# Priority Area: Cultural and Linguistically Appropriate Services

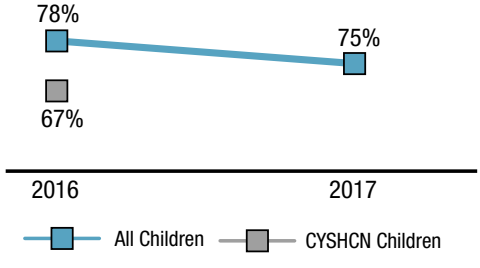
☐ National Priority Area ☑ State Priority Area ☐ Emerging State Topic

## Significance of the issue

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

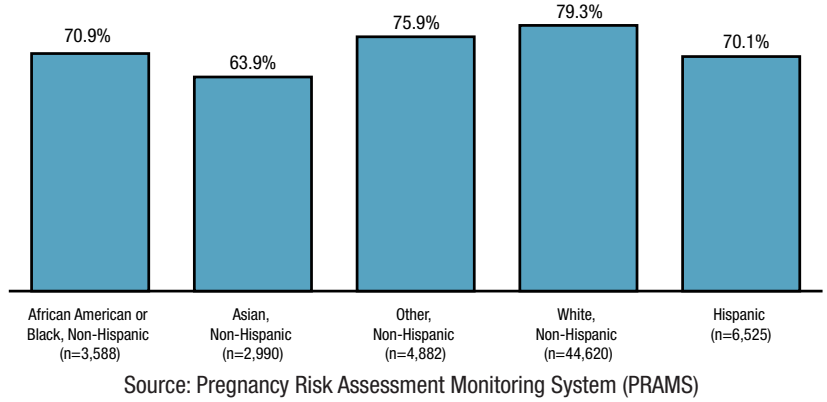
## State performance measures

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



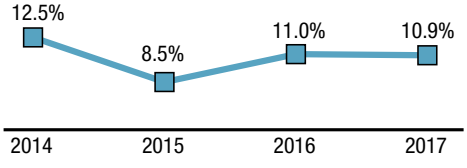

*Source: National Survey of Children's Health (NSCH).*
*Note: In 2017, sample size too small to disaggregate by CYSHCN*

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



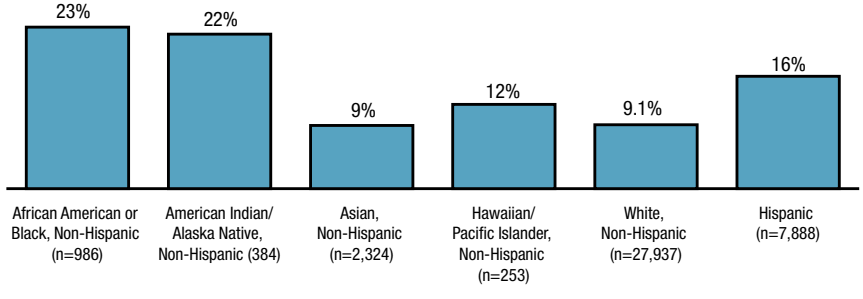

Source: Pregnancy Risk Assessment Monitoring System (PRAMS)
*Note: Nationwide data used since Oregon data is underrepresented. "Other, Non-Hispanic" includes American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, and some* other race.

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




Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

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




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

### Health status data

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

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

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

## Context for the issue in Oregon

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

### Local MCAH Title V implementation

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

## Needs assessment results

**Environmental scan**

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

**Partner survey**

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

**Community voices**

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

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[1] Williams DR, Sternthal M. Understanding racial-ethnic disparities in health: sociological contributions

[2] Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees

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

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

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

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

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

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



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# Priority Area: Food Insecurity

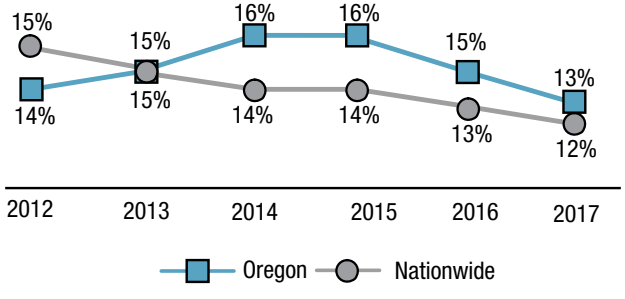
☐ National Priority Area ☑ State Priority Area ☐ Emerging State Topic

## Significance of the issue

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

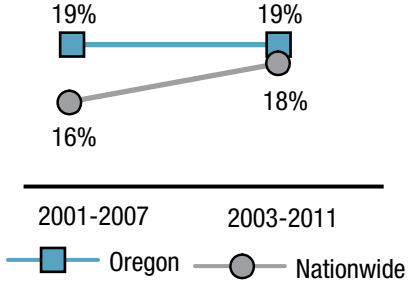
## State performance measures

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




Source: United States Department of Agiculture (USDA)

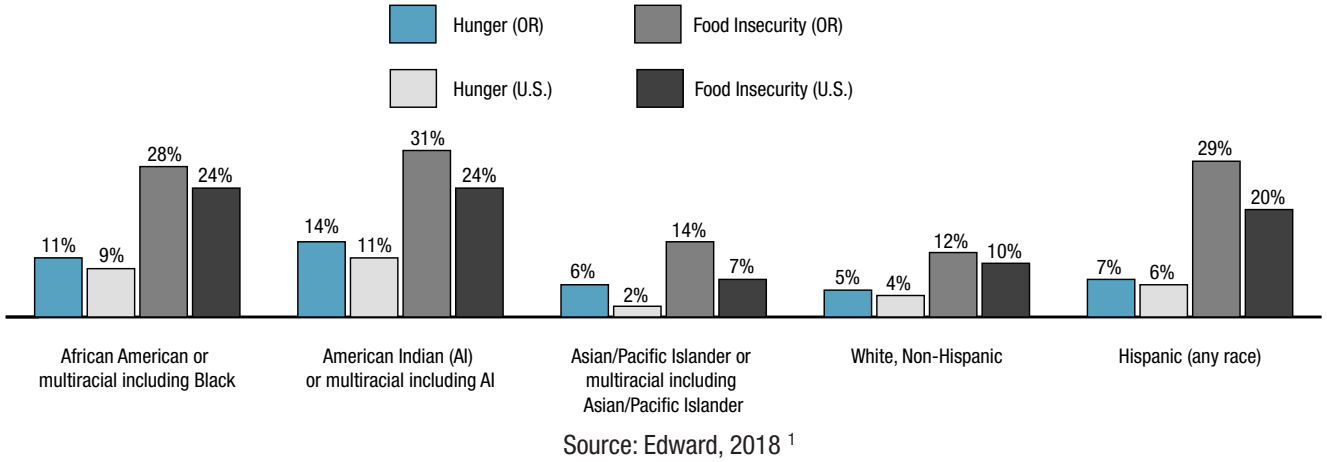
**Figure 2. Percent of households with children <18 years experiencing food insecurity, 2001-2011**




Source: United States Department of Agiculture (USDA)

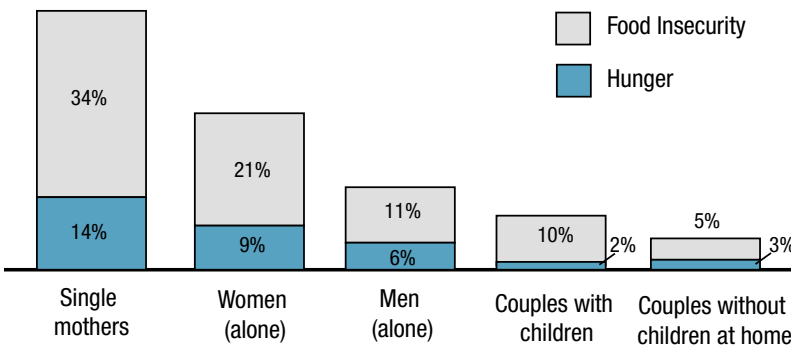
## Health status data

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




Source: Edward, 2018 [1]

**Figure 4. Hunger and Food Insecurity, by relationship status, Oregon, 2013-2017**




Source: Edward, 2018 [1]

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

## Context for the issue in Oregon

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

**Success and challenges**

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

**Local MCAH Title V implementation**

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

**Partner alignment**

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

**Changes in federal rules**

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

## Needs assessment results

**Environmental scan**

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

**Partner survey**

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

**Community Voices**

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

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

[2] Oregon Department of Education, 2018-19

[3] Status of Hunger in Oregon 2018

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

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

## Significance of the issue

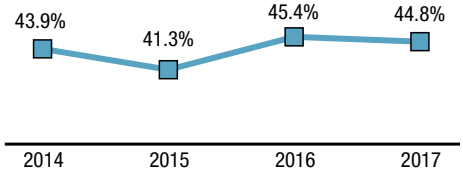
Trauma and adversity [including historical trauma, racism, adverse childhood experiences (ACEs), and adverse peer, school, and/or adult experiences] can create toxic stress. Toxic stress influences the biology of health and development, and may manifest in multiple mental, physical, relational, and productivity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

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

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

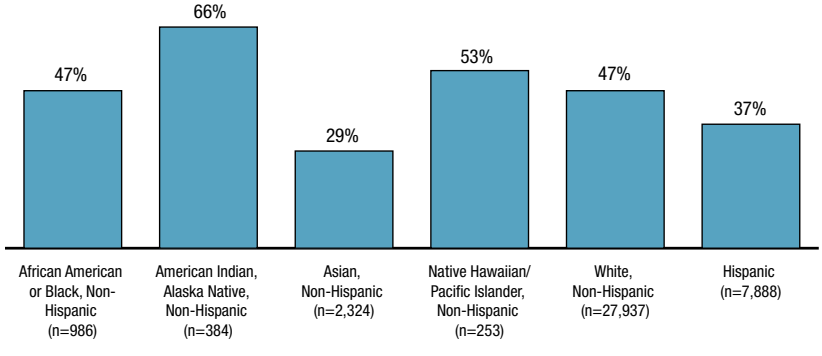
## State performance measures

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



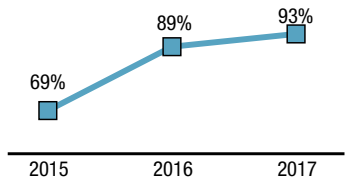

Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

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



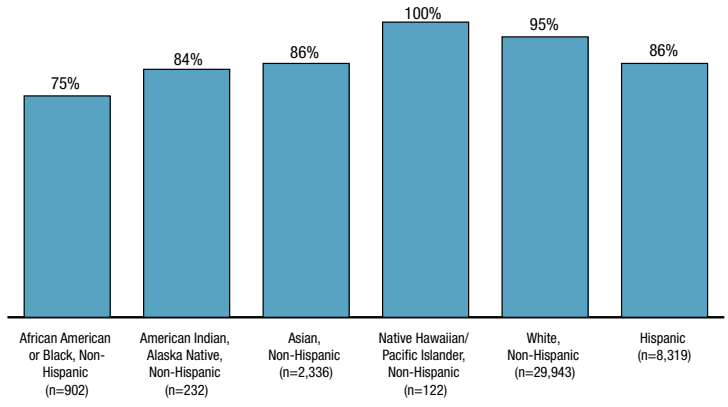

Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

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




Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

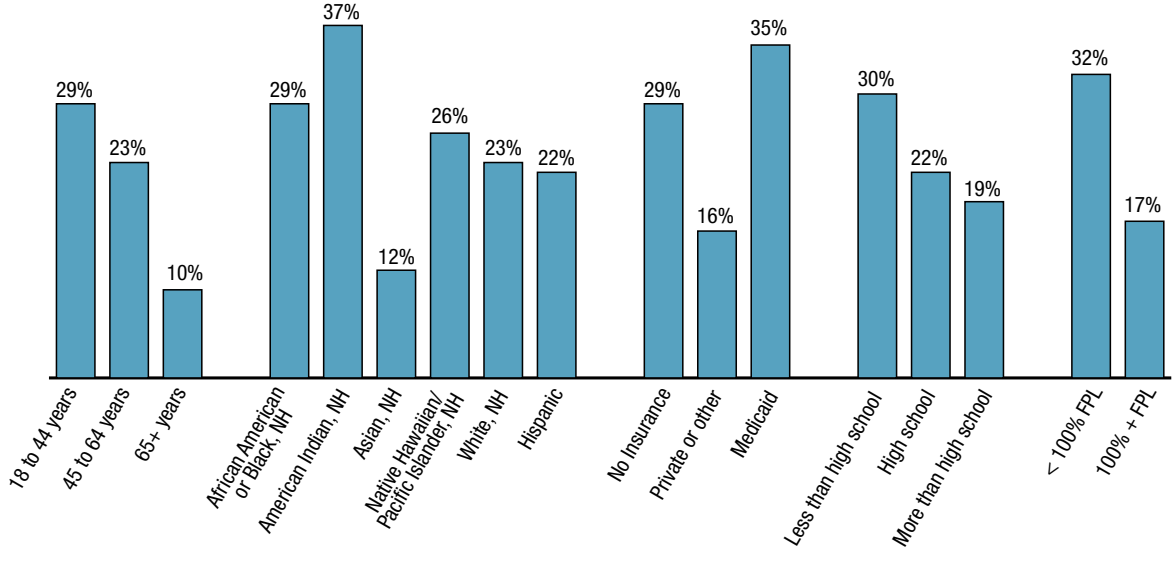
**Figure 4. Percent of mothers of 2 year olds who have adequate social support, by race/ethnicity, Oregon, 2017**




Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

## Health status data[1]

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




*Note: NH = Non-Hispanic*

## Context for the issue in Oregon

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

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

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

**Partner alignment**

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

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

## Needs assessment results

**Environmental scan**

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

**Partner survey**

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

**Title V grantee meeting**

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

**Community voices**

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

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

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