

# Oregon Title V Maternal and Child Health Services Block Grant Five Year Needs Assessment Report

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## **Welcome message**

We are pleased to present this report of the findings from the Title V Block Grant Five Year Needs Assessment in Oregon. This report contains a wealth of information on the health needs of women, children and families in Oregon.

While this report is intended primarily as a resource for maternal and child health professionals in Oregon, particularly those at agencies which are recipients of Title V funding, we hope that citizens and community leaders across Oregon will find the information useful for a wide variety of purposes.

We would like to express our thanks to the large number of dedicated people who have been involved in guiding the needs assessment. In addition, we would like to express our thanks to our partner organizations, who took the time to complete surveys of maternal and child health needs, which was instrumental in ensuring we had a comprehensive picture of the need of women, children and families in the state.

## Acknowledgements

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## **EXECUTIVE SUMMARY**

Every five years, Oregon's Title V program conducts a comprehensive assessment of the need for maternal and child health services in Oregon. Title V funds are then used to design and implement a wide range of activities that address state needs. Beginning with the 2015 Block Grant Application, transformational changes have been made to the Title V Block Grant. The new three-tiered framework includes: National Outcome Measures, National Performance Measures, and Evidence-based Strategy Measures. Each of the NPMs correspond to one of fifteen national priority areas, which are organized into six population domains. Oregon was tasked with selecting eight of the fifteen national priority areas, and three to five state priority areas.

In response to the transformational changes, Oregon conducted a needs assessment which utilized a mixed methods approach, consisting of the following stages:

1. System forces of change assessment

- a. Online discussion forum: An online discussion forum was conducted to gather information about the capacity of Oregon's health systems. The lead administrators and Maternal and Child Health Coordinators of every county health department and tribal health agency in the State of Oregon were invited to participate.

- b. Listening sessions: Three listening session were conducted in support of the needs assessment, one with the Regional Health Equity Coalitions and two with the Oregon Parenting Education Collaborative.

- c. Key informant interviews: Three interviews were conducted with key informants; the Oregon Health Authority Child Health Director, the Oregon Health Authority Transformation Center Innovator agent, and the Early Learning Division Director of Policy and Research.

- d. Webinar with Oregon tribes: Nine tribal representatives participated in the webinar with Oregon Tribes.

2. Partner survey

The survey was conducted using an online format. The content of the survey was divided into population domains, following the federal organization of national priority areas. Each of the current state priority areas were also included in the survey. For each national and current Oregon priority areas, respondents were asked to rate the health issue for four dimensions; Impact on health, importance for addressing equity, time and resources currently being applied to the issue, and likelihood of leveraging additional resources. Respondents were also asked to identify any emerging maternal and child health priority areas in their communities.

### 3. Environmental scan

Health and needs assessment reports were gathered from local health departments and other organizations. Fifty three separate documents were analyzed using qualitative analysis software. The documents were searched for mentions of the national and current state priority areas, and related terms. The reports were also analyzed to identify rising maternal and child health themes, in order to assist in identifying emerging state priority areas.

### 4. Examination of health status data

Health status data was compiled to examine the current status of health in regard to each of the national and state priority areas. For every national and state health priority area, if data were available, the health status data were stratified by race/ethnicity to look for possible health disparities.

### 5. CYSHCN stakeholder surveys

OCCYSHN administered surveys to families of CYSHCN, and to young adults between the ages of 12 and 26 years with a special health care need. OCCYSHN also administered surveys to community-based medical providers who treat CYSHCN, and to professionals who provide care coordination services to CYSHCN and their families.

6. CYSHCN group discussions with CaCoon public health nurses and nurse supervisors  
OCCYSHN hosted a series of four regional professional development meetings for county public health nurses and nurse supervisors who implement the CaCoon home visiting program.

### 7. CYSHCN key stakeholder panel discussion

OCCYSHN invited professionals representing a wide range of organizations and institutions that serve CYSHCN and representatives of families of CYSHCN to participate in a facilitated discussion.

### 8. Identification of emerging needs

Emerging needs were identified using a variety of data sources: the environmental scan; information from program partners, medical providers, community stakeholders, Tribal and local public health leaders, and key informants/partner agencies; demographic, health status and behavioral data; and state and national policy forums.

### 9. Creation of data tools

The results of the needs assessment were summarized in data tools, to be used in the prioritization process. The data tools were organized into national population domains, current state priority areas, and emerging state priority areas.

### 10. Prioritization meeting

A group of stakeholders met to consider the needs assessment results and to make recommendations for Oregon’s priority needs. After presentation of the findings of the needs assessment using the data tools, stakeholders were provided with selection parameters and criteria, and participated in small group and full group discussions before recommending priorities.

The final priorities were selected for work in Oregon during the grant cycle:

Population Domain	Priority Area
National Priority Areas	
Women’s/Maternal Health	Well woman care
Perinatal/Infant’s Health	Breastfeeding
Child Health	Physical activity
Adolescent Health	Adolescent well-visit
Children with Special Health Care Needs	Medical home
	Transition
Cross-cutting/Life course	Oral health
	Smoking
State Priority Areas	
Cross-cutting/Life course	Toxic stress and trauma
	Nutrition and food insecurity
	Culturally and linguistically responsive services

## **BACKGROUND**

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 PROGRAM**

Oregon’s Title V program is dedicated to working with partners across the state to address health inequities and ensure that all women, children, youth, families and communities can thrive and reach their potential for life-long health and well-being. The Oregon Public Health Division and the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) jointly manage Oregon’s MCH Block Grant. Funds are used to carry out MCH programs and related activities through State Public Health, OCCYSHN, Local Public Health Departments, and Oregon Tribes. The funded agencies are accountable to work with their communities and partners to meet the Federal grant requirements.

At the state level, Block Grant funds are used to support assessment and monitoring of MCH health needs and disparities; policy and program development; statewide health promotion activities; training, technical assistance and oversight of local level MCH services; and coordination among state agencies and systems to better serve the needs of Oregon’s MCH population – including children with special health needs.

At the local level, Block Grant funds are used to support health promotion, assessment, monitoring, and system coordination activities; as well as to deliver MCH programs and services through local health departments and tribes.

Every five years, Oregon’s Title V program conducts a comprehensive assessment of the need for maternal and child health services in Oregon. Title V funds are then used to design and implement a wide range of activities that address state and national needs. The following is a report on the needs assessment that was conducted from 2014 – 2015, to determine priorities and activities for the 2016 – 2021 Title V Block Grant.

### **TITLE V BLOCK GRANT TRANSFORMATION**

Beginning with the 2015 Block Grant Application, transformational changes have been made to the Title V Block Grant, to achieve the following three goals: a reduction of the reporting burden on states, a maintenance of the flexibility of funds, and an improvement of the accountability of the program. The changes are intended to drive improvements throughout the program, but they will be particularly noticeable in the revision of the performance measure framework. A new performance measure system is intended to show more clearly the contributions of Title V programs in impacting health outcomes while still maintaining flexibility

for states. The new framework is designed to track areas where the program can best demonstrate the impact of the Title V Block Grant.

The new three-tiered framework includes:

- National Outcome Measures (NOMs) – intended to represent the desired result of Title V program activities and interventions. These measures for improved health are longer-term than NPMs.
- National Performance Measures (NPMs) – intended to drive improved outcomes relative to one or more indicators of health status (i.e., NOMs) for the MCH population.
- Evidence-based Strategy Measures (ESMs) – intended to hold states accountable for improving quality and performance related to the NPMs and related public health issues. ESMs will facilitate state efforts to more directly measure the impact of specific strategies on the NPMs.

Each of the NPMs correspond to one of fifteen national priority areas, which are organized into six population domains, as illustrated below:

Population Domain	National Priority Area
Women’s/Maternal Health	Well woman care
	Low risk cesarean deliveries
Perinatal/Infant’s Health	Perinatal regionalization
	Breastfeeding
	Safe sleep
Child Health	Developmental screening
	Injury
	Physical activity
Adolescent Health	Injury
	Physical activity
	Bullying
	Adolescent well-visit
Children with Special Health Care Needs	Medical home
	Transition
Cross-cutting/Life course	Oral health
	Smoking
	Adequate insurance coverage

## **OVERVIEW OF NEEDS ASSESSMENT**

The goals of the needs assessment process were to engage stakeholders and community members in examining Oregon's current and emerging MCH needs, and in determining areas in which Title V could most productively focus its work to improve maternal and child health and health equity.

States were tasked with selecting eight of the fifteen national priority areas, including at least one from each population domain, based on the results of the needs assessment. States were also instructed to select three to five state priority areas, which did not have to be aligned with the six population domains. These three to five state priority areas were selected from among the current state priority areas identified in the previous grant cycle, and emerging state priority areas. The emerging areas were identified in various stages of the needs assessment, as described in detail in this report.

The needs assessment guiding questions were as follows:

1. How are the current and emerging needs of the MCH population the same or different from those identified and prioritized in 2010?
2. How do Oregon's MCH needs align with the MCHB's new Title V 3.0 priorities and performance measures?
3. How can the Title V program direct/prioritize its work to promote equity in the MCH population, and address root causes of MCH health problems and disparities across the life course?
4. How will health care and early learning systems transformations impact the way we structure our Title V work and use our resources?
5. What structural or capacity needs/issues (state and local) should the Title V program should focus on to maximize our reach and impact?
6. How can we use the NA process to strengthen our partnerships and shared commitment/capacity to improve MCH?

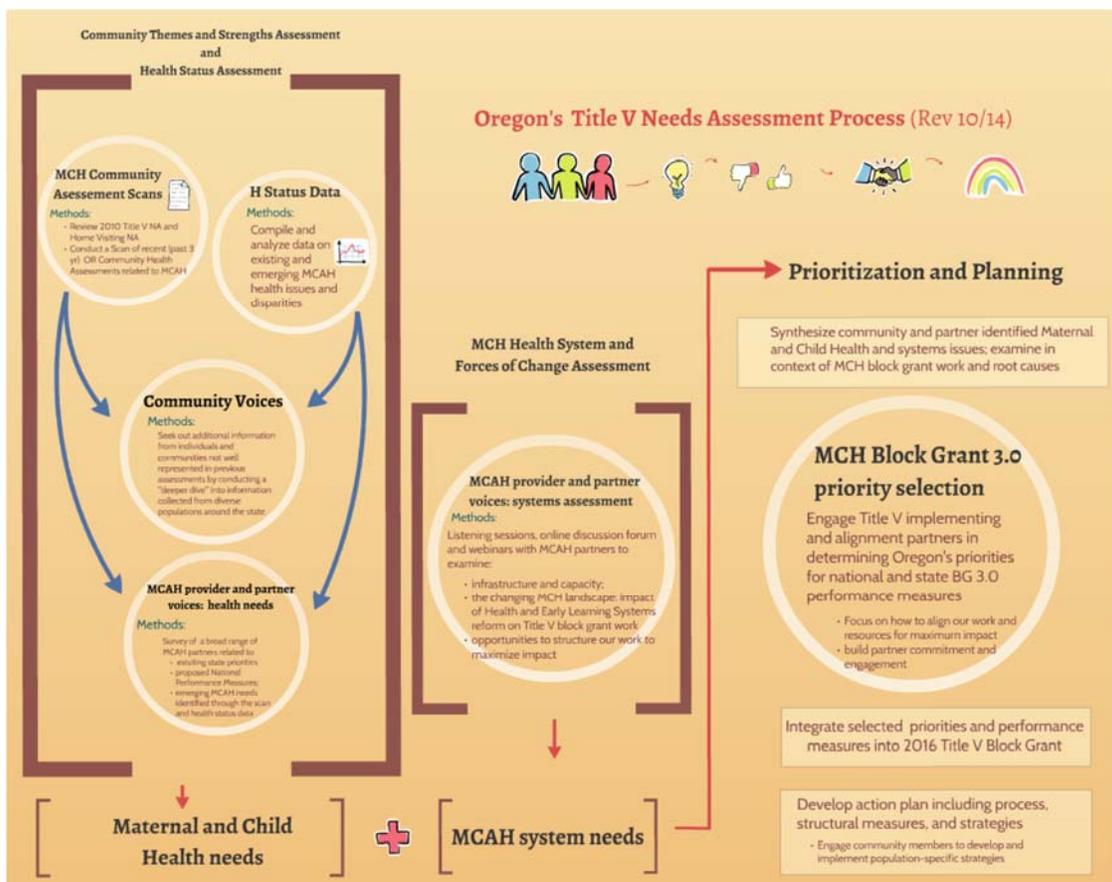
OCCYSHN, Oregon's Title V CYSHCN program, assessed CYSHCN and their families' needs in partnership with OHA's statewide Title V Block Grant needs assessment. Two key questions guided OCCYSHN's needs assessment:

1. What are the current needs of Oregon CYSHCN and their families?
2. What are the challenges and strengths of the system of care serving CYSHCN?

The needs assessment was conducted using a mixed methods approach, consisting of the following stages:

1. System forces of change assessment
  - a. Online discussion forum
  - b. Listening sessions
  - c. Key informant interviews
  - d. Webinar with Oregon tribes
2. Partner survey
3. Environmental scan
4. Examination of health status data
5. CYSHCN stakeholder surveys
6. CYSHCN group discussions with CaCoon public health nurses and nurse supervisors
7. CYSHCN key stakeholder panel discussion
8. Identification of emerging needs
9. Creation of data tools
10. Prioritization meeting

The stages of the needs assessment can be seen outlined in the following diagram:



The needs assessment was designed to maximize engagement of wide array of MCH stakeholder voices with scarce resources. Over 1,600 people participated directly including 857 in the MCH Section's assessment and 743 in the OCCYSHN needs assessment. Each of these stages is described in detail in this report. Data tools were created to summarize the findings of the needs assessment, to be used in the prioritization and planning.

Data tools were created for:

- Each of the national priority areas
- Each of the current state priority areas from the previous grant cycle
- The emerging priority areas identified during the needs assessment.

Eight national priorities and three new state priorities were selected.

## **METHODS**

### **1. System forces of change**

#### **a. Online discussion forum**

##### **METHOD**

An online discussion forum was conducted to gather information about the capacity of Oregon's health systems. The forum was open for comments for two weeks, from October 20 through November 3, 2014. The Muut online discussion platform was selected for the forum after a review of several online discussion tools.

##### *Participants*

The intent was to receive input about the capacity of the maternal and child health system from across the state of Oregon. The lead administrators and Maternal and Child Health Coordinators of every county health department and tribal health agency in the State of Oregon were invited to participate. In addition, each lead administrator was able to designate other participants. Eighty-eight individuals were invited to participate in the discussion forum. These invitees received a set of instructions for participating in the forum via email.

##### *Questions*

Two discussion channels were created for the discussion forum, one for general maternal and child health issues and one for a discussion of issues related to services for children with special health care needs.

##### *Moderators*

In order to encourage comments to the questions, moderators were selected for each question. They were asked to review comments at least once or twice a day and to elicit additional responses.

##### **RESULTS**

Twenty-eight participants left comments during the two week course of the discussion forum. These participants made a total of 82 comments, excluding all comments made by moderators.

The following table outlines the questions posed and answers received during the online discussion.

<b>Working well / successes (8 comments)</b>
Coordination of services, through use of multi-disciplinary teams, and partnerships with medical providers, schools, DHS, Early Head Start, the Oregon Child Development Coalition, CaCOON, and behavioral health providers.
<b>Service and system barriers (10 comments)</b>
Lack of child care, problems serving undocumented clients, home visiting program eligibility limits, lack of transportation and refusal of services by families. The home visiting subcommittee was suggested as a potential solution to service barriers.
<b>Changes caused by partnership with CCOs (4 comments)</b>
Funding changes, structural features of the healthcare system, reduced duplication of services, a focus on obesity reduction, and a focus on mental health.
<b>Changes caused by partnership with Early Learning Hubs (10 comments)</b>
Creation of shared plans and service coordination. Barriers to successful partnerships include difficulty connecting with key stakeholders, personnel changes, and failure to focus on children with highest risk of poor school readiness.
<b>Opportunities for system coordination with CCOs and Early Learning Hubs (17 comments)</b>
Use of multi-disciplinary teams, implementation of a child fatality review team, coordinating on related goals, coordinating with local medical providers, information sharing, and coordination among home visiting, CCOs and Early Learning Hubs.
<b>Ideas for improved family, youth and consumer engagement (12 comments)</b>
Improved marketing, administration of surveys, use of incentives, targeting of specific population groups, engagement of consumers at home, use of phone apps, focus groups, the inclusion of consumers in the planning process, and advisory board membership.
<b>Ideas for improving cultural competency of systems and service (8 comments)</b>
Better responsiveness to language needs such as translation services and bilingual staff, the use of a trauma informed system of care, and funding for culturally specific organizations.
<b>Unmet needs for CYSHCN services (4 comments)</b>
Transportation, respite care, the accommodation of siblings, and support groups.
<b>Barriers to providing CYSHCN services (9 comments)</b>
Transportation, the lack of services in certain local areas, language barriers, a lack of a shared plan across agencies, and missing school and work to travel to services.

## b. Listening sessions

Three listening sessions were conducted in support of the needs assessment, one with the Regional Health Equity Coalitions and two with the Oregon Parenting Education Collaborative.

### 1) Regional Health Equity Coalition Listening Session

#### METHOD

The Regional Health Equity Coalition Listening Session was conducted at a conference of the Regional Health Equity Coalitions on November 6, 2014. A facilitated discussion was conducted focusing on a set of five questions. Responses were recorded in notes and the session was recorded. Participants were provided with comment sheets to add written comments. Notes of the oral discussion and the written comments were analyzed using NVIVO qualitative analysis software.

#### RESULTS

The following table outlines the questions posed and answers received during this listening session.

<b>Working well / successes</b>
Specific interventions, such as the use of the 'One Key Question' in WIC clinics, and breastfeeding policies adopted by multiple agencies. Specific programs, such as a WIC program which excelled at supporting migrant families. Other successes included collaboration with other agencies, coordination with Early Learning Hubs and CCOs, inclusion in a legislative platform, inclusion of health in other policy efforts, capacity-building, wrap-around services, and awareness of equity.
<b>Challenges working with partner agencies</b>
Coordination and integration of services, including lack of interagency coordination, leading to frustration among families and disengagement from programs. Need for culturally relevant services, such as those for tribal members and migrant workers. Transportation issues, particularly in rural areas of the state.
<b>Opportunities for partnership with public health, CCOs, and Early Learning Hubs</b>
Service integration, including sharing goals with other service providers and cooperation between programs. Wrap-around services, such as housing and childcare, and attention to equity.
<b>Opportunities to address health equity</b>
Cultural competence training, specifically aimed at providers such as community health workers and doulas. Addressing family income and rurality, involving clients in policy decisions, and requiring partnerships with equity coalitions.
<b>Other comments/feedback</b>
Increase the number of community health workers and to expand their role, including utilizing them to address culturally and linguistically appropriate service standards. Increase educational opportunities and culturally and linguistically appropriate services. Work on addressing poverty, access to health care, oral health, and mental health. Promote use of midwives and doulas. Obtain and implement client feedback.

## 2) Oregon Parenting Education Collaborative Listening Sessions

### METHODS

Two listening sessions were conducted at the Oregon Parenting Education Collaborative (OPEC) conference October 3, 2014. Each session lasted one hour. Two groups of parent educators participated in the listening session: those who received “Small Grants” and OPEC Hubs.

Four questions were addresses in each session. A facilitated discussion was conducted focusing on each of these questions. Responses were recorded on newsprint sheets and an audio recording of each session was made. Participants were provided with comment sheets to add written comments. Notes of the oral discussion and the written comments were analyzed using Nvivo qualitative analysis software.

### RESULTS

The following table outlines the questions posed and answers received during this listening session.

<b>Successes in partnership between parenting education and public health</b>
Collaboration, including collaboration with county and federal programs, schools, early learning partners, CCOs, hospitals, and local medical providers. Referrals, such as to childhood mental health services, and the Healthy Birth Initiative. Public health nurses and home visiting. Community-based classes and parenthood information. Teen pregnancy services. Efforts to serve non-English speaking families.
<b>Challenges in working with partner agencies</b>
Challenges related to the service delivery system, including service coordination challenges, restrictions on sharing information, service system navigation challenges, and lack of clarity about roles. Funding and the closely related issues of staff burden and turnover. Cultural competence issues. Lack of integration of physical, oral and mental health services, and issues with referrals. The need for services in rural communities, and lack of transportation. Lack of training, lack of trauma-informed care, lack of basic services, and parenting education not being seen as relevant.
<b>Opportunities for partnership with public health, CCOs, and Early Learning Hubs</b>
Collaboration and training opportunities. Understanding and promoting the value of parenting education, increasing business investment in maternal and child health, and referrals.
<b>Opportunities to increase parent and other consumer engagement</b>
Using surveys and working with existing parent groups. Contact agencies for recommendations of parents, and provide parents and consumers meaningful roles in the health service delivery system.

### **a. Key informant interviews**

### METHODS

Three interviews were conducted with key informants; the Oregon Health Authority Child Health Director, the Oregon Health Authority Transformation Center Innovator agent, and the Early Learning Division Director of Policy and Research. These interviews probed for information about barriers to the delivery of maternal and child health services, the impact of the transition to Coordinated Care Organizations (CCOs) and Early Learning hubs on service delivery, increasing family, youth and other consumer engagement in program/policy development and decision making, and culturally competent service delivery.

**RESULTS:**

The key informant interviews gave us a better understanding of what aspects of the Maternal and Child Health Program were working well to serve community needs. In general, these included specific programs and initiatives and evolving relationships between public health and other areas.

The following table outlines the questions posed and answers received during the key informant interviews.

<b>Working well / successes</b>
<ul style="list-style-type: none"> <li>• Effective communication between public health and CCOs, to develop new working partnerships, including clearly defining roles of each.</li> <li>• Focus on incentive metrics in partnership with CCOS.</li> <li>• Perinatal collaborative, including the “One Key Question”, hard stop on elective deliveries, and COIIN.</li> <li>• Nexus of health, early learning and family self-sufficiency more broadly understood at the state level.</li> <li>• Developmental screening.</li> </ul>
<b>Barriers / challenges</b>
<ul style="list-style-type: none"> <li>• Lack of funding may lead to the compromise of health promotion/prevention activities, because focus is on clinical care, including primary care.</li> <li>• Not enough focus on disparities, including among both racially and culturally disenfranchised groups. This is partly due to lack of surveillance data. Also inadequate data on CYSHCN.</li> <li>• Cross system work will take more than the duration of the grant (5 years).</li> <li>• Behavioral, mental health, and physical health silos.</li> </ul>
<b>Impact of CCOs</b>
<ul style="list-style-type: none"> <li>• Increase in desire and motivation to collect and share data, specifically the CCO metrics. The public reporting of these metrics drives change.</li> <li>• Natural parallels between early learning hubs and CCOs, but formal work needs to be done to build the connections.</li> <li>• Community advisory committees enhances consideration of consumers.</li> </ul>
<b>Impact of Early Learning Hubs</b>
<ul style="list-style-type: none"> <li>• There will be alignment among education, CCOs, and home visiting, but this has not been implemented yet.</li> <li>• The early learning hubs are very new, so while there is enthusiasm, goodwill, energy, there is not a lot of money and no power to align with CCOs and public health.</li> <li>• However there are already successes in building new relationships with education. There is more opportunity for streamlining and connecting health promotion activities to high needs populations.</li> </ul>

### Opportunities for partnership between public health, CCOs, and Early Learning Hubs

- Opportunity to reach target populations of children we are currently missing or inadequately reaching.
- Metrics that cross systems allow for alignment at all levels, and examination of what is or is not working.
- Improved contraceptive care.
- Increased focus in CYSHCN.

### Suggestions for increasing family, youth and other consumer engagement

- Dedicating room on the Community Advisory Council. The CCOs have a constant need for consumer members on this council.
- Statewide learning collaborative.
- Increased family engagement on how funds for early learning hubs are used.
- Adequate resources and support for family involvement, such as parent development.
- Consumer representation at agency advisory groups.

### Opportunities to address health equity

- Cultural competency assessments such as those done at CCOs, to reduce health disparities.
- Involvement in regional health equity coalitions.
- LGBTQ competency education and training.
- Analysis of data to ensure service of disenfranchised communities.
- Professional development, including a focus on community health workers.
- Regional equity coalitions.

### Other comments/feedback

- Since funding is in siloes, we need to be flexible about use of funds to serve the whole family, and rural communities must be able to access funds.
- Need to identify issues which are inadequately addressed, and have the most opportunity for improvement.

## b. Webinar with Oregon Tribes

### METHODS

Nine tribal representatives participated in the webinar with Oregon Tribes.

### RESULTS:

The following table outlines the questions posed and answers received during the webinar.

<b>Working well / successes</b>
Having a clinic with WIC, public health nursing, medical, dental lab, x-rays, allows multiple needs to be met at one time. A clinic with prenatal services coordinates with obstetrics and gynecology providers, in addition to dental and radiology labs in the clinic, to provide a full service.
<b>Barriers / challenges</b>
Although a clinic now has a prenatal provider to retain prenatal clients, they lose children as clients, since they do not have a pediatric provider. Adolescent self-care, since adolescents are not connected with their own health care, due partly to a lack of a personal doctor or nurse. Compliance with appointments for all clients, due to transportation, drug use, and domestic violence.
<b>Opportunities for partnership with public health, CCOs, and Early Learning Hubs</b>
Communication between WIC and CCO staff nurses, and WIC and early learning. Some conflict of interest with CCOs, since some tribes want to serve as their own CCO. Attendance at community meetings by Head Start directors has improved communication between health providers and early learning. A list of resources available in the area helps consumers to access different kinds of services.
<b>Opportunities to address health equity</b>
Loss of children to external providers is an issue, which could be helped by having a database which shows the children's needs, so they can be addressed. Difficulty in accessing this data because current CYSHCN database information cannot be shared without release, so CYSHCN often don't get the services they need. Rurality inhibits families from accessing services, e.g. no dental care, pediatrician, or obstetrician/gynecologist.
<b>Other comments/feedback</b>
Tribes have been attending CCO meetings, but this has not had an impact of maternal and child health services yet. Tribal providers serve the tribal population best.

## 2. Partner survey

### METHODS

A partner survey was developed as one of the components of the Title V needs assessment. The survey was conducted using an online format, and potential respondents were invited by email to respond to the survey. A link to the survey was included in the email. For groups of partners with which MCH staff had direct contact, invitation emails were sent directly to the individual members of the groups. For others, MCH reached out to professional groups and other organizations, and asked that the organization send an invitation to its members.

The content of the survey was divided into population domains, following the federal organization of national priority areas. Each of the current state priority areas were also included in the survey. For each national and current Oregon priority areas, respondents were asked to rate the health issue on a scale from 0 to 5 for four dimensions: Impact on health, importance for addressing equity, time and resources currently being applied to the issue, and likelihood of leveraging additional resources. Respondents were also asked to identify any emerging maternal and child health priority areas in their communities.

The survey was online from July 18 to August 25, 2014. 718 individuals responded to the survey. The survey was distributed through 1,558 emails from targeted lists that included service providers that serve women, pregnant women, mothers, infants, adolescents and children, and agencies that receive Title V funds. Participants were asked to invite others to participate, so it is not possible to know exactly how many people received the link to the survey.

Responses were received from all 36 Oregon counties. Survey respondents included administrators, managers, and front-line service providers. Four out of five respondents to the survey worked for agencies that provided direct services. Ninety-two respondents (13%) reported that they worked for a Coordinated Care Organization. Seventy-three respondents (10%) reported that they worked for an Early Learning Hub.

Most respondents were non-Hispanic (78%). Oregon's non-Hispanic population is 88%. Seven percent of the respondents reported their ethnicity as Hispanic (Oregon's Hispanic population is 12%.) 14% did not report an ethnicity.

Eighty-seven percent of the respondents were White, (compared to Oregon's White population of 88%). 1.5% were American Indian or Alaska Natives (compared to Oregon's American Indian or Alaska Native population of 1.8%). 1.4% were Black or African American (compared to Oregon's Black or African American population of 2%). 1.4% were Asian (compared to Oregon's Asian population of 4.1%). Slightly more than one third of respondents were 55 years old and older. Two percent were between 18 and 24, and 14% were between 25 and 34 years of age.

(Source of Oregon demographic information: <http://quickfacts.census.gov/qfd/states/41000.html>) It is not possible to know the rate of responses to invitations because invitation recipients were encouraged to invite other appropriate professionals to respond, as mentioned above.

## RESULTS

Detailed results of the partner survey can be found under each of the priority area results.

### **3. Environmental scan**

To begin Oregon's environmental scan, health and needs assessment reports were gathered from local health departments and other organizations. These reports, in electronic format, were imported into NVIVO, a type of qualitative analysis software. Fifty three separate documents were uploaded to the software for analysis. The documents were searched for mentions of the national and current state priority areas, and related terms. Each mention was examined to determine if it was a description of a need. The reports were also analyzed to identify rising maternal and child health themes, in order to assist in identifying emerging state priority areas.

For the purposes of the needs assessment, the number of documents in which each priority area was discussed was used as an indicator of the importance of that topic as assessed by health and social services leaders and researchers in Oregon.

A list of data sources used is included in Appendix 1.

### **4. Health Status Data**

Health status data was compiled to examine the current status of health in regard to each of the national and state priority area. The sources of data included the census, vital statistics, and survey data. Specific sources of data are listed under the needs assessment results for each priority areas in this report. This data includes both the national or state performance measure, and other data, which is provided to add breadth to the picture of the health issue.

For every national and state health priority area, if data were available, the health status data were stratified by race/ethnicity to look for possible health disparities. Subject matter experts within the Oregon Health Authority were consulted in order to select the most important and relevant data to include in the needs assessment.

A list of data sources used is included in Appendix 1.

## **5. CYSHCN stakeholder surveys**

OCCYSHN administered electronic and paper surveys in English and Spanish to families of CYSHCN between the ages of birth and 26 years, and to young adults between the ages of 12 and 26 years with a special health care need. OCCYSHN also administered electronic surveys to community-based medical providers who treat CYSHCN, and to professionals who provide care coordination services to CYSHCN and their families. A detailed report on the results of these surveys can be found in the needs assessment report released by OCCYSHN available at: .....

## **6. CYSHCN group discussions with CaCoon public health nurses and nurse supervisors**

OCCYSHN hosted a series of four regional professional development meetings for county public health nurses and nurse supervisors who implement the CaCoon home visiting program. The meetings occurred in Bend, Pendleton, Roseburg, and Tigard. OCCYSHN staff facilitated a two-hour discussion at each meeting using a standard set of questions. In addition, these county health department CaCoon staff participated in a Nominal Group Technique in which they voted to identify priority areas of focus for their counties. A detailed report on the results of these group discussions can be found in the needs assessment report released by OCCYSHN available at: .....

## **7. CYSHCN key stakeholder panel discussion**

OCCYSHN invited professionals representing a wide range of organizations and institutions that serve CYSHCN and representatives of families of CYSHCN to participate in a facilitated discussion. Participants represented the following organizations: APS Healthcare; Child's Health Alliance; county department of human and developmental disability services; county public health, including maternal and child health director; Early Hearing Detection & Intervention (EHDI) program; Greater Oregon Behavioral Health, Inc.; Oregon Child Development Coalition; Oregon Health & Science University Child Development and Rehabilitation Center (genetics consultant, nutrition consultant, and occupational therapist); Oregon Pediatric Society; Oregon Pediatric Improvement Partnership; parent of a CYSHCN; and Providence Swindells Family Resource Center. The discussion focused on the needs of CYSHCN and the capacity of Oregon's system of services to address those needs. Participants also recommended priority areas of focus for OCCYSHN for the next five years. A detailed report on the results of these facilitated discussions can be found in the needs assessment report released by OCCYSHN available at: .....

## 8. Identification of Emerging Needs

Emerging needs were identified using the following data sources:

Previously described data sources:

*Environmental scan:* A qualitative scan of fifty three community assessments and community health improvement plans conducted in Oregon over the past three years. Sixteen CCO community health improvement plans were also analyzed to identify emerging needs.

*Program partners and medical providers:* the results of the partner survey were analyzed to identify the most frequently mentioned emerging needs.

*Community stakeholders:* Listening sessions with regional health equity coalitions, Oregon Parenting Education Collaborative, and a webinar with Oregon tribes

*Tribal MCH & local public health leaders:* Online discussion forum with local public departments and tribes, and CaCoon Program nurses

*Key informants/partner agencies:* In-depth interviews with key informants; CYSHCN expert panel

*Demographic, Health Status & Behaviors Data:* e.g. NSCH & NSCH-CYSHN, PRAMS & PRAMS2, Oregon Healthy Teens, BRFSS, Census, Etc.

Additional source of data:

*State and national policy forums:* such as MCH policy meetings, national MCH conferences, state policy forums, etc.

Table: Emerging needs identified by each data source

	Scan of community assessments	MCH provider and partner survey	Online discussion, listening sessions, key informant interviews, tribal webinar	Health status data (need, disparities)	State and national MCH policy forums
<b>Health priority areas</b>					
Mental health, depression, suicide	X	X	X	X	X
Drug abuse and misuse	X	X		X	X
Nutrition and food insecurity	X	X		X	X
Toxic Stress and Trauma	X	X		X	X
<b>Systems issues</b>					
Culturally and linguistically responsive services	X		X		X
Systems Coordination and integration			X		X

## 9. Data Tools

The results of the needs assessment were summarized in data tools, to be used in the prioritization process. The data tools were organized into national population domains, current state priority areas, and emerging state priority areas. The data tools included the following components:

1. A summary of each population domain
  - a. Demographic data
  - b. Key background and issues of concern for the population
  - c. Health status data
  - d. Partner survey results
2. Data on each priority area
  - a. National or state performance measure data
  - b. Health status data (stratified by race/ethnicity where possible)
  - c. Narrative on the significance of the issue
  - d. Narrative on the context for the issue in Oregon
  - e. Stakeholder input, which included information from the environmental scan and the partner survey
  - f. Information on alignment of the priority area with partners such as CCOs and Early Learning Hubs

The data tools can be found online at .....

## RESULTS OF NEEDS ASSESSMENT

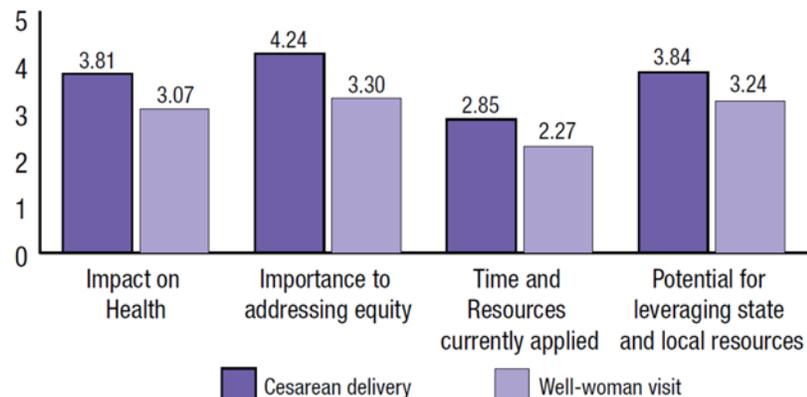
The following are the results of the needs assessment, presented by population domain and priority area. In order to facilitate comparison of national priority areas within a population domain, partner survey results are presented by population domain. Performance measure and other data, in addition to key findings, are presented for each national priority area, current state priority area, and emerging state priority area. Key findings include health status data and stakeholder input, including the results of the environmental scan.

### Population Domain: Women's / Maternal Health Priority Areas: Well Woman Care and Low-risk Cesarean Delivery

#### 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.

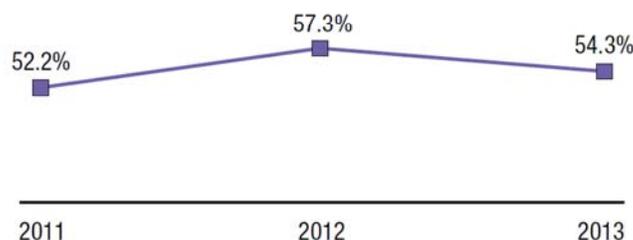


### Well Woman Care

#### 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

#### Key Findings:

- Just over 50% of this population reported having a routine check-up in the past year (2011-13).

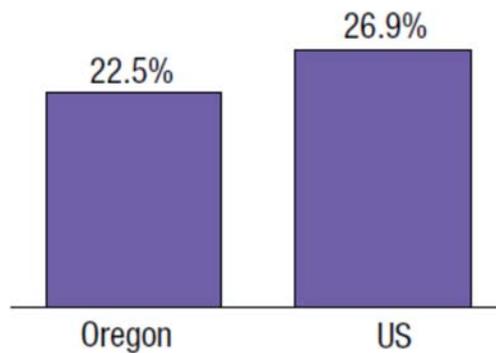
- In 2011, the percent of women ages 18-44 years who received a routine checkup within the past year was significantly worse in Oregon than the national average.
- Environmental Scan: ranked eleventh out of fifteen national priority areas (in terms of the number of times it was referenced) in the statewide scan of community health assessments, the highest of the two priority areas in this domain.
- This measure is aligned with the Collaborative Improvement & Innovation Network (CoIIN) 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”.

## Low-risk Cesarean Delivery

### National performance measure:

Percentage of cesarean deliveries among low-risk first births

Percent of low-risk Cesarean deliveries, 2013



Data source: OHA Center for Health Statistics

### Key Findings:

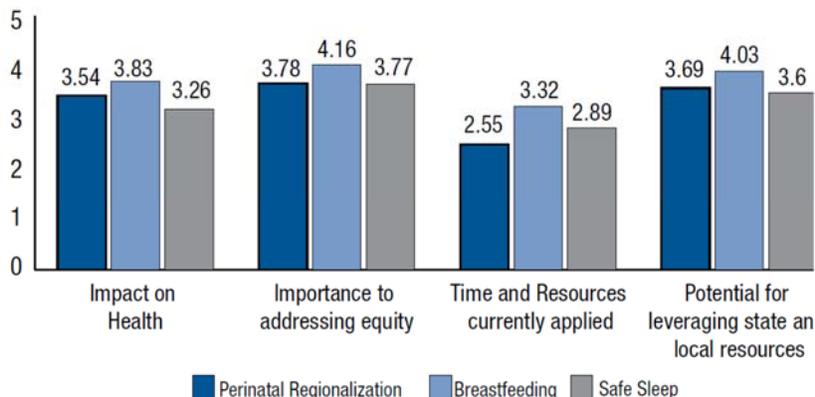
- Oregon’s rate (22.5%) is better than the national average (26.9%); rates have decreased in recent years.
- Rates are higher among some populations (Native Hawaiian/Pacific islander/Non-Hispanic, Black/Non-Hispanic, Asian/Non-Hispanic).
- Environmental Scan - ranked fourteenth out of fifteen national priority areas (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- 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.
- 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.

# Population Domain: Perinatal / Infant's Health

## Priority Areas: Safe Sleep, Breastfeeding, and Perinatal Regionalization

### Partner Survey: Perinatal/Infant Health

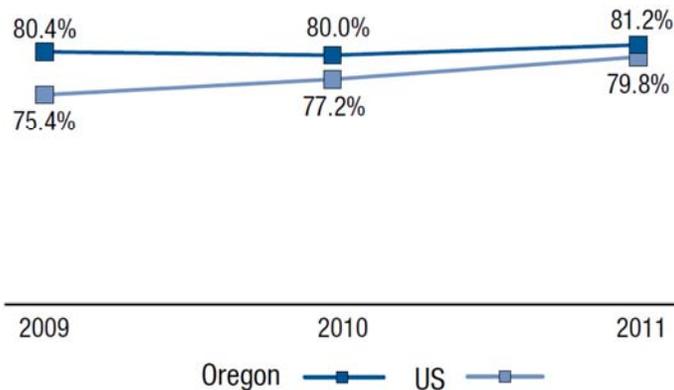
In a survey, service providers that serve women, pregnant women, mothers, infants, adolescents and children and agencies that receive Title V funds were asked to rate 29 areas in terms of their impact on health, the time and resources currently applied, importance to addressing equity and potential for 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.



## Safe Sleep

**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

### Key Findings:

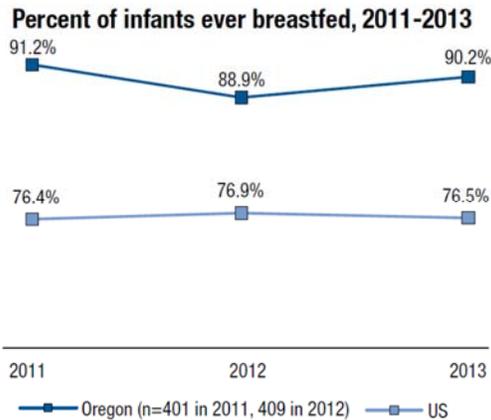
- Oregon's rate (81.6%) of mothers reporting "back to sleep" is slightly better than the U.S.(79.1%).

- Rates are lower among some populations (Black/Non-Hispanic and Asian/Non-Hispanic).
- Environmental scan: 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.
- This measure is aligned with the Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality.

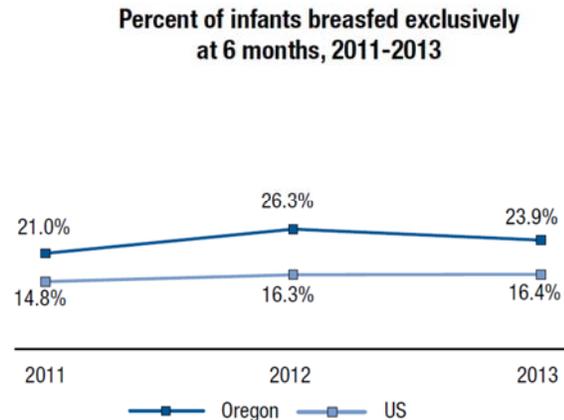
## Breastfeeding

### National performance measure:

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



Source: National Immunization Survey



Source: National Immunization Survey

### Key Findings:

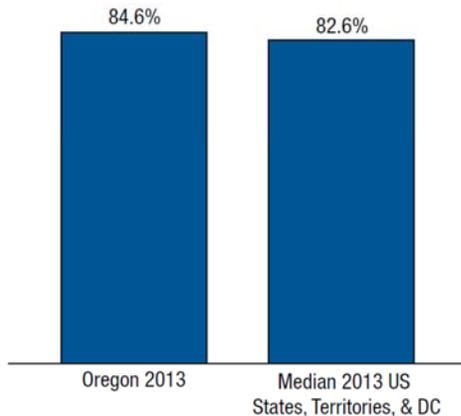
- Oregon rates are significantly better than the U.S.; ever (90.2% vs. 76.5%) and exclusively at 6 months (23.9% vs. 16.4%).
- Disparities: lower rates of initiation among Black/Non-Hispanics and American Indian/Alaska Native/Non-Hispanics and lower rates of exclusive at 6 months among White/Non-Hispanics and Black/Non-Hispanics.
- Environmental scan: 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.
- Oregon has many supports in place to encourage women to initiate and continue breastfeeding, however sustaining breastfeeding remains the primary challenge in Oregon.
- 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.

## Perinatal Regionalization

### 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

### Key Findings:

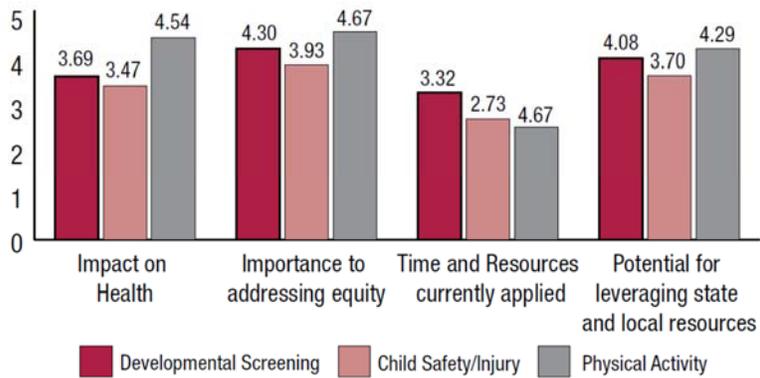
- Oregon's rate (84.6%) of VLBW infants born in level-III NICU's is just slightly better than the U.S. (82.6%).
- Oregon has a slightly higher percentage of very low birth weight infants who were born at a facility with a Level III NICU than the median percentage for 59 states, territories, and the District 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).
- 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.
- Environmental scan: 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.
- 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.

# Population Domain: Child Health

## Priority Areas: Developmental Screening, Physical Activity, Safety/Injury

### 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.

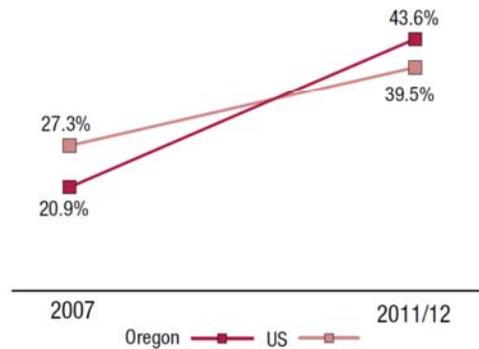


## Developmental Screening

### National performance measure:

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

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

### Key Findings:

- Oregon's rate is better than the national average, but less than half of children are screened.
- Screening initiatives have increased rates substantially in recent years.
- Disparities: Rate of screening among White, Non-Hispanic children higher than other race/ethnicities.
- Environmental Scan: 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.

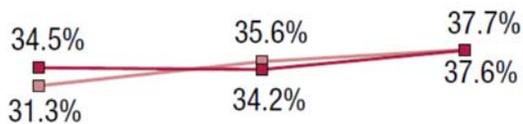
- Currently, Oregon is transforming health care and early education service delivery specific to developmental screening. Work is occurring at multiple levels, including state legislative directives, government policy makers, medical providers, home visiting programs and child care quality improvement programs.

## Physical Activity

### 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**



2003                      2007                      2011/12

Oregon ■ US ■

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**



2009                      2011                      2013

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

### Key Findings:

- Oregon rate for 20 minutes of exercise is quite low (37.7%), but is the same as the U.S. average (37.6%).
- Disparities: lower percentage of Asian Non-Hispanic and Hispanic 8<sup>th</sup> graders exercise for at least 60 minutes a day, compared to other race/ethnicity groups.
- In 2007 the Oregon Legislature passed physical education standards for public schools. The number of schools that meet requirements for PE has declined 54% from the 2008-2009 school year to the 2009-2010 school year.
- Environmental scan: 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.

## Safety / Injury

### National performance measure:

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



### Key Findings:

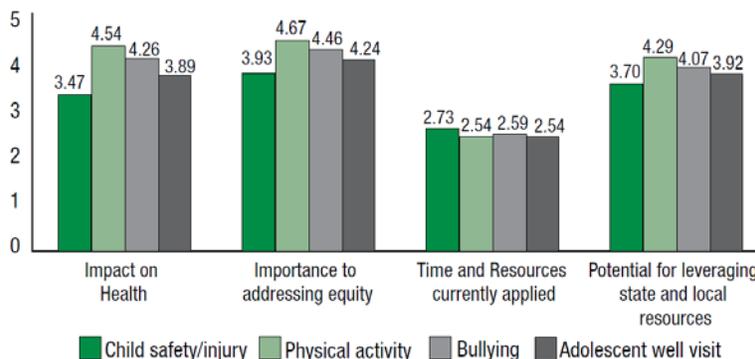
- Oregon's child mortality rate from injury is slightly better than the national average.
- Oregon's rates of injury hospitalization for children are consistently much worse than the U.S.
- Since 2000, injury has been the leading cause of mortality for Oregon children ages 1-19.
- Children ages 0-9 were hospitalized most often for traumatic brain injuries followed by motor vehicle traffic injuries.
- 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.
- Environmental scan: 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.
- Oregon Public Health Division's 2015 Strategic Plan includes strategies for reduction and prevention of family violence, suicide and child maltreatment.

# Population Domain: Adolescent Health

## Priority Areas: Physical Activity, Safety/Injury, Adolescent Well Visit, and Bullying

### 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.

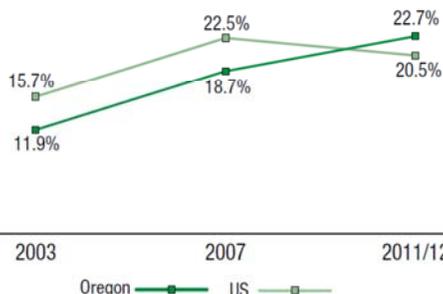


## Physical Activity

### National performance measure:

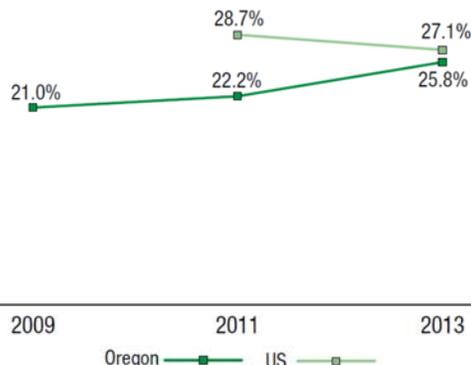
Percentage of adolescents ages 12 through 17 years who are physically active at least 60 minutes per day.

**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

### Key Findings:

- Only about ¼ (25.8%) of Oregon's adolescents get the recommended amount of physical activity; this is slightly lower than the national average (27.1%).
- This measure has the highest percent of population at risk of all national priority areas.
- Disparities: lower percentage of Asian Non-Hispanic and Hispanic 11<sup>th</sup> graders exercise for at least 60 minutes a day, compared to other race/ethnicity groups.

- In 2007 the Oregon Legislature passed physical education standards for public schools. The number of schools that meet requirements for PE has declined 54% from the 2008-2009 school year to the 2009-2010 school year.
- Environmental scan: 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.

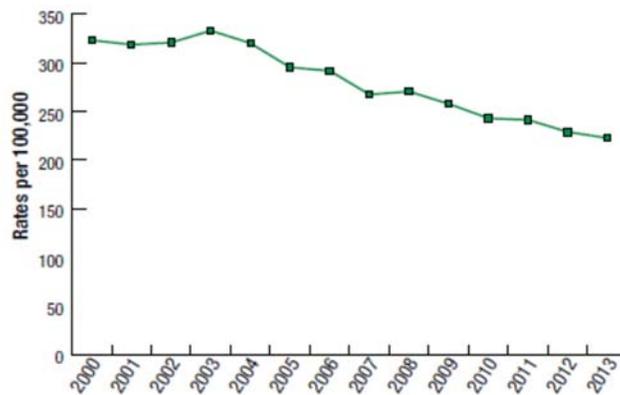
## Safety / Injury

### 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*

### Key Findings:

- Oregon’s injury-related fatality rate is better than the national average.
- Oregon’s injury hospitalization rate is worse than the national average.
- Since 2000, injury has been the leading cause of mortality for Oregon children ages 1-19.
- Children and adolescents ages 10-19 were hospitalized most often for suicide attempts, followed by traumatic brain injuries and motor vehicle traffic injuries.
- 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.
- Environmental scan: 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.
- Oregon Public Health Division’s 2015 Strategic Plan includes strategies for reduction and prevention of family violence, suicide and child maltreatment.

## Adolescent Well Visit

### 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

### Key Findings:

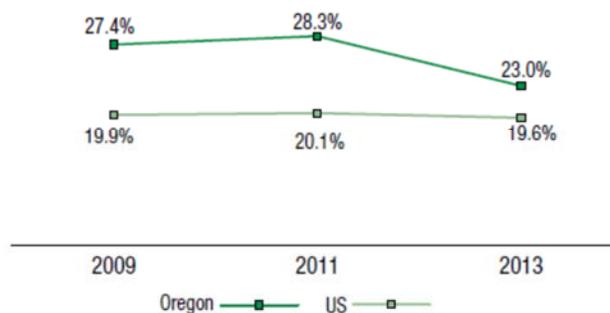
- Oregon's rate (74.2%) is worse than national average (81.7%), but has improved in recent years.
- There are no statistically significant disparities.
- Of national priority areas, this has the highest percentage at risk in adolescent health.
- Environmental scan: ranked eighth out of fifteen national priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.

## Bullying

### 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.

### Key Findings:

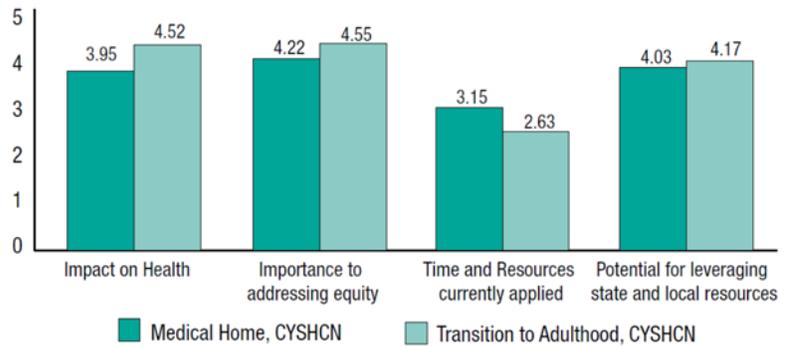
- Oregon's rate (23%) of bullying is slightly worse than the U.S.(19.6%), but decreased in the most recent survey year.
- Disparities: There are disparities among the populations of adolescents who experience bullying, based on race/ethnicity, sexual orientation, and gender identity.

- Environmental scan: 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.

## Population Domain: Children and Youth with Special Health Care Needs Priority Areas: Medical Home and Transition to Adulthood

### 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.

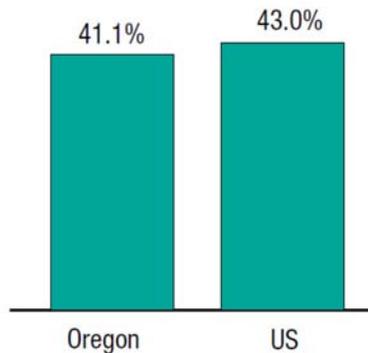


## Medical Home

### 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



Source: National Survey of Children with Special Health Care

### Key Findings:

- As of 2011-2012:
  - More than one-third of families of CYSHCN are not receiving family-centered care.
  - More than one-third of families of CYSHCN are not receiving all elements of care coordination.
  - One-fifth of families had one or more unmet care needs.

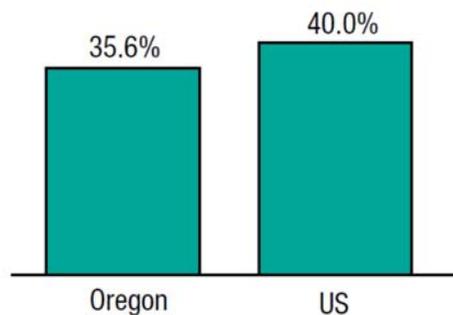
- Patient-Centered Primary Care Homes (PCPCH) are not equally distributed around the state. As of December 2014, 532 practices were recognized as PCPCHs, and the majority are clustered along the I-5 corridor between Portland and Eugene. PCPCHs are particularly sparse in central and eastern Oregon, and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

## Transition to Adulthood

### 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



Source: National Survey of Children with Special Health Care Needs

### Key Findings:

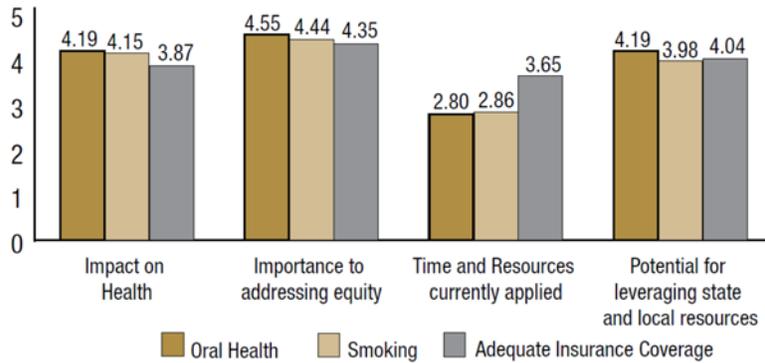
- Transition is a new concept; providers need more awareness
- Practices lack transition processes
- In general, few providers available to work with young adults/adults with special health care needs
- Less than one-third of families reported that their child's primary care provider talked with the 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.

# Population Domain: Cross-cutting / Life Course

## Priority Areas: Oral Health, Smoking, and Adequate Insurance Coverage

### 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.

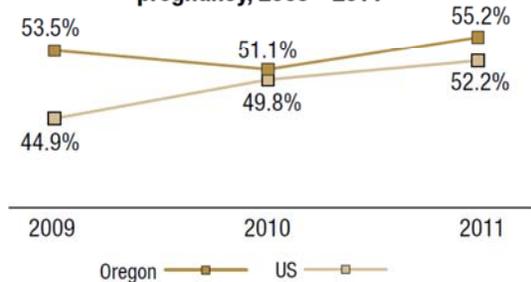


## Oral Health

### National performance measure:

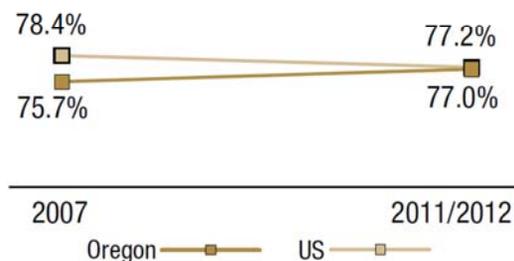
A) Percentage of women who had a dental visit during pregnancy and B) percentage of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year.

**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

### Key Findings:

- For both pregnant women and children, the percentages who had a preventive dental visit in the past year in Oregon were about equal to the U.S.; 55.2% vs. 52.2% and 77.2% vs. 77.0% respectively.
- 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%.

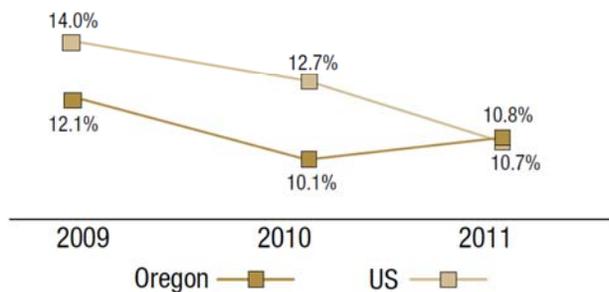
- Children residing in rural and frontier areas have less access to care and higher rates of decay.
- Environmental scan: ranked fifth out of fifteen national priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.

## Smoking

### National performance measure:

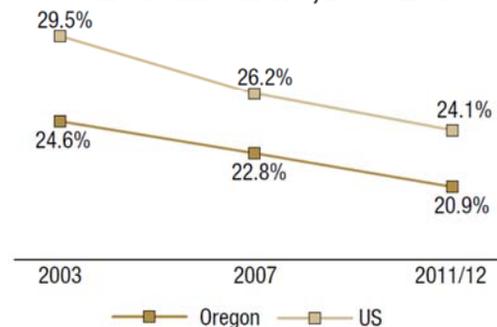
A) Percentage of women who smoke during pregnancy, and B) percentage of children who live in households where someone smokes

**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

### Key Findings:

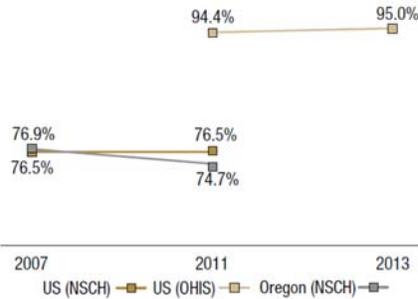
- The percentage of pregnant women in Oregon (10.8%) who smoked during the last trimester is the same as the U.S. (10.7%).
- The percentage of children in Oregon (20.9%) who live in a household with someone who smokes is better than the national average (24.1%).
- Pregnant women who are younger, have a low level of education, and are unmarried are more likely to smoke during pregnancy.
- Environmental scan: 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.

## Adequate Insurance Coverage

**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

**Key Findings:**

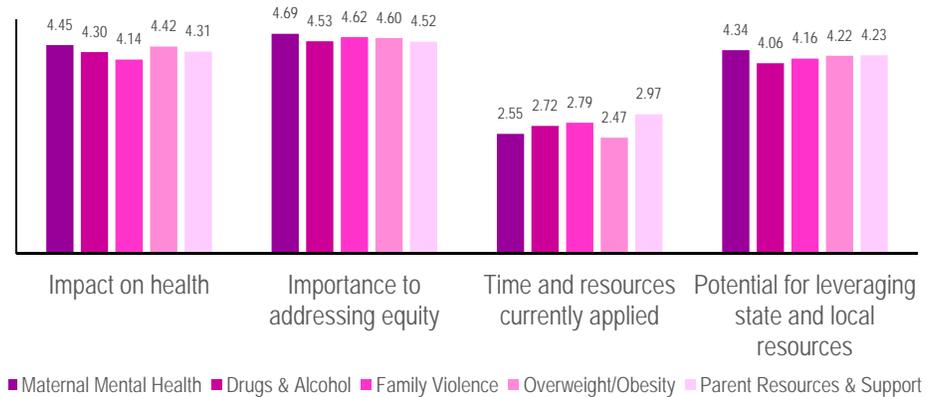
- By 2013, only 5% of Oregon children were uninsured.
- Environmental scan: ranked third out of fifteen national priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.

**Current State Priority Areas:  
Maternal Mental Health, Drugs & Alcohol, Family Violence,  
Overweight/Obesity, and Parent Resources & Support**

(Adolescent Well Visit and Oral Health were also current state priorities; however since they are presented in National Priority Areas, they are not presented here.)

**Partner Survey: Current State 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 five current state priority areas are shown to the right.



**Maternal Mental Health**

**State performance measure:**

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

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



Source: Pregnancy Risk Assessment Monitoring System

**Key Findings:**

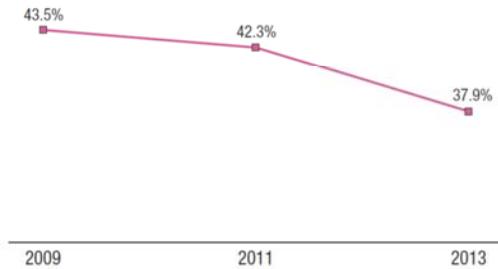
- From 2009 to 2011, 10.8% of women in Oregon self-reported depressive symptoms prior to pregnancy, and 10.2% self-reported depressive symptoms after giving birth (Oregon PRAMS).
- Title V is convening and collaborating with public, private, and non-profit partners around the state to strengthen Oregon's systems, services, and supports for perinatal and postpartum families.
- Environmental scan: ranked first out of five current state priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.

## Drugs & Alcohol

### 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.

**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.

### Key Findings:

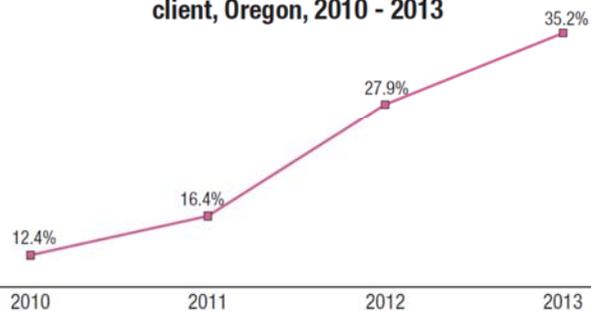
- More than half (51.7 percent) of new mothers reported drinking alcohol before they knew they were pregnant and 8.7 percent consumed alcoholic beverages during their last trimester.
- Environmental scan: ranked third out of five current state priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.

## Family Violence

### 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

### Key Findings:

- Disparities: A much higher percentage of Non-Hispanic Black and Non-Hispanic American Indian/Alaska Native women experience intimate partner violence before and during pregnancy, compared with other race and ethnicities.

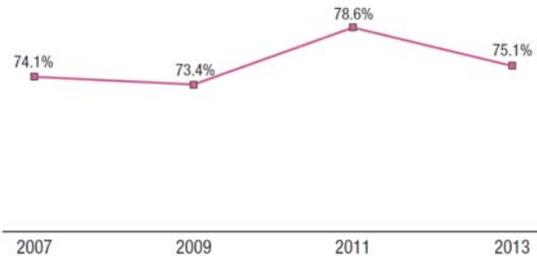
- Environmental scan: ranked fifth out of five current state priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.

## Overweight/Obesity

### 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*

### Key Findings:

- Consumption of fruits and vegetables by eighth-graders 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.
- Environmental scan: ranked second out of five current state priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.

## Parent Resources & Support

### 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.

### Key Findings:

- Environmental scan: ranked fourth out of five current state priority measures (in terms of the number of times it was referenced) in the statewide scan of community health assessments.
- The following activities are being conducted by the Oregon Public Health Division:
  - 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.

## Emerging State Priority Areas:

### Toxic Stress & Trauma, Nutrition/Food Insecurity, Drug Abuse/Misuse, Adolescent Mental Health, Cross System Coordination, Culturally & Linguistically Responsive Services

**Partner Survey:** Not all emerging state priority areas were included in the partner survey, so no comparison graph is shown here.

## Toxic Stress & Trauma

### Key Findings:

- 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 demonstrate a strong dose relationship between the number of ACEs Oregonians experienced and their adult health outcomes.
- 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.
- 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.

## Nutrition/Food Insecurity

### Key Findings:

- 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.
- 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.

## Drug Abuse/Misuse

### Key Findings:

- 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.
- 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.

- 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”.

## Adolescent Mental Health

### Key Findings:

- 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.
- Risk factors for adolescent depression include low self-esteem and social support, negative body image and cognitive style, and ineffective coping.
- Youth who identify as gay/lesbian, bisexual or questioning (LGBQ) are more likely to report being depressed and to contemplate suicide.
- 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.

## Cross System Coordination

### Key Findings:

- 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.
- 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.

## Culturally & Linguistically Responsive Services

### Key Findings:

- 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.
- 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.

- Key OCCYSHN 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.

## **PRIORITIZATION PROCESS**

A group of stakeholders met for two day-long sessions to consider the needs assessment results and to make recommendations for Oregon’s priority needs. (Day 1 – national priorities; Day 2 – current and emerging state priorities). Stakeholders were invited to participate representing key constituencies including: local public health, Oregon tribes, adolescent health, maternal and child health, children with special health needs, mental health, early education, and Medicaid.

After presentation of the findings of the needs assessment using the data tools, stakeholders were provided with selection parameters and criteria, and participated in small group and full group discussions before recommending priorities.

In addition, OCCYSHN asked its key stakeholder panel to recommend priority areas for CYSHCN, which were incorporated into the state prioritization process.

The final stakeholder recommended priority areas are highlighted in green and blue in the figure below:

## Oregon MCH Title V Stakeholder Meeting Priority Recommendations

National Title V priority area	Current State MCH priority area	Oregon emerging priority area
<b>MATERNAL AND WOMEN'S HEALTH</b>		
<b>Well woman care</b>		
Low risk cesarean births		
	Family violence	
	Alcohol use	
<b>PERINATAL AND INFANT HEALTH</b>		
Perinatal Regionalization		
<b>Breastfeeding</b>		
Safe sleep		
	Maternal mental health	
<b>CHILD HEALTH</b>		
Developmental screening		
<b>Physical Activity</b>		
Injury		
	Parent resources and support	
<b>ADOLESCENT HEALTH</b>		
Injury		
Physical activity		
<b>Adolescent well-visit</b>		
Bullying		
	Overweight and obesity	
		Mental health, depression and suicide
<b>CYSHN</b>		
<b>Medical home</b>		
<b>Transition</b>		
	Access to Mental Health Services	
	Access to specialized health and related services	
	Family Support	
<b>CROSS-CUTTING OR LIFECOURSE</b>		
<b>Oral health</b>		
<b>Smoking</b>		
		Toxic stress and trauma
		Nutrition and food insecurity
		Drug misuse/abuse
<b>SYSTEM</b>		
		Culturally and linguistically responsive services
		Cross system coordination

As seen in the table above, the national priority areas selected were:

1. Well woman visit
2. Breastfeeding
3. Child physical activity
4. Adolescent well visit
5. CYSHCN medical home
6. CYSHCN transition to adulthood
7. Oral health
8. Smoking

The state priority areas selected were:

1. Toxic stress and trauma
2. Nutrition and food insecurity
3. Culturally and linguistically responsive services

Work on these priority areas will take place from 2016 to 2020.

## Appendix 1: Sources

### Environmental Scan Sources:

1. Baker County health Department annual Plan 2013-2014
2. Benton County Community Health Assessment
3. Roadmap to Health Communities. A Community Health Assessment 2012 Update
4. Healthy Columbia Willamette
5. The Public Health Foundation of Columbia county Annual Plan 2013-14
6. Crook County Annual Plan
7. Central Oregon Regional Health Assessment
8. Clatsop County Community Health Assessment
9. Clatsop Pacific Coordinated Care Organization (CCO), Clatsop County Data Summary
10. Coos County Community Health Assessment
11. Curry County Public Health Annual Plan FY 2013-2014
12. Deschutes County Annual Plan
13. Community Health Assessment Douglas County
14. North Central Health District Annual Plan 2013-2014
15. Grant County Community Health Needs Assessment 2012-2013
16. Summary Report Community Health Needs Assessment
17. Hood River County Public Health Annual Plan 2013-2014
18. Community Health Assessment 2013 Jackson County Josephine County
19. Jefferson County Annual Plan
20. Klamath County Community Health Assessment 2013
21. The 2011 Lake County Community Health Assessment
22. Lane County Community Health Assessment
23. Community Health Assessment 2012
24. Community Health Assessment 2013
25. Linn County Annual Plan 2013
26. Annual Plan for Malheur County
27. Marion County Community Health Assessment 2011
28. Marion-Polk County Health Care System Capacity and Access Assessment 2013
29. Polk County Annual Plan
30. Morrow County Public Health Department Annual Plan 2013-2014
31. Local Public Health Authority for Multnomah County FY 2013/2014 Annual Plan
32. Tillamook Regional Medical Center Community Health Needs Assessment
33. Tillamook County Health Department Comprehensive Local Public Health Authority Plan 2013-2014
34. Umatilla County Public Health Division Annual Plan 2013
35. Union County Oregon Community Health Assessment and Community Health Improvement Plan
36. Wallowa Memorial Hospital Community Health Needs Assessment Summary Report April 2013
37. Washington County Annual Plan
38. Wheeler County Public Health Comprehensive Plan Update July 1, 2013 through June 30, 2014

Health Status Data Sources:

1. American Fact Finder, United States Census Bureau
2. Behavioral Risk Factor Surveillance System Survey
3. National Immunization Survey
4. National Survey of Children with Special Health Care Needs
5. National Survey of Children's Health
6. National Vital Statistics
7. Oregon Center for Health Statistics
8. Oregon Department of Education
9. Oregon Health Authority Center for Health Statistics
10. Oregon Healthy Teens Survey
11. Oregon Hospitalization Data
12. Oregon State Health Profile
13. Pregnancy Risk Assessment Monitoring System
14. Title V Information Center
15. U.S. Department of Health and Human Services, Maternal & Child Health Bureau
16. Youth Risk Behavior Surveillance System