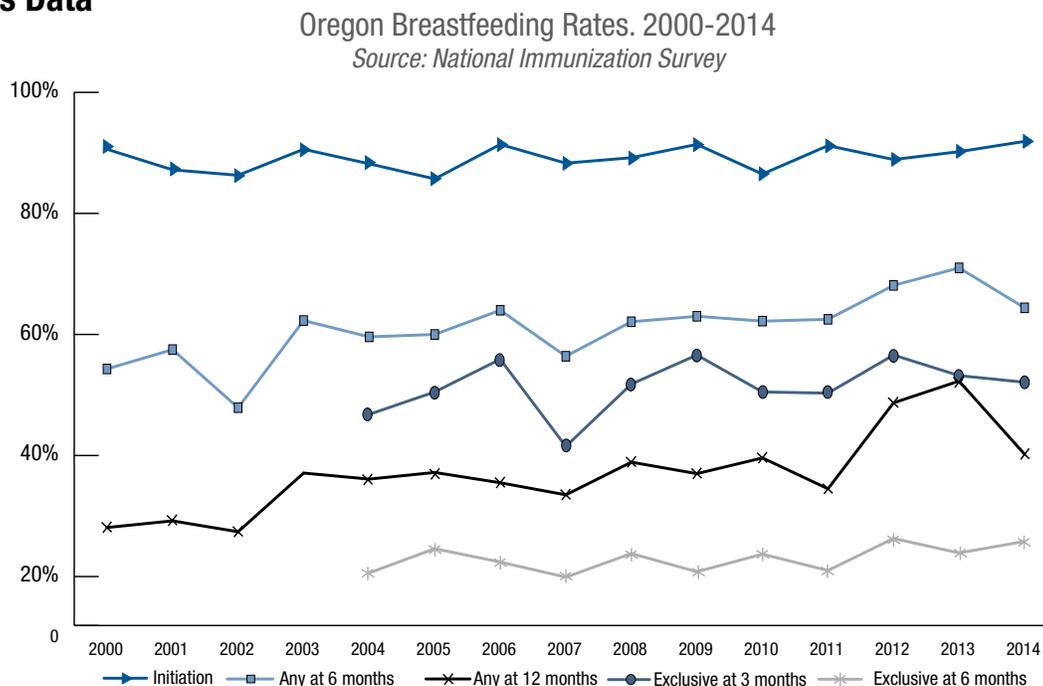
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Significance of the issue

The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for six months and to continue breastfeeding, with the addition of complementary foods, for at least 12 months of age as human milk supports optimal growth and development. 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. Mothers who do not breastfeed have higher rates of breast, uterine and ovarian cancer, diabetes, heart disease and osteoporosis. Breastfeeding also supports attachment by promoting close bonding with their infant and reduces the risk of postpartum depression.

Despite positive breastfeeding trends, significant racial disparities persist. Although Oregon race/ethnicity data is limited, national data indicate lower breastfeeding rates among African American, Native American and Asian women, and rates are lower among Hispanic women who have become more acculturated.

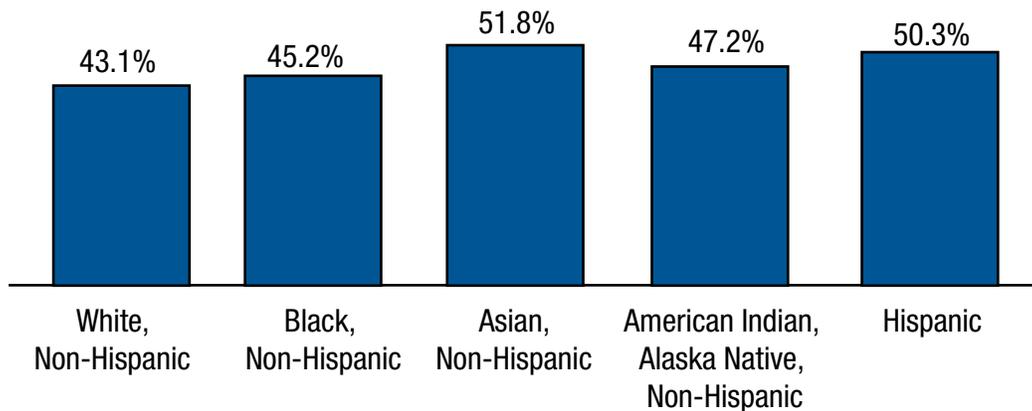
Health Status Data



National Priority Area: Breastfeeding

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

Source: Pregnancy Risk Assessment Monitoring System



Context for the Issue in Oregon

Oregon has one of 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). Trends for any breastfeeding at all time periods appear to be slowly increasing; trends for exclusive breastfeeding, especially at 6 months, appear stagnant over time, indicating that there are many barriers that prevent women from continuing to exclusively breastfeed.

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.

Work in progress

Oregon has many supports in place to encourage women to initiate and continue breastfeeding, as described below, however sustaining breastfeeding remains the primary challenge in Oregon.

- Community Support: Oregon has a law that supports breastfeeding in public, a network of geographic and culturally specific breastfeeding coalitions and peer support programs in some counties.
- Health Care: The majority of hospitals are making progress in maternity care practices that support breastfeeding and the number of Baby Friendly Hospitals has increased from 5 in 2007 to 10 in 2015.
- Workplace: State and Federal laws that support breastfeeding accommodation in the workplace provide legal protection to the vast majority of Oregon women
- Child Care: Programs that are enrolled in the Child and Adult Care Food Program are able to be reimbursed for breast milk feeding of infants.

National Priority Area: Physical Activity for Children

National performance measure: Percentage of children ages 6 through 11 years who are physically active at least 60 minutes per day.

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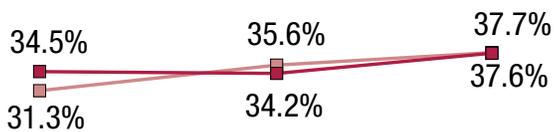
Significance of the issue

Physical activity contributes to achieving and maintaining a healthy weight, promotes emotional health and self-esteem, reduces anxiety and stress, supports the development of social skills, promotes good sleep, promotes the ability to learn, and builds and maintains strong bones muscles and joints. 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. It also reduces the risk for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone- strengthening activities are especially important for children in order to build peak bone mass.

Health Status Data

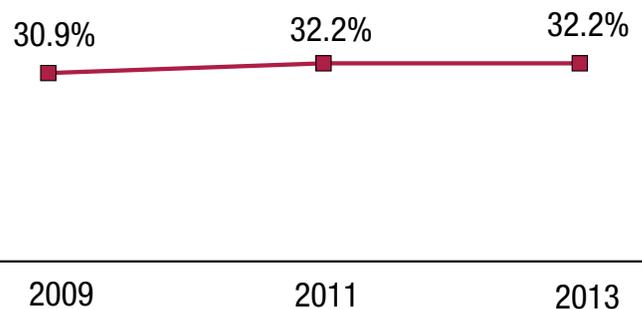
Percent of children ages 6-11 years who are physically active at least 20 minutes per day, 2003-2011/12

Source: National Survey of Children’s Health



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

Source: Oregon Healthy Teens



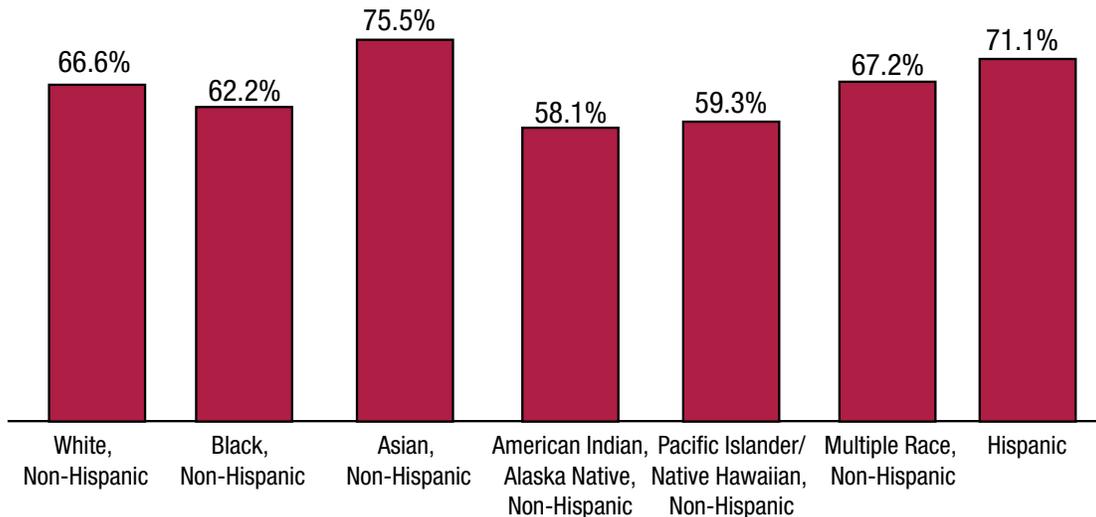
Note: NSCH reports 20 minutes of physical activity, and racial/ethnic stratification not available

Note: US data not available for 8th graders

National Priority Area: Child Physical Activity

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

Source: Oregon Healthy Teens



Context for the Issue in Oregon

Children spend a significant portion of their day in school, making schools a critical setting for increasing physical activity. In 2007, the Oregon Legislature passed physical education standards for public schools, specifying that all K-5 students receive 150 minutes per week of physical education and that students in grades 6-8 receive 225 minutes per week by 2017. According to the February 2015 Physical Education Legislative Report, few schools offered the required amount of instruction to all students all year long, and the average minutes per week of physical education instruction for all grades remains significantly below the levels outlined in HB3141.

There are many initiatives and partners around the state promoting comprehensive approaches to increase physical activity throughout the day, including implementation of the Comprehensive School Physical Activity Program (CSPAP). CSPAP includes activity before and after school (e.g. Walk and Bike to School), during school (recess) and physical education. Finally, physical activity habits learned early in life influence lifelong health and success in learning. Child care settings offer critical opportunities to support the promotion of healthy behaviors like physical activity.

Work in progress

- Increasing opportunities for physical activity is a key strategy to slow the increase of obesity in Oregon's State Health Improvement Plan as well as the Public Health Division's Strategic Plan.
- 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 primary focus of a current CDC grant held by the Center for Prevention and Health Promotion in the Public Health Division.
- Promoting and increasing physical activity are among the health and safety standards promoted in Oregon's Quality Rating Improvement System (QRIS) for child care facilities.

National Priority Area: Oral Health

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 preventative dental visit in the last year.

Title V MCH Block Grant in Oregon

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Significance of the issue

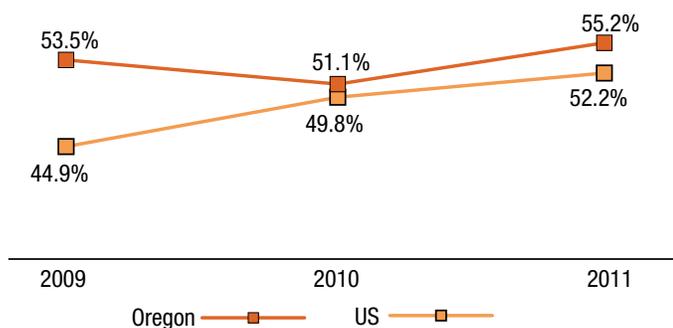
Oral health is a vital component of overall health and well-being across the lifespan. Access to dental care, good oral hygiene, and adequate nutrition are essential components of oral health to help ensure that children, adolescents, and adults achieve and maintain a healthy mouth. People with limited access to preventive oral health services are at greater risk for oral diseases. Among pregnant women, oral infections can increase the risks for premature delivery and low birth weight babies.

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, speech, nutrition, growth, social development, and the ability to learn. 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.

Health Status Data

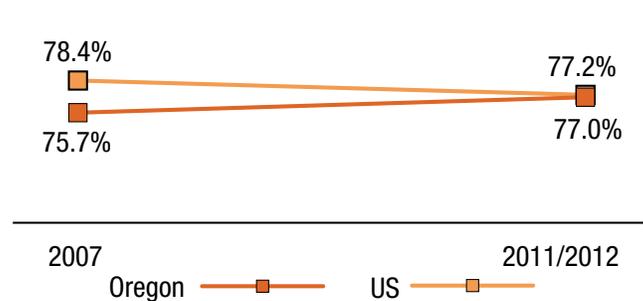
Percent of women who had a dental visit during pregnancy, 2009-2011

Source: Pregnancy Risk Assessment Monitoring System



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

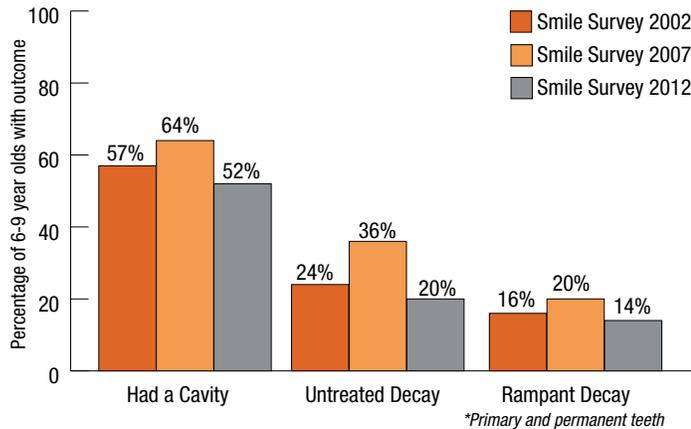
Source: National Survey of Children’s Health



National Priority Area: Oral Health

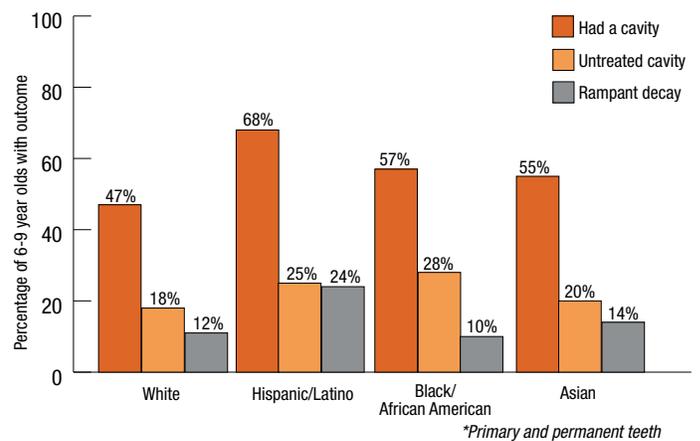
Oral health status* among children 6-9 years old, Oregon

Source: Smile Survey 2002-2012



Oral health status* among children 6-9 years old by race/ethnicity, Oregon, 2012

Source: Smile Survey 2012



- 48% of first graders have had a cavity. This rate jumps to 58% by third grade, to 70% in 8th grade and 74% in 11th grade. Cavities are almost entirely preventable.
- Hispanic/Latino children experienced particularly high rates of cavities, untreated decay and rampant decay compared to White children.
- Black/African American children had substantially higher rates of untreated decay compared to White children.

Context for the Issue in Oregon

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. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride; providing oral health services during well-child visits; following the American Congress of Obstetricians and Gynecologists (ACOG) oral health recommendations for pregnant women; incorporating oral health in chronic disease prevention and management models; and increasing the number of community and school-based health centers with an oral health component.

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:

- Non-traumatic dental needs are one of the most common reasons for emergency department visits.
- The statewide fluoridation rate remains around 22.6%.
- Children residing in rural and frontier areas have less access to care and higher rates of decay.

Work in Progress

- Oral health is one of the six priority areas in the State Health Improvement Plan for 2015-2019.
- Oregon released the Strategic Plan for Oral Health in Oregon: 2014-2020 that comprehensively outlines the priorities for improving oral health across the lifespan.
- Oregon Coordinated Care Organizations (CCOs) have a dental sealant performance metric.
- As part of Senate Bill 738, dental pilot projects are now being accepted to test various types of new and expanded workforce models to improve access and outcomes for the most vulnerable populations.

National Priority Area: Smoking

National performance measure: A) Percentage of women who smoke during pregnancy and
B) the percentage of children who live in households where someone smokes.

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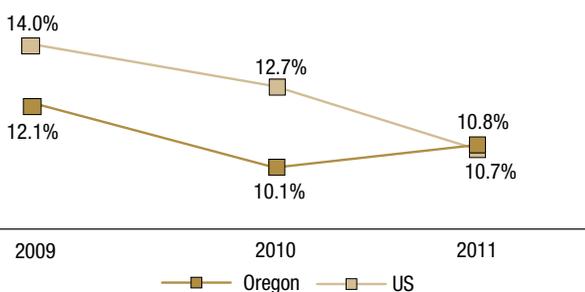
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Significance of the issue

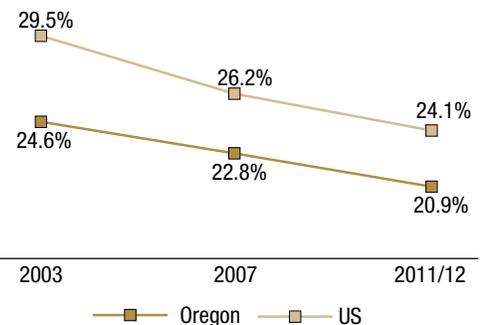
Tobacco use during pregnancy is a special concern because of the effects of smoking on both the mother and the developing fetus. Those exposed in-utero have a 5.5 times greater risk of becoming smokers in adolescence.¹ Prenatal cigarette smoke exposure is also related to lifetime tobacco dependence.² Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Secondhand smoke is a mixture of mainstream smoke (exhaled by smoker) and the more toxic side stream smoke (from lit end of nicotine product) and is classified as a known human carcinogen by the US Environmental Protection Agency. 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.

Health Status Data

Percent of women who smoked during the last 3 months of their pregnancy, 2009-2011
Source: Pregnancy Risk Assessment Monitoring System



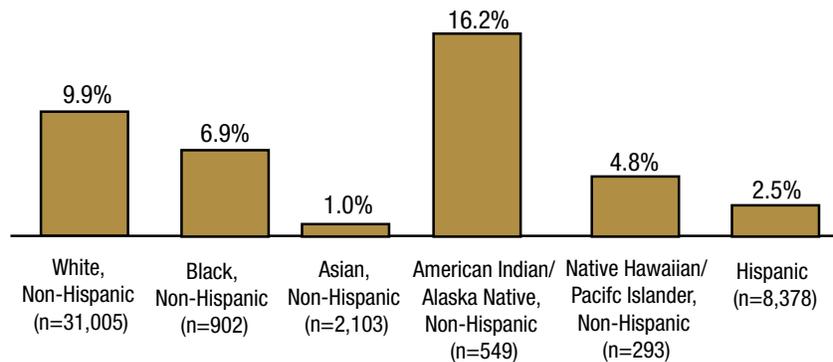
Percent of children who live in a household with someone who smokes, 2003-2007
Source: National Survey of Children's Health



- Oregon's rate of smoking during pregnancy has always been above the national average. An estimated 10,381 women smoked at the time of pregnancy in 2011.³
- Pregnant women who are younger, have a low level of education, are non-Hispanic White or Native American, and are unmarried are more likely to smoke during pregnancy.⁴
- 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.

National Priority Area: Smoking

Percent of women who smoked during the last 3 months of their pregnancy, by race/ethnicity. Oregon, 2011 Births
Source: Pregnancy Risk Assessment Monitoring System



- Smoking rates 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.
- Children with Special Health Care Needs are more likely to live in a household where someone smokes and to be exposed to second-hand smoke inside the home than children who don't have special health care needs.⁵

Context for the Issue in Oregon

Community programs: Public Health Nurses are routinely trained in the evidenced-based 5As intervention (Ask, Advise, Assess, Assist, and Arrange). Maternity Case Management home visiting programs throughout Oregon are required to conduct the 5As on women who smoke each and every time a woman is seen. This intervention is also conducted in other home visiting and maternal and child health programs.

Local Tobacco Prevention and Education Programs (TPEP) convene a workgroup on the topic of tobacco use and pregnant women. They share successful strategies and learn from guest speakers regarding pregnant women and tobacco use using policy and systems change approaches. MCH Programs focusing on tobacco as a Title V priority will also participate in a corresponding workgroup, joining forces when shared issues arise.

Cessation: The Oregon Tobacco Quit Line offers enhanced services to smokers who are pregnant. The program offers pregnant smokers increased support with women receiving ten consultation calls, up to six months post-partum, from the Quit Line. (www.quitnow.net/oregon) This pregnancy program is grounded in existing scientific evidence, and provides pregnant smokers the resources they need to be successful in quitting tobacco use.

Work in progress

- Maternal and child programs have tobacco cessation as a priority for pregnant women and children affected by second-hand smoke.
- Addressing tobacco use for the entire population is a primary priority of Oregon's State Health Improvement Plan.
- Tobacco use is an incentivized 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.

1. Cornelius, M.D., Leech, S.L., Goldschmidt, L., & Day, N. (2000). Prenatal tobacco exposure: Is it a risk factor for early tobacco experimentation? *Nicotine & Tobacco Research*, 2, 45-52, doi:10.1010/14622200050011295

2. Buka, S., Shenassa, E., & Niaura, R. (2003). Elevated risk of tobacco dependence among offspring of mothers who smoked during pregnancy: A 30-year prospective study. *American Journal of Psychiatry*, 160, 1978-1984. Doi:10.1176/appi.ajp.160.11.1978

3. Oregon Pregnancy Risk Assessment Monitoring System (PRAMS), 2011.

4. Child Trends Data Bank. <http://www.childtrends.org/?indicators=mothers-who-smoke-while-pregnant>

5. Children with Special Health Care Needs in Context: A portrait of States and the Nation 2007. <http://mchb.hrsa.gov/nsch/07cshcn/national/2chf/1hdr/pages/01sh.html>

National Priority Area: Well-woman care

National performance measure: Percentage of women with a preventive visit in the past year.

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Significance of the issue

Access to high-quality well-woman care is a key driver for optimizing the health of women before, between and beyond potential pregnancies. By taking action on health issues throughout the lifespan, future problems for the mother and baby can be prevented. Access to high-quality well-woman care:

- Provides a critical opportunity to receive recommended clinical preventive services, screening and management of chronic conditions such as diabetes, counseling to achieve a healthy weight and smoking cessation, and immunizations.
- Increases the likelihood that any future pregnancies are by choice rather than chance.
- Decreases the likelihood of complications for future pregnancies.

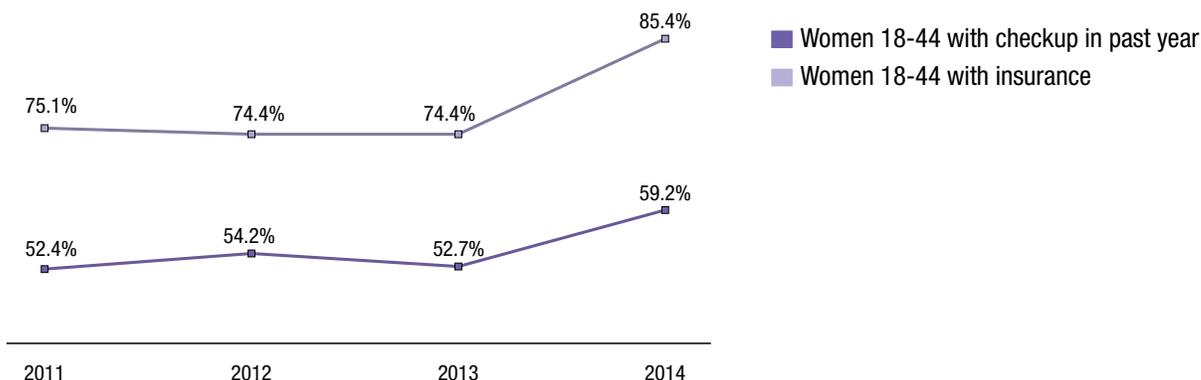
High-quality well-woman care includes pre/interconception health care education that is tailored to each woman.

- Pregnancy Intention Screening allows for individualized care to best meet overall and reproductive health needs.
- Preconception care is focused on reducing maternal and fetal morbidity and mortality, increasing the chances of conception when pregnancy is desired, and providing contraceptive counseling to help prevent unintended pregnancies.
- Interconception care refers specifically to care provided between pregnancies. Details and risk factors associated with previous pregnancies are integral to interconception care.
- Postpartum care provides important opportunities to assess the physical and psychosocial well-being of the mother, counsel her on infant care and family planning, and detect and give appropriate referrals for preexisting or developing chronic conditions such as diabetes, hypertension, or obesity. In 2014 in Oregon, only 57.7 percent of women who had a baby during the measurement period also had a postpartum care visit.

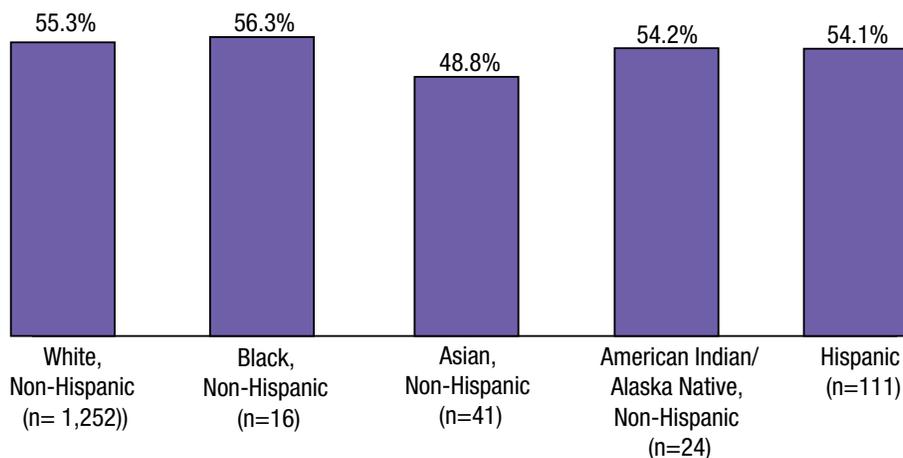
Health Status Data

National Performance Measure: is defined as the percent of women aged 18-44 with a past-year preventive medical visit. The measure is based on self-report to the following survey question: “About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.”

Oregon women 18-44 with insurance, with checkup in the past year
 Source: Behavioral Risk Factor Surveillance System



Percent of women ages 18-44 who had a routine checkup within the past year, by race and ethnicity, Oregon, 2011
 Source: Pregnancy Risk Assessment Monitoring System



Context for the Issue in Oregon

In 2014, approximately 59% of women in Oregon aged 18-44 years had a routine check-up within the past year. This percentage has increased slightly since 2011. In 2011, 55.3% of non-Hispanic white women, 56.3% of non-Hispanic black women, and 54.1% of Hispanic women had a routine checkup in the past year. The 2014 Behavioral Risk Factor Surveillance System (BRFSS) in Oregon found that 41% of the women aged 18-44 without insurance coverage had a routine checkup in the past year, while 62% of women in that age group with insurance had a checkup in the past year.

According to the Pregnancy Risk Assessment Monitoring System (PRAMS), 24.9% of 2012 Oregon births were unintended. 21.1% of all Oregon women who had a live born infant during 2012 were obese at the beginning of their pregnancy, 54.4% of women did not take the recommended folic acid supplements, and 8.4% smoked during the last three months of their pregnancy.

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.¹ 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.²

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.³

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.⁴ 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.

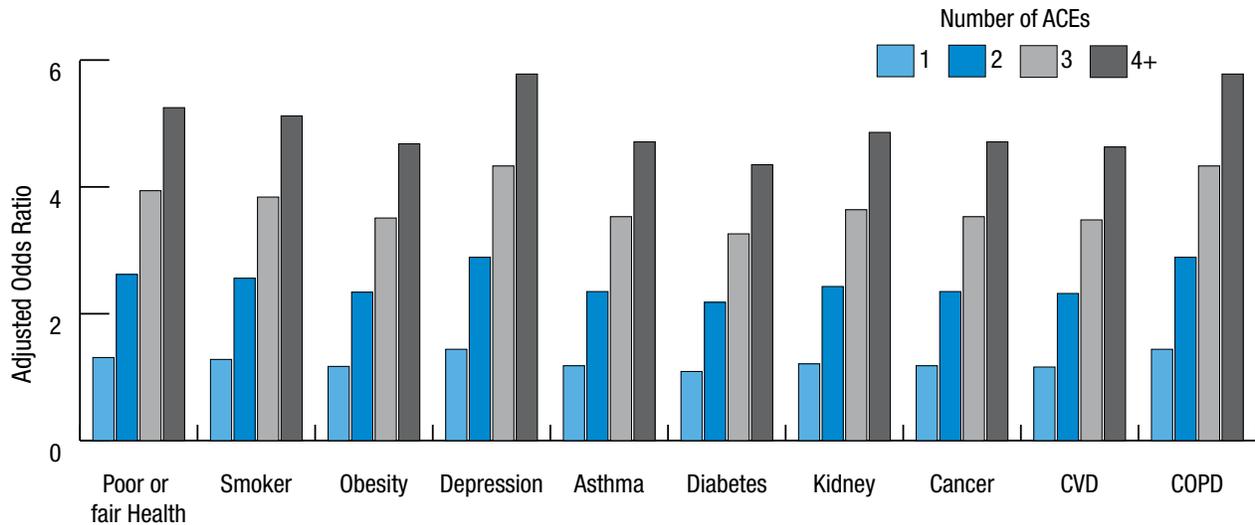
¹ Middlebrooks, Jennifer S. and Audage, Natalie C. “The Effects of Childhood Stress on Health Across the Lifespan” available at http://www.cdc.gov/ncipc/pub-res/pdf/Childhood_Stress.pdf

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

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

⁴ 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/

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).

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: Nutrition and food insecurity

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

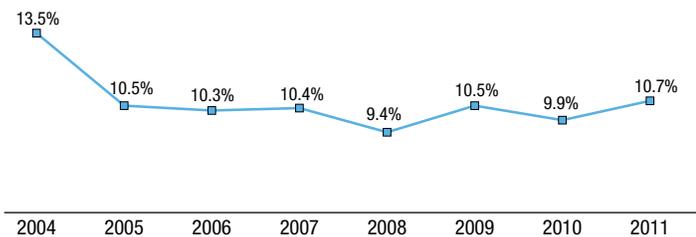
Significance of the issue

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.

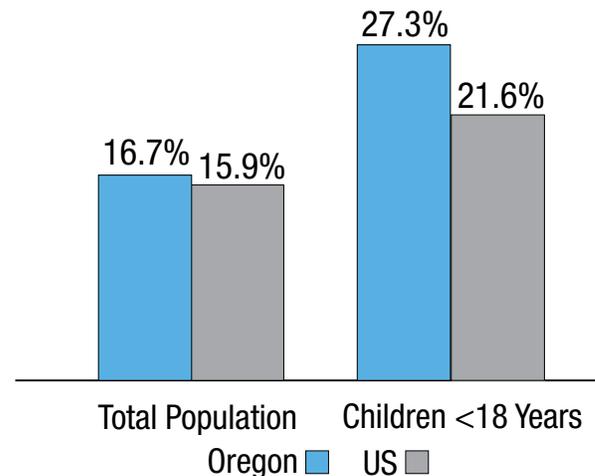
Rural communities are hit hard by food insecurity; and some populations experience hunger at higher rates. African-Americans, Latinos, and female-headed single parent families experience food insecurity at higher rates than the national average.

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

Context for Oregon

- In 2012 over 16% of Oregon households were food insecure.¹ 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.

¹ <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.