Maternal and Child Health Services Title V Block Grant

Washington

FY 2023 Application/ FY 2021 Annual Report

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2021 Annual Report & Application to the U.S. Health Resources & Services Administration

Maternal & Child Health Block Grant

2023 Application & 2021 Report

July 2022

Washington State Department of Health

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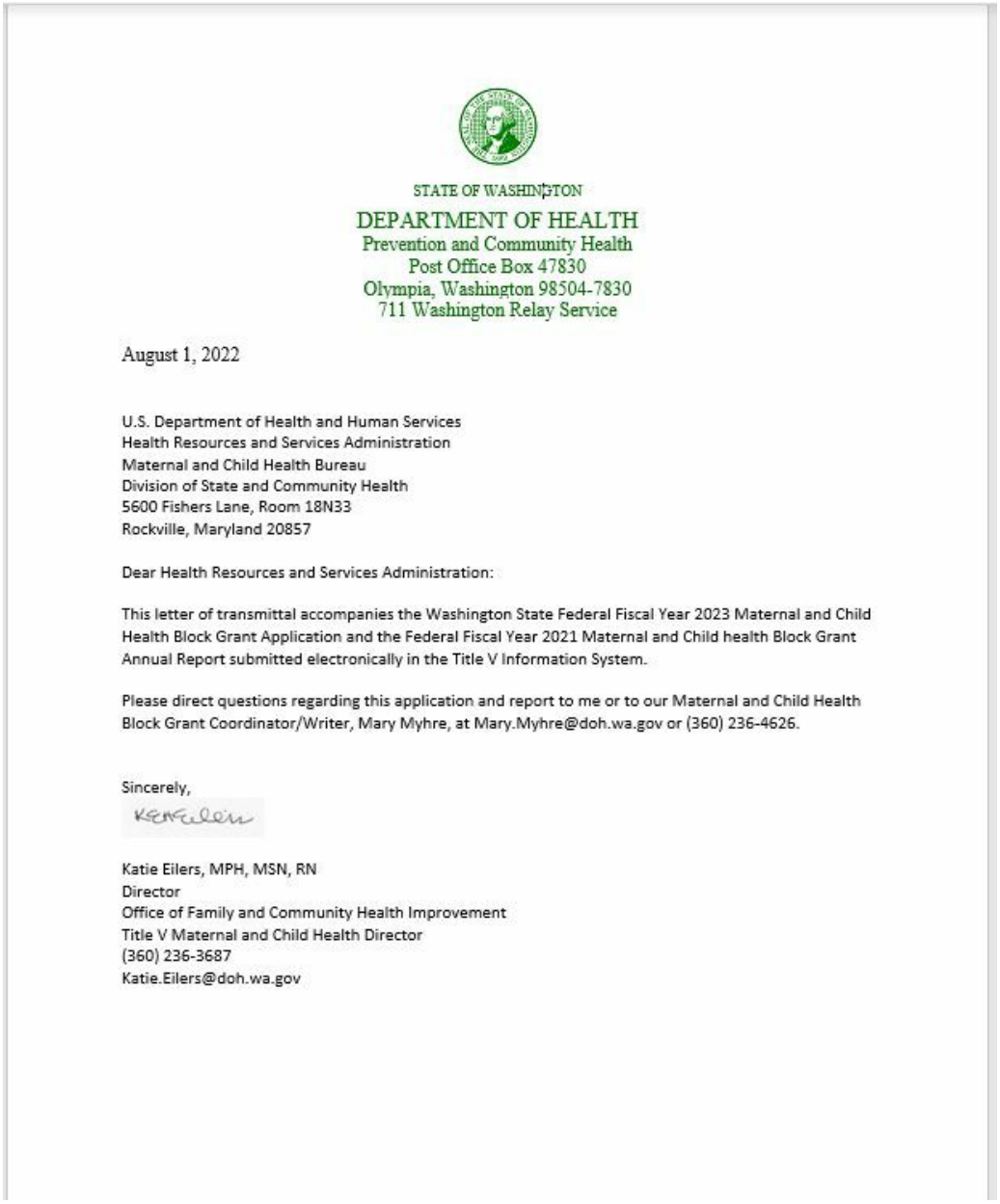

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Prevention and Community Health
Post Office Box 47830
Olympia, Washington 98504-7830
711 Washington Relay Service

August 1, 2022

U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
Division of State and Community Health
5600 Fishers Lane, Room 18N33
Rockville, Maryland 20857

Dear Health Resources and Services Administration:

This letter of transmittal accompanies the Washington State Federal Fiscal Year 2023 Maternal and Child Health Block Grant Application and the Federal Fiscal Year 2021 Maternal and Child health Block Grant Annual Report submitted electronically in the Title V Information System.

Please direct questions regarding this application and report to me or to our Maternal and Child Health Block Grant Coordinator/Writer, Mary Myhre, at Mary.Myhre@doh.wa.gov or (360) 236-4626.

Sincerely,

Katie Eilers, MPH, MSN, RN
Director
Office of Family and Community Health Improvement
Title V Maternal and Child Health Director
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I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

III.A.1. Program Summary

The Department of Health works with others to protect and improve the health of all people in Washington state. This is our mission statement. Our vision is equity and optimal health for all. Our programs and services help prevent illness and injury, promote healthy places to live and work, provide information to help people make healthy choices, and ensure our state is prepared for emergencies. We work with many partners daily to do this work. We are also working to center community leadership and voice in all our efforts.

The state's Title V Maternal and Child Health (MCH) program is part of the Office of Family and Community Health Improvement in the Prevention and Community Health division of the Department of Health (DOH).

The Title V Maternal and Child Health Block Grant (MCHBG) provides the state with essential financial and technical support. It helps programs that improve the well-being of parents, infants, children, and youth, including children and youth with special health care needs (CYSHCN), and their families. MCHBG also adds to state and local public health's abilities to provide foundational public health services, which are the capabilities and programs *essential to communities everywhere for the health system to work anywhere*. As the grant program is focused on providing assistance to those with low income or with limited access to health services, it supports the state's work to address issues of health equity.

Our Title V work focuses on issues of equity, addressing the needs of underserved populations, and where there is demonstrated need. This has led us to focus our work on increasing health equity by supporting community-driven solutions and tailoring system improvements tied to disparities. We are working to improve birth outcomes for Black or African American and American Indian/Alaska Native people. We are also identifying gaps where the demand for services is more than the supply, such as perinatal and genetic services in rural areas, and we develop agreements with providers to better serve those regions.

All our MCHBG work relates to key state priorities. Washington conducted a needs assessment between fall 2018 and spring 2020 to identify priority needs for maternal and child health services and inform objectives and strategies for MCHBG work over a five-year period.

We identified **four core principles** as the basis of our work:

- All people deserve the opportunity to thrive and achieve their highest level of health and well-being. Improving systems that serve families and children to be more equitable is a core responsibility of public health practitioners. We embrace this responsibility in our maternal and child health work. We commit to being anti-racist in our programs and policies.
- We value both evidence-based and community-developed promising practices. These practices ensure our health systems serve everyone, especially those marginalized by mainstream society. We work in ways that embrace cultural humility and appropriateness.
- We are working to ensure trauma-informed approaches are built into all our programs and services.
- We must continue to assess the effects of COVID-19 on all programs and adjust as needed. We must do this with particular focus on our values and goals associated with racial and ethnic equity.

The **key priority needs** we identified in the assessment and focused our work on are:

- Increase capacity of the local public health workforce to strategically identify, plan for, and address the needs of women and children throughout the state.
- Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve people's health across the life course.
- Identify and reduce barriers to quality health care.
- Improve the safety, health, and supportiveness of communities.
- Promote mental wellness and resilience through increased access to behavioral health and other support services.
- Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.
- Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.
- Optimize the health and well-being of children and youth, using holistic approaches.
- Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.
- Identify and respond to emerging priority needs associated with public health emergencies and their effects on the maternal and child populations.

These state priority needs have guided our choices of which of the grant's national performance measures to focus on, which are:

- Well-woman visits
- Breastfeeding
- Developmental screening
- Adolescent well visits
- Medical home
- Adequate insurance

We are also tracking progress on the following state performance measures:

- Reduce the percentage of pregnant individuals who use illegal substances during their pregnancy
- Increase the percentage of pregnant individuals who are checked for depression by their providers during pregnancy
- Increase the number of infants with at least one entry in the Washington state universal developmental screening system
- Increase the percentage of children receiving mental health care when they needed it
- Increase the percentage of children starting kindergarten showing the social and emotional characteristics of children of their age
- Increase in resilience measures according to the family resilience metrics as part of the National Children's Health Survey
- Reduce the percentage of 10th grade students who report having used alcohol in the past 30 days
- Increase the percentage of 10th grade students who report they have an adult to talk to when they feel sad or hopeless
- Increase the percentage of adolescents reporting at least one adult mentor
- Reduce the percentage of 10th grade students with special needs who report having suicidal ideation
- Start the next five-year maternal and child health needs assessment as a continuous planning process that begins again this year
- Support COVID-19 vaccination campaign efforts

Here are a few examples of how we use MCHBG funding and how this program impacts communities:

- We pass most of the MCHBG funding through to 35 local health jurisdictions (LHJs) and 1 local hospital district. We do this to improve public health systems and provide MCH services across the state. One of the block grant requirements is to use at least 30 percent of the funding on preventive, primary care, and family support services for CYSHCN. For this reason, we ask each LHJ to include this work in their annual action plan. LHJs can use their remaining funding on a menu of options that support the state priorities included in our grant application, and for foundational maternal and child health services.

- DOH maintains connection with and support of the LHJs' MCH programs in various ways, including two staff consultants whose primary focus is LHJ coordination. They provide connection with DOH subject matter specialists and biweekly emails with information and resources relevant to MCH work. They also host conference calls and meetings on MCH topics, and reporting requirements. These community consultants understand MCH services and gaps across the state, which helps inform our understanding of local needs.

- LHJs have had to change how they serve CYSHCN because total program funding for public health nursing has not kept up with the increasing costs of doing business. In the past, most LHJs centered their CYSHCN work on nursing case management. Few can provide competitive salaries to hire or replace nursing professionals. To maintain sustainable programs and services they need to develop partnerships with schools, community organizations, faith-based organizations, and others. The advantage of this transition in scope, is that many LHJs are interested in investing in policy and systems solutions to meet the needs of CYSHCN. The CYSHCN Program updated the Focus of Work for CYSHCN coordinators at LHJs to highlight opportunities for them to engage with the systems that serve CYSHCN in their communities and participate in statewide activities to improve the system of care for CYSHCN. We aligned these strategies with the new CYSHCN strategic plan which was developed with input from families, LHJs, and providers. It incorporates key elements from the new CYSHCN Blueprint. DOH will talk with LHJs over the next year to look at our MCHBG funding distribution model and requirements. We will review our current requirement that all LHJs do some work to serve CYSHCN. identify ways to leverage efficiencies and better meet statewide needs. We had planned this action for 2020 but delayed it due to urgent COVID-19 priorities.

- DOH provides technical assistance to providers via the CYSHCN Communication Network meetings and other trainings. The MCHBG contracts with the University of Washington Center for Human Development and Disability's Medical Homes Partnership Project and Nutrition Network. The MCHBG provides support for family engagement and leadership through the Washington State Leadership Initiative (WSLI), and contracts with family led and family serving organizations. The MCHBG collaborates with other state agencies and providers on statewide systems enhancements to improve the system of care and coordination for CYSHCN. This includes utilizing state funding to support a network of neurodevelopmental centers and maxillofacial review boards. The MCHBG is also supporting education and outreach on Medicaid services for CYSHCN through an interagency agreement with our state Medicaid agency, the HCA.

- Washington works to prevent maternal deaths using a blend of state and federal funding. The state convenes a state Maternal Mortality Review Panel to review all cases of maternal deaths. This panel determines contributing factors and develops recommendations for preventing deaths. Their findings highlight several racial and socioeconomic inequities that have contributed to these deaths. We are using this information is influencing our future work and priorities.

- Our perinatal health unit is working with many partners to address issues related to opioid use, especially as it

affects pregnant individuals and newborns. Our work on the state's Washington State Opioid and Overdose Response Plan and related resources, and the Promoting Healthy Outcomes for Pregnant Women and Infants bill (Substitute Senate Bill 5835) includes developing strategies to prevent neonatal abstinence syndrome and other effects of opioid misuse and standardization of care for infants born with symptoms of withdrawal. This workgroup also developed COVID-19 guidance for pregnant and postpartum women and infants.

- An important area of our work to improve child health is promoting the value and availability of developmental screening, with early follow-up and referral for intervention services when needed. We work to reduce barriers to well-child health visits, increase and track rates of developmental screening, increase connection to services, and improve provider billing practices. Having received funding through the Legislature, we are working to create a new universal developmental screening system. This system will be accessible to providers and parents, to track screening rates and help ensure all children in the state receive screening for developmental delays.

- To promote adolescent health, DOH works with school-based health centers (SBHCs). Youth, especially those part of populations with disparate health and social outcomes, may have difficulty accessing the medical care system due to many factors. Factors may include lack of transportation, social isolation, complex life situations, or underlying racial bias. These youth might find accessing health care more convenient at a school setting, where they attend and may be more comfortable. There is strong evidence that access to an SBHC and regular well-adolescent health visits reduce school absences, dropout rates, chronic illness, substance use, sexually transmitted infection rates, and pregnancy rates. While increasing graduation rates and improving the management of diabetes, asthma, and mental illness.

- School-based health centers face many barriers to receiving adequate reimbursement for services provided, affecting their sustainability. Remote learning during the COVID-19 pandemic created additional challenges for SBHCs. We are working with SBHCs, the Health Care Authority, and others to address billing and reimbursement issues. Many Washington adolescents and young adults are eligible for Medicaid but are not yet enrolled. We are developing strategies to increase enrollment to help increase the number of youth who receive health care services. Thanks to the 2021 passage of Substitute House Bill 1225: Concerning School Based Health Centers, we are starting exciting new work. This bill directs DOH to establish a SBHC program office to expand and sustain the availability of services to students with a focus on historically underserved populations. It is another example of how we use funding from multiple sources to address priority needs.

- We have adjusted our priorities and work activities to address the COVID-19 pandemic. We have helped provide supplies and other assistance to people who need to isolate or quarantine. We have helped make vaccine available throughout the state. We have also supported data collection and analysis to better understand the effects of the virus and how to protect people.

Various state and federal funding sources support our overall MCH program. We use MCHBG funds to pay portions of the salaries of program managers who plan and oversee strategic work to improve public health systems. They work to ensure women and children receive the health benefits they are entitled to, including preventive health services and screening. They also promote the importance of coordinated care within a medical home, and address issues of insurance coverage adequacy.

Our investments in maternal, child, and adolescent prevention and wellness also helps fulfill the Governor's Office of Equity's vision that "Everyone in Washington has full access to opportunities, power, and resources they need to flourish and achieve their full potential and there is equity and justice for all, for the next seven generations and beyond."

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

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The COVID-19 pandemic clearly illustrated the harmful effects of failing to adequately fund public health. In response, the state budget was increased to better support foundational public health services in WA, amounting to $147 million in the current 2021-2023 biennium and $296 million in future biennia. Over time, using the resources at the state and local levels will strengthen work in specific programmatic areas. These include communicable disease control, environmental public health, maternal and child health, chronic disease and injury prevention, and access to care. Resources will also help with infrastructure to support information systems and laboratory capacity, and capabilities like assessment, communications, emergency planning, policy and planning, community partnership development, and leadership development. Much of the Foundational Public Health Services (FPHS) MCH investments in the state will be dedicated to local governmental public health, providing much needed support to a chronically underfunded body of public health work.

The MCHBG provides core funding support that we leverage to maximize our investments, both at the state and local level, in maternal, child, and adolescent health services. Whenever possible, we embrace a braided funding model that combines MCHBG with state general funds and other grant funding. LHJs receive 68% of Washington's Title V funding to provide services based on a menu of options aligned with our state priority needs. Less than ten percent of our grant supports contracts with health care and community service organizations working with the Department of Health on state priorities. The rest supports statewide maternal and child health services, surveillance and evaluation, statewide needs assessment and planning, high priority policy initiatives, and addressing underfunded priorities.

Throughout 2020 and 2021, the 35 LHJs in Washington redirected staff from regular MCHBG duties to respond to the COVID-19 pandemic. Although the pressures of the pandemic started to ease after vaccines were made available, many LHJs continued to need extra staff to respond to the pandemic, including to staff vaccine and testing sites. Their monthly reports reflected these needs. Some LHJs felt positive about meeting the needs of families and communities. They provided COVID-19 support within a context of adolescent health, trauma informed education to LHJ staff and activities that support equity within systems caring for all focus MCH populations.

III.A.3. MCH Success Story

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The pandemic had a significant impact on staffing levels at most LHJs. Burnout of public health staff became a significant issue during the reporting period and local partners have experienced a high staff turnover rate. Amidst this, LHJs embraced innovative partnerships and new strategies to care for their communities. Some created robust partnerships with their school districts to manage Covid-19 infections, exposures, quarantine supports, and linking families to basic supportive needs (like food and financial assistance). Others have invested in trauma-informed care and support of youth behavioral health needs through coalitions and partnerships with child welfare, school-based health centers, and service agencies. Still others have focused on perinatal and infant health, highlighting disparities in pregnancy and birth outcomes, and investigating with local coalitions how to improve primary prevention investments.

LHJs have had to change how they serve CYSHCN and other MCH priority populations because total program funding for public health nursing has not kept up with the increasing costs of doing business. The MCH CYSHCN team has worked closely with LHJs to align their strategies with the new CYSHCN strategic plan which was developed with input from families, LHJs, and providers (see plan goals below). It incorporates fundamentals from the new CYSHCN Blueprint. Additionally, the state CYSHCN team has been working closely with HCA to identify alternative sources of funding for the care coordination provided by public health nurses. The team has worked to identify care coordinators currently funded by Medicaid that could benefit from consultation with LHJ CYSHCN coordinators on the unique needs of the CYSHCN population.

III.B. Overview of the State

III.B. Overview of State

Demographics, Geography, and Economy

The April 1, 2021, population estimate places Washington's population at 7,766,925, representing an increase of 110,725 people over the past year, this is a 1.4% gain, compared to a 1.5% gain the previous year. For the fourth year in a row, the highest growth (over 70%) occurred in the five largest metropolitan counties (Clark, King, Pierce, Snohomish, and Spokane). (Washington State Office of Financial Management [OFM])

The April 1, 2021, population estimate for Washington's incorporated cities and towns is 5,064,210, an increase of 73,520 people from the prior year. The top 10 cities for population growth, in descending order, are Seattle, Vancouver, Pasco, Auburn, Everett, Kent, Lacey, Yakima, Bellevue, and Ridgefield. The largest numeric increase in population is associated with Seattle, which grew by 8,400 people to 769,500. (OFM)

Births in Washington declined rapidly during the "Great Recession" of the late 2000s and began to recover a few years later. After increasing to a record high of 90,489 in 2016, they have been trending down again. In 2020, there were 83,101 births in Washington, a 2% decrease from 2019's 84,918 births, and an 8% decrease from 2016's high. (Department of Health [DOH] Birth Certificate Data)

In 2020, an estimated 19.5% of the state's population, or 1.49 million, were female of reproductive age (15 to 44). There were approximately 1.70 million children under the age of 18 in the state, making up 22.2% of the state's residents. (DOH Community Health Assessment Tool)

Washington is gradually becoming more racially and ethnically diverse. Communities of considerable diversity include the population centers of and those surrounding Seattle and Tacoma. The percentage of state residents identifying themselves as Hispanic or Latino grew from 11.5% in 2011 to 13.5% in 2020, while the percentage identifying as non-Hispanic Asian grew from 7 to 9%. Non-Hispanic American Indian/Alaska Native residents decreased from 1.3 to 1.2% while non-Hispanic White residents also decreased from 72% to 67%. (OFM) Increasingly, mothers identifying themselves as more than one race on their infant's birth certificate, with that category increasing 35 percent since 2011 (DOH Birth Certificate Data).

According to 2020 Census estimates, Hispanic or Latino people make up the majority of the population in Franklin, Adams, and Yakima counties located in the Columbia Basin of eastern Washington, which include large agricultural areas. However, the largest number of Hispanic or Latino people are in the more populous western Washington counties. Black/African American, Asian, and Native Hawaiian or Pacific Islander populations are also generally concentrated in a few western counties, though a significant population of people of Marshallese Island descent live in Spokane County in eastern Washington.

Washington is home to 29 federally recognized Indian tribes, each with varying populations and land areas. The American Indian/Alaska Native population of Washington State is 140,345 (OFM). There are seven additional tribes, some of which are seeking federal recognition. DOH also works with two urban Indian health organizations and 4 recognized American Indian organizations in the Pacific Northwest.

Geographically, the state is divided by the Cascade Range. This results in a notable difference in climate and geography between the two regions, with the west being wetter with a moderate climate and the east being drier with a more extreme climate. The northwest quadrant of the state is also split into two distinct land areas by Puget Sound. The most densely populated region of the state is on the east side of Puget Sound, where seven of the state's 10

most populous cities are located, including Seattle (1), Tacoma (3), Bellevue (5), Kent (6), Everett (7), Renton (8) and Federal Way (9). Vancouver, the fourth largest city in Washington, is in the far southwest of the state, across the Columbia River from Portland, Oregon and part of its recognized metropolitan statistical area. Many residents of Vancouver receive services in Portland. Residents of Clarkston in Asotin County in the southeast corner of the state have a similar dynamic with Lewiston, Idaho, across the Snake River.

Olympia, the state capital, lies at the southern end of Puget Sound. On the west side of Puget Sound is the less-populated Olympic Peninsula, including the Olympic Mountains wilderness area and coastal shorelines. Much of the north central area of the peninsula consists of the Olympic National Park, which is designated wilderness, isolating the Pacific Coastal communities from those along the east side of the peninsula. The Columbia Plateau dominates the area east of the Cascades. Eastern Washington is an area of less population density than Western Washington, with two major population centers: Spokane, the state's second-largest city, and its metropolitan area, which includes Spokane Valley, the tenth-largest city; and the Tri-Cities metropolitan area, comprising Richland, Kennewick, and Pasco in Benton and Franklin counties.

Washington has a highly diversified economy. It is a leading national producer of agricultural commodities, including apples, pears, wheat, milk, potatoes, hops, asparagus, berry crops and forest products. High-growth industries also include aerospace, clean energy technology, information and communication technology, online sales, life science/global health, maritime, and military/defense sectors. It has many leading research Universities including the University of Washington in Seattle and Washington State University in Pullman. It is the most foreign-trade-dependent state in the United States.

Washington's seasonally adjusted unemployment rate in March 2022 was 4.2%, compared to 5.8% in March 2021. Among the industries gaining the most jobs in the prior month were professional and business services (2,300), leisure and hospitality (1,400) jobs, information (1,400) and construction (1,300) jobs. The leisure and hospitality sector disproportionately employs women and lower income workers. Retail trade, another sector which disproportionally employs women and lower income workers experienced the greatest loss (-1,000) jobs over the prior month (Washington Employment Security Department, Monthly Employment Report).

Health Status of Maternal and Child Populations in Washington State

The *Needs Assessment Update* and *State Action Plan Narrative by Domain* sections of this application and report include relevant data and discussion about the state's maternal and child population and health status.

For most maternal and child health outcomes, rates of poor outcomes in Washington are lower than national rates. However, we see significant differences as we examine data by race and ethnicity, household income, education, and place of residence. In general, minority racial/ethnic populations, people with lower household income, people with less than a high school education, and people living outside of urban areas are less likely to report "good" to "excellent" health (Behavioral Risk Factor Surveillance System).

In July 2022, 2,219,770 people in Washington had access to Medicaid services, including 903,756 children under age 19. HCA contracts with managed care organizations to provide physical and behavioral health care services.

A recent state review of hospital utilization rates and mortality rates showed poorer outcomes in rural areas. The hospitalization rates overall and the hospitalization rates specifically related to cancers and diabetes are higher in rural areas of the state. Some mortality rates are also significantly higher, including the overall mortality rate, rates for young people (ages 1 to 24), and rates for deaths from transportation accidents, suicide, and diabetes. Many factors may contribute to these poorer outcomes, including geographic isolation and decreased access to care, lower socioeconomic status, and older age. Disparities in health outcomes for different populations have been amplified

by the effects of the COVID-19 pandemic with the older population, communities of color and individuals with underlying health conditions being disproportionally affected.

COVID-19 Pandemic in Washington

Washington state recorded the first officially identified case of SARS-CoV-2 infection in the United States on January 21, 2020. On March 23, 2020, Gov. Jay Inslee issued a stay-at-home order to help to control the spread of the virus. Washington did not see the same degree of infection rates many other states did, in large part due to the "Stay Home, Stay Safe" campaign. Through the remainder of 2020 and early 2021, statewide regulations on public gathering, space capacity limits, and facial coverings changed based on current conditions. The state launched the "Healthy Washington – Roadmap to Recovery" campaign in January 2021, which outlined a phased recovery plan using a regional approach. On June 30, 2021, the state moved beyond this recovery plan to allow for full reopening of services. In April 2022 the indoor mask mandate was lifted. The impact of the April 2022 Federal court decision to strike down Federal mask mandates is still incompletely understood at this time.

Washington has experienced over 1,666,000 confirmed cases and 13,238 COVID-19-related deaths as of July 2022. As of April 2022, 81.5% of Washingtonians 5 years or older have had at least one dose of vaccine while 74.0% have been fully vaccinated. Disparities in vaccination rates remain, especially in rural communities. Vaccine uptake in younger Washingtonians lags behind older residents. Strategies in our statewide vaccination efforts to address these disparities are continually evolving.

In Washington state, as in other parts of the country, COVID-19 has disproportionately impacted poor and minority communities with Hispanic, Black or African American, American Indian/Alaska Native, and Native Hawaiian or Pacific Islander communities' especially hard hit. DOH surveys infection rate, recovery rate, hospitalization rate, mortality, and vaccination by race/ethnicity, and reports on the disparate impact to communities of color. Updated data and analysis are available on the DOH COVID-19 website; an example report is COVID-19 Morbidity and Mortality by Race, Ethnicity and Spoken Language in Washington State.

Statutory Environment for Public Health

In Washington state, the governmental public health system is a decentralized model characterized by local control and state-local partnerships. It is comprised of four main sectors: The State Board of Health, local health jurisdictions, the state Department of Health, and the tribal health system. Local and state government agencies work with a network of public and private hospitals, nonprofit and for-profit health care systems, rural health care clinics, and tribal, community, and migrant health centers. They often contract with nonprofit agencies, institutes of higher education, or other community organizations to extend program reach into communities.

The State Legislature established the Department of Health in 1989, combining programs from several state agencies. State law directs DOH to "provide leadership and coordination in identifying and resolving threats to the public health," primarily by "working with local health departments and local governments to strengthen the state and local governmental partnership in providing public protection" (RCW 43.70.20). This language supports the concept that DOH should have a limited role in providing direct services. In accordance with this philosophy, state law gives primary responsibility for the health and safety of Washington state residents to county governments. It charges the counties' legislative authorities with establishing either a county health department or a health district within the same boundaries as the county (Chapter 70.05, 70.08, and 70.46 Revised Code of Washington [RCW]), as well as a local board of health (RCW 70.05.060). There are 35 health departments or districts – collectively "local health jurisdictions" (LHJs) – serving 39 counties; several counties have chosen to combine to form a joint district. Board of health members are often county commissioners or council members, but the boards may include other elected or nonelected officials, as long as the majority are elected officials.

A State Board of Health is authorized to make recommendations to the Secretary of the Department of Health. The Board of Health is directed to “provide a forum for the development of public health policy in Washington state” (RCW 43.20.050), and to adopt rules on disease control, environmental health, public water systems, and other health issues.

Most of the 29 federally recognized Indian tribes in Washington provide public health and health care services. While some members, especially those not living on tribal lands, seek and receive care outside of tribal services, those services remain available to their members.

Washington State Department of Health
The Department of Health works with others to protect and improve the health of all people in Washington state. The Washington State Board of Health made up of ten members appointed by the Governor, sets the rules governing public health in the State of Washington. The SBOH is also responsible for drafting public health administrative code for the State.

Our programs and services help prevent illness and injury, promote healthy places to live and work, provide information to help people make good health decisions, and ensure our state is prepared for emergencies. To accomplish this, we help ensure a safer and healthier Washington by:

- Working to improve health through disease and injury prevention, immunization, and newborn screening.
- Providing health and safety information, education, and training so people can make healthy choices.
- Promoting a health and wellness system where we live, learn, work, play, and worship.
- Addressing environmental health hazards associated with drinking water, food, air quality, and pesticide exposure.
- Protecting people by licensing health care professionals, investigating disease outbreaks, and preparing for emergencies.
- Ensuring equity is prioritized in all we do

A visual portrayal of DOH’s programs and some key facts are available in a DOH at a Glance infographic.

Strategic Plan
DOH has adopted an approach to promote equity and optimal health for all. This is the agency’s vision for how to best promote health in the state. It’s approach to acting on this vision, its mission, is to collaborate and work with others in innovative ways to achieve the goals of protecting and improving the health of all people in Washington state.

The DOH Strategic Plan is available online. The strategic plan focuses on making four foundational transformations. First is incorporating an outward mindset approach to create an organizational culture that values the humanity of people and focuses on achieving agency objectives in ways that are helpful to employees, partners, and the general public in achieving theirs. Second, on how funding of work is aligned with public health priorities set through inclusive processes. Third, by fostering data sharing, integration and analysis to support improved health outcomes. Fourth, creating a diverse and inclusive workplace that engages with underrepresented communities, and respects their agency, to ensure equity in access to services, opportunities, and information. The agency is currently revising its strategic plan, which will be finalized by 2023.

DOH is working to incorporate Culturally and Linguistically Appropriate Services (CLAS) across all programs. This

includes adopting internal policies to improve CLAS compliance, staff training, development of resources and tools, and creating a sustainability system for compliance. This work is supportive of the Governor's Interagency Council on Health Disparities' 2018 State Policy Action Plan to Eliminate Health Disparities, which recommends a wide variety of statewide activities in support of equitable health opportunities for all.

The Governor recently established the Office of Equity which is focused on "everyone in Washington having full access to the opportunities, power, and resources they need to flourish and achieve their full potential and there is equity and justice for all, for the next seven generations and beyond." The Office of Equity is helping cabinet state agencies to shift our systems and processes to be more embedded in principles of equity. DOH is charged in the coming years to create pathways for communities to direct more of our work and to diversify our workforce.

Healthier Washington

Washington has been implementing the Healthier Washington initiative, a Medicaid Transformation project, for almost a decade. At the time of this report, the Health Care Authority is seeking to reauthorize its Healthier Washington initiative, which has been adapted to strengthen a focus on care coordination to meet the social determinants of health. The Accountable Communities of Health continue to serve as regional hubs for community-clinical linkages and leaders in value-based purchasing.

Dismantling Poverty

In 2017, Governor Inslee established a statewide Poverty Reduction Workgroup, which was tasked with developing a 10-year plan to dismantle poverty in Washington State. The resulting **plan** contains several systems level recommendations, including health-focused investments, critical to undermining the legacy of poverty in our communities. Every cabinet state agency has committed to investing in this plan, including the DOH. There are important links to the maternal, child, and adolescent health work in our state.

CHW Workforce Development

The COVID-19 Pandemic has increased the staff recruitment and retention, and workforce development challenges. The Department of Health has significantly increased its staffing to respond to COVID-19 related needs. This has had multiple trickle-down effects on all programs, including Title V. Many staff members have been activated for temporary incident management and response assignments, taking them temporarily away from their regular work. In addition, as new response and recovery teams have been developed, some staff members have chosen to move into long-term COVID-19 project positions, leaving six Title V position vacancies. However, COVID-19 response has also offered opportunities for many staff members to learn more about the specific needs of the state's maternal and child populations and practice new skills in response.

The total number of DOH full-time equivalent (FTE) positions funded by MCHBG federal funding is 18.79 FTE. This represents 40 to 45 individuals, as most positions are funded from multiple sources. This is an increase from last year's level of 17.76 FTE (portions of 40 positions).

Health Care Infrastructure

The majority of the health care delivery system in the state is located in urban areas along the Interstate 5 corridor in western Washington and Spokane near the Idaho border. There are 93 acute care hospitals and 1,419 primary care clinics across Washington. Among these, the large rural areas of the state are served by 39 critical access hospitals (24 beds or less), seven rural hospitals (49 beds or less) and 120 rural health clinics. In 2020, DOH provided licensing and regulation of 11,288 health care facilities and 423,567 health care providers, including physicians, nurses, dentists, pharmacists, emergency medical technicians, mental health counselors, and other health care professionals.

Washington has 58 public hospital districts, which are local government entities that run hospitals, clinics, and home health services. A few of these districts also organize emergency medical services; often, they provide the only access to such services in isolated areas. Independently elected board members guide public hospital districts.

Three are dedicated children's hospitals, located in Seattle, Tacoma, and Spokane. In addition to the many other hospitals that see pediatric patients. Over 1,100 pediatric health care providers practice in the state. The Washington Academy of Family Physicians reports approximately 3,700 family physician members in the state.

Nineteen community nonprofit and hospital-based neurodevelopmental centers provide therapy and related services to young children with neuromuscular or developmental disorders. The centers are located across the state, each meeting needs specific to its community.

National Accreditation

One element of DOH's commitment to excellence and continuous improvement is maintaining accreditation by the Public Health Accreditation Board (PHAB). DOH was one of the country's first PHAB accredited public health departments, achieving national accreditation in February 2013. In March 2019, DOH became one of the initial health departments and the first state to be reaccredited.

Title V in DOH

The Title V program is located in the Prevention and Community Health (PCH) division of the Department of Health. Most of the Title V activities are within PCH's Office of Family and Community Health Improvement (OFCHI), and the OFCHI Director is the state's Title V Maternal and Child Health Director. Washington's Title V Children with Special Health Care Needs Director position is also within OFCHI. Organization charts are included in the Appendix.

Additional information about how Washington's Title V program is organized, and how our work is directed and supported by the agency, is included in the *State Title V Program Purpose and Design* section.

III.C. Needs Assessment
FY 2023 Application/FY 2021 Annual Report Update

III.C. 1. Needs Assessment Update

Ongoing Needs Assessment Activities

Throughout the 2021-2022 grant year, we have continued to collect data and information to better understand MCHBG priority populations, including changes in disparities, and emerging and future needs. We are making progress toward improving our surveillance systems and data linkage across previously siloed systems, have identified specific research projects to better understand the needs of priority populations, and have initiated ongoing needs assessment activities to collect feedback from priority populations and community leaders over the next four years. We are also continuing to plan and develop dashboards and materials to communicate public health findings to the public better.

The Surveillance and Evaluation unit continued our Title V activities include analyzing new data available from the Pregnancy Risk Assessment Monitoring System (PRAMS) and the state birth file to assess trends in behavior, access to care, and birth outcomes among the maternal/women's and perinatal/infant health domains. Data on health outcomes and behaviors among pregnant women and their infants (in prior years referred to as the Perinatal Indicators Report) from 2020 were run and presented to the Washington State Perinatal Collaborative in May of 2022. During the past year, we developed topical fact sheets and materials specific to adolescent pregnancy, breastfeeding, infant mortality, and oral health in children and pregnant women.

In support of the work being conducted by the Surveillance and Evaluation Unit programs within OFCHI have been conducting their own needs assessment activities and working in support of S&E to complete theirs. Adolescent Health is planning a "mini-NA," reaching out to youth and providers to inquire about experiences and perceptions around care. In addition, they are planning to partner with local health to create a youth-oriented data platform and engaging School Based Health Centers to further understand their needs and capacities. CYSHCN have employed various information gathering approaches to learn more about CYSHCN and their families, including outreach to multicultural families, outreach to different geographic entities, and engaging in listening sessions for families with CYSHCN. The Women's/Perinatal program, working with S&E's Maternal Mortality Epidemiologist, have looked into substance abuse services at the county level and started to compare outcomes with community services available in an analysis of gaps in services.

The 2020 Home Visiting Needs Assessment highlights persistent racial and ethnic disparities among families with young children, particularly among American Indian and Alaskan Native, Black or African American, Native Hawaiian or Pacific Islander, and Hispanic populations. Findings were based on composite scores that included a range of indicators from four categories: socioeconomic status, maternal and child health, behavioral health, and education indicators. American Indian/Alaska Native populations were high risk or very high risk in all four categories, Black or African American populations were high risk or very high risk in all but behavioral health, and Native Hawaiian or Pacific Islander and Hispanic populations were each high risk or very high risk in two of four domains. The report determined that the highest number of children ages 2 and younger in priority populations reside in Yakima, King, Pierce, Spokane, Snohomish, and Benton counties, with Black or African American populations specifically concentrated in urban areas. These findings were similar to those described in the Washington State Maternal Mortality Review Panel Report: 2014-2016. These include higher maternal mortality ratios for American Indian/Alaska Native mothers compared with all other racial/ethnic groups, and higher mortality rates among women covered by Medicaid, often used as a proxy measure of low socioeconomic status.

Update of Health Status Among MCH Populations

Overall MCH Population Data Indicators

Access to care was a concern identified by all populations in the 2020 needs assessment, along with the cost of living, housing, and food security. Concerns about disparities by race and ethnicity, income, and geography were identified throughout the needs assessment.

In 2019, an estimated 9.8% of all Washingtonians, and 12.0% of those under 18 years old, lived in poverty (<125 percent federal poverty level [FPL]). Both of these rates were statistically significantly lower than the national rate, ranking 43rd and 41st lowest among states, respectively. Income is unevenly distributed around the state, however. In the 2019 American Community Survey 21 of 35 Washington counties were ranked by median income. Of those with median incomes greater than the national average, only two, Benton County and Clark County, were not in the Puget Sound region. Seven of the eight below the national average were in majority rural counties in both Western and Eastern Washington. There were significant racial and ethnic disparities as well, with an estimated 30% of Black or African American, 27% of American Indian/Alaska Native, 24% of Native Hawaiian or Pacific Islander, 21% of Hispanic, 12% of Asian, and 8% of white residents living in poverty. (American Community Survey, 2019).

In 2020, 10% of women 18-44 years of age in Washington reported poor or fair physical health. 31% of women 18-44 years of age reported having been diagnosed with depression. This is higher than the percent of depression reported in the general population of adults in Washington, at 23%. 65% of women of childbearing age had a medical check-up in the past year (compared with 70% for the general adult population. 13% of women of childbearing age did not receive medical care due to cost, compared to 9% for the general adult population. (2020 Behavioral Risk Factor Surveillance System [BRFSS])

Maternal and Child Health Populations

The *Overview* section at the beginning of each report in the *State Action Plan Narrative by Domain* includes data and discussion of the health status of each MCH population domains.

Impacts of COVID-19 Pandemic

In February 2022 Washington State began its second year of the COVID-19 Pandemic. As in the prior years, its effects continued to be felt in different ways by the MCH population.

In the fall most public schools returned to in-person learning, marking the first time many school-aged children went back into classrooms physically. In March of 2022 the state lifted the indoors mask mandate, allowing individuals to assess their risk and act accordingly.

Statewide there have been 1,984,668 total cases of COVID-19 since the pandemic began with 66,318 cases hospitalized and 13,245 deaths. (WA State COVID-19 Data Dashboard)

As of June 2022, 82.3% of all Washingtonians aged 5 and older have been immunized with at least one dose of vaccine, while 74.8% are fully vaccinated. These totals include data from the Department of Defense and the Veteran's Administration. Disparities in infection rates by race and ethnicity show that some groups are making up disproportionate numbers. These include Hispanic, Black/African American, American Indian/Alaska Native and Pacific Islander communities. (WA State COVID-19 Data Dashboard).

While DOH has continued to work to better understand the impacts of COVID-19, data collection on some aspects of the pandemic among children and adolescents lags somewhat. Early data indications suggested that access to care decreased during 2020. Among 3- to 4-year-olds covered by Medicaid, preliminary reports show that only 54 % received adequate well-child visits in 2020. This figure is compared with 67% in 2019 and 66% in 2018. For adolescents, among 12- to 21-year-olds covered by Medicaid, only 28% received well visits in 2020. This is compared with 43% in 2019 and 40% in 2018 (MCO). In fall of 2020, Washington administered the COVID-19 Student Survey (CSS) to better understand how the pandemic had affected high school students lives'. Among the 30,000 students surveyed, 7% had received a positive COVID-19 diagnosis and 16% had at least one diagnosis in

their household. Around 30% reported not having received regularly scheduled medical care since the beginning of the 2020 school year. Data from the Healthy Youth Survey from 2018 and 2021 among 10th Graders do not show a difference in percent of students who had seen a doctor or health care provider in each year, however. In 2018 68% reported having seen a provider in the prior year and in 2021 67% reported having seen one. (HYS)

The Community Recovery-Oriented Needs Assessment (CORONA) survey explored the behavioral, economic, social, and emotional impacts of COVID-19 on Washington residents. The survey found that 43% of pregnant respondents and 42% of all women ages 18 to 44 were unable to see a doctor when they wanted to after February 2020 due to COVID-19. Respondents also indicated reduced access to medication, with 13% of pregnant respondents and 13% of women ages 18 to 44 reporting an inability to access medicine due to COVID-19. Among households with children, 57% reported that children experienced more difficulties with emotions, concentration, behavior, or getting along with others.

Working Toward a Better Understanding of MCH Needs

We are continuing to develop the Child Health Intake Form (CHIF) data system to better capture and use data related to CYSHCN in the state. We will use this data to influence and improve services. Data from CHIF on percent of CYSHCN with insurance is used as an ESM. We continue to develop a UDS data system. Work on our Birth Defects Surveillance System also continues, including work with an outside vendor.

Our Title V and Office of Family and Community Health Improvement (OFCHI) staff are exploring and developing new methods to bring data and information to our stakeholders in a more accessible and engaging way. As part of its core functions, the MCH Surveillance and Evaluation unit has continued to focus on the development of data dashboards, including dashboards featuring perinatal data and data on CYSHCN, story sheets, and other material that will enable us to communicate public health findings to the various populations we serve. We have and will continue to use, and where possible, collect data to inform ongoing decision-making leading up to the next Five Year Needs Assessment process. We are engaging in trainings and discussions about how to increase awareness and inclusion of voices and opinions from marginalized communities, including communities of color, to influence our work and priorities.

III.C. 2. Five-Year Needs Assessment Summary

States will not be required to submit a Five-Year Needs Assessment Summary during the three-year period covered by this Application/Annual Report Guidance.

Click on the links below to view the previous years' needs assessment narrative content:

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$8,916,002	$8,450,065	$8,930,530	$8,011,365
State Funds	$7,573,626	$7,573,626	$7,573,626	$7,573,626
Local Funds	$0	$0	$0	$0
Other Funds	$1,203,470	$1,203,470	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$17,693,098	$17,227,161	$16,504,156	$15,584,991
Other Federal Funds	$23,699,780	$22,044,275	$21,852,047	$16,351,318
Total	$41,392,878	$39,271,436	$38,356,203	$31,936,309

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$8,900,000	$7,569,106	$8,900,000	
State Funds	$7,573,626	$7,573,626	$7,573,626	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$16,473,626	$15,142,732	$16,473,626	
Other Federal Funds	$12,716,080	$12,719,080	$17,698,731	
Total	$29,189,706	$27,861,812	$34,172,357	

	2023	
	Budgeted	Expended
Federal Allocation	$9,242,405	
State Funds	$7,573,626	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$16,816,031	
Other Federal Funds	$13,831,634	
Total	$30,647,665	

III.D.1. Expenditures

III.D. Financial Narrative

III.D.1. Expenditure Narrative

At the time of this writing, Washington has expended an estimated $7,569,106 of the $8,811,411 of Title V Maternal and Child Health Block Grant (MCHBG) funding awarded for federal fiscal year (FFY) 2021

To date, the federal investment in services benefitting specific populations:

$1,227,168	17%	Pregnant women
$1,227,168	17%	Infants
$2,144,446	31%	Children 1 through 21 years
$2,464,647	35%	Children and youth with special health care needs

We continue to work under this funding source and anticipate full expenditure by the end of the performance period. We also anticipate meeting the 30% requirements of the program.

To date, the federal investment from the perspective of service level:

$21,938	<1%	Direct services
$208,661	3%	Enabling services
$6,843,041	97%	Public health services and systems

Washington is aware of and dedicated to compliance with legislative financial requirements (e.g., 30/30/10% requirements) and all program regulations. For accountability and tracking, we use master index codes to indicate the funding source for each expenditure, identifying whether it is federal, state, or other. The codes also indicate what population domain the activity supports. Washington is careful to ensure that services and activities supported by MCHBG are not able to be covered or reimbursed through the Medicaid program or another provider. The Department of Health (DOH) Financial Services division participates in an annual State of Washington Single Audit conducted by the State Auditor's Office, and the MCHBG program was last audited in 2014.

Of the funding retained by DOH, a majority of the funds were used for personnel-related costs.

Contracts Distributing Title V Funding
65% of the budget for FFY 2021, or $4,579,860, was allocated to be distributed to local health jurisdictions (LHJs) throughout the state, as described in the first paragraph below. The additional contracts we held in FFY 2021 are also described here.

Local Health Jurisdictions: DOH contracted with 35 LHJs and one hospital district to ensure funding supported maternal and child health (MCH) programs in all areas of the state. Key areas of work in these contracts included support for children and youth with special health care needs (CYSHCN), universal developmental screening, adverse childhood experiences, participation in regional Accountable Communities of Health, healthy weight, injury prevention, breastfeeding, immunizations, safe sleep, oral health, and youth pregnancy prevention. LHJs could choose projects aligned with any of the areas of work listed above, but because such a large proportion of our funding goes to LHJs, we required each to use some funding toward services for CYSHCN. This helped ensure that statewide we met the 30% requirement of funding for this population domain. When COVID-19 began impacting

communities in early 2020, LHJs requested permission to adjust their work plans to reallocate resources to the pandemic response. With authorization from the Maternal and Child Health Bureau, this was allowed. See *Appendix B – Maternal and Child Health Block Grant Local Work* for additional information about these contracts and work.

Supports National Performance Measures (NPMs) 1, 4, 6, 7, 10, 11, 15
2016-2020 State Performance Measures (SPMs) 1, 2, 3, 4, 5
Priorities: All

American Indian Health Commission: Support implementation of the Tribal Maternal-Infant Health Strategic Plan to address health disparities among American Indian and Alaska Native women and children in Washington state and improve their health.

Supports NPMs 1, 4; SPM 3
Priorities: Healthy Starts, Sexual and Reproductive Health, Health Equity

WithinReach: Manage the Help Me Grow Washington Hotline (the state's MCH toll-free telephone line), which promotes healthy starts and ongoing wellness, and prevents illness and injury through outreach that improves access to health benefits, resources, and information. Efforts are targeted to Medicaid-eligible pregnant women, children, and families. With one call, people can connect with a variety of services to support their health. The hotline data and technical infrastructure integrates with the information available through WithinReach's online support. Support is provided directly by staff in English and Spanish, and additional resources and tools are used to support other non-English-speaking callers.

Supports NPMs 1, 4, 6, 11; SPM 1
Priorities: Healthy Starts; Screening, Referral and Follow-up; Health Equity

Kindering Center (Washington State Fathers Network): Provide opportunities for fathers of CYSHCN to meet, learn from, and mentor each other. Promote the concept of this networking. Share information about resources available. Advocate for issues important to these fathers.

Supports NPM 11

Partners for Action, Voices for Empowerment (PAVE) Family to Family Health Information Center: Use the knowledge and experience of families and project partners with expertise in federal and state programs, and public and private health care systems, to work with families to increase the percent of CYSHCN who have access to needed services, including the resources to obtain them. Provide respite to meet planned (not crisis) needs for unserved and unpaid family caregivers through recognized provider agencies. Work as a key leader to build infrastructure, such as website development and hosting, to support the Washington Statewide Leadership Initiative, and support its infrastructure to facilitate participation of family-led information, support, and advocacy organizations across the state. Provide emphasis on support for family leaders from diverse cultural backgrounds. This work serves to advance goals around family and consumer partnerships.

Supports NPM 11

University of Washington, Center on Human Development and Disability – Nutrition Program: Assure access to quality nutrition services across the state by: (1) Expanding workforce capacity through the development and support of a network of trained Registered Dietitian Nutritionists to provide nutrition services to CYSHCN, (2)

Promoting the availability of quality, community-based nutrition and feeding team services for CYSHCN within the context of a medical home, (3) Acting as a resource for pediatric nutrition information for CYSHCN including available services, guidelines, standards of practice and evidence-based procedures, (4) Implementing aspects of national Standards for Systems of Care for CYSHCN across training and other venues to include topics such as, (a) care that is family-centered and culturally sensitive, and (b) access to affordable care through insurance and other systems of financing, and (5) Assisting in the evaluation of needs and barriers across the state for access to these services.

Supports NPM 11
Priorities: Healthy Starts, Health Equity

University of Washington, Center on Human Development and Disability – Medical Home Partnerships Project: Increase the percentage of CYSHCN who have a medical home and address selected domains in the national Standards for Systems of Care for CYSHCN, including medical home and access to care. Increase the number of parents who report their child received a developmental screen. Move toward the goal: CYSHCN will receive coordinated, ongoing, comprehensive care within a medical home. Work to improve and promote policy and training recommendations to the Health Care Transformation Team and the Executive Steering Committee to support pediatric practice transformation in Washington.

Supports NPMs 6, 11
Priorities: Screening, Referral and Follow-up

Multicare Health System, Providence Health Care, and Virginia Mason Yakima Valley Memorial Hospital: Coordinate regional Perinatal Regional Networks and participate in project work to reduce perinatal and neonatal risk and increase healthy outcomes for all pregnant women and newborns. Implement state quality improvement projects to decrease poor pregnancy outcomes, for which Medicaid clients are at disproportionately increased risk.

Supports NPMs 1, 4; SPMs 3, 5
Priorities: Health Equity; Screening, Referral and Follow-up

Seattle Children's Hospital: Provide clinic consultations for community-based genetic evaluation, counseling, diagnostic, referral, and educational services in order to reduce the prevalence and effects of genetic disorders and birth defects.

Supports priorities: Screening, Referral and Follow-up

Kadlec Regional Medical Center, Genetic Support Foundation, Providence Physician Services, and Virginia Mason Yakima Valley Memorial Hospital: Provide accessible, comprehensive clinical and prenatal genetic services to patients, including genetic counseling, diagnostic, referral, and educational services, in order to reduce the prevalence and effects of genetic disorders and birth defects.

Supports priorities: Screening, Referral and Follow-up

State Match of Federal Title V Funds
The MCHBG requires a dual federal-state investment, at least a $3 match in non-federal funds for every $4 of federal MCHBG funds expended, and maintenance of effort from 1989. Washington’s 1989 maintenance of effort amount is $7,573,626, and that was our state match amount.

We provided this state match through two primary sources:

- The universal vaccine program of our Office of Immunization, which provided immunizations for underinsured and uninsured children in the state. We used the funds that purchase the vaccine supply as our match.

- State dollars contributing to the salaries and benefits costs of staffing our maternal and child health program and supporting contract work to provide services aligned with the MCHBG and NPM 11.

Impacts of Federal Title V Funding

Title V provides dedicated funding for state and local health jurisdictions to focus on foundational maternal and child health services. As mentioned in the section entitled, *How Federal Title V Funds Support State Maternal and Child Health Efforts*, Washington estimated a $450 million per biennium deficit to provide foundational public health services at the state and local government levels. Although funding has been allocated, it does not come close to closing that gap. It is clear that federal support is needed to augment our capabilities to address basic public health needs.

Several of the contracts listed above focus on important health equity issues and providing medical services to support unmet needs in rural areas. Our state does not have the resources to provide that support independently. Other contracts listed above focus on providing services, assistance, and social support to CYSHCN and their families. This helps infants, children, and youth with special needs receive necessary health services as early as possible and enhances the community support systems that serve them. These investments truly work toward giving this population the ability to live their best, healthy lives.

Title V-funded positions provided management and oversight for other related maternal and child health investments, such as Essentials for Childhood and our maternal mortality review, as mentioned in the population domain narrative sections.

An important function of the Title V investment is to dedicate staff resources to identifying and addressing gaps. Title V staff are involved in identifying cases where women, children, and youth underutilize health benefits they are eligible for, to the detriment of their health. Title V staff are involved in systems-building work, such as working with health care providers and systems to successfully transition from fee-for-service models to value-based models.

The flexibility allowed to use MCHBG funding in ways that best meet the maternal and child health needs identified by each state has been invaluable as the COVID-19 pandemic has affected us all. We have appreciated the ability to use staff funded by MCHBG in our pandemic response. We have also appreciated the Maternal and Child Health Bureau’s understanding that it may be difficult to meet original objectives we had set, and that in some cases it has been necessary to change the focus our work to meet emerging needs. Title V funds greatly enhance our state’s ability to coordinate and improve health care for children and families, and therefore improve health outcomes.

III.D.2. Budget

III.D.2. Budget Narrative

Washington made an allocation assumption of an estimated $9,242,405 in federal Title V Maternal and Child Health Block Grant funding, based on the prior year's allocation and consistent with the grant guidance. We have prepared a budget as follows:

$2,067,164	Salaries and benefits
$6,127,891	Contracts
$103,904	Goods and services
$95,552	Travel costs
$0	Capital equipment
$103,904	Intra-agency costs (e.g., employee workspace, computer, computer support)
$743,990	Administrative costs. The Department of Health Prevention and Community Health division provisional indirect rate is 30.5 %.
$9,242,405	**Estimated total allocation**

The federal investment in services benefitting specific populations:

$933,840	10%	Pregnant women
$933,841	10%	Infants
$3,176,278	34%	Children 1 through 21 years
$3,291,505	36%	Children and youth with special health care needs

The federal investment from the perspective of service level:

$94,722	1%	Direct services
$545,808	6%	Enabling services
$7,694,934	93%	Public health services and systems

Washington is aware of and dedicated to compliance with legislative financial requirements (e.g., 30/30/10% requirements) and all program regulations. For accountability and tracking, we use master index codes to indicate the funding source for each expenditure, identifying whether it is federal, state, or other. The codes also indicate what population domain the activity supports.

Of the funds to be retained by DOH, most support personnel-related costs.

Contracts Distributing Title V Funding

Of the $6,127,891 budgeted for contracts, most of that, $5,143,804, is budgeted to distribute to local health jurisdictions (LHJs) throughout the state, as described in the first paragraph below. The additional contracts in our budget are also described here.

Local Health Jurisdictions: DOH contracts with 35 LHJs and one hospital district to ensure funding supports maternal and child health programs across all areas of the state. Key areas of work in these contracts include support for children and youth with special health care needs (CYSHCN), universal developmental screening,

adverse childhood experiences, participation in regional Accountable Communities of Health, healthy weight, injury prevention, breastfeeding, immunizations, oral health, youth pregnancy prevention, and addressing health equity. LHJs can choose projects aligned with any of the areas of work listed above.

For the LHJ contracts, we have made a slow transition to the new five-year state action plan. LHJs have been overwhelmed with the impact of COVID-19, so we will not make significant changes to their contract statements of work until January 2022. We will work through fall 2021 to get LHJ feedback on the revised focus-of-work guidance for LHJs, allow LHJs time to determine what activities they want to include in their contracts based on the current five-year state action plan, and then prepare new contract documents. See *Appendix B – Maternal and Child Health Block Grant Local Work* for additional information about these contracts and work.

Supports National Performance Measures (NPMs) 1, 4, 6, 10, 11, 15
State Performance Measures (SPMs) All
Priorities: All

WithinReach: Manage the Help Me Grow Washington Hotline (the state's MCH toll-free telephone line), which promotes healthy starts and ongoing wellness, and prevents illness and injury through outreach that improves access to health benefits, resources, and information. Efforts are targeted to Medicaid-eligible pregnant women, children, and families. With one call, people can connect with a variety of services to support their health including services for CYSHCN. The hotline data and technical infrastructure integrates with the information available through WithinReach's online support. Support is provided directly by staff in English and Spanish, and additional resources and tools are used to support other non-English-speaking callers.

Supports NPM 1, 4, 6, 11, 15; SPMs 3, 6
Priorities:
Identify and reduce barriers to quality health care.
Improve the safety, health, and supportiveness of communities.
Promote mental wellness and resilience through increased access to behavioral health and other support services.
Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

Kindering Center (Washington State Fathers Network): Provide opportunities for fathers of CYSHCN to meet, learn from, and mentor each other. Promote the concept of this networking. Share information about resources available. Advocate for issues important to these fathers.

Supports NPM 11; SPM 4, 6
Priorities:
Improve the safety, health, and supportiveness of communities.
Promote mental wellness and resilience through increased access to behavioral health and other support services.
Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

University of Washington, Center on Human Development and Disability – Nutrition Program: Assure access to quality nutrition services across the state by: (1) Expanding workforce capacity through the development and support of a network of trained Registered Dietitian Nutritionists to provide nutrition services to CYSHCN, (2)

Promoting the availability of quality, community-based nutrition and feeding team services for CYSHCN within the context of a medical home, (3) Acting as a resource for pediatric nutrition information for CYSHCN including available services, guidelines, standards of practice, and evidence-based procedures, (4) Implementing aspects of national Standards for Systems of Care for CYSHCN across training and other venues to include topics such as, (a) care that is family-centered and culturally sensitive, and (b) access to affordable care through insurance and other systems of financing, and (5) Assisting in the evaluation of needs and barriers across the state for access to these services.

Supports NPMs 11, 15
Priorities:
Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.
Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

University of Washington, Center on Human Development and Disability – Medical Home Partnerships Project: Increase the percentage of CYSHCN who have a medical home and address selected domains in the national Standards for Systems of Care for CYSHCN, including medical home and access to care. Increase the number of parents who report their child received a developmental screen. Move toward the goal: CYSHCN will receive coordinated, ongoing, comprehensive care within a medical home. Work to improve and promote policy and training recommendations to the Health Care Transformation Team and the Executive Steering Committee to support pediatric practice transformation in Washington.

Supports NPMs 6, 11; SPMs 3, 5, 10
Priorities:
Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve people's health across the life course.
Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

Partners for Action, Voices for Empowerment (PAVE) Family to Family Health Information Center: Use the knowledge and experience of families and project partners with expertise in federal and state programs, and public and private health care systems, to work with families to increase the % of CYSHCN who have access to needed services, including the resources to obtain them. Provide respite to meet planned (not crisis) needs for unserved and unpaid family caregivers through recognized provider agencies. Work as a key leader to build infrastructure, such as website development and hosting, to support the Washington Statewide Leadership Initiative, and support its infrastructure to facilitate participation of family-led information, support, and advocacy organizations across the state. Provide emphasis on support for family leaders from diverse cultural backgrounds. This work serves to advance goals around family and consumer partnerships.

Supports NPM 11, 15, SPM 10
Priorities:
Improve the safety, health, and supportiveness of communities.
Promote mental wellness and resilience through increased access to behavioral health and other support services.
Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

Multicare Health Systems, Providence Health Care, University of Washington Medical Center, and Virginia Mason Yakima Valley Memorial Hospital: Coordinate Perinatal Regional Networks and participate in project work to reduce perinatal and neonatal risk and increase healthy outcomes for all pregnant women and newborns. Implement state quality improvement projects to decrease poor pregnancy outcomes, for which Medicaid clients are at disproportionately increased risk.

Supports NPM 1, 4; SPM 2
Priorities:
Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.
Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.

Seattle Children's Hospital: Provide clinic consultations for community-based genetic evaluation, counseling, diagnostic, referral, and educational services in order to reduce the prevalence and effects of genetic disorders and birth defects.

Supports priorities:
Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.
Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve people's health across the life course.

Kadlec Regional Medical Center, Genetic Support Foundation, Providence Medical Group, Providence Maternal Fetal Medicine, and Yakima Valley Memorial Hospital: Provide genetics services regionally throughout the state. Provide accessible, comprehensive clinical and prenatal genetic services to patients, including genetic counseling, diagnostic, referral, and educational services, in order to reduce the prevalence and effects of genetic disorders and birth defects.

Supports priorities:
Improve prenatal, infant, and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.
Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve people's health across the life course.

State Match of Federal Title V Funds
The Title V Maternal and Child Health Block Grant requires a dual federal-state investment, at least a $3 match in non-federal funds for every $4 of federal MCHBG funds expended, and maintenance of effort from 1989. Washington's 1989 maintenance of effort amount is $7,573,626, and that is our state match amount.

We provide this state match through two primary sources:

- The universal vaccine program of our Office of Immunization, which provides immunizations for underinsured and uninsured children in the state. We use the funds that purchase the vaccine supply as our match.

- State dollars contributing to the salaries and benefits costs of staffing our maternal and child health program and supporting contract work to provide services aligned with the MCHBG and NPM 11.

Impacts of Federal Title V Funding

Title V provides dedicated funding for state and local health jurisdictions to focus on foundational maternal and child health services. As mentioned in the section titled *How Federal Title V Funds Support State Maternal and Child Health Efforts*, Washington estimated a $450 million per biennium deficit to provide foundational public health services at the state and local government levels. Although funding has been allocated, it does not come close to closing that gap. It is clear that federal support is needed to augment our capabilities to address basic public health needs.

Several of the contracts listed above focus on important health equity issues and providing medical services to support unmet needs in rural areas. Our state does not have the resources to provide that support independently. Other contracts listed above focus on providing services, assistance, and social support to CYSHCN and their families. This helps infants, children, and youth with special needs receive necessary health services as early as possible and enhances the community support systems that serve them. These investments truly work toward giving this population the ability to live their best, healthy lives.

The Washington maternal mortality review is coordinated from within our Title V program. The state Legislature allocates funding to cover basic infrastructure to conduct the review process and write the report. MCHBG provides support to oversee and expand the review program.

An important function of the Title V investment is to dedicate staff resources to identifying and addressing gaps. Title V staff are involved in identifying cases where women and children underutilize health benefits, they are eligible for, to the detriment of their health. Title V staff are involved in systems-building work, such as working with health care providers and systems to successfully transition from fee-for-service models to value-based models. Title V funds greatly enhance our state's ability to coordinate and improve health care for children and families, and therefore improve health outcomes.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Washington

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

III.E. Five Year Action Plan

Introduction

Like other public health agencies and organizations around the country, the Washington State Department of Health was a primary responder for the COVID-19 emergency throughout 2020, 2021, and continuing into 2022. While the pandemic continues to impact our communities, we have moved into a "recovery phase" for much of our work, with staff returning to their dedicated positions after being activated for the emergency. We have continued to have significant staffing transitions, and a few exciting staff changes. Astrid Newell, MPH, MD, joined us in February 2022 as the Thriving Children and Youth Manager. Astrid brings with her years of expertise in children's wellness and has been a state leader in mitigating the impacts of child maltreatment and improving community and family resiliencies. Within the same section, Angie Funaiole was promoted to become our Child Health Manager. We were delighted to have Mary Myhre join us as our new MCHBG Coordinator. Mary has spent much of career managing complex grants for tribal partners in our state.

As a team, we have become increasingly aware of the need for greater intentionality around gender equity. For this five-year cycle, we have been using core principles to guide our work. We expanded our first principle to incorporate gender equity: "*All people deserve the opportunity to thrive and achieve their highest level of health and well-being. Improving systems that serve families and children to be more equitable is a core responsibility of public health practitioners. We embrace this responsibility in our maternal and child health work. We are committed to being anti-racist and to supporting gender equity in our programs and policies*."

Based on feedback from our previous year's review, we attempted to streamline our action plan by integrating the Cross-cutting and Systems Building into other population domains. We found that much of the work previously highlighted in that section fit better in specific domains. We also consolidated and streamlined our strategies for CYSHCN based on feedback from last year's review. We aligned these strategies with the new CYSHCN strategic plan which was developed with input from families, LHJs, and providers and incorporates key elements from the new CYSHCN Blueprint.

As part of our on-going needs assessment process initiative to align measures with work being done by the Washington State Title V Program and HRSA evidence-based/results-based accountability strategies, a few new measures have been identified. In the child health domain, we are developing an ESM measuring the number of children in the state who receive a developmental screen through Help Me Grow WA, a participant in the Strong Start developmental screening system, as well as an SPM utilizing the family resilience metrics collected and reported on from the National Survey of Children's Health. In the perinatal health domain, we are proposing a new ESM based on a hospital-based breastfeeding promotion intervention called Lactation and Infant Feeding-Friendly Environment which many of the state's birthing hospitals are in the process of adopting. These changes will replace prior measures that were not as closely aligned with our current work and with HRSA recommendations. In the coming year, the WA Title V program will continue to review and revise other measures as evidence and workflows develop.

III.E.2.a. State Title V Program Purpose and Design

The Washington State Department of Health (DOH) is led by Secretary of Health Umair A. Shah, MD, MPH, appointed by the governor in December 2020. Organizationally, Washington's Title V program is based in the Office of Family and Community Health Improvement (OFCHI), part of the Division of Prevention and Community Health.

The Office of Family and Community Health Improvement is dedicated to enhancing the health and wellbeing of individuals, families, and communities. The office works with local health jurisdictions, tribal public health partners, community-based organizations, health systems, health care providers, and other state agencies. The Washington State Plan for Healthy Communities guides the office's work to promote health across the life course through policies, systems, and environmental changes with emphasis on health equity, primary prevention, social determinants of health, and community-clinical linkages. The state's Title V Maternal and Child Health (MCH) Director, Katie Eilers, is the Director of OFCHI.

Our strategy to put Title V Maternal and Child Health Block Grant (MCHBG) funding to best use in Washington includes emphasis on the areas described below.

Ensure foundational public health services related to maternal, child and family health are delivered: Foundational public health services are the governmental capabilities and programs essential to communities everywhere for the health system to work anywhere. Focusing on essential services that only government can or will provide effectively is our priority.

Determine and address areas of priority need: We use MCHBG resources to conduct needs assessments to define current priorities, gaps, and areas of need, which shape our work plan. In development of the current list of state priority needs and state action plan, we identified the following ***core principles*** to guide all our work:

- All people deserve the opportunity to thrive and achieve their highest level of health and well-being. Improving systems that serve families and children to be more equitable is a core responsibility of public health practitioners. We embrace this responsibility in our maternal and child health work. We commit to being anti-racist in our programs and policies.
- We value both evidence-based and community-developed promising practices. These practices ensure our health systems serve everyone, especially those marginalized by mainstream society. We work in ways that embrace cultural humility and appropriateness.
- We are working to ensure trauma-informed approaches are built into all our programs and services.
- We must continue to assess the effects of COVID-19 on all programs and adjust as needed. We must do this with particular focus on our values and goals associated with racial and ethnic equity.

Promote a healthy start in life: In addition to addressing equity issues as stated in our core principles above, Washington prioritizes universal developmental screening, readiness for kindergarten, addressing and preventing adverse childhood experiences, preventive health visits, immunizations, and other measures supporting children's healthy starts in life. We and our contract partners use a life course perspective and the national Standards for Systems of Care for Children and Youth with Special Health Care Needs in developing programs and services.

Direct public health funding to the local level: Related to the provision of foundational public health services, we are committed to passing a majority (57 %) of the MCHBG funding to local health jurisdictions (LHJs) to ensure community-driven, localized maternal and child health services are available across the state. LHJs are able to choose their particular focus of work from a menu of options based on the state's MCHBG priorities. An additional 11% goes to other contractors.

Build surveillance and evaluation capabilities: Public health must collect and use data to identify community health problems and where health inequities exist to guide planning and decision making. This requires developing data systems, analyzing data and identifying trends, and partnering with others to exchange data and health information as appropriate. These activities are critical to support evidence-based and -informed approaches and solutions to well-known and emerging health issues.

While many factors contribute to decisions made about how to use MCHBG funding, these overarching principles form the backbone of how we set priorities and serve as a convener, collaborator, and partner with other organizations to promote health and provide services to the people of Washington.

Organization charts showing the Title V functions and organizational relationships are included in this application. We have also included two new appendices in this year's application: an overview of major MCHBG partners and an organizational chart of state agencies in Washington. Our MCH personnel are funded by a blend of federal formula and competitive grants, state funds, and other program funding as available. Staffing assignments are based on mandates, statewide and internal priorities, contract obligations, and federal and state funding availability for specific projects and programs.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

2020 and 2021 have been challenging years for staff retention and workforce development. The Department of Health has significantly increased its staffing to respond to COVID-19 related needs, and has had a significant change in senior leadership, with the appointment of Dr. Umir Shah as Secretary of Health. This has had many trickle-down effects on all programs, including Title V. Initially, many staff were activated for temporary incident management and response assignments, taking them temporarily away from their regular work and some staff members chose to move into long-term COVID-19 project positions. Now those activations and longer term COVID-19 assignments have sun-setted, and we are juggling the return of staff to former positions. While we continue to manage COVID-19 waves and disruptions, most of our energy is dedicated to recovery efforts, recognizing that the pandemic has exacerbated challenges for our maternal, child, and adolescent health populations.

The total number of DOH full-time equal (FTE) positions funded by MCHBG federal funding is 18.79 FTE. This represents 40 to 45 individuals, as multiple sources fund most positions. This is an increase from last year's level of 17.76 FTE (portions of 40 positions). Title V activities are the predominant focus of the Office of Family and Community Health Improvement, shown in the attached organization chart.

Recruitment and Retention

Our division and office leadership teams focus on employee retention and succession planning. When we have a position vacancy, we consider whether to fill it as it is currently organized and funded, or whether a long-term workforce strategy might warrant a change.

Learning and advancement opportunities are readily available, and we encourage and support employee development. Some examples include:

We promote and use the Association of Maternal and Child Health Programs (AMCHP) and National MCH Workforce Development Center (WDC) workforce development resources. MCH staff have participated in the AMCHP Leadership Lab development series. Staff have successfully submitted program practices to the AMCHP Innovation Station (now known as Innovation Hub), and they use this resource to learn from other organizations' best practices. A team of eight, including the Title V MCH Director and Children and Youth with Special Health Care Needs (CYSHCN) Director, participated in the 2020 WDC Strategic Skills Institute sessions. In the previous WDC Strategic Skills Institute, three staff and a local health jurisdiction (LHJ) representative attended and used their experience to launch a health equity pilot project with LHJs, leading to the inclusion of health equity as a regular component of the LHJ contracts and statements of work. We also promote AMCHP's new MCH Essentials Series and MCH Navigator learning resources to MCH staff. Both the MCH Director and the CYSHCN Director completed applied for and completed the 2021 Leader to Leader cohort, which included several hours of mentorship and training in many things related to the MCHBG.

Over the past several years, DOH has adopted "outward mindset" as our core culture and performance strategy, and we have incorporated it into our agency strategic plan as one of four key transformation areas. This concept is based on "The Outward Mindset: Seeing Beyond Ourselves; How to Change Lives and Transform Organizations," a book by the Arbinger Institute. Our mindset is the lens through which we see our work, our relationships, and the world. Outward mindset training asks participants to shift from focusing on their own goals and objectives to having an outward mindset, with a focus on the organization as a whole. It helps individuals change the way they work with and

relate to people and see how their behaviors and actions affect others. In addition to improving the internal organizational culture, this training seeks to improve the way we collaborate with others and provide services to the public. All DOH employees participate in outward mindset training, and supervisors attend outward leadership training.

In addition to Outward Mindset training, staff are offered an array of training and engagement opportunities related to diversity, equity, and inclusion. Several MCHBG-supported staffing completed the People's Institute Undoing Institutional Racism training, while others participated in learning cohorts focused on improving equity in our contracting and funding.

Washington's Learning Management System offers training opportunities on a broad range of topics including leadership training, facilitation skills, and communication. DOH requires specific mandatory training courses for all employees and for supervisors and managers, but a majority of the course offerings are elective and available to complete at will.

The University of Washington's Northwest Center for Public Health Practice (NWCPHP) provides training, research, evaluation, and communications services to support public health organizations, particularly those in Alaska, Idaho, Oregon, and Washington. DOH leadership promotes NWCPHP training opportunities for employee professional development. In past years Title V staff have attended the NWCPHP Leadership Institute, a nine-month program that includes both on-site and distance learning. NWCPHP also offers a yearlong Public Health Management Certificate program. They facilitate a Learning Laboratory, which supports local health departments transitioning from clinical services to more population-based strategies that address the social determinants of health. NWCPHP's "Hot Topics in Practice" monthly webinar series provides interactive learning and discussion of issues currently affecting public health practice. Topics covered over the past year include:

- Connecting Work to Wellness
- Building Trust in Local Public Health
- Managing Infodemics and Conspiracy Theories
- Vaccines, Public Health, and the Media
- Public Health, This is Your Shot!
- Racial Justice, Healing, and Action in Tacoma-Pierce County
- Adolescent Intimate Partner Violence
- Trauma-Informed Change Management
- Alaska Tribal Perspectives on COVID-19 Vaccination Efforts

All section managers completed a three-part tribal history and engagement training provided by the DOH Tribal Relations Director. The DOH State Tribal Public Health Partnerships series offers a workforce development opportunity to help employees understand Native American tribal sovereignty, the policy and program infrastructure for government-to-government relationships with tribes at the federal and state levels, and how DOH uses its consultation/collaboration procedure to fulfill its responsibilities under RCW 43.376 regarding government-to-government relations with Indian tribes. Section managers also collaborated with the Tribal Relations Director to develop a tribal engagement manual for use throughout the agency. OFCHI offered to provide a pilot testing space for this manual.

Ideally, each employee develops an individual training plan with their supervisor as part of their annual performance development plan. In addition to the learning resources mentioned in this section, it can also include attendance at local and national topical training sessions and conferences, as resources allow. Examples include the AMCHP

Conference and the American College of Medical Genetics and Genomics Annual Meeting. Some employees maintain professional association memberships that relate to their field of work. Equity training and interactive staff development help create positive teaming and high morale/productivity.

Current and Anticipated Training Needs
The following needs have been identified by specific work groups:

- Leadership coaching and mentorship, for navigating challenging workloads and team dynamics. Foundational Public Health Services orientation and technical assistance, for internal and external partners, including local public health MCH leaders

- Continued training around telehealth and teleintervention, particularly for our EHDDI program and partners and our Sexual and Reproductive Health program and partners.

- Federal and state policy training on rulemaking and the role of federal decisions on state level legislation.

- Equity and social justice training, including how to center community expertise in program planning and funding distribution, as well as diversity in staffing.

Innovations in Staffing Structures and Key Training Partnerships
We are widening our scope of partners to learn from and involve in program planning, including the creation of a few regularly scheduled meetings specifically focused on cross-walking and leveraging of work. For example, we have begun meeting monthly with colleagues at the Department of Children, Youth and Families regarding alignment between our MCHBG, Essentials for Childhood initiative, Early Childhood Comprehensive System work, and the statewide Early Learning Coordination Plan (led by DCYF). Similarly, we have begun meeting monthly with the WA Chapter of the American Academy of Pediatrics to collaborate around community health workforce investment in the pediatric and perinatal provider settings. We have expanded our partnership with the Health Care Authority, which administers Medicaid, to determine how we can align the MCHBG with policy initiatives (like the recent expansion of Medicaid coverage through one year postpartum) and systems improvements (like determining funding mechanisms for community health workers and doulas). Finally, we have dedicated participation on a variety of legislatively mandated workgroups, including the Children and Youth Behavioral Health Workgroup and the Dismantling Poverty workgroup, both of which provide opportunities for our agency to promote the unique health needs and challenges of the maternal, infant, child, and adolescent health populations.

Staff facilitate several different coalitions in the state, all of which provide rich collaborative learning environments and opportunities for unique partnership engagement. Under the leadership of our new Thriving Children and Youth Section Manager, we have continued to expand state and local partners to the Essentials for Childhood steering committee, and have reconvened our Data Workgroup, which is focused on expanding our understanding of resiliency as it relates to mitigation of trauma impact.

We continue to contract with the University of Washington (UW) to host the Washington State EHDDI Learning Community (WSELC), which provides training and technical assistance to individuals who perform newborn hearing screening, pediatric audiologists, and professionals involved in early intervention services for children who are deaf or hard of hearing and their families. We also convene the EHDDI Advisory Group, which is dedicated to identifying gaps in services and supports for families experience hearing loss, and addressing these gaps through partnership expansion, policy improvement, and streamlining care across childhood. Similarly, we host the statewide Critical Congenital Heart Disease (CCHD) Workgroup which is focused on challenges, gaps, and barriers to effective

CHHD screening and diagnoses in Washington.

We regularly bring on practicum students to assist with gathering information, evaluation, quality improvement activities, and education/outreach.

We use a variety of strategies to communicate information, training opportunities, and news to the broader Title V workforce and partners in Washington. For example, the Genetics program publishes its bimonthly eBlast that goes out to a listserv of genetic providers statewide who work on genetics across the lifespan, including pregnant women, infants, and children. The eBlast contains information on current trainings, programs, relevant information on policies, legislation, education, and job postings for genetic services positions in Washington (sent in by partners). Our Community Consultants send communications related to their specific programs to LHJs, and the Family Engagement Coordinator sends communications to the Washington Statewide Leadership Initiative collaborative. Title V staff convene regular online meetings with our CYSHCN Communications Network, several perinatal health groups, LHJs, and others to exchange information and updates about emerging issues and best practices.

III.E.2.b.ii. Family Partnership

III.E.2.b.ii. Family Partnership

The Department of Health values consumer and family partnership and involvement. A DOH Community Engagement Guide assists programs with community partnership activities, with the intent to advance health equity, promote social connection, strengthen cross-sector partnerships, and build trusting relationships with the communities we serve.

DOH has a paid Family Engagement Coordinator position in its Title V Children and Youth with Special Health Care Needs program. This position provides leadership for inclusion of family and community perspectives in policy and program development, oversees parent and lived-experience inclusion and outreach, and serves as a statewide subject matter expert in family engagement by local health jurisdictions, contracted partners, and within other population domains internally at DOH.

Our Family Engagement Coordinator continues to partner with our state affiliate Family-to-Family Health Information Center (F2F), Partnerships for Action, Voices for Empowerment (PAVE), to support the Washington Statewide Leadership Initiative (WSLI). WSLI is a collaborative that uses a collective impact model to better enable and enhance partnership connections between family-led organizations and their community- and state-level partners. Together, the Family Engagement Coordinator and PAVE serve as the backbone support for WSLI, providing funding and staff time to set up, facilitate, and follow up on meetings and decisions made, along with maintaining the group's online presence.

The purpose of WSLI is to facilitate collaborative, family-centered partnerships, provide a mechanism to identify needs for family leadership training, and provide opportunities to recruit family advisors at all levels and systems. WSLI serves as a central hub, connecting Washington's Title V program with a variety of non-profit and family-led community-based organizations located all around the state, serving our culturally, linguistically, and geographically diverse families, including those with special health care needs. The structure of WSLI has helped to facilitate increased partnerships and create stronger collaborations between small family-led and family-serving organizations. It also broadens the reach of the Title V program into culturally and geographically underserved communities through an increased emphasis on partnership and serving as a connector and convener.

The collaboration has hosted an in-person summit annually since its inception in 2016; however, no summit was held in 2020 due to the COVID-19 pandemic. Funds that were previously allocated to host this event were quickly shifted to help create online learning opportunities around telehealth services for people with developmental disabilities and autism. There is always funding available to reimburse family leaders for participation in leadership and advocacy training opportunities (including, but not limited to the summit), but in 2020 there was a bigger push to get this information out to families and encourage those following stay-at-home orders to pursue virtual learning opportunities and conferences when possible.

Throughout 2020, the WSLI Steering Committee worked with the National MCH Workforce Development Center to become familiar with Results-Based Accountability (RBA). The Steering Committee engaged with WDC to put these principles into practice as a method of shared data collection. RBA allowed members to analyze quantitative and qualitative data equally and allowed the group to form a baseline dataset on the impact of being a part of the collaborative for current members. The Steering Committee wrapped up this work with WDC doing systems-level mapping for each current committee member, looking at needs, resources, and wishes. The Steering Committee decided to host a virtual summit in August 2021 to promote work around health equity and family leadership and involvement, as well as to bring new agencies to the table. There was an uptick in interest around WSLI immediately following the summit, as noted by unique website data points and additional attendance at the regular meeting in

September 2021.

We migrated the WSLI website to a new platform to allow for more accessibility features for partners and families with disabilities. This includes adjustable font sizes, compatibility with word scanner programs, and a more mobile-friendly interface. PAVE has continued to manage the website, supported by Title V funds, to provide updated material and links to relevant and timely trainings and events around the state, including virtual events as we continued to navigate COVID-19 restrictions. PAVE staff supported WSLI in creating a Facebook group to better facilitate quick and seamless information sharing among WSLI members. This group is updated regularly by partners, with between five and 10 events shared a month.

The Family Engagement Coordinator disseminates a weekly bulletin aimed at promoting family leadership and partnership through trainings and events in collaboration with WSLI. It draws from national, statewide, and regional content, such as webinars from the Association of Maternal and Child Health Programs (AMCHP), Family Voices, and local organizations. Throughout the COVID-19 pandemic, it has focused on connecting family leaders to support groups, mental health and self-care resources, as well as relevant and timely COVID-19 information.

PAVE uses a public health approach and lens to support Parent to Parent (P2P) programs throughout the state. PAVE receives Title V funding directly from the Maternal and Child Health Bureau. DOH provides additional Title V funding to PAVE to extend their reach throughout the state and provide leadership and support to the WSLI collaborative. As part of this partnership, PAVE supports P2P in a variety of ways, including funding for the annual statewide and semiannual regional training weekends and providing regular support and development to new and continuing coordinators. In a year of continued shutdowns, restrictions, and uncertainty, this funding allowed P2P coordinators to connect with each other through Zoom meetings, which was particularly important for allowing the multicultural coordinators in the state to establish a network of peers during this isolating time. The annual training featured important information on cultural humility, compassion fatigue, and boundaries for family leaders, during a time when lines between roles and places have become blurred. To help increase visibility on the work P2P programs do around the state, several short videos were recorded to provide snapshots of services, history of the program, and other information in an easy-to-access, on-demand format.

One staff member at PAVE serves as a family navigator for families of children with special health care needs on the Olympic Peninsula, an underserved area that includes several rural counties and six federally recognized tribes. Staff partners with the two rural hospitals, local clinics, and hospitals in Seattle to support families on their journey, including families who have received a new diagnosis, or are in or transitioning out of the neonatal intensive care unit (NICU) or pediatric intensive care unit (PICU). Referrals have expanded to include direct connections to local pediatricians along with families through word of mouth. In early 2021, the staff member hosted a talking circle session via Zoom to help support families through increased engagement, and connection to local supports and each other. This model was well received, leading to future sessions with the University of Washington's Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program to further support local families, hospitals and clinics, as well as new trainees.

PAVE has also supported families impacted by mental and behavioral health, regionally and at the state level, through systems-building, supporting connections, and providing stipends to families and youth self-advocates to be able to attend and participate in the Family, Youth, and System Partner Round Tables (FYSPRT). PAVE has partnered closely with the Washington State Community Connectors (WSCC), who provide mental and behavioral support wraparound services to children, youth, and their families.

In fall 2019, PAVE's F2F Director and the DOH Family Engagement Coordinator joined a cohort led by Family Voices, National F2F. This cohort consisted of five state teams, each co-led by the state's F2F affiliate and CYSHCN

or other state agency lead. The Washington cohort worked through the curriculum to create a team mission and vision, as well as a plan of action to achieve the final goal. They partnered with members of the WSCC to focus on creating a community forum that authentically engaged youth and community members, including tribal members, of Clallam County, a geographically rural and underserved area.

As this project was put on hold due to COVID-19, PAVE connected with the Clallam Resilience Project that is founded on neurobiology, epigenetics, adverse childhood experiences (ACEs), and resilience (NEAR) sciences. Through the Clallam Resilience Project, members of the team made connections with community members, including working with families of CYSHCN, to elevate issues of ACEs and chronic stress. The team had planned to hold listening sessions with local tribes, but these were cancelled in March of 2020. Fortunately, the team was able to build a relationship with a few local tribes, connecting their board members and elders to federal information sessions about funding and resources as the pandemic set in. This allowed a local team member to become a trusted entity for these tribes and for family engagement work on multiple levels. The team held informal listening sessions with the elders to better understand what the tribal communities needed during this trying time.

Title V contractor Washington State Fathers Network (WSFN) receives Title V funding for father-specific support networks and to promote strategies for inclusive community and recreational activities for CYSHCN and their families. Throughout 2021, WSFN continues to offer virtual meetings for its local chapters, allowing fathers from across the state to join groups outside of their local community, this was very beneficial to fathers in counties without a local chapter. Social media engagement continued to be more important throughout the continued shutdowns and restrictions, allowing the WSFN to reach their population in a timely and engaging manner. Responding to the death of George Floyd and Black Lives Matter protests in 2020, the network continues to regularly share information regarding systemic racism and available supports for Black and Indigenous families, and other families of color, particularly those with CYSHCN.

Partnerships with family-led organizations, including but not limited to those we contract with, have greatly expanded the reach of Title V staff in engaging families. Family leaders are connected to projects and opportunities through the networking functionality of WSLI.

The Essentials for Childhood (EfC) initiative at DOH is actively working to center parent voice in partnership work on policy, systems, and program change to reduce child abuse and neglect and promote child and family resilience. Over the years, EfC has included a few caregiver members on the EfC Steering Committee. In 2020, a father with lived experience in the child welfare system joined. He is also an active participant at the state and national level on work to strengthen and support families and improve outcomes for families at risk of or involved with the child welfare system.

EfC has learned from this experience that successful parent engagement takes investment and staffing and has since dedicated resources to this work. In April 2021, EfC planned and launched a comprehensive effort to incorporate parent representatives into the Steering Committee, with the help of a parent policy leader consultant with lived child welfare system experience. Starting in June 2021, the consultant recruited and facilitated 3 meetings with a group of diverse parents, called the Parent Leadership Group. The consultant presented preliminary themes that emerged from the meetings to the EfC Steering Committee in September. A final report capturing key findings, recommendations, and proposed next steps was completed in September 2021. The report included a parent engagement map, capturing lessons learned and best next steps to collaborate with parents throughout policy and systems development initiatives.

DOH partnered with Seattle Children’s Hospital on a collaborative improvement and innovation network (CoIIN)

project for children with medical complexity. The CoIIN team worked with two parent peer partners as part of a care coordination and family navigation model with families transferring out of the NICU. The inclusion of the parent peer partners was already a critical component of this ongoing work, and engagement with the families in the project increased during COVID-19 due to stay-at-home orders, lack of supports, and ongoing isolation. The parent partners saw this increased need and started monthly social support groups for interested families. The project followed families for an average of a year and showed significant improvement in families of medically complex children engaging early intervention services.

In August 2021, DOH was awarded an Early Childhood Comprehensive Systems (ECCS) grant. Through the WA State ECCS program, DOH and partners aim to build state capacity and infrastructure that strengthen parent/caregiver and early childhood systems to improve individual and family well-being. Amplifying the voices of family leaders is central to implementing the ECCS program. In part, this will be accomplished through a Family Leadership Advisory Council (Council). The Council will guide efforts to strengthen and build systems for pregnant/parenting families and those caring for and raising children up to age three at the community and state level that are family centered. Systems may include childcare, health care, and other family supports and services.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

III.E.2.b.iii.a. MCH Epidemiology Workforce

Surveillance and Evaluation Section

The mission of the Surveillance and Evaluation (S&E) section in the Office of Family and Community Improvement (OFHCI) is to provide strategic information to guide public health policy and programs that serve the populations of Washington. S&E gathers, analyzes, interprets, and reports on data that describe the health status, health care, behaviors, and other issues related to health. S&E, in partnership with MCH program managers and other partners, leads the design, implementation, data analysis, and reporting for the Five-Year MCH Needs Assessment, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Needs Assessment, and domain-specific needs assessments tied to categorical grant funding. S&E provides program evaluation, data management, analysis, and/or technical assistance to almost all programs within OFCHI. S&E leads and manages the Pregnancy Risk Assessment Monitoring System (PRAMS), Home Visiting data system, Birth Defects Surveillance System (BDSS), and Child Death Review. S&E is currently providing technical assistance in MCH epidemiology to the COVID in Pregnancy Registry, which is in the Division of Disease Control and Health Statistics at DOH. We are also partnering with the Center for Health Statistics in the development of a linkage between PRAMS and Washington hospital discharge data.

Analytic Positions in S&E: FTE, Classifications, and Qualifications

Of the approximate 24 FTE in S&E, 17 are analytic staff positions. All analytic staff focus on maternal and child health topics. Analytic staff are funded through MCHBG (2.8 FTE); State Systems Development Initiative (SSDI) (0.7 FTE); MIECHV and state Home Visiting Funds (4.0 FTE); other federal grants (4.7 FTE); and by state and other funds (4.8 FTE). Of the 17 positions, 14 are currently filled and four are in the process of recruitment. Non-analytic staff funded by MCHBG in S&E include PRAMS operations and administrative support staff. Additional non-permanent staff include a full-time Council of State and Territorial Epidemiologist (CSTE) fellow, who started October 2021, and a 0.5 FTE Health Services Consultant working on data product planning and development.

The analytic staff classifications in S&E include Epidemiologist 1 (2.0 FTE), Epidemiologist 2 (8.0 FTE), Epidemiologist 3 (5.0 FTE), Sr. Epidemiologist (1.0 FTE), and Research Investigator 3 (1.0 FTE). All epidemiologist positions require a master's degree or Ph.D. in epidemiology or related field, and 12 graduate quarter credits of both epidemiology and biostatistics. The Epi 1 position requires a minimum of one year experience in epidemiology; the Epi 2 master's level requires four years' experience; the Epi 3 requires two years' experience for those with a Ph.D. and six years of experience for master's level; and the Senior Epidemiologist requires five years' experience for those with a Ph.D. and eight years' experience for master's level. The Research Investigator 3 position requires a Ph.D. in physical, biological, social, behavioral, or health-related sciences and two years' experience; the master's level requires three years' experience.

Title V MCH Analytic Staff

Approximately 2.8 FTE of MCH analytic staff are paid for by MCHBG and are responsible for Title V MCH data products, as well as supervision of MCH analytic staff and leadership and planning in MCHBG data-related activities. An additional 0.7 FTE of SSDI funds support the development of Title V data products and analytic activities on neonatal abstinence syndrome. Title V data products include the Five-Year MCH Needs Assessment, identification and development of state performance measures and evidence-based strategy measures, ongoing needs assessment activities, and updates to the Perinatal Indicators Report and the MCH Data Reports, among other activities.

The Epidemiologist 1 supported by Title V works on the MCH Needs Assessment, data requests, Perinatal Indicators Report updates, MCH Data Report chapter updates, and development of evidence-based strategy measures and state performance measures, among other tasks. The Epidemiologist 2 positions support the analytic needs of the CYSHCN program, BDSS, and MCH Needs Assessment activities. The Epidemiologist 3 supervisory positions provide S&E leadership in MCH Five-Year and ongoing MCH Needs Assessments, BDSS, and supervision of the Evaluation and Surveillance units. The Senior Epidemiologist position provides supervision of unit supervisors and leadership in S&E and OFCHI.

All Title V analytic staff are supported by other funding sources in addition to MCHBG.

Current Workforce Capacity

While all of S&E's analytic staff focus on MCH issues, the majority are categorically funded by grants or Home Visiting funds for specific bodies of work outlined in the MCHBG. One of our challenges is to accommodate new bodies of work, especially those with limited or no funding.

The high number of open analytic positions related to COVID-19 continues to impact the candidate pool in filling some of S&E's positions.

Emerging Needs

Emerging needs within the Surveillance and Evaluation section include increasing our ability to develop complex data linkage, data systems, reports, and on-line dashboards; providing technical assistance to the COVID in pregnancy program within the Division of Disease Control and Health Statistics and increasing PRAMS data access and utilization. We are currently drafting report templates that will better integrate health equity and stakeholder engagement into MCH Data Reports.

More information about emerging needs is described in the section titled, *Other MCH Data Capacity Efforts*.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

III.E.2.b.iii.b. State System Development Initiative

The DOH Surveillance and Evaluation section continues to use State Systems Development Initiative funding to support and enhance data capacity for our Title V program. We continued to build and expand our MCH data capacity to support Title V program activities and contribute to data-driven decision-making in programs, including assessment, planning, implementation, and evaluation.

SSDI provided needed capacity, including funding portions of three epidemiologist positions. One of these positions worked on data collection, analysis, and interpretation to support the annual submission of the block grant and MCH Needs Assessment. The epidemiologist also worked to update both Washington state MCH Data Report chapters and the Perinatal Indicators Report. Further, SSDI helped develop, support, and assess both structural and process measures to address the national performance measures, as well as the continued improvement and reporting of state performance measures and evidence-based strategy measures.

Over the past year the MCH staff supported by SSDI contributed to the annual submission of the MCH Block Grant, including ESMs, SPMs, and trend data, and updated data and content for the MCH needs assessment.

We are continuing ongoing qualitative data collection model to understand emergent needs, both in general and in relation to COVID-19. Though our ongoing interactions with stakeholders, we are integrating key questions into facilitated discussions and other data collection methods. Specific questions include unmet needs, community strengths, impacts of COVID-19, trusted sources of health information, and opportunities for improvement. This model of ongoing data collection will cover a broader period and will provide timely identification of emerging issues across racial/ethnic groups, ages, and geography.

We are still in process of developing a new state-wide Birth Defects Surveillance (BDS) data system and plan the linkage of BDS and vital statistics data over the next 12-18 months; work that had been delayed due to COVID-19. In addition, staff within the Center for Health Statistics are currently developing an updated methodology for birth and hospitalization data linkage. These data will inform our understanding of maternal perinatal opioid use as well as maternal morbidity in WA. Through funding from ASTHO, we anticipate completion of an initial linkage of hospitalization data with PRAMS by early fall.

Data products developed by SSDI-supported staff include three MCH Data Report Chapters and a presentation to the Perinatal Advisory Board. Staff also contributed to the Safe Care of Obese Patients document developed by our office.

Neonatal Abstinence Syndrome and Perinatal Substance Use Disorder

S&E advanced the development and use of linked information systems between key MCH datasets in Washington, such as the linkage between Women, Infants and Children Nutrition Program (WIC) data with birth certificates (BC). The WIC-BC linkage has been developed and we are in the process of completing a data sharing agreement. When this process is finalized, S&E expects to have access to the data, which will greatly improve our information about WIC among those giving birth, often used as a proxy indicator for socioeconomic status.

As mentioned above, S&E, in partnership with CHS is in the process of linking to 10 years of Washington PRAMS data with the Washington Comprehensive Hospital Abstract Reporting System (CHARS). The final dataset will include PRAMS and hospitalization data at time of birth for birthing parent and infant. In addition, CHS will include

hospitalization data for birthing parent approximately 10 years before the birth, and/or hospitalization data after the birth for both birthing person and infant, based on available data. All activities will be completed by DOH staff dedicated to this project. This project is scheduled to be complete by September 30, 2022.

The PRAMS-CHARS linkage will provide rich data on birth and clinical outcomes for both mothers and infants, informing patient-centered outcomes research, perinatal programs, and clinical quality improvements efforts. DOH has a close relationship with faculty, researchers, and students at the University of Washington and other research institutions. We anticipate strong interest from researchers and perinatal programs, such as members of Washington's Maternal Mortality Review Panel (MMRP), in using the PRAMS-CHARS linked files.

Currently Washington State's Prescription Drug Monitoring (PMP) System is in the process of linking records to Washington birth certificates. S&E has had a preliminary discussion with PMP about the linkage, including the development of an analytic files, data sharing processes, and strengths and limitations of the data.

Collaboration between S&E and CHS has also yielded a preliminary linkage of deceased mothers to their baby's hospitalization records and revisit files for the MMRP. This new linkage will provide expanded opportunities to understand neonatal abstinence syndrome (NAS) so that we may address needs related to maternal opioid use, prevention, and treatment, as well as the care and treatment of the infant.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

There is a range of additional data capacity efforts taking place in the Surveillance and Evaluation section.

Pregnancy Risk Assessment Monitoring System

In addition to receiving Association of State and Territorial Health Officials (ASTHO) funding to link PRAMS with hospitalization data, the PRAMS program is currently implementing the COVID Vaccine Supplement and continues to implement the opioid supplement. The intent is to gather adequate numbers of responses for stratified and other analyses. These data will provide new and important information for Prevention and Community Health's Office of Immunizations and OFCHI's neonatal abstinence work.

Birth Defects Surveillance System

Surveillance & Evaluation Section (S&E), along with OFCHI leadership and partners across the agency, are currently working with a vendor on the development of new Birth Defects Surveillance (BDS) data system. This data system is part of the Health Information Technology for Economic Clinical Health Act (HITECH) funding from the Center for Medicare and Medicaid Services.

The new BDS data system will allow for increased use of health information exchange, improved data cleaning and deduplication, easier access to BDS data, and more timely monitoring and tracking of birth defects. Long-term, S&E plans to integrate the use of existing birth, death, fetal death, and hospitalization records to increase data quality and case ascertainment.

Universal Developmental Screening Data System

S&E has recently hired an Epidemiologist 2 to lead the data use, planning and analysis of the UDS data system. In addition to leading the UDS data work, this position will work in partnership with the UDS program, supporting continuous quality assurance and program evaluation.

Home Visiting Data Management

S&E staff, through funding from the Department of Children, Youth, and Families, provides data management, reporting, and evaluation work for the Home Visiting Services Account. This involves maintenance of a home visiting data system that compiles and processes data from multiple data systems and programs. Priority work in the coming year will focus on implementing new recommendations from the Home Visiting Advisory Committee. These recommendations include streamlining data collection on the part of the home visiting implementing agencies; creating space for family, community and agency engagement in understanding and using the data; and continued development of a comprehensive data infrastructure. The current system is a patchwork of databases that is neither sustainable nor adequate for the growing needs of home visiting. An assessment of future data infrastructure options with recommendations, will guide decisions moving forward on best data infrastructure investments for Washington.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The Washington State Comprehensive Emergency Management Plan sets a framework for statewide mitigation, preparedness, response to, and recovery from emergencies and disasters. Based primarily on the state Emergency Management Act, the plan complies with US Department of Homeland Security and Federal Emergency Management Agency requirements.
DOH holds key responsibilities in this plan, including:

Primary agency for:

- Emergency Support Function (ESF) 8 – Public Health, Medical, and Mortuary Services
- ESF 11 – Agriculture and Natural Resources

Support agency for:

- ESF 5 – Emergency Management
- ESF 6 – Mass Care, Emergency Assistance, Temporary Housing, and Human Services
- ESF 7 – Logistics Management and Resource Support
- ESF 9 – Search and Rescue
- ESF 10 – Oil and Hazardous Material Response
- ESF 14 – Long-Term Community Recovery
- ESF 15 – External Affairs

The statewide plan is reviewed regularly, and updates are maintained on a five-year schedule or sooner as appropriate. The plan was most recently updated in March of 2019. All ESFs are scheduled, in a staggered manner, for updates at least every five years. The plan addresses planning for and mitigation against hazards, and response to specific needs of people with access and functional needs of all ages. It also provides a framework for including people with access and functional needs, and organizations serving them, in the statewide planning and response processes. The plan does not specifically name the maternal and child health population other than a few references, but its “whole community” approach encompasses MCH needs.

DOH holds a seat on the Washington State Emergency Management Council. This council is the primary advisory body on matters pertaining to state and local emergency management to the Governor and the Adjutant General of the Washington Military Department, where the state’s Emergency Management Division is located.

For its primary role in coordinating ESF 8, DOH has developed a DOH Basic Plan with supporting annexes and appendices. Leadership of the Prevention and Community Health division are involved in agencywide emergency planning and preparedness for the state. This plan outlines core capabilities identified under five mission areas: Prevention, Protection, Mitigation, Response, and Recovery. Much of the MCH ongoing work falls within the Mitigation and Recovery mission areas, where community resilience and social/health infrastructure investments are prioritized.

Title V staff have been involved in emergency response activities in varying roles from leadership, to operations, planning, logistics, and administrative support. During FFY2021, 20 Title V staff were reassigned for short- or long-term activations for COVID-19, with eight of them supporting vaccination efforts. In 2022, the DOH surveyed all agency staff to determine which emergency response roles they might envision themselves filling in the future, based on exposure and training to emergency response activities as part of the COVID-19 incident command.

Prior to COVID-19, Title V staff have been involved in emergency activations for other communicable disease

outbreaks as well. All staff in the Division of Prevention and Community Health are expected to be available for reassignment for emergency response – this is included as standard language in position descriptions within the division.

As the COVID-19 response has evolved, local and state public health level staff has largely transitioned to routine work. Some components of the COVID-19 incident command have been integrated into divisions and programs as part of our ongoing program responsibilities, including COVID-19 vaccines. MCH staff integrate have begun and will continue to integrate key learnings about the impact of COVID-19 into recovery efforts, which include emphasis on economic stability for families and assurance of access to social and health services.

Emergency Planning and Preparedness Work at the Local Level

In the local health jurisdiction MCHBG contracts, we continue to allow MCHBG funds to be expended on COVID-19 response activities that align with maternal and child health priorities, though the need to dedicate block grant funds to the response is dwindling. Examples may include:

- Providing support in educating the MCH population about COVID-19 through partnerships with other local agencies, medical providers, and health care organizations.
- Working closely with state and local emergency preparedness staff to assure that the needs of the MCH population are represented.
- Funding infrastructure that supports the response to COVID-19. For example, public health nurses who are routinely supported through the Title V program may be mobilized, using Title V funds or separate emergency funding, to support a call center or deliver health services.
- Partnering with parent networks and health care providers to provide accurate and reliable information to all families.
- Engaging community leaders, including faith-based leaders, to educate community members about strategies for preventing illness.
- Promoting COVID-19 vaccination for all ages

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

III.E.2.b.v.a. Public and Private Partnerships

The multifaceted health care delivery system in Washington includes a variety of private and public providers, and individual, private, and public payers. Sources of health insurance for people in Washington include the following:

Coverage Type:	Employer	Non-Group	Medicaid	Other Public	Uninsured
Children 0-18	51.5%	4.0%	38.7%	2.7%	3.1%
Adults 19-64	65.5%	6.6%	14.8%	3.7%	9.4%
Full population	52.9%	5.0%	19.8%	15.7%	6.6%

Henry J. Kaiser Family Foundation estimates based on Census Bureau's American Community Survey, 2019

Washington has long worked on health care reform. Collaborative regional organizations called Accountable Communities of Health (ACHs) work to integrate how physical and behavioral health needs are met in ways that focus on the whole person. ACHs support providers as they transition to value-based payment, where quality is rewarded over volume of services.

These regional ACHs lead local practice-transformation efforts. Five local health jurisdictions use MCHBG funding to support their participation in their regional ACH. The Department of Health and the Health Care Authority (HCA) foster alignments, make connections, and provide technical assistance and tools to support health care providers' ability to coordinate care, increase capacity, and benefit from value-based reimbursement strategies. One of these tools is the Healthier Washington Collaboration Portal, built in partnership between the UW Department of Family Medicine Primary Care Innovation Lab and DOH to help facilitate practice transformation. The portal is a participatory effort between members of the clinical and public health communities of Washington, providing resources to address the health needs of communities.

At the local level, LHJs partner with community organizations and health care delivery partners on new models for referrals and services. One example: Whatcom County participates in a community partnership called Whatcom Taking Action that provides coordinated evaluation, navigation and referral services for children who may have autism, children who may need specialized care and support, and their families.

At the statewide level, since 2017, DOH, HCA, and the five Medicaid managed care organizations (MCOs) have been working collaboratively to increase the rates of well-child visits in a formal managed care organization performance improvement project.

The Department of Health:

- Facilitates and leads the collaborative workgroup.
- Provides recommendations for evidence-based interventions and/or evidence-informed interventions to the workgroup.
- Provides connections and recommendations for experts to consult.
- Shares workgroup progress, challenges, and emerging promising practices with stakeholders through reports, webinars, mixed media, and conference presentations.
- Leverages DOH expertise and resources to support the collaborative work.
- Aligns DOH-sponsored grant work such as the MCHBG for a greater collective impact on performance

improvement.

Some children whose care is managed by Medicaid face barriers to completing well-care visits. The workgroup implemented the following interventions and strategies in 2020 to address barriers.

Fall 2020 Clinic Pilot Project: Engaged 23 clinical sites, primarily in Snohomish and Spokane counties, in the 2020 Statewide Children's Health Promotion Initiative project. The project focused on the following five tasks and had a potential to impact 19,186 children and adolescents.

Collecting and reporting well-care visit rates for the three months prior to the clinic project.
Reconciling the list of MCO-assigned patients and the list of patients from the electronic health record covered by the partnering MCO.

Contacting unestablished and overdue patients, reminding them about the value of a well-care visit and encouraging them to schedule an appointment.
Reconciling the care gap report and identifying any billing or other errors that are preventing credit for well-care visits provided. Correcting internal process(es) as needed.
Completing two Plan, Do, Study, Act improvement cycles using new strategies from the tip sheet that the partnering MCO provides to encourage well-care visit completion.

Oregon Coordinated Care Organization (CCO) Webinar: Held online seminar for the Oregon CCOs to help continue the implementation of the clinic project in surrounding states.

Community Flyer Distribution: Implemented a community-based strategy to improve well-visit rates of young children by partnering with Child Care Aware, who distributed over 4,000 flyers to parents of children who may need well visits. This partnership resulted from key conversations with the Department for Children, Youth, and Families; Help Me Grow; and Essentials for Childhood.

Community Communications – Social Media Postings: Posted eight notices on the DOH Facebook page to encourage readers to engage with their primary care providers and schedule well-care visits for children and adolescents. The Facebook links were distributed to the MCOs to post on their websites, if allowed, to expand opportunities to view the posts. These postings were multicultural in that they were presented in various languages, including English and Spanish.

III.E.2.b.v.b. Title V MCH - Title XIX Medicaid Inter-Agency Agreement (IAA)

Medicaid in Washington

The Washington State Health Care Authority administers Washington Apple Health, the "brand name" for the state's medical assistance programs, including Medicaid. HCA purchases health care for more than 2.5 million people, around a third of Washington residents, through its programs including Apple Health (Medicaid), the Public Employees Benefits Board program, the School Employees Benefits Board program and the Compact of Free Association (COFA) Islander Health Care program.

In July 2022, 2,219,770 people in Washington had access to Medicaid services, including 903,756 children under age 19. HCA contracts with managed care organizations to provide physical and behavioral health care services. As of April 2021, around 85 percent of Apple Health clients were enrolled in a managed care plan, the rest in fee-for-service. (HCA website)

The state Title V program works in partnership with HCA in many ways. Both agencies provide staff to common working groups that focus on specific efforts to improve women's and children's health, including children and youth with special health care needs. We work to help ensure alignment of resources, services, and programs, and that women and children are provided their covered benefits such as preventive services, health examinations, treatments, and follow-up care. The CYSHCN Director participates in the state Title XIX Advisory Committee.

The Title V program maintains agreements with HCA to: 1) reimburse expenditures made by Title V program that are eligible for Medicaid coverage, 2) help us determine the reach and effectiveness of programs and assist us in determining whether people receive their appropriate services, and 3) provide for data sharing between the departments. Our Title V program agreements with HCA are included in Section IV of this application and are described below.

Contract No.	Purpose	Section IV Document Location
GVS19903	Increase access to Medicaid covered services for children with special health care needs by providing outreach and application assistance and collaborating with the Health Care Authority in program policy and planning efforts for Medicaid programs and services available for CYSHCN clients.	Page 1 – current amendment Page 6 – agreement
GVS19968	Improve access to and availability of genetic counseling, evaluation and related medical services to Medicaid clients. Provide DOH genetics expertise, including consultation and reporting, to HCA staff.	Page 18 – current amendment Page 21 – agreement
GVS24425	Interagency reimbursement agreement for prenatal diagnosis genetic counseling services.	Page 28 – current amendment Page 31 – agreement
GVS23567	Interagency reimbursement agreement for	Page 39 – agreement

	maternal and infant health activities associated with Perinatal Regional Networks (PRNs) and Pregnancy Risk Assessment Monitoring System (PRAMS) data services.	
GVS24432	Support outreach efforts and linkage to First Steps services to Medicaid-eligible African American pregnant women in Pierce County and to provide them with culturally appropriate health messages.	Page 52 – agreement
GVS21399	Mutual information sharing agreement (data share agreement) to meet requirements associated with coordination and continuity of care, to identify Title V recipients who are potential Supplemental Security Income applicants and identify Title V children also enrolled in Medicaid. Provide ability for data matching to improve data quality, identify Medicaid-enrolled children that receive lead screening, and explore laboratory reporting trends.	Page 58 – agreement
GVS21788	Data share agreement between DOH, HCA and Department of Social and Health Services for access to ProviderOne and Predictive Risk Intelligence System (PRISM) data to enable care coordination, determine eligibility, improve quality and manage services for CYSHCN clients.	Page 72 – current amendment Page 74 – agreement
GVS23372	Data share agreement to support maternal mortality review.	Page 90 – current amendment Page 92 – agreement

Medicaid Section 1115 Waiver – Medicaid Transformation Project

For the past five-years, Washington state has been administering its Medicaid Transformation Project with the Centers for Medicare & Medicaid Services (CMS). This $1.5 billion in federal investments to promote innovative, sustainable and systemic changes that improve the overall health of Washingtonians has been primarily used to:

- Integrate physical and behavioral health
- Convert 90 percent of Medicaid provider payments to reward quality of care
- Improve health equity so all can benefit
- Increase and improve services that support our aging population

In July 2022, the HCA and Department of Social and Health Services submitted a renewal application for the transformation project. Several existing projects will continue or expand as part of the waiver, including expansion of work around substance use disorder and mental health services. The proposal includes new programs such

continuous Apple Health enrollment for children, reentry coverage for continuity of care, and Apple Health postpartum coverage expansion. Several of these new programs are critical to maternal, child and adolescent health and well-being, and DOH MCH staff will proactively collaborate with HCA and DSHS around these initiatives.

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

III.E.2.b.v.c. State Action Plan Narrative by Domain

Introduction

Like other public health agencies and organizations around the country, the Washington State Department of Health was a primary responder for the COVID-19 emergency throughout 2020, 2021, and continuing into 2022. While the pandemic continues to impact our communities, we have moved into a "recovery phase" for much of our work, with staff returning to their dedicated positions after being activated for the COVID-19 response. We have continued to have significant staffing transitions, and a few exciting staff changes. Astrid Newell, MPH, MD, joined us in February 2022 as the Thriving Children and Youth Manager. Astrid brings with her years of expertise in children's wellness and has been a state leader in mitigating the impacts of child maltreatment and improving community and family resiliencies. Within the same section, Angie Funaiole was promoted to become our Child Health Manager. We were delighted to have Mary Myhre join us as our new MCHBG Coordinator. Mary has spent much of her as managing complex grants for tribal partners in our state.

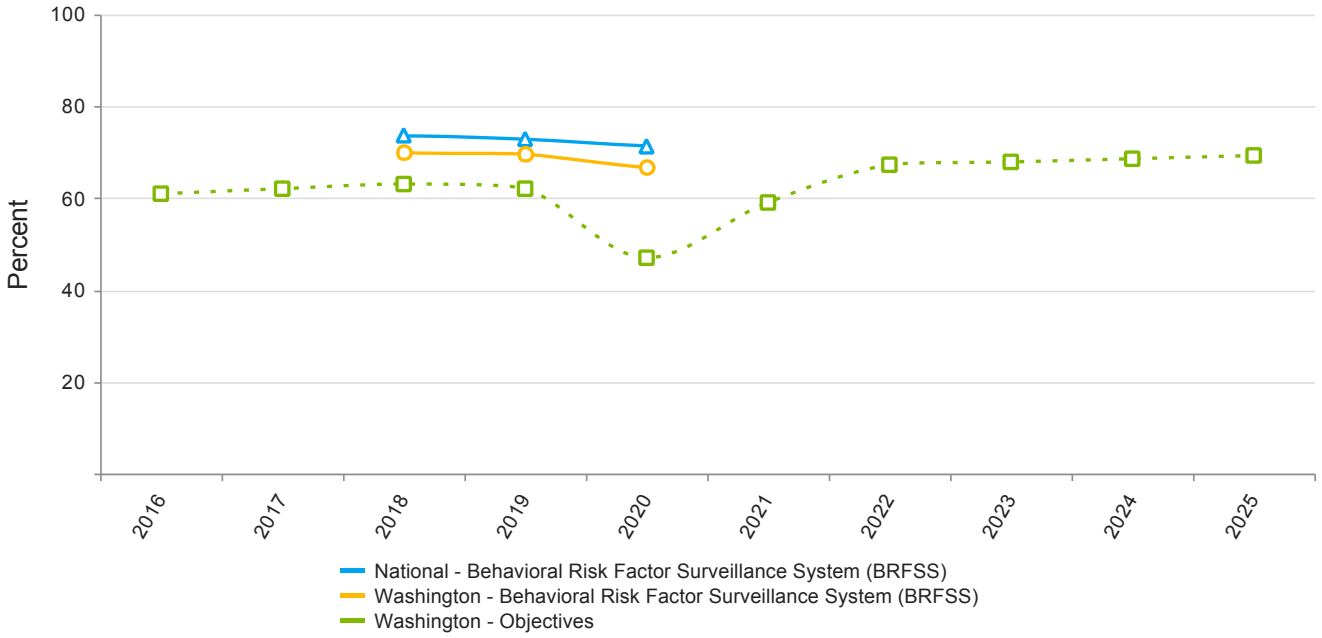
Based on feedback from our previous year's review, we attempted to streamline our action plan by integrating the Cross-cutting and Systems Building section into other population domains. We found that much of the work previously highlighted in that section fit better in specific domains. We also consolidated our strategies for CYSHCN based on feedback from last year's review. We aligned these strategies with our CYSHCN strategic plan which was developed with input from families, LHJs, and providers and incorporates key elements from the national CYSHCN Blueprint for Change.

As a team, we have become increasingly aware of the need for greater intentionality around gender equity. For this five-year cycle, we have been using core principles to guide our work. We expanded our first principle to incorporate gender equity: "*All people deserve the opportunity to thrive and achieve their highest level of health and well-being. Improving systems that serve families and children to be more equitable is a core responsibility of public health practitioners. We embrace this responsibility in our maternal and child health work. We are committed to being anti-racist and to supporting gender equity in our programs and policies*."

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				47	59
Annual Indicator			69.7	69.3	66.5
Numerator			919,438	939,935	908,611
Denominator			1,318,605	1,355,481	1,366,228
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	67.2	67.8	68.5	69.2

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percentage of women reporting in PRAMS that they had a preventive medical visit in the prior year

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			43
Annual Indicator	67.3	66.4	67.2
Numerator			
Denominator			
Data Source	WA PRAMS	WA PRAMS	WA PRAMS
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	67.9	68.6	69.3	70.0

State Performance Measures

SPM 1 - Substance use during pregnancy

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	16.1	14.9
Numerator	180	176
Denominator	1,118	1,180
Data Source	PRAMS	PRAMS
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	15.0	15.0	15.0

SPM 2 - Provider screening of pregnant women for depression

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	87.2	88.3
Numerator		
Denominator		
Data Source	Washington State PRAMS Survey	Washington State PRAMS Survey
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	88.3	88.3	88.3	88.3

State Action Plan Table

State Action Plan Table (Washington) - Women/Maternal Health - Entry 1
Priority Need
Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.
NPM
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Objectives
By Sept 2023, maintain communications and guidance documents for COVID and pregnancy/birth/postpartum/children to reflect up-to-date COVID data and understanding, to include racial disparity considerations.
By December 2022, distribute health promotion materials in relation to Senate Bill 6128 passed by the Washington State Legislature to expand Medicaid coverage to one year postpartum.
By September 2023, collaborate with community birth experts from the doula, home visiting, nursing, and community health worker workforce, to identify a process for birth equity priorities and funds distribution and program development in line with anti-racist values.
By September 30, 2022, create training opportunities for perinatal care providers on mood disorders and suicide risk during and after pregnancy, and determine feasibility of modifying existing legislation requiring mandatory provider suicide training to include content on maternal suicide, risk factors, and interventions.
By December 2022, collaborate with tribal partners to hold a listening session that includes plans to better understand maternal mortality in tribal and Indigenous communities, and content to be included in the next Maternal Mortality Review Panel report that includes recommendations centered on the tribal context, with added consideration of unique challenges and opportunities of tribal members and nations in relation to quality improvement.

Strategies
Integrate MCH COVID communications into the DOH COVID team communications and maintain current guidance documents and communications.
Support the “One Vax Two Lives” campaign to dispel misinformation, and address fears some expecting families may have about COVID vaccines. This campaign is a partnership with The University of Washington‘s Center for an Informed Public and the UW Medicine‘s Department of OB-GYN.
Support access to and communication clarity around emerging guidance for COVID-19 vaccination during pregnancy and lactation.
Support access to and communication clarity around emerging guidance for COVID-19 vaccination during pregnancy and lactation.
Support women during the “fourth trimester”; enhance postpartum care to allow providers to check in with mothers about their mental health and other medical issues.
Promote standardized depression, anxiety, and substance use screening across the life course.
Address the need for more services, support, providers, and insurance coverage, particularly in rural communities and remote areas.
Support active engagement by birthing hospitals, licensed birth centers, and perinatal providers in quality improvement efforts that reduce the leading causes of maternal mortality and morbidity.
Support healthy pregnancies, births, and maternal recovery; address inequities and prevent maternal mortality and morbidity.
Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges.
Implement trauma-informed services into community services, health care systems, and the public sector.
Support interventions to address suicide ideation among pregnant and parenting people.
Support efforts to address and mitigate individual and community effects of substance use.
Build on efforts to identify scope of impacts of substance use, including inequities at the local and state levels.
Increase and improve reimbursement for behavioral health care from preconception through all phases of pregnancy and the first year postpartum, including screening, treatment, monitoring, and support services.

ESMs	Status
ESM 1.1 - Percentage of women reporting in PRAMS that they had a preventive medical visit in the prior year	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Washington) - Women/Maternal Health - Entry 2

Priority Need

Promote mental wellness and resilience through increased access to behavioral health and other support services.

SPM

SPM 1 - Substance use during pregnancy

Objectives

By September 30th, 2023, and in partnership with the Child Welfare Division at the Department of Children, Youth, and Families, Within Reach and the Washington State Hospital Association, implement the state's new portal and policy for infants who are born substance exposed, including promotion of supports for the substance-affected mother/infant dyad.

Strategies

Build on efforts to identify scope of impacts of substance use, including inequities, at the local and state levels.

Provide training for clinical staff providing care at birthing hospitals

Improve the care of infants with neonatal abstinence syndrome (NAS) and neonatal opioid withdrawal syndrome (NOWS).

Support efforts to address and mitigate individual and community effects of substance use.

State Action Plan Table (Washington) - Women/Maternal Health - Entry 3

Priority Need

Promote mental wellness and resilience through increased access to behavioral health and other support services.

SPM

SPM 2 - Provider screening of pregnant women for depression

Objectives

By February 1, 2023, submit a revised maternal mortality review panel report to the Washington State Legislature, covering the deaths that occurred to women during pregnancy or within one year of pregnancy, inclusive of deaths resulting from suicide, substance overdose, homicide, and deaths that occurred out of state, and covering data from 2014-2020. The report will include identification of gaps and issues contributing to preventable, pregnancy-related deaths in the maternal behavioral health system and recommendations for improvement. Recommendations will address disparities and health equity improvements to reduce maternal mortality and will include contributions from our tribal and Indigenous partners.

By March 31, 2026, ensure 80 percent of birthing hospitals in Washington state have established processes to universally screen everyone giving birth for substance use disorders and perinatal mood and anxiety disorders as part of the Alliance for Innovation on Maternal Health (AIM) patient safety maternal mental health protocols.

Strategies

Support interventions to address suicide ideation among pregnant and parenting people.

Support efforts to address and mitigate individual and community effects of substance use.

Build on efforts to identify scope of impacts of substance use, including inequities, at the local and state levels.

Increase and improve reimbursement for behavioral health care from preconception through all phases of pregnancy and the first year postpartum, including screening, treatment, monitoring, and support services.

Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges.

Implement trauma-informed services into community services, health care systems, and the public sector.

Explore implementation of Maternal Levels of Care in Washington state.

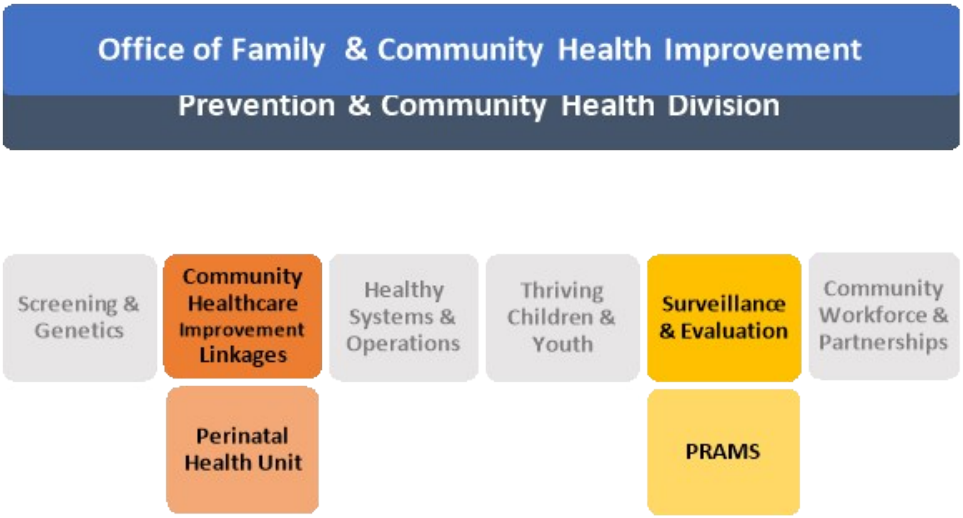
Promote standardized depression, anxiety, and substance use screening across the life course.

Promote verbal screening for substance use for every person giving birth, using validated tools.

Improve the care of infants with neonatal abstinence syndrome (NAS) and neonatal opioid withdrawal syndrome (NOWS).

Support interventions to address suicide ideation among pregnant and parenting people.

III.E.2.b.v.c. State Action Plan Narrative by Domain



Women and Maternal Health Domain Narrative

Overview

The women's and maternal health program at the Department of Health (DOH) is within the Perinatal Health unit of the Community Health Improvement Linkages section of the Office of Family and Community Health Improvement in the Division of Prevention and Community Health. Key activities of the unit include promoting, influencing, adopting, and revising policies and processes to improve the health and well-being of women and families.

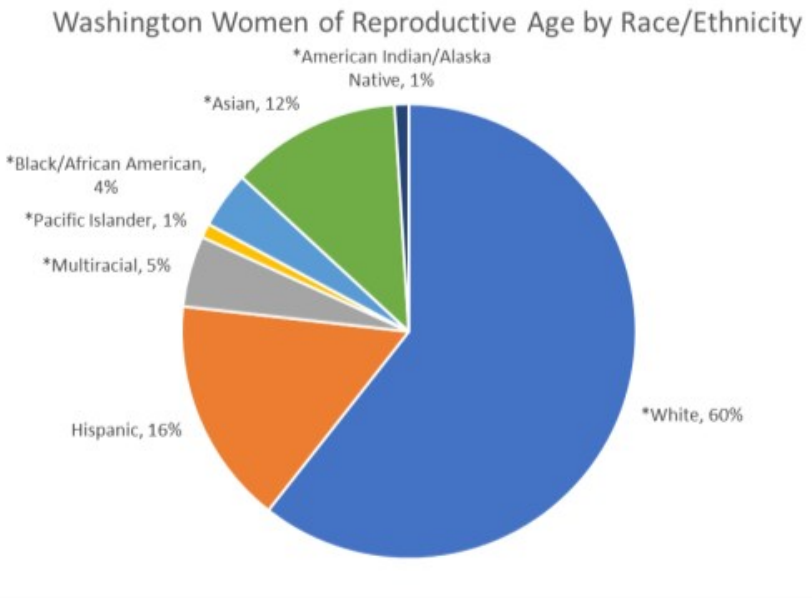
The Washington State Department of Health has a long history of supporting our vision of equity and optimal health for all through working with others to improve the health of all people in Washington State. The work done by DOH and our partners is based on the perspective of the life course health development. This perspective is used to explain how individual health develops over the course of a lifetime and is impacted by multiple determinants in all facets of life. This approach means that we can positively impact the health of individuals by positively impacting the health of women and pregnant people. Through our work in this area, DOH is actively working to ensure the health of all Washingtonians.

In support of this vision and based on the life course health development perspective, we offer educational materials and resources to the public on a wide range of topics, including healthy eating, physical activity, vitamins and nutrients, oral health, genetic illness, mental health and depression, safe relationships, family planning, pregnancy, sexually transmitted illnesses, and substance use on our website. Materials are also made available in a variety of languages.

Much of our work is informed by the recommendations developed by the Maternal Mortality Review Panel (MMRP), which was established into law in 2016. The Panel reviews maternal deaths that occur during pregnancy or one year postpartum. Based on this review, the Panel identifies recommendations to policy makers, state agencies, and health care providers on ways to improve perinatal health and prevent future maternal deaths.

In 2020, there were 1,494,885 women of reproductive age (ages 15 to 44) in Washington, about one fifth of the total population. White non-Hispanic women made up 62% of women of reproductive age in 2011; this decreased to 57% in 2020, an 8% decline. The population of American Indian/Alaska Native women also decreased over this period,

decreasing from 1.6% to 1.3%. Groups whose populations of women of reproductive age increased include Hispanic (20% of births), Asian (11%), Black or African American (5%), Native Hawaiian/Pacific Islander (1.6%), and multiracial (35%). The largest population increases from 2011 to 2020 were to Native Hawaiian/Pacific Islander (increased 47%), multiracial (increased 35%) and Asian (increased 21%).



*non-Hispanic

In 2020, 65% of women of childbearing age (ages 18-44) in Washington received a medical check-up in the prior year, compared to 70% in the general adult population. 10% of women 18-44 years of age in Washington reported poor or fair physical health. 31% of women 18-44 years of age reported having been diagnosed with depression. This is higher than the percent of depression reported in the general population of adults in Washington, at 23%. (BRFSS)

The DOH Sexual and Reproductive Health Program (SRHP) works with sexual and reproductive care providers across the state to support and ensure services. In 2020, the SRHP supported services for 90,910 clients during 126,052 clinic visits across the state. An estimated 87% of female clients of reproductive age served in 2020 across the state had some form of contraceptive method. Contraception puts women at lower risk of unintended pregnancy, unplanned births, and abortions. The clients supported by the SRHP in 2020 were 90% female, 51% were a racial/ethnic minority, and 53% were at or below the poverty level.

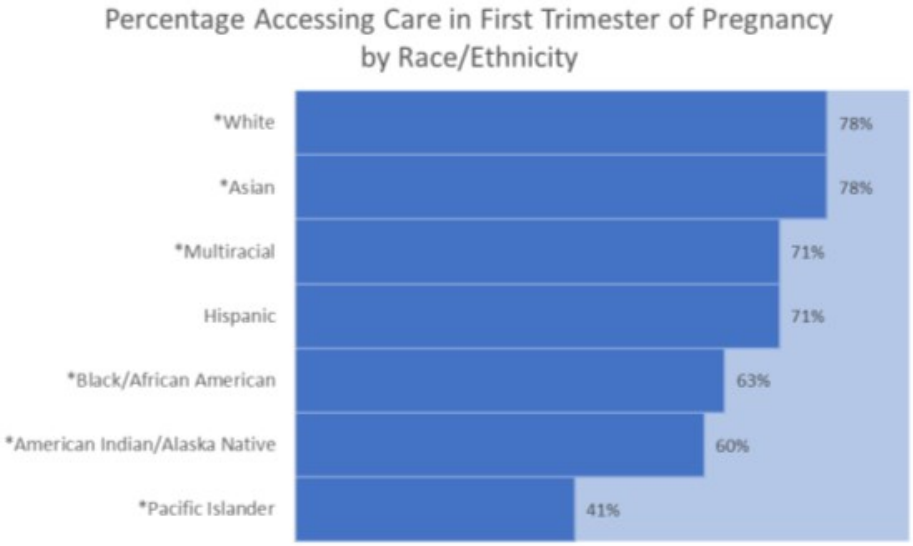
Between 2011 and 2020, the overall birth rate in Washington decreased by 14%. This drop is most pronounced among women ages 15 to 17 (64% decrease), ages 18 to 19 (50% decrease), and ages 20 to 24 (37% decrease). During the same time period, birth rates increased among women ages 35 to 39 (10% increase) and ages 40 to 44 (6% increase), suggesting a shift in age among women giving birth over the past decade. Trends in births and pregnancies are not identical across racial and ethnic groups. From 2018-2020, birth rates to teenagers were highest among Native Hawaiian/Pacific Islander (NHOPI), American Indian/Alaska Native (AI/AN), and Hispanic populations. Pregnancy rate, which includes births, fetal deaths, and abortions, decreased from 78 to 67 pregnancies per thousand women from 2011 to 2020.

Access to first trimester prenatal care varied among different MCH populations. Persons with Medicaid-funded

deliveries initiated prenatal care later than persons with non-Medicaid funded deliveries (67% versus 81%). Differences in starting care in the first trimester were also seen in some racial groups. In 2020, NHOPI, Black/African American and AI/AN pregnant people were much less likely to begin prenatal care in the first trimester than were Hispanic, Asian and White people. (WA Birth Certificate).

There are also changes in how women are choosing to give birth. From 2011 to 2020, deliveries by a physician decreased by 6%, while deliveries by certified midwives increased by 51%. Midwives delivered a total of 16.7% of births in Washington State in 2020. Broken down, certified Midwives delivered 13.0% and Licensed Midwives 3.7%. Births in birthing centers increased by 43% and home births increased by 35%.

Access to care, particularly among Black, Indigenous, and people of color (BIPOC) populations, was the most consistent need identified among women of childbearing age during the 2020 five-year maternal and child health needs assessment. Washington did not achieve the Healthy People 2020 goal of 85% first trimester prenatal care for all women giving birth.



Diabetes during pregnancy increased 70% from 2011 to 2020, including a 73% increase in gestational diabetes. In 2020, among all pregnancies, 12% of expectant mothers experienced some form of diabetes. Hypertension during pregnancy increased 76% over this same period, impacting about 12% of pregnancies. Postpartum depressive symptoms were reported in an estimated 12% of individuals in 2020 (WA Pregnancy Risk Assessment Monitoring System [PRAMS]). This does not represent a significant change from 10% reporting symptoms in 2012. 15% of respondents with Medicaid coverage reported depressive symptoms, compared with 10% of respondents who did not have Medicaid. In 2012 14% of respondents with Medicaid coverage and 7% of respondents not receiving Medicaid reported symptoms. Neither represents a significant change in percent. (PRAMS)

National Performance Measure 1 – Well-Woman Visit
Percent of women, ages 18 through 44, with a preventive medical visit in the past year.

In 2019, 69.3% of women received a preventive medical visit within the past year. This exceeded our objective of 47% but is slightly lower than the previous year. The percentage remained relatively steady between 2009 and 2017, but the survey data from those years are not comparable to 2018 and 2019 due to a change in a survey question (BRFSS).

Perinatal Health unit staff continued to monitor issues related to the recommended prevention services and works with the Office of Insurance Commissioner and Health Care Authority (HCA), the state's Medicaid administrative agency, when appropriate to try to ensure access to these benefits.

The DOH needs assessment found that many individuals lacked Medicaid coverage after pregnancy, preventing them from accessing services like behavioral health to address postpartum depression. In 2021, Washington state policymakers cited the MMRP's report in Senate Bill 5068 to **extend Medicaid coverage to 12 months postpartum**. This bill was passed and signed by the governor in 2021. In 2021, Medicaid expanded postpartum coverage to be automated and to extend to 12 months after the end of pregnancy. Starting July 2022 this coverage will be permanent in Washington and includes both obstetric/postpartum care as well as all healthcare services covered by Medicaid. The After Pregnancy Coverage has been announced and information for this coverage is available to the public on the HCA's website.

COVID-19

The Women's and Perinatal Nurse Practitioner has re-convened a perinatal COVID-19 workgroup that includes representation from DOH, Washington State Hospital Association (hereafter WSHA), HCA, birthing hospitals, and many different types of inpatient and outpatient perinatal providers. We coordinated a meeting with community and care providers to hear their experiences and to learn more about additional supports that may be needed as well as any emerging needs. Patient education materials and website content was updated and released in many languages. DOH also received a grant from the CDC for case tracking measures for COVID-19 in pregnancy, and for looking at maternal/infant outcomes longitudinally. As part of this work, DOH has been collecting chart abstracted data on every person who tested positive for COVID during pregnancy. That data is being analyzed and will be publicly available in the coming months.

The University of Washington, ACOG representatives, the chair of the perinatal collaborative and DOH staff collaborated to coordinate with the COVID response teams to include pregnancy as an indication for early access to vaccination. Additionally, they partnered to develop and release communication about safety and efficacy of the COVID vaccine during pregnancy/postpartum/lactation 2020, we continued to use the DOH website and social media to disseminate messages about issues impacting women's health, including the importance of folic acid, safe relationships, and substance use awareness. We also shared messages around special events, including Black Maternal Health Week, National Women's Health Week, and the Centers for Disease Control and Prevention's (CDC) Hear Her campaign.

State Performance Measure 1 - Substance use during pregnancy
Percent of women, _14.9%___

State Performance Measure 2: Provider screening of pregnant women for depression
Percent of women, __88.3%__

We have developed two state performance measures to track work related to behavioral health and pregnancy.

Key partnerships in this work are HCA/Medicaid, the Washington State Hospital Association, the March of Dimes (MOD), and Swedish Addiction Services in Seattle. These partnerships encourage an increase in the number of providers offering trauma and harm reduction informed care for pregnant and parenting people. This work is also informed by elements of the Washington State Opioid Response Plan that addresses the specific needs of pregnant and parenting people, as well as children and families. Specific strategies include working towards addressing bias and inequities, improved access to safe and affordable housing, quality medical services for mothers at delivery and during the prenatal and postpartum periods, group prenatal care for individuals with substance use disorder, hospital policies, and partnerships with the Child Protective Services programs. that addresses the specific needs of pregnant and parenting people, as well as children and families. Specific strategies include working towards addressing bias and inequities, improved access to safe and affordable housing, quality medical services for mothers at delivery and during the prenatal and postpartum periods, group prenatal care for individuals with substance use disorder, hospital policies, and partnerships with the Child Protective Services programs.

AIM
DOH has partnered with WSHA to join the Alliance for Innovation on Maternal Health (AIM), which is a national organization run in partnership with the American College of Obstetricians and Gynecologists (ACOG) to improve maternal outcomes through the **implementation of hospital wide quality improvement protocols, called "bundles**." Title V staff have participated in coordinating monthly trainings and biannual in-person trainings, and most participating birthing hospitals have access to the data system. The state began to transition from work on the

hemorrhage bundle and piloted the opioid bundle during 2021. We had 13 birthing hospitals participate in the initiative and coordinated 2 half day online trainings as well as monthly training and coaching call sessions. DOH and WSHA also began developing plans to launch a statewide Perinatal Substance Use Learning Collaborative. We continue to integrate equity and elimination of inequities into all our quality improvement efforts.

In addition to AIM, DOH is working on a number of interagency initiatives to address the maternal/child/family **impact of the opioid epidemic**:

We have partnered with the Division of Behavioral Health and Recovery (DBHR) at the HCA; WSHA; MOD; the Department of Children, Youth, and Families (DCYF); and other organizations to form a workgroup of the state opioid taskforce. DOH leads the state opioid response team, and Title V staff leads the workgroup that addresses the perinatal child impact. The purpose of this workgroup is to address the needs of women, transgender, gender fluid, pregnant and parenting people who have been impacted by substance use.

This workgroup has several areas of focus, which include:

- Decreasing stigma
- Addressing clinician bias
- Improving perinatal care and ease of access to care
- Linking pregnant and postpartum women to clinical and community resources
- Conducting a community-level gap analysis
- Expanding access to medication-assisted treatment (MAT)
- Expanding wraparound services
- Working with birthing hospitals to develop rooming-in policies for mothers and babies with withdrawal to stay in the same room, and transition to using the “Eat, Sleep, Console” tool
- Working with DCYF to increase consistency in child welfare decisions
- Supporting evidence-informed breastfeeding/chestfeeding guidelines
- Decreasing addiction to opiates, and increasing recovery for women and their families

In partnership with DCYF, we’ve worked to: (a) clarify and write policy around the federal 2016 Child Abuse Prevention and Treatment Act (CAPTA) regulations to notify Child Protective Services of all infants who are substance exposed, and (b) address the needs of women who have not received substance use treatment and prenatal care during pregnancy and want to move into recovery and parent their child. To address the first initiative, DOH has partnered with DCYF to look at the state’s child welfare policy that directs the reporting and notification of infants born exposed to substances. They have clarified existing policy and created definitions for infants exposed to substances and are piloting a new system notification/report and referral to wraparound services. DCYF has partnered with an outside agency (Within Reach) and has launched the new reporting portal. Additionally, they're planning implementation to support hospitals in understanding the policy and training on the new portal.

To address the second initiative, HCA is creating billing structures for birthing hospitals to treat the birthing parent and baby together. This allows the birthing parent to start on medication-assisted treatment while hospital staff monitor baby for withdrawal. Washington will be the first state to do this, and we are awaiting CMS (federal) approval. Additionally, we are working to create systems of care that address withdrawal support and addiction care for birth parents who are not stable in recovery at the time of birth and have begun cross agency/organization listening session with birthing hospitals to learn more about what supports are needed to implement this model of care. We are also looking at what is needed to reduce wait-times for birth parents and infants to directly transfer together from the hospital to residential treatment services. This assures the safety of the infant and supports the maternal recovery and parenting transition of the birth parent.

DOH Title V staff are creating a gap analysis of county-by-county perinatal services and are working to integrate this information into an online resource finder that can be used to integrate into and between clinical and community services. Additionally, one of the Title V epidemiologists is working on an analysis of the data looking at perinatal and child outcomes to see if there are correlations to service availability.
DOH is conducting a literature review of lactation and substance use and is creating lactation guidance for substance use that integrates harm reduction strategies.

DOH funded five community mini-grants to increase knowledge and skill of providers, patients, and families about behavioral health conditions during and after pregnancy, and the treatment and resources that are available. These projects support maternal Medication Assisted Treatment (MAT) programs and increase perinatal peer support groups and services.

DOH partnered with the University of Washington to launch a pilot program to train and support members of primary care clinics to address perinatal suicide risk and substance use overdose. Aspects of this suicide risk reduction care include screening for suicide risk (including identifying risk factors and the use of screening tools), evaluate the severity of any identified risk, prepare a risk mitigation plan, and initiate a team-based care approach within the care setting or in conjunction with community resources to address this risk. The UW team will recruit participating facilities to receive training, as well as develop and carry out their own site-specific perinatal suicide risk improvement component with and measurement and reporting of clinic screening and care rates.

In 2021, Washington state policymakers amended a law, Second Substitute House Bill 1325, to permanently fund a **perinatal psychiatric information line** at the University of Washington (UW) Psychiatry and Behavioral Sciences called Partnership Access Line (PAL) for Moms. This “warm line” allows all types of providers to easily contact and access a perinatal psychiatrist for consultation, and to receive written documentation of consult and resources. Funding this line was one recommendation submitted to policy makers in the 2019 MMRP Report to increase access to perinatal behavioral health providers and information.

DOH explored the feasibility of amending Revised Code of Washington (RCW) 43.70.442 to require that suicide training standards for licensed health care professionals include content on risk factors and intervention for pregnant and postpartum people. Significant barriers made this amendment unfeasible at this time. However, we developed a collaborative partnership with the DOH Injury and Violence Prevention team to increase awareness and educational opportunities for health care providers and other key partners on suicide risk during and after pregnancy. Furthermore, the revised Washington State Suicide Prevention Plan, scheduled for release in 2022, will include an appendix with information on suicide among this population.

Additional Work Supporting Women’s/Maternal Health
Maternal Mortality Review
Background
In March 2016 (amended in 2019), the legislature passed Engrossed Second Substitute Senate Bill 6534 (codified at RCW 70.54.450), creating the Maternal Mortality Review Panel to conduct multidisciplinary review of all maternal deaths in Washington. The law set out to identify factors associated with the deaths and make recommendations for system changes to improve women’s health care services in the state. The law requires a report outlining the findings of the review and panel recommendations to be submitted to the health care committees of the Washington State House of Representatives and Senate every three years.

The MMRP is a diverse and multidisciplinary group of over 70 people from around the state. This group includes

clinicians and non-clinicians, physicians, midwives, social workers, behavioral health experts, pathologists, prosecuting attorneys, advocates for people affected by domestic violence, doulas, community health workers, Indigenous representatives, patients, and patient advocates. With staffing and support provided by DOH, the MMRP reviews pregnancy-associated deaths (death of a woman during pregnancy or within the first 365 days after pregnancy from any cause), and distinguishes which deaths were pregnancy-related (the death occurred during the woman's pregnancy or within 365 days after the end of her pregnancy from a cause that was complicated by pregnancy, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiological effects of pregnancy) and which deaths are preventable. The MMRP then makes decisions on the factors that contributed to preventable deaths and what recommendations are needed to prevent them.

Report of Findings

In October 2019, we published the second report of findings and recommendations. The report included recommendations for improving health equity and reducing stigma and bias; supporting hospitals and providers to implement evidence-based and recommended quality improvement activities; improving postpartum care; and improving and increasing access to perinatal behavioral health care, treatment, support, resources, and knowledge for patients and providers.

Dissemination

We presented MMRP findings and recommendations to a variety of internal and external audiences, included county heath committees; perinatal providers and hospital groups; the WA State Action Alliance for Suicide Prevention; Tribal health leaders and other Indigenous groups; and members of the Washington State Hospital Association.

Tribal Collaboration

In December 2019, we presented the findings and recommendations from the 2019 report to the American Indian Health Commission. The commission works on behalf of 29 federally recognized tribes and two Urban Indian Health Organizations in Washington to improve health outcomes for American Indian and Alaska Native communities and people. After our presentation, we received invaluable feedback and realized there was an opportunity to collaborate with the commission on the maternal mortality review and reduction work. As a result, we have been working with the commission to coordinate a listening session to learn more about what tribal communities want us to know about maternal mortality in their community, and if and how they want to engage with the department and Perinatal Health unit in the maternal mortality review and reduction work. This listening session is being led by the commission. Perinatal staff will provide support and consultation as needed for planning and will attend the session, which will take place sometime in early 2022. We hope the session will result in a product or a plan to contribute information and recommendations to the next MMRP report, scheduled for release in early 2023.

Second-Generation MMRP

Publishing the second legislative report in October 2019 marked the end of the initial MMRP's service period. In January 2020, a new MMRP was established. This second-generation MMRP comprises over 70 clinical and non-clinical disciplines from all over Washington. In addition, the new panel includes more non-clinical members and more perinatal support providers, perinatal advocates, and patients or patient representatives.

Health Equity

We continued work to center health equity into our maternal mortality review process as well as the work we produce. To start, we developed a plan to provide health equity resources and training for the MMRP to apply not only during their role on the panel, but also in their own lives. We recruited more non-clinical members to join the MMRP, and also worked with our partners at the CDC to better identify evidence and incidences of discrimination, bias, and stigma during the maternal mortality review process. The MMRP implemented specific equity process improvements

through changes to the amount of time spent on each review, the role of experts in reviews, tools for engagement, and methods to evaluate and improve these processes continually. These changes included:

- Expanding the panel to include more members with expertise in health equity, including members with lived experience, community advocates, and peer birth workers.
- Ensuring lead panel members with relevant expertise pre-review cases. Each case has a lead reviewer focused on health equity.
- Ensuring panel members receive cases two weeks prior to review.
- Extending review time per case from 20 minutes to 60 minutes.
- Providing opportunity for members to ask questions prior to meetings.
- Fostering more robust conversations at the meeting to engage panel members and ensure sharing space and power. Remote meetings have supported this, using additional engagement tools such as chat boxes.
- Structuring discussions about equity to be more deliberate, such as asking specifically about discrimination and preventability from clinical and health equity perspectives.
- Paralleling these changes, the MMRP expanded its work to include cases related to domestic violence and intimate partner violence (DV, IPV), an intersectional equity issue. This included broadening the role of non-clinical experts by adding members with expertise on DV and IPV. Subject matter experts on health equity or violence prevention educate fellow panel members and take the lead on discussions relevant to their knowledge areas.

Expanded Scope of Review

In addition to adding review of deaths related to suicide and accidental overdose, we have continued expanding the scope of the review to now include deaths from homicide where domestic violence and/or behavioral health conditions were also involved, as well as deaths that occurred to Washington residents out of state. This expansion came following feedback from the MMRP and the CDC, as well as our partners and constituents. We now review all these maternal deaths to determine if they are pregnancy-related and preventable. We have been recruiting additional subject matter experts in the fields of domestic violence and law enforcement to assist us with the review of homicide deaths.

To date, the new MMRP has successfully reviewed maternal deaths from 2017 and 2020, and deaths that occurred out of state from 2014-2020. Our next report will be published in early 2023 and will include data on 2017-2020 maternal deaths, as well as information and recommendations related to COVID-19 impact on maternal deaths (based on the maternal mortality review findings).

Funding

Funding for basic infrastructure and staffing for the maternal mortality review and report was largely provided by state funding and MCHBG in 2020. In 2019, DOH was awarded $375,000 annually for five years as part of the CDC's Preventing Maternal Deaths Grant, Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM). These funds have been used to enhance the review process to identify deaths in a timelier way, and to increase activities around implementing the MMRP's recommendations as outlined in reports. These activities included hiring a program coordinator, prioritizing which recommendations to focus on for the next year, planning a stigma and bias training for perinatal care providers, and continuing work on a Centers of Excellence for Perinatal Substance Use certification program.

DOH manages contracts with four regional perinatal centers in Washington to coordinate and implement state and regional quality improvement projects to improve pregnancy and newborn outcomes.

WithinReach is a Maternal and Child Health Block Grant (MCHBG) contracted provider. This private, not-for-profit organization serves as our state's central access point to the many resources a family needs to be healthy. They connect Washington families to health and food resources; promote awareness and education about specific health issues; provide insurance information; and make connections in person, online, and over the phone. They provide eligibility screening and referrals to Medicaid; the Women, Infants and Children Nutrition Program (WIC); and other services. They offer referrals and health education information about pregnancy, prenatal care, maternity support, childbirth, immunizations, and family planning.

WithinReach's ParentHelp123.org resource website had 26,627 page views with 20,624 total unique page views in calendar year 2021.

WithinReach's Help Me Grow Washington (HMG-WA) Hotline is the state's maternal and child health hotline. During federal fiscal year (FFY) 2021, the hotline received and responded to 13,204 calls. Questions relating to food and nutrition resources generated the greatest number of inbound calls and resulted in 7,293 food assistance referrals and 6,383 referrals to WIC. Numerous additional referrals were made for pregnancy-related services and determinants of health, including 651 referrals for housing assistance calls and resulted in 7,293 food assistance referrals and 6,383 referrals to WIC. Numerous additional referrals were made for pregnancy-related services and determinants of health, including 651 referrals for housing assistance.

WithinReach provides health information in a variety of languages for people who are not proficient in English. During FFY 2021, the total number of HMG-WA hotline Spanish phone calls was 1,065. The hotline averaged 321 non-English calls per quarter. Nearly all of the call center staff are bilingual, and nearly 99 % of Spanish-language calls are completed without a third-person interpreter.

Led by perinatal contractors, the **obesity workgroup** met regularly with guidance from the Title V-supported Perinatal Nurse Consultant. The obesity workgroup developed guidelines and protocols for the care of pregnant women with a high body mass index (BMI). These can be found on the DOH Maternal Mortality website.

As part of quality improvement resulting from the MMRP recommendations, perinatal staff worked to have the state's maternal mortality law amended in 2019. The law now requires birthing hospitals and licensed birth facilities to report deaths that occur during pregnancy or within 42 days of the end of the pregnancy to the local county coroner or medical examiner's office. Upon reporting, county offices are required to conduct a death investigation, and autopsy is strongly recommended using the Guidelines for Maternal Death Autopsy as developed by the workgroup. The law went into effect on July 28, 2019. Perinatal staff continued to monitor the number of autopsies reported and performed as outlined by the law. In addition, in-service training sessions took place when requested by partners.

Additional Work Supporting Women's/Maternal Health at the Local Level

COVID-19 and Local Health Jurisdictions

Throughout this program year, the on-going COVID-19 pandemic continued to have significant impacts on our LHJ partners. Many LHJ staff members usually assigned to tasks associated with MCH funded activities were required to assist with the local response to the pandemic. This included staffing vaccination and testing sites, providing COVID-19 response support, and finding innovative ways to provide information and services to families while many were following the Stay Home, Stay Safe recommendations.

Unfortunately, although not uniquely, the pandemic increased staff turnover rates at LHJs. This created another challenge for LHJs in conducting MCH funded activities. Vacancies and a lack of staffed with the training to fill in, delayed some of the work. However, most LHJs did find creative ways to ensure that families continued to receive

vital services and supports throughout the program year.

Local Health Jurisdictions Women and Maternal Health Work

While all LHJs are doing work that impacts Women and Maternal Health, few have selected to work on strategies specifically listed in the Women/Maternal Health Domain. Work with breastfeeding/chestfeeding, including breastfeeding/chestfeeding coalitions, is listed in the Perinatal/Infant Health Domain. Breastfeeding/chestfeeding efforts includes collaborating with community resources to serve pregnant and post-partum people to increase capacity for and access to lactation support. Adverse Childhood Experiences work is another strategy that tends to interrelate with Women and Maternal Health, which is included in the Child Health Domain. The following examples articulate county efforts pertaining to the Women/Maternal Health Domain:

- **Snohomish -** Snohomish County is working on connecting community experts with county residents. In one example of Women/Maternal Health Domain efforts, they presented resilience strategies at a Total Wellness for the Latina Women group meeting, which is facilitated by the Latino Education Training Institute (LETI). The Resilience Workbook for Adults was translated into Spanish and shared with Liberty Elementary's Spanish Speaking Family Engagement Specialist, as well as attendees of the LETI presentation.

- **Spokane -** Spokane County has a Public Health Nurse who is continuing to co-facilitate the Birth Outcomes Taskforce. This taskforce focuses on collaboration to improve upstream interventions to reach healthier birth outcomes and promote racial equity in maternal health throughout Spokane. The group consists of hospital partners, subject matter experts, child welfare services, and primary care practitioners.

III.E.2.b.v.c. State Action Plan Narrative by Domain

Women and Maternal Domain Plan for FY2023

Priority:

Promote mental wellness and resilience through increased access to behavioral health and other support services.

State Performance Measures:

Substance use during pregnancy.
Provider screening of pregnant women for depression.

Objective:

By September 30th, 2023, and in partnership with the Child Welfare Division at the Department of Children, Youth, and Families, Within Reach and the Washington State Hospital Association, implement the state's new portal and policy for infants who are born substance exposed, including promotion of supports for the substance-affected mother/infant dyad.

Strategies:

Provide training for clinical staff providing care at birthing hospitals.

Support efforts to address and mitigate individual and community effects of substance use.

Improve the care of infants with neonatal abstinence syndrome (NAS) and neonatal opioid withdrawal syndrome (NOWS).

Build on efforts to identify scope of impacts of substance use, including inequities, at the local and state level.

Currently, Washington systems of care do not uniformly and equitably identify, and support mother/infant dyads affected by substance use. This includes a lack of streamlined child protective policies, resulting in disparities in which infants are reported to Child Protective Services (CPS) for intervention. Plans of safe care for infants and their birth parents are a requirement of federal CAPTA legislation and Washington is implementing a new online referral and notification portal to provide care coordination and wrap around services for these families.

DOH has been partnering with DCYF, Help Me Grow, and clinicians providing direct patient care to this population, to create clear definitions and processes in their policy.

Washington has created clear definitions and a notification pathway for infants who are born substance exposed but have no identified safety risks for the dyad. Additionally, there are clear definitions and a reporting pathway for dyads with identified safety risks. The services provided to infants/birth parents who meet the policy definitions for notification and wrap around services, are being provided by Within Reach which is an organization that is contracted and funded through DCYF but is not connected to CPS. The program is being piloted in a few different areas of the state with statewide implementation being planned for to begin later in 2022.

Objective:

By February 1, 2023, submit a revised maternal mortality review panel report to the Washington State Legislature, covering the deaths that occurred to women during pregnancy or within one year of pregnancy, inclusive of deaths

resulting from suicide, substance overdose, homicide, and deaths that occurred out of state, and covering data from 2014-2020. The report will include identification of gaps and issues contributing to preventable, pregnancy-related deaths in the maternal behavioral health system and recommendations for improvement. Recommendations will address disparities and health equity improvements to reduce maternal mortality and will include contributions from our tribal and Indigenous partners.

Strategies:
Support interventions to address suicide ideation among pregnant and parenting people.

Support efforts to address and mitigate individual and community effects of substance use.

Build on efforts to identify scope of impacts of substance use, including inequities at the local and state level.

Increase and improve reimbursement for behavioral health care from preconception through all phases of pregnancy and the first year postpartum, including screening, treatment, monitoring, and support services.

Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges.

Implement trauma-informed services into community services, health care systems, and the public sector.

Explore implementation of Maternal Levels of Care in Washington state.

In 2016, the Washington State Legislature (in RCW 70.54.450) mandated DOH to convene a multidisciplinary review panel to conduct comprehensive reviews of deaths that occur within a year of pregnancy, regardless of cause. The goal of the maternal mortality review is to understand the root cause of maternal mortality and morbidity, and the inequities therein, so the department and partners can identify and implement strategies and activities to prevent these tragic deaths and improve perinatal care for all people and families in the state. The panel includes clinical and non-clinical professionals from all over Washington state and from diverse racial/ethnic, geographic, and professional backgrounds. The panel also includes perinatal psychiatrists and addiction medicine providers, perinatal social workers, community organizations, patients, and patient advocates.

To meet these goals, the department and the panel, work to identify all deaths that occur within a year of pregnancy, determine which of those deaths are preventable pregnancy-related deaths, determine underlying causes of preventable deaths, and identify the issues and factors that contributed to them. The panel and the department use analyses of data and findings to make evidenced-based recommendations for health care and systems changes. The department submits recommendations to policymakers for consideration in a legislative report every three years and works with partners – including Health Care Authority (HCA), the Washington State Hospital Association, and the Washington State Perinatal Collaborative – to implement prioritized recommendations.

To date, the panel has reviewed maternal deaths from 2014-2020. This includes deaths from substance overdose, suicide, and domestic violence. The forthcoming report will include findings from deaths through 2020. The findings from the most recent report, published in 2019, include:

From 2014-2016, 100 people died within one year of pregnancy in Washington state; a quarter of these deaths were related to behavioral health conditions.

- 15 deaths were from accidental overdose: most related to opioid use.
- 13 deaths were from mental health conditions resulting in suicide.

- 11 of the deaths from behavioral health conditions were found by the panel to be directly related to pregnancy.
- Most people whose deaths were related to behavioral health conditions had Medicaid insurance coverage at the time of death.
- The majority of these deaths occurred six weeks to a year after the end of pregnancy; many occurred six months or more after pregnancy ended.
- Deaths from substance overdose affected a disproportionate number of people who were American Indian/Alaska Native.
- Most of these deaths impact people living in urban areas.

Some of the factors identified by the Maternal Mortality Review Panel (MMRP) to have contributed to preventable deaths from behavioral health conditions included:

- Gaps in knowledge among patients and their families about behavioral health conditions and care during pregnancy, and the resources that are available.
- Gaps in clinical skill and quality of care among perinatal providers and facilities about screening, assessment, management, and resources for behavioral health conditions that result in suicide and substance overdose.
- Lack of access to behavioral health care and services–including inpatient and outpatient services that accommodate people with children–throughout Washington state, including in urban areas.
- Persistent stigma and bias among patients, families, providers, and communities about behavioral health conditions and care during pregnancy.
- Lack of universal support structures (like home visiting and doulas) and care coordination (like perinatal patient navigators and community health workers) for parents and families who struggle with behavioral health conditions during pregnancy.

Work has already begun to implement recommendations based on these findings; however, there is still more to be done. The panel found that at least 60% of pregnancy-related deaths in 2014-2016 were preventable, and that most of the preventable factors occurred at the systems level. Additionally, more information is needed to understand the nature of racial/ethnic, geographic, and economic disparities in maternal mortality. To continue efforts to understand the root causes of maternal deaths from behavioral health conditions and determine where interventions are needed most, it is essential to continue to conduct comprehensive maternal mortality reviews of these types of deaths.

In the next year, the MMRP will continue to center health equity in the maternal mortality review process and work. Some of the strategies we will implement over the next year include:

- Prioritize health equity expertise and lived experience, along with other expertise areas and affiliations, as we recruit for new members of the MMRP as part of our empanelment process every three years.
- Provide access to health equity learning and other education opportunities for the MMRP.
- Work with the CDC to align practices of identifying discrimination, racism, bias, and stigma in the deaths we review so we can make recommendations for change using data from the maternal mortality review work. This includes participating in monthly workgroups/meetings, and collaboration with other states on successful strategies and practices that meet these goals.
- Work with the health equity and social justice experts on the MMRP to help us better identify evidence in the information we review and present it to the MMRP so they can make informed decisions.
- Consult with agency health equity experts to create a more formal health equity training/learning plan for all of the MMRP.
- Move forward with and support the listening sessions with the American Indian Health Commission (AIHC) and hope to learn more about how to better collaborate with these partners. DOH will ensure that the

recommendations developed by the AIHC are included as an appendix in the next report and that other recommendations included in the report reflect input from the AIHC as well as feedback gathered from other partners in the state.

Following the report's release in early 2023, DOH staff will share the findings widely with partners and community members around the state. DOH will also include applying lessons learned from the AIHC listening sessions in work to implement the report's recommendations.

Plan to review the CDC LOCATe℠ (Levels of Care Assessment Tool℠) survey results for Washington birthing hospitals with a committee representing people interested in Maternal Levels of Care as well as Neonatal Levels of Care. The committee will make decisions for Washington state regarding next steps for Maternal Levels of Care. DOH already has an established certificate of need for Neonatal Levels of Care.

Objective:
By March 31, 2026, ensure 80% of birthing hospitals in Washington state have established processes to universally screen everyone giving birth for substance use disorders and perinatal mood and anxiety disorders as part of the Alliance for Innovation on Maternal Health (AIM) patient safety maternal mental health protocols.

Strategies:
Promote standardized depression, anxiety, and substance use screening across the life course.

Promote verbal screening for substance use for every person giving birth, using validated tools.

Improve the care of infants with neonatal abstinence syndrome (NAS) and neonatal opioid withdrawal syndrome (NOWS).

Support interventions to address suicide ideation among pregnant and parenting people.

Maternal morbidity and mortality rates have been on the rise in the United States for the past 40 years, with marked disparities in the rates for women of color, women from low-income backgrounds, and women from rural areas.[1],[2] It is estimated that for every maternal death, 50 or more women are affected by severe maternal morbidities each year, nationally.[3] The CDC estimates that one in eight women experience a depressive episode after pregnancy.[4] Untreated maternal depression or other more extreme mood disorders can lead to significant morbidity, and in extreme situations, maternal suicide and infanticide.

In Washington state, all maternal deaths are reviewed by a panel of clinical and nonclinical perinatal experts and assessed for cause of death and underlying contributing factors. The panel found that in review of maternal deaths from 2014-2016, at least 60% of pregnancy-related deaths were preventable, and that the leading causes of pregnancy-related deaths were associated with behavioral health conditions, including suicide and accidental overdose. According to our Pregnancy Risk Assessment Monitoring System (PRAMS) data, in 2018, 11 percent of women interviewed expressed experiencing postpartum depression symptoms.

DOH has partnered with Washington State Hospital Association (WSHA) to join the Alliance for Innovation on Maternal Health (AIM), which is a national organization run in partnership with the American College of Obstetricians and Gynecologists (ACOG) to improve maternal outcomes through the implementation of hospital-wide quality improvement protocols called "safety bundles." In the next five years, MCHBG-funded staff will collaborate with WSHA to roll out the Maternal Substance Use safety bundle. In alliance with recommendations from the American

Academy of Pediatrics, ACOG, and the United States Preventive Services Task Force, the bundle promotes routine and standardized screening of pregnant and postpartum women for substance use. Recommendations include mother/birth parent and infant rooming in together and non-pharmacologic interventions as first-line treatment for signs and symptoms of withdrawal in the infant. The bundle is being piloted by 13 birthing hospitals during 2021 and a second cohort of hospitals will begin implementing the bundle beginning January of 2022. We are also looking at the feasibility of beginning implementation of the Maternal Mental Health: Depression and Anxiety bundle before March 2026.

To support the implementation of the Maternal Substance Use safety bundle, DOH, HCA, and WSHA will promote the Centers of Excellence for Perinatal Substance Use certificate program. This program will certify birthing hospitals that meet a specific set of criteria for care of people giving birth with a substance use disorder. These criteria will include verbally screening every person giving birth for substance use disorders and perinatal mood and anxiety disorders, as well as implementation of hospital policies and support for pregnant and parenting individuals who screen positive for a substance use disorder. Additionally, WSHA and DOH launched a Perinatal Substance Use Learning Collaborative that offers monthly learning sessions and a toolkit of resources to support hospitals in implementing bundle components and become a Center of Excellence for Perinatal Substance Use.

Priority:
Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.

National Performance Measure:
Percent of women, ages 18 through 44, with a preventive medical visit in the past year.

Objective:
By Sept 2023, maintain communications and guidance documents for COVID and pregnancy/birth/postpartum/children to reflect up-to-date COVID data and understanding, to include racial disparity considerations.

Strategies:
Integrate MCH COVID communications into the DOH COVID team communications and maintain current guidance documents and communications.

Support the "One Vax Two Lives" campaign to dispel misinformation, and address fears some expecting families may have about COVID vaccines. This campaign is a partnership with The University of Washington's Center for an Informed Public and the UW Medicine's Department of OB-GYN.

Support access to and communication clarity around emerging guidance for COVID-19 vaccination during pregnancy and lactation.

The next maternal mortality review report scheduled for release in early 2023 will include data and findings from reviews of deaths that occurred within a year of pregnancy in 2020. We anticipate 2020 deaths will include some related to COVID-19, either directly or indirectly, and as such, we anticipate related recommendations COVID-19 around vaccine and pregnancy.

Objective:
By December 2022, distribute health promotion materials in relation to Senate Bill 6128 passed by the Washington State Legislature to expand Medicaid coverage to one year postpartum.

Strategies:
Support women during the "fourth trimester"; enhance postpartum care to allow providers to check in with mothers about their mental health and other medical issues.

Promote standardized depression, anxiety, and substance use screening across the life course.

Address the need for more services, support, providers, and insurance coverage, particularly in rural communities and remote areas.

Staff will collaborate with HCA to conduct outreach through local health jurisdictions (LHJs) regarding Medicaid expansion to 1 year postpartum. This will include presentations and materials distribution at the Washington Public Health Association conference and through routine LHJ and Accountable Community of Health collaborative meetings.

Objective:
By September 2023, collaborate with community birth experts from the doula, home visiting, nursing and community health worker workforce, to identify a process for birth equity priorities and funds distribution and program development in line with anti-racist values.

Strategies:
Support active engagement by birthing hospitals, licensed birth centers, and perinatal providers in quality improvement efforts that reduce the leading causes of maternal mortality and morbidity.

Support healthy pregnancies, births, and maternal recovery; address inequities and prevent maternal mortality and morbidity.

Support women during the "fourth trimester"; enhance postpartum care to allow providers to check in with mothers about their mental health and other medical issues.

To address disparities in birth outcomes among communities of color, particularly the Black and African American community, DOH has committed to creating space to learn from community perinatal and birth leaders about their equity priorities to help inform ongoing funding and program areas of focus.

As part of these community engagement efforts, DOH developed a survey for people serving birthing families, primarily Black and African American birthing families. The purpose of the survey was to gather feedback on how best to distribute the remaining birth equity project funds (which will be focused on Black and African American birthing families of greater King County), explore development of a community advisory committee, and discuss best practices for recognizing community-rooted organizations and programs. There were 51 unique respondents to the survey, with the majority of respondents representing King, Pierce, and Snohomish counties. DOH staff hosted two virtual community meetings to share key themes from the survey and discuss next steps.

Key themes of survey feedback regarding potential community advisory committee formation included:

- Strong support for the development of a community advisory committee that will guide the allocation of the remaining birth equity project funds and share expertise with DOH.

- The importance of including birth workers, doulas, and other people who work closely with the community on the community advisory committee. These committee members can share community concerns and insights about the impact of programs and policies.
- Investing time in the community advisory committee and grantee selection to get the process and the outcome right.

Guidance about best practices when recognizing community-rooted organizations and programs included:

> "A community led program is a program where the leaders have shared the same experiences as those they serve. They then take those experiences and use them as a driving force to improve the community."

DOH can better engage with community by asking the community what they want, what has and hasn't worked in the past, what they view as barriers to successful, culturally relevant programs in their community, and how sustainability can be created or ensured.

> "Ask community members. Not just the ones that seem to be in spokesperson positions, not just the most adept at navigating DOH culture, not just the code-shifters. Ask the broadest range of community members possible. Meet them where they are, support their needs in participating in meetings, and listen."

DOH should ask applicants "What proportion of your membership/leadership reflects the communities we are focused on? What proportion of your membership/leadership includes birth workers who are members of those communities? What work have you been doing to increase/expand equity in birthing experiences?"

Based on this feedback, DOH has partnered with two facilitators to conduct ongoing community engagement around birth equity in Washington state. These two facilitators represent and are rooted in the Black/African American, Pacific Islander, and Indigenous community. Their work will include key informant interviews and listening session around the state. A community advisory committee is also in development and will continue to provide insight into birth equity work during this time period. During this reporting period, the findings from this work will be used to adapt programing and continue to shift the power of decision making to those impacted by programs and health disparities.

DOH will also be launching a new Birth Equity RFA in 2022, with new projects starting in early 2023. These projects will be informed by the community facilitator's findings as well as guidance from the community advisory group. Funded projects are expected to serve the Black/African American, Pacific Islander, and Indigenous community and other communities as funding allows.

Once a cohort of birth equity project partners have been selected, they will work with DOH contract staff to develop scopes of work, implement their projects, and connect with the other grantees to ensure partnership and shared learning between organizations.

Objective:
By September 30, 2022, create training opportunities for perinatal care providers on mood disorders and suicide risk during and after pregnancy, and determine feasibility of modifying existing legislation requiring mandatory provider suicide training to include content on maternal suicide, risk factors, and interventions.

Strategies:
Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges.

Implement trauma-informed services into community services, health care systems, and the public sector.

Promote standardized depression, anxiety, and substance use screening across the life course.

In the most recently published report on maternal deaths from 2014-2016, the Maternal Mortality Review Panel found that 30% of pregnancy-related deaths were caused by behavioral health conditions resulting in suicide. The majority of these deaths occurred in urban areas, and most of these women had Medicaid health insurance coverage. The panel identified a number of gaps in the perinatal health and service system that contributed to these deaths, including lack of knowledge among perinatal health care and service providers around screening, assessment, and management of suicide during pregnancy and through the first year; lack of knowledge of postpartum mood disorders and the treatment and resources that are available; and lack of access to inpatient and outpatient services when they were needed most.

To increase awareness and knowledge of suicide risk and pregnancy, DOH explored the feasibility of amending the law that outlines suicide training requirements for health care professionals in the state, RCW 43.70.442. There are significant barriers that made this amendment unfeasible. The minimum standards are general at this time, and this amendment would open the door for a change in the scope of the standards towards more specialized standards. Furthermore, it could take years to progress and have minimal impact on reach of training materials. However, we developed a collaborative partnership with the DOH Injury and Violence Prevention team to increase awareness and educational opportunities for health care providers and other key partners on suicide risk during and after pregnancy. Planned activities include presentations to behavioral health groups, resources included in the injury prevention listserv, and sharing of data between the MMRP and Injury Prevention units.

DOH staff are pursuing various methods of creating and distributing training opportunities on perinatal mental health to the Washington provider community.

In spring 2021, DOH released a request for applications to fund projects that meet the MMRP's recommendation to "increase knowledge and skill of providers, patients, and families about behavioral health conditions during and after pregnancy, and the treatment and resources that are available for support." These projects aim to support maternal Medication Assisted Treatment (MAT) programs; increase perinatal peer support groups and services; and offer provider trainings to improve skill in addressing perinatal behavioral health.

DOH will also partner with the University of Washington to develop a program to train and support members of primary care clinics to address perinatal suicide risk. Aspects of this suicide risk reduction care include screening for suicide risk (including identifying risk factors and the use of screening tools), evaluating the severity of any identified risk, preparing a risk mitigation plan, and initiating a team-based care approach within the care setting or in conjunction with community resources to address this risk.

The Perinatal Health unit will continue to partner with the DOH Injury and Violence Prevention unit to promote training opportunities and data regarding suicide in the pregnant and parenting population to the behavioral health community. Furthermore, the revised Washington State Suicide Prevention Plan, scheduled for release by the end of 2022, will include an appendix with information on suicide among the pregnant and parenting population. This partnership provides new audiences and venues to disperse findings from the Maternal Mortality Review Report, as well as partnerships in the behavioral health field.

Objective:

By December 2022, collaborate with tribal partners to hold a listening session that includes plans to better

understand maternal mortality in tribal and Indigenous communities, and content to be included in the next Maternal Mortality Review Panel report that includes recommendations centered on the tribal context, with added consideration of unique challenges and opportunities of tribal members and nations in relation to quality improvement.

Strategies:
Support interventions to address suicide ideation among pregnant and parenting people.

Support efforts to address and mitigate individual and community effects of substance use.

Promote standardized depression, anxiety and substance use screening across the life course.

Build on efforts to identify scope of impacts of substance use, including inequities at the local and state levels.

Increase and improve reimbursement for behavioral health care from preconception through all phases of pregnancy and the first year postpartum, including screening, treatment, monitoring, and support services.

Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges.

Implement trauma-informed services into community services, health care systems, and the public sector.

The MMRP includes clinical and nonclinical professionals from all over Washington state and from diverse racial/ethnic, geographic, and professional backgrounds. To reaffirm our state's commitment to improving systems that serve families to be more equitable, the maternal mortality review law now ensures the panel will always include people who are American Indian/Alaska Native and people who serve tribal and urban Indian communities in the state. These members do not need to apply and there is never a capacity on the number of members to represent these communities.

Representatives from tribal and urban Indian communities have participated in the maternal mortality review proceedings since 2017, and contributed to the report published by DOH in 2019 outlining data and findings on maternal deaths from 2014-2016, including total counts of pregnancy related deaths, causes of death, and demographic descriptions.

Data analyses of the three years indicate American Indian/Alaska Native women had the highest maternal mortality rate of all racial/ethnic groups in 2014-2016. These data, combined with gaps in care and services identified by the panel, as well as history of medical care and treatment of American Indian/Alaska Native people throughout the country, indicate a persistent and historically rooted disparity that has impacted these communities for over a hundred years. To understand the nature and root causes of this and other disparities, DOH and the MMRP will continue to review maternal deaths in the state, as well as identify strategies to better collaborate with tribal and Indigenous partners to reduce maternal mortality in those communities.

DOH is committed to working with tribal and urban Indian partners to begin learning how to improve collaborative relationships in public health care systems, so all communities can thrive and achieve their highest level of health and well-being. In December 2019, the American Indian Health Commission (AIHC)'s representative on the MMRP invited DOH staff to present data and findings from the report released that same year. After the presentation concluded, members of the Commission provided invaluable feedback and posed a number of relevant and challenging questions. In response to the commission (and to feedback from American Indian/Alaska Native

representatives on the panel), DOH has been collaborating with the commission to fund and coordinate one or more listening sessions. The purpose is to learn more about maternal mortality in tribal/Indigenous communities and how these communities want to engage with panel efforts to reduce maternal mortality; identify opportunities for creating additional tribal/Indigenous-led MMRP recommendations and quality improvement activities centered on the tribal context; and outline next steps. Planning for the listening session will take place over the rest of 2021, with the actual listening session(s) scheduled to occur sometime in 2022.

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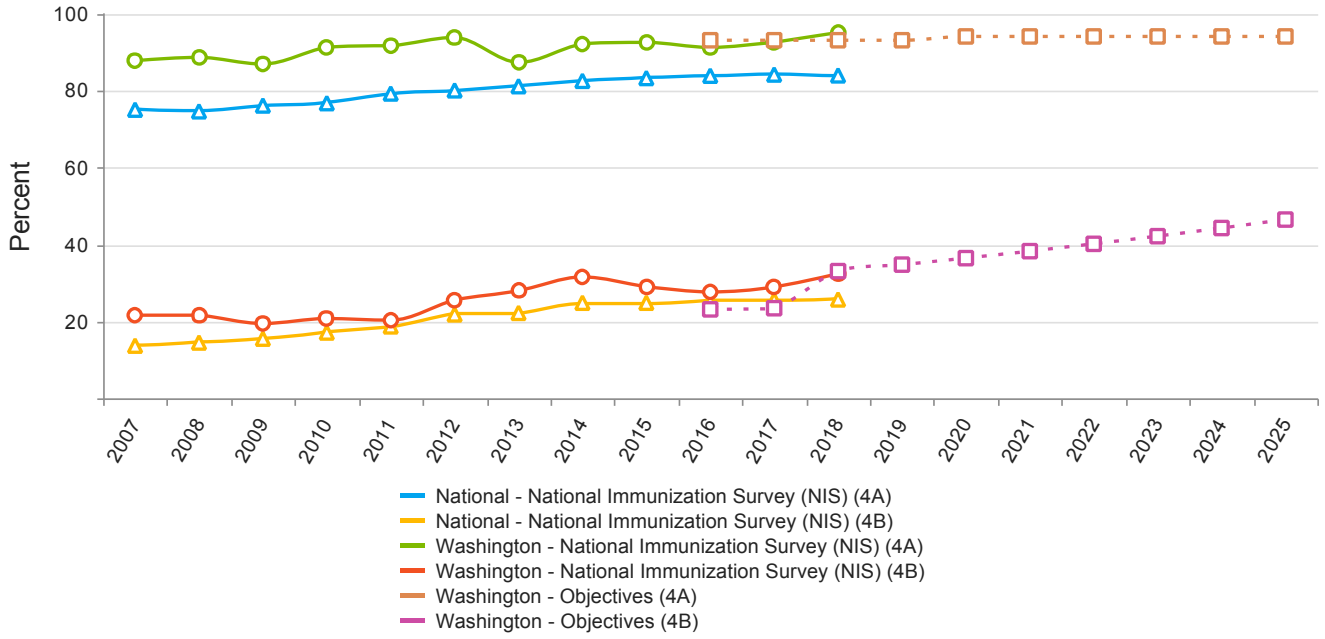
[3] Callaghan, W. M., MacKay, A. P., & Berg, C. J. (2008). Identification of severe maternal morbidity during delivery hospitalizations, United States, 1991-2003. *American Journal of Obstetrics and Gynecology*, *199*(2), 133. Found at https://www.sciencedirect.com/science/article/abs/pii/S0002937807023320

[4] Centers for Disease Control (2020). Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression – United States, 2018. *Morbidity and Mortality Weekly Report, May 15, 2020/69(19);*575-581. Found at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919a2.htm?s_cid=mm6919a2_w

Perinatal/Infant Health

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	93	93	93	94	94
Annual Indicator	92.1	92.4	91.0	92.5	95.1
Numerator	81,019	80,672	71,525	75,591	76,014
Denominator	87,977	87,274	78,591	81,714	79,899
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	93	93	93	94	94
Annual Indicator	94.5	94.2	94.1	94.1	
Numerator	81,550	80,140	79,016	79,016	
Denominator	86,284	85,113	83,941	83,941	
Data Source	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate	
Data Source Year	2017	2018	2019	2019	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	94.0	94.0	94.0	94.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	23.5	33.1	34.8	36.5	38.3
Annual Indicator	31.6	29.1	27.6	28.9	32.3
Numerator	27,184	24,761	20,413	23,021	24,865
Denominator	86,004	84,974	74,010	79,683	76,973
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	40.2	42.2	44.3	46.5

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percentage of eligible facilities certified "Breastfeeding Friendly Washington" by Department of Health

Measure Status:	Inactive - Intervention measured in this ESM is being phased-out by hospitals in favor of a different breastfeeding promotion intervention.

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	26	46.1	57	58	60
Annual Indicator	43.4	55.3	57.9	59.2	22.4
Numerator	33	42	44	45	17
Denominator	76	76	76	76	76
Data Source	DOH	DOH	DOH	DOH	DOH
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

ESM 4.2 - Percentage of births taking place in facilities certified as Breastfeeding Friendly by Department of Health

Measure Status:	Inactive - Intervention measured by this ESM is being phased-out by participating facilities and replaced with a different breastfeeding promotion intervention.

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	59.2	
Numerator	50,259	
Denominator	84,918	
Data Source	WA Birth Certificate	
Data Source Year	2019	
Provisional or Final ?	Final	

ESM 4.3 - Percentage of births taking place in facilities certified as compliant with LIFE by Washington State Department of Health.

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	1.0	1.0	1.0

State Performance Measures

SPM 3 - Universal developmental screening system participation

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	0.0	0.0	0.0	0.0

State Action Plan Table

State Action Plan Table (Washington) - Perinatal/Infant Health - Entry 1
Priority Need
Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.
NPM
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Objectives
Annually, partner with at least eight local health jurisdictions to offer perinatal home visitation services to low income women in local communities, supporting well-newborn visits, on-schedule vaccination, and breastfeeding initiation/sustenance.
Continue to promote awareness and training opportunities to health care providers on provider bias and disparities on an ongoing basis.
By September 20, 2023, in partnership with Child Protective Services at the Department of Children, Youth, and Families and Help Me Grow, finalize piloting the diagnostic definition for neonatal abstinence syndrome as a central component to improve care of substance-affected newborns in Yakima and Pierce counties.
By December 31, 2023, complete the development of a new data system for the Birth Defects Surveillance System (BDSS), which will combine birth defects reporting data from providers and facilities with existing information from vital statistics, including birth, death, fetal death, and hospital discharge data.

Strategies
Promote breastfeeding and lactation support programs and services.
Promote home visiting to provide support to families where they are.
Implement trauma-informed services into community services, health care systems, and the public sector.
Implement and promote fatherhood inclusion opportunities and support resources.
Support active engagement by birthing hospitals, licensed birth centers, and perinatal providers in quality improvement efforts that reduce the leading causes of maternal mortality and morbidity.
Support healthy pregnancies, births, and maternal recovery; address inequities and prevent maternal mortality and morbidity.
In collaboration with internal and external partners, provide health equity learning and education opportunities, including implicit and explicit bias and antiracism trainings, for perinatal health providers across Washington state and members of the Maternal Mortality Review Panel.
Provide training for birthing hospital clinical staff about the policy definitions for infants exposed to substances and the online referral process for notification and wrap around services.
Integrate motivation interviewing and reflective listening training into hospital trainings to facilitate trauma-informed communication about notification and reporting requirements.
Promote and facilitate education for health care professionals and systems regarding stigma, cultural sensitivity, and implicit bias in perinatal health care systems.
Identify and develop methods to monitor systems and data gaps and improvements needed.
Develop monitoring systems to identify leading causes of infant mortality/morbidity.

ESMs	Status
ESM 4.1 - Percentage of eligible facilities certified “Breastfeeding Friendly Washington” by Department of Health	Inactive
ESM 4.2 - Percentage of births taking place in facilities certified as Breastfeeding Friendly by Department of Health	Inactive
ESM 4.3 - Percentage of births taking place in facilities certified as compliant with LIFE by Washington State Department of Health.	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Washington) - Perinatal/Infant Health - Entry 2

Priority Need

Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course.

SPM

SPM 3 - Universal developmental screening system participation

Objectives

By September 30, 2023, support infant vaccinations as outlined by the CDC, and continue COVID-19 vaccination campaign efforts for pregnant people through providers, managed care organizations, pharmacies, and local health jurisdictions.

By June 30, 2023, secure funding through 2023 legislative session to fully support the EHDDI program's data system, referral services, and outreach activities to ensure quality, family-centered newborn hearing screening, diagnostic, and early support services are provided in Washington.

.By December 31, 2022, complete a statewide gap analysis for perinatal substance use services, and align this analysis with county-level maternal and infant data.

By February 1, 2023, launch statewide roll-out of implementation phase of new developmental screening program, working with early childhood partners as part of a statewide effort to increase developmental screening rates and connection to responsive services.

Strategies

Support the "One Vax Two Lives" campaign to dispel misinformation, and address fears some expecting families may have about COVID vaccines. This campaign is a partnership with The University of Washington's Center for an Informed Public and the UW Medicine's Department of OB-GYN.

Support access to and communication clarity around emerging guidance for COVID-19 vaccination during pregnancy and lactation.

Collaborate with Office of Immunization on infant vaccine promotional messaging to providers and families.

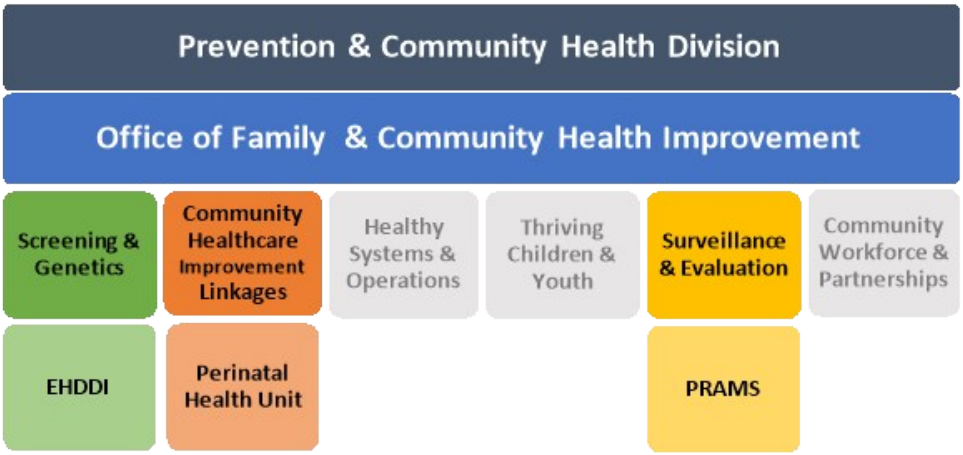
Support and promote bidirectional referral and linkage systems at the local, regional, and statewide levels.

Identify and develop methods to monitor systems and data gaps and improvements needed in preventive care, early screening, and referral.

Engage partners and stakeholders, including those in historically marginalized communities, to promote the value of universal developmental screening and use of the data system. Provide training and technical support to data system end users. Conduct data analysis and generate reports to inform decision-making and program planning.

Identify existing disparities and work with historically marginalized communities to develop tailored outreach and education.

III.E.2.b.v.c. State Action Plan Narrative by Domain



Perinatal and Infant Health Domain Annual Report

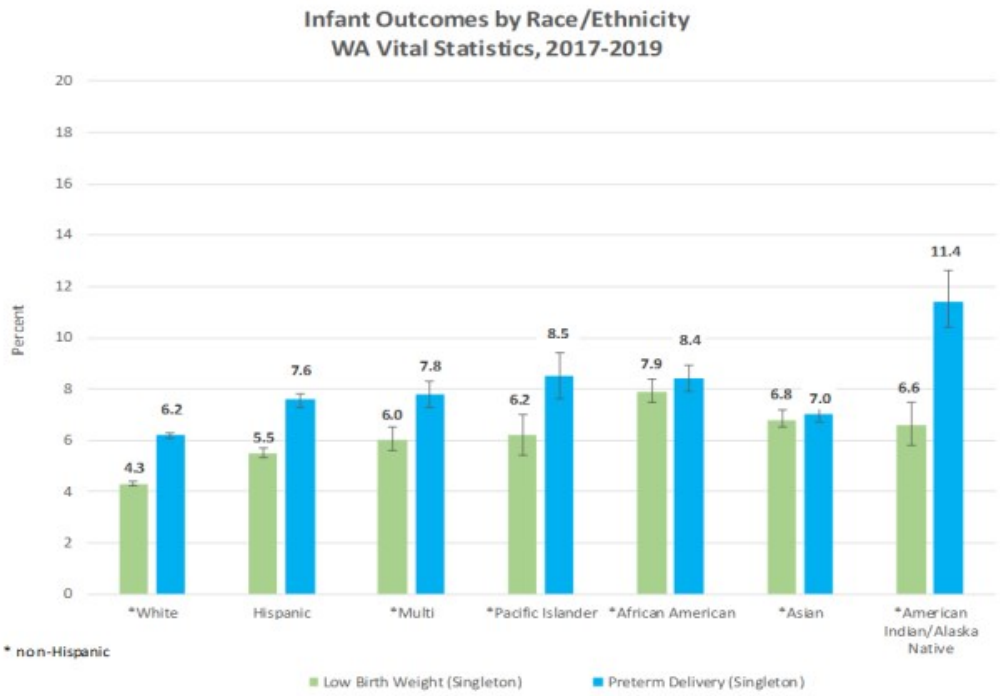
Overview

The Perinatal Health unit at the Department of Health (DOH) resides in the Community Health Improvement Linkages section of the Office of Family and Community Health Improvement in the Division of Prevention and Community Health.

In 2020, there were 82,483 births in Washington. Births have declined each year since a historic peak in 2016 of 90,489. In 2019, 58% of births were to white, 19% to Hispanic, 11% to Asian, 5% to Black or African American, 1% to American Indian/Alaska Native, 1% to Native Hawaiian or other Pacific Islander, and 5% to multiracial mothers. Births have become more racially diverse over the past 10 years, decreasing among white and American Indian/Alaska Native, while increasing among Asian, Black or African American, and multiracial populations.

While birth outcomes are generally favorable in Washington, persistent disparities continue to disproportionately impact some populations, including Black, Indigenous, and people of color (BIPOC).

Incidences of low birth weight and preterm births were analyzed using a 3-year roll up to create a more stable estimate of these indicators for infant and perinatal health. Low birth weight among singleton births was higher among Black and African American (7.9%), Asian (6.8%), and American Indian/Alaska Native (6.8%) births, and lower among Native Hawaiian, Pacific Islander (6.2%), multiracial (6.0%), Hispanic (5.5%) and white (4.3%) births. Pre-term births were more common among American Indian/Alaska Native (11.4%), Pacific Islander (8.5%), and Black or African American (8.4%) births, and less common among multiracial (7.8%), Hispanic (7.6%), Asian (7.0%), and white (6.2%) births (see figure below).



The most recent infant mortality data, from 2018, align with disparities seen in other birth outcomes. Infant mortality (infant deaths per 1,000 livebirths) was higher among Black or African American (9.7), Native Hawaiian, Pacific Islander (7.6) and American Indian/Alaska Native (6.7) infants, and lower among Hispanic (4.9), white (3.8), and Asian (3.3) infants.

Breast/chestfeeding initiation rates by Medicaid coverage status have equalized while rates for continuation of breast/chestfeeding remain distinct between groups. Most parents initiated lactation, with 97% of non-Medicaid and 96% of Medicaid-covered parents reporting having initiated breastfeeding in 2020. At the time of the PRAMS survey (2-4 months postpartum), a disparity had developed with 87% of non-Medicaid and 78% among Medicaid-covered parents reporting breast/chestfeeding their infants. These rates were similar among all racial/ethnic groups, for both initiation and duration. Overall rates for initiation and breast/chestfeeding at 2-4 months have remained relatively steady since 2010 (Pregnancy Risk Assessment Monitoring System [PRAMS]).

In 2019, 89% of non-Medicaid-covered mothers reported placing infants on their back to sleep (the preferred method for minimizing risk of sudden unexpected infant death [SUID]), compared with 76% of Medicaid-covered mothers. Infant sleeping on stomach, a known risk factor, was only reported by 3% of Medicaid-covered and 4 percent of non-Medicaid-covered mothers.

The overall SUID death rate per 1,000 infants declined 12 percent (0.8 to 0.7) from 2010 to 2019 and was lower than the 2019 national rate of 0.9. Using a 5-year roll up from 2015 to 2019, the SUID rate per 1,000 infants was highest among American Indian/Alaska Native (2.8), Native Hawaiian or Pacific Islander (2.7), and Black or African American (1.1) infants, and lowest among Asian infants (0.2).

The Perinatal Health unit offers resources and technical assistance to parents, childcare, foster care, group care, juvenile and correctional institutions, community action groups, and others on how to prepare and keep infants safe and healthy. We work with many organizations to promote health care standards associated with infants and pregnant women.

The DOH Screening and Genetics Section contains three programs that are relevant to infant and perinatal health. The Early Hearing Detection, Diagnosis and Intervention (EHDDI) program ensures that infants who are deaf or hard of hearing are identified and enrolled in early support services as early as possible. The Genetic Services program promotes the early identification of individuals with, or at risk of, genetic disorders or birth defects, and help connect people with the health and social services resources they need. And finally, the Universal Developmental Screening (UDS) program is home to Washington state's Strong Start UDS system, which is a secure web application where parents and providers can track their children's developmental screenings.

In 2020, 98% of Washington-born infants received their newborn hearing screening. However, some challenges remain, including ensuring screening for infants born out-of-hospital. The EHDDI program increased the percentage of out-of-hospital births who received a hearing screening from 17% in 2011 to 68% in 2020 through providing hearing screening equipment and training to midwives. In partnership with pediatric audiologists, we were also able to decrease the percentage of infants who did not receive a needed comprehensive diagnostic evaluation from 24% in 2011 to 6% in 2020. However, challenges still exist in the Washington state EHDDI system. In 2020, only 54% of infants identified as deaf or hard of hearing were identified by three months of age, as is nationally recommended. Too many infants do not receive timely diagnostic evaluations and the COVID-19 pandemic created further challenges for families needing EHDDI services.

Pregnancy Risk Assessment Monitoring Systems (PRAMS) is a survey conducted by DOH's Surveillance and Evaluation section and the Centers for Disease Control and Prevention (CDC), which gathers information from new mothers about their experiences before, during, and after their most recent pregnancy.

National Performance Measure 4 - Breastfeeding
Percent of infants who are ever breastfed.
Percent of infants breastfed exclusively through 6 months.

According to the 2020 CDC Breastfeeding Report Card, the percentage of infants born in 2017 who were ever breastfed was 92.5%, an increase from 87% in 2013 before the Breastfeeding Friendly Washington program launched. The percentage of infants who were exclusively breastfed through 6 months was 28.9%, compared to 28% in 2013. These rates are above the national average. DOH updated its state report on post-partum breastfeeding in 2017, which addresses overall breastfeeding rates as well as rates for specific populations, including those receiving Medicaid benefits, racial/ethnic populations, and by maternal age.

Hospitals play an important role in supporting breastfeeding. The Baby-Friendly® Hospital Initiative is an international designation program developed by the World Health Organization and the United Nations Children Fund and implemented by Baby-Friendly USA. DOH recognized that becoming a Baby-Friendly designated hospital may be challenging administratively and financially for facilities. Therefore, we designed the Breastfeeding Friendly Washington initiative to promote and support breastfeeding in our state, even for hospitals that have financial barriers to becoming Baby-Friendly, as our program requires no fees.

In late 2015, DOH launched the recognition program for hospitals; in early 2016, we launched the same program for free-standing birth centers, and in 2017 we launched a clinic program for all health care facilities that serve pregnant and breastfeeding parents or breastfed babies and children. This program is coordinated by our Breastfeeding Coordinator.

Our evidence-based strategy measure (ESM) is the percentage of eligible hospitals and birthing centers certified "Breastfeeding Friendly Washington" by DOH. There are 75 total eligible birthing facilities (57 civilian birthing

hospitals plus 18 outpatient birth centers) in the state. We now have 37 hospitals certified, and eight free-standing midwife operated birth centers, for a total of 45 birthing facilities across the state. Our percentage of eligible birthing facilities now certified is 60%, exceeding our ESM goal. In addition to these birthing facilities, 11 clinics are Breastfeeding Friendly Washington sites. DOH uses social media and other means to recognize and celebrate Breastfeeding Friendly sites.

The Breastfeeding Coordinator, along with the interagency DOH Breastfeeding Workgroup, coordinates activities around breastfeeding. The workgroup includes representatives from the American Indian Health Commission (AIHC); the Breastfeeding Coalition of Washington and local breastfeeding coalitions; Women, Infants, and Children Nutrition Program (WIC); and Title V staff, including the Perinatal/Infant Nurse Consultant. Partners including the American College of Obstetricians and Gynecologists, the Childhood Obesity Prevention Coalition, Mahogany Moms Community Coalition, Midwives Association of Washington State, Washington Chapter of the American Academy of Pediatrics, Washington Chapter of the American Academy of Family Practice Physicians, Washington State Hospital Association, and Washington State Perinatal Collaborative also take part in meetings as appropriate.

The Breastfeeding/Chestfeeding Coordinator:

- Coordinates breastfeeding/chestfeeding messages and educational resources across programs within DOH.
- Reviews applications and modifies the Breastfeeding Friendly Washington program together with the DOH Breastfeeding/Chestfeeding Workgroup.
- Maximizes opportunities for cross-program collaboration across various sectors.
- Provides leadership and technical assistance to DOH, other state agencies, and the public in the area of breastfeeding promotion, support, and health equity.
- Uses evidence-based interventions to achieve Healthy People 2030 breastfeeding/chestfeeding objectives.

- Maintains up-to-date work plans that reflect current best practices and research in lactation promotion and support.
- Provides worksite support and technical assistance for Executive Order 13-06, which is mandated for all state executive agencies. Part 1.b. of this order mandates conditions and facilities to provide for breastfeeding wellness needs.

Our Children and Youth with Special Health Care Needs (CYSHCN) program continued contract activities to promote and support breastfeeding with CYSHCN nutritionists, and the development of feeding teams working with families with infants experiencing feeding difficulties.

The Child Profile Health Promotion System continued to include breastfeeding information in mailings to families with young children in its regular mailings to parents. These mailings include a wide variety of information for new parents. Local WIC agencies continued to provide breastfeeding education and support. Maternity Support Services (MSS) continued breastfeeding messaging and support. Title V staff also continued to disseminate information to the public on the importance of breastfeeding, including through the use of social media and our website.

Objective:
By December 31, 2021, complete the development of a new data system for the Birth Defects Surveillance System (BDSS), which will combine birth defects reporting data from providers and facilities with existing information from vital statistics, including birth, death, fetal death, and hospital discharge data.

Throughout 2020 and early 2021, progress on the development of the new data system for BDSS was limited due to COVID activations of BDSS epidemiology and other staff. In spring and summer of 2021, BDSS staff completed the development of data system rules and requirements, in partnership with the DOH Health Technology Solutions team. At this time BDSS staff gained full access to historic BDSS data. In early fall 2021, after the Universal Developmental Screening System went live, the team began actively working with our vendor on the BDSS data system build, which included outlining a process for migrating the historic BDSS data into the new data system.

State Performance Measure 3 - Universal developmental screening system participation
Universal Developmental Screening
The DOH received authorization from the Washington State legislature in 2019 to plan and develop a statewide data system to track developmental screening of children birth through age five in Washington State. The data system project was funded by a CMS HI-TECH award, with 10% matching state funds approved by the legislature.

The system went live in fall 2021 and the DOH has begun a focused soft launch with a Help Me Grow sub-affiliate county as well as contracting with the Washington Chapter of the American Academy of Pediatrics (WCAAP) to include UDS system training in an upcoming Bright Futures Learning Collaborative with two community health centers. This marks the beginning of a phased implementation, with plans for a statewide rollout in 2023.

The legislature approved additional funding for UDS system maintenance and operation, including staffing a dedicated UDS program within the Office of Family and Community Health Improvement. The UDS program will support the new data system and conduct education, outreach, and data analysis in a focused effort to increase developmental screening rates, connection to supportive services, and greater health equity. The UDS program coordinated with internal and external Maternal Child Health partners and stakeholders throughout the system build and will continue to do so in program implementation.

Early Hearing Detection, Diagnosis, and Intervention

DOH conducted stakeholder engagement regarding the feasibility of establishing by statute a newborn hearing screening fee. In November 2020 we presented information to the Early Hearing Detection, Diagnosis, and Intervention (EHDDI) Advisory Group about the EHDDI program's challenges with not having a sustainable funding mechanism and the possibility of establishing a newborn hearing screening fee. We also discussed exploring whether a mandate for newborn hearing screening would be required to implement a fee and what costs/benefits a mandate may have for implementing the EHDDI system in Washington. The EHDDI Advisory Group did not voice any concerns with a newborn hearing screening fee or mandate. They noted that a lack of funding seemed to cause a disconnect between what Washington can do versus other state EHDDI programs.

In August 2021, DOH engaged with the Midwives Association of Washington State (MAWS) around the possibility of implementing a newborn hearing screening fee and mandating newborn hearing screening. The midwives reacted generally positive regarding the draft language for the mandate, however concerns about an additional fee were noted. Although the fee should be covered by insurance or the birthing individual, midwives reported that they sometimes were left having to pay the newborn screening fee. Midwives also shared that the hearing screening equipment and associated costs (e.g., calibrations and disposable ear tips) were very expensive for midwifery practices. The DOH currently supports midwives in obtaining hearing screening equipment through a lending program and also provides training to midwives on how to use equipment and report results to the EHDDI program. Midwives hoped that this support would continue and could even be strengthened in the future.

Additional Work Supporting Perinatal/Infant Health at the Local Level

Black Infant Health - Health Ministers Program Contract

Black and African American individuals who are Medicaid-eligible are at disproportionately increased risk for poor pregnancy outcomes. The statement of work of this contract supports outreach and linkage to First Steps services (a nurse home visiting program) for Medicaid-eligible Black or African American pregnant people in Pierce County. Tacoma-Pierce County Health Department (TPCHD) provides resources and support to volunteer community health ministers who provide families with culturally appropriate health messages and services. Title V staff work closely with TPCHD, the Health Care Authority (HCA), the state's Medicaid administrative agency. Title V staff meet with HCA and TPCHD quarterly to discuss programmatic updates and progress. TPCHD also networks with and provides information to community groups that address health issues for communities of color.

American Indian Health Commission Contract

DOH worked on a number of initiatives with the American Indian Health Commission and tribal health leaders to address health disparities affecting American Indian communities in Washington. Activities support the

Commission's Healthy Communities: A Tribal Maternal-Infant Health Strategic Plan. The plan identifies interventions likely to make the greatest difference in addressing health concerns identified by the tribes.

The agency's partnership efforts support the foundational goal of AIHC's strategic plan, which is to address problems through a policy, environment, and systems change approach. This is reflected in their *Pulling Together for Wellness* framework and process steps to address chronic disease prevention.

Process steps in the *Pulling Together for Wellness* framework include:

- Mobilizing at the Tribal/Community Level
- Leadership and Community Engagement
- Recruit and Retain Partners
- Specific Outreach to Youth and Elders
- Engagement of Cultural Resources and Traditional Healers
- Inclusion of Cultural Consideration in the Planning Process
- Use of Storytelling – Balance of Data and Stories
- 7 Generation Strategies – Strength-based
- Integrates Trauma-Informed Strategies

DOH continued to promote the ongoing development of culturally appropriate maternal and infant health strategies most helpful to serving American Indian/Alaska Native parents and babies. DOH continued partnerships with AIHC and HCA to increase awareness and build capacity for the important work of tribal Community Health Representatives, and to support AIHC in community engagement strategies to better understand current maternal and child health programs and services and patient experience.

DOH is committed to honoring the tenets of the Washington State Centennial Accord. This agreement, ongoing since 1989, outlines the government-to-government working relationship between the state and each of the sovereign governments of the 29 federally recognized tribes. The accord provides a structure for building relationships and providing services within a framework of mutually recognized sovereignty.

Additional Work Supporting Perinatal Health at the Local Level

COVID-19 and Local Health Jurisdictions

Of the local health jurisdictions, most still faced challenges during the reporting period due to the on-going COVID-19 pandemic. This has included LHJ staff member being deployed to respond to these emergency health needs including staff vaccine and testing sites within their communities.

Local Health Jurisdictions Perinatal Work

Perinatal and Infant Health has become an increasingly popular focus area among LHJ partners, particularly with an increase in the understanding of the life course perspective. Improving perinatal and infant health is a natural starting point for improving the health of all. Within this focus area, LHJs have found opportunities to make improvements through with the Nurse Family Partnerships (NFP), and breastfeeding/chestfeeding efforts. The application of a hybrid telehealth model has increased adaptability of NFP, with improved accessibility for and engagement with clients. Many LHJs have also utilized this domain to participate in local, regional, and statewide coalitions to improve collaboration and cross-pollination among maternal and child health resources.

- **Chelan-Douglas -** This LHJ has been utilizing a hybrid model of telehealth and in person visits for NFP, which has increased flexible accessibility for clients. This hybrid model has resulted in more appointment follow-through, and an increased engagement. The NFP caseload continues to grow with steady referrals, and NFPs enroll new

clients as other clients disengage/withdraw/graduate.

- **Kitsap -** This LHJ is working on increasing accessibility of breastfeeding/chestfeeding resources via language and cultural accommodations. For example, when working with a hospital social worker their team shared information detailing local Guatemalan indigenous residents' language and culture, in addition to sharing more general community resources for working with this population. These collaborations and focus on cultural responsiveness assist in caring for families during labor and delivery, as well as during lactation support. Kitsap's cultural responsiveness work will continue via the Kitsap Breastfeeding Coalition, who is supporting the establishment of an indigenous breastfeeding/chestfeeding group. Kitsap County is home to two federally recognized tribes, the Suquamish and Port Gamble S'Klallam, but is also home to members of over twenty other tribes who are located in the urban centers of Bremerton and Gig Harbor.

- **Sea King -** A Seattle King County Public Health Nurse regularly attends the Breastfeeding Friendly Child Care WA workgroup (a partnership with Snohomish County, DOH, and other community partners). The goal of this workgroup is to produce materials and guidance for childcare facilities to promote a breastfeeding/chest-feeding welcoming atmosphere for parents across counties.

III.E.2.b.v.c. State Action Plan Narrative by Domain

Perinatal and Infant Health Domain Application Year

Priority:

Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course.

State Performance Measure 3:

Universal developmental screening system participation.

Strategy:

Support the "One Vax Two Lives" campaign to dispel misinformation, and address fears some expecting families may have about COVID vaccines. This campaign is a partnership with The University of Washington's Center for an Informed Public and the UW Medicine's Department of OB-GYN.

Support access to and communication clarity around emerging guidance for COVID-19 vaccination during pregnancy and lactation.

Support and promote bidirectional referral and linkage systems at the local, regional, and statewide levels Collaborate with Office of Immunization on infant vaccine promotional messaging to providers and families.

Objective:

By September 30th 2023, continue to support infant vaccinations as outlined by the CDC, and continue COVID-19 outreach efforts to pregnant people through providers, managed care organizations, pharmacies, and local health jurisdictions.

The Title V program will continue to support these efforts by implementing the DOH outreach plan, and by focusing on opportunities to emphasize positive vaccine messaging. We will continue to collaborate with community partners at local health jurisdictions to help combat vaccine resistance. This includes partnership with home visitors, community health workers, care coordinators in managed care organizations, and community leaders in the nonprofit sector. In the future, these efforts will likely be combined with flu vaccine messaging, as our collective aim is to reduce the overall respiratory disease in the community, and thereby reduce stress on the health care system.

We are also working with Medicaid managed care organizations in a formal performance improvement project to increase the rates of well-child visits. This is an especially important area of focus for the next few years because of significant decreases in well-child visits and immunization rates due to COVID-19. Information about this work is included in the *Child Health Annual Report* section.

Objective:

By June 30, 2023, secure funding through 2023 legislative session to fully support the EHDDI program's data system, referral services, and outreach activities to ensure quality, family-centered newborn hearing screening, diagnostic, and early support services are provided in Washington.

Strategy:

Support and promote bidirectional referral and linkage systems at the local, regional, and statewide levels.

The Early Hearing Detection, Diagnosis, and Intervention (EHDDI) program works to ensure that all infants born in Washington state receive their newborn hearing screening so that infants who are deaf or hard of hearing can be identified and enrolled in early intervention services. Infants with hearing loss who do not receive early intervention by 6 months of age are at risk for significant cognitive, language, and emotional delays, and are not on track with their peers for kindergarten readiness.

Federal funds historically used to support the EHDDI program are no longer sufficient to fully support the program. We need sustainable funding solutions to ensure universal access to a successful program that supports a healthy start to life for all Washington newborns. Children who are the most at risk for not receiving services include children born to people who are in rural areas, younger, non-white, less educated, or covered by Medicaid. These children risk not having the EHDDI program as a safety net to ensure they receive quality screening, diagnostic, and early intervention services. Overall, this could mean that more children who are deaf or hard of hearing will be identified later or not at all, and fewer children will enter kindergarten ready to learn.

We will work with DOH leadership and policy team to secure state general funds through a 2023 legislative budget request to fully fund the EHDDI program. We will also explore feasibility of amending Washington's newborn screening mandate to add a section requiring hospitals, birthing facilities, or providers attending a birth outside of the hospital to perform newborn hearing screening, record and report the results to the department, and if necessary, refer the newborn for appropriate services. This would provide the regulatory incentive for providers to conduct newborn hearing screening and report results to the EHDDI program in a timely manner, which would help improve screening rates and the EHDDI program's ability to ensure infants receive timely services

Objective:
By December 31, 2022, complete a statewide gap analysis for perinatal substance use services, and align this analysis with county-level maternal and infant data.

Strategy:
Identify and develop methods to monitor systems and data gaps and improvements needed in preventive care, early screening, and referral.

Developing sustainable, multidisciplinary perinatal behavioral health services is challenging in large spans of rural area and in culturally diverse communities. Failure to identify gaps in services can lead to action plans and decisions that do not fully address the needs of patients and providers, especially when considering populations furthest from opportunity, including pregnant and postpartum individuals. The purpose of this ecological gap analysis is to identify and develop methods to monitor systems and data gaps, and improvements needed in preventive care, early screening, and referrals.

The development of this gap analysis focuses on an ecological scan, including mapping of existing perinatal substance use providers, behavioral health clinics, and community services, and identification of gaps in services to the perinatal population. The intent of this scan is to better understand the delivery and access to perinatal substance use services across the state, and support connection into and between clinical and community services. We aim to identify specific communities that are not seeing multidisciplinary perinatal behavioral health services in their area and determine if this is ecologically linked to maternal and infant outcomes. By making this determination, it becomes possible to create a model for delivering perinatal behavioral health services in target populations that considers burden, context, and integration.

The data for the assessment has been collected and an analysis will be generated in the coming year. Preliminary

data indicate that 19 counties have five or fewer local service organizations, 19 counties have more than five organizations providing services, and one county has 166. Generally, rural areas have fewer services in their communities, however analysis is needed to look deeper into wait times to access services and distance to perinatal specialists, while considering population density. Additional findings indicate the eastern side of the state (east of the Cascades) does not have any Chemical Using Pregnant Women programs.

We have met with cross-agency state partners to determine what data measures to include in the analysis and to connect outcomes, such as maternal recovery and foster care placement, to local resources such as housing, supportive prenatal/postpartum care, dyadic care at birth, and community services.

Additionally, the information collected for the gap analysis will be used to create a perinatal substance use services resource that birthing hospitals and perinatal providers can use to facilitate referral to addiction, mental health, and community services. DOH has met with contractors for the creation if an online resource finder that contains county level data that is specific to perinatal substance use and community services.

Objective:
By February 1, 2023, launch statewide roll-out of implementation phase of new developmental screening program, working with early childhood partners as part of a statewide effort to increase developmental screening rates and connection to responsive services.

Strategies:
Engage partners and stakeholders, including those in historically marginalized communities, to promote the value of universal developmental screening and use of the data system. Provide training and technical support to data system end users. Conduct data analysis and generate reports to inform decision-making and program planning.

Identify existing disparities and work with historically marginalized communities to develop tailored outreach and education.

The DOH received authorization from the Washington State legislature in 2019 to plan and develop a statewide data system to track developmental screening of children birth through age five in Washington State. The data system project was funded by a Centers for Medicare and Medicaid Services Health Information Technology for Economic and Clinical Health (CMS HI-TECH) award, with 10% matching state funds approved by the legislature.

The system went live in fall 2021 and the DOH has begun a focused soft launch with a Help Me Grow sub-affiliate county as well as contracting with the Washington Chapter of the American Academy of Pediatrics (WCAAP) to include UDS system training in an upcoming Bright Futures Learning Collaborative with two community health centers. This marks the beginning of a phased implementation, with plans for a statewide rollout in 2023.

The legislature approved additional funding for Universal Developmental Screening (UDS) system maintenance and operation, including staffing a dedicated UDS program within the Office of Family and Community Health Improvement. The UDS program will support the new data system and conduct education, outreach, and data analysis in a focused effort to increase developmental screening rates, connection to supportive services, and greater health equity. The UDS program coordinated with internal and external Maternal Child Health partners and

stakeholders throughout the system build and will continue to do so in program implementation.

DOH has been working with state and local partners for several years to identify critical needs and gaps in developmental screening and connection to responsive services. The priority need that surfaced was lack of a statewide system to track early screenings and referrals. In April 2019, the Washington State Legislature granted the department's request for funding to develop a statewide data system to track developmental screening of children birth through 5 years of age. The project was funded through September 2021 using a 90/10 match from CMS. The 2021 Legislature has approved general state funding for ongoing maintenance and support.

Priority:
Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.

National Performance Measure*:*
Percent of infants who are ever breastfed.
Percent of infants breastfed exclusively through 6 months.

Objective:
Annually, partner with at least eight local health jurisdictions to offer perinatal home visitation services to low-income women in local communities, supporting well-newborn visits, on-schedule vaccination, and breastfeeding initiation/sustenance.

Strategies:
Promote breastfeeding and lactation support programs and services.

Promote home visiting to provide support to families where they are.

Implement trauma-informed services into community services, health care systems, and the public sector.

Implement and promote fatherhood inclusion opportunities and support resources.

In recent years, the focus of local MCH programming has largely turned away from individual services and toward population-based and systems work, though home visiting is still a vital support for many families. For local health jurisdictions (LHJs), Adverse Childhood Experiences (ACEs) is an optional focus area for their contracts, and home visiting is called out as an ACEs prevention/mitigation strategy. Eight of the LHJs receiving MCHBG funding are devoting a portion of their funds to home visiting, primarily through the Nurse Family Partnership (NFP) program. MCHBG supplements staff time – six of them cover a portion of the NFP nurse time, ranging from 0.5 FTE to 0.9 FTE. Because the LHJs all directed staff to COVID-19 response over the past year, we did not require them to revise their plans for the new contract year. The same plans continue to be in place until pandemic response is no longer the primary focus of LHJ efforts.

For 2020-21, LHJs were asked to explain how they used a health equity lens when designing their plans for the upcoming contract year. Two of them mention the importance of having a Spanish-speaking nurse doing home visiting. Three of them spoke specifically to home visiting as an avenue for increasing equity. One wrote:

Efforts are currently in progress to increase outreach in regions with the highest need. For King County those underserved regions in South and Southeast King County. This is where we have dedicated our MCH Block Grant funding for NFP services. Our NFP program is working to hire staff with experience and skills specific to

communities with the highest need. For example, we recent hired a new NFP Nurse who is fluent in Spanish. This new Spanish-speaking nurse is centrally located and available to families county-wide.

Yakima County, which has a hospital providing MCH services in lieu of the LHJ, devotes most of its efforts to a robust home visiting program. The MCH program serves as a triage and referral source for community agencies, thus avoiding duplication of services. If parents or families are not eligible for other services provided in the community, they provide home visiting to identified families, using the evidenced-based Strengthening Families Framework to promote and build protective factors.

Due to the COVID-19 situation, home visiting has of course been modified. LHJ partners are reporting successfully maintaining contact with families via Zoom and other platforms, and some have found great success with this approach. They have commented that families who struggle to make in-person visits are finding it easier to keep their virtual appointments. Home visiting nurses also got creative in their efforts to meet individually with families, having distanced appointments on front porches and in local parks. Because home visiting provides such a fundamental, evidence-based/informed support for parents and young children, we will continue to prioritize investment of MCH funds in this work at the LHJ level.

Breastfeeding and lactation support has become an increasingly popular strategy, with 10 LHJs now actively pursuing these efforts. The pandemic has made this work increasingly difficult, as most local coalitions suspended their meetings and individual support for mothers was forced to be done virtually. How delivery of these services and supports will transition in the future remains to be seen.

Objective:
Continue to promote awareness and training opportunities to health care providers on provider bias and disparities on an ongoing basis.

Strategies:
Support active engagement by birthing hospitals, licensed birth centers, and perinatal providers in quality improvement efforts that reduce the leading causes of maternal mortality and morbidity.

Support healthy pregnancies, births, and maternal recovery; address inequities and prevent maternal mortality and morbidity.

In collaboration with internal and external partners, provide health equity learning and education opportunities, including implicit and explicit bias and antiracism trainings, for perinatal health providers across Washington state and members of the Maternal Mortality Review Panel.

In 2019, data and findings of maternal mortality reviews from deaths occurring in 2014-2016 indicate that some population groups are more impacted by maternal mortality than others. American Indian/Alaska Native women and women with Medicaid health insurance had higher maternal mortality rates than other comparable groups. Additionally, the panel found during their review of deaths that stigma and bias among perinatal health care and service providers may have contributed to some of the preventable pregnancy-related deaths.

While these data and findings are based on only three years of maternal mortality reviews, they indicate possible inequities in maternal mortality and morbidity in Washington state. DOH and the Maternal Mortality Review Panel (MMRP) are committed to increasing health equity in perinatal care and recommended that all perinatal health care and service providers participate in education and training on health equity and implicit bias to begin reducing the impact of these pervasive issues.

To build on our work toward improving health equity in perinatal care and services, we will continue to collaborate with internal and external partners to provide health equity learning opportunities for perinatal providers around the state and for members of the MMRP. Our planned topics for provider trainings include understanding linkage between intimate partner violence and maternal mortality, best practices for suicidality screening and referrals, community health worker training module on perinatal mental health, and best practices for breastfeeding for families experiencing opioid use disorder. During the summer of 2019, three trainings were coordinated for DCYF staff that touched on how bias and discrimination show up in clinical care and the intersection of child welfare. Through the Perinatal Substance Use Disorder Learning Collaborative, DOH and WSHA will offer a toolkit of resources and a learning opportunity related to improving trauma-informed care and reducing stigma and bias toward people who are pregnant and have a substance use disorder. We are also working with WSHA to stratify birth quality improvement data measures by race/ethnicity so we can look at disparities in the provision of perinatal care.

Objective:
By Sept 30, 2023, in partnership with Child Protective Services at the Department of Children, Youth, and Families (DCYF), Within Reach and the Washington State Hospital Association implement the policy and definitions for infants exposed to substances, as well as prepare for and implement a statewide launch of the referral portal.

Strategies:
Provide training for birthing hospital clinical staff about the policy definitions for infants exposed to substances and the online referral process for notification and wrap around services.

Integrate motivation interviewing and reflective listening training into hospital trainings to facilitate trauma-informed communication about notification and reporting requirements.

Promote and facilitate education for health care professionals and systems regarding stigma, cultural sensitivity, and implicit bias in perinatal health care systems.

In response to Washington state's ongoing opioid crisis and in alignment with the interagency State Opioid Response Plan to "Partner with the Department of Children, Youth, and Families (DCYF) child welfare division to increase consistency in child welfare decisions, including working to strengthen connections between child welfare social workers and community resources at local levels."

DCYF has coordinated a workgroup to clarify definitions and to create policy, program and an online notification portal for infants exposed to substance use. These definitions have been finalized and a new notification pathway with wrap around services has been created for infants who are born substance exposed but do not meet the requirements for a CPS report. Educational and outreach materials are included in the Appendix. The notification and wrap around service programs are being run by Within Reach which is and organization that is separate from CPS, to increase birth parents trust in accepting services.

The definitions have been finalized, the portal and program has been piloted in 2 counties and is now being piloted in 13 additional hospitals. With implementation plans being developed for a statewide launch to begin in 2022.

Objective:
By December 31, 2023, complete the development of a new data system for the Birth Defects Surveillance System (BDSS), which will combine birth defects reporting data from providers and facilities with existing

information from vital statistics, including birth, death, fetal death, and hospital discharge data.

Strategies:
Identify and develop methods to monitor systems and data gaps and improvements needed.

Develop monitoring systems to identify leading causes of infant mortality/morbidity.

The Washington State Birth Defects Surveillance System (BDSS) began in 1986 as an active statewide surveillance system. In 1992, the system changed to a passive surveillance system that relies on hospitals to report cases of children with birth defects. About 40 priority facilities currently report to the Washington BDSS monthly. BDSS monitors the prevalence of the sentinel nine conditions: anencephaly, spina bifida, cleft lip with and without cleft palate, cleft palate alone, hypospadias/epispadias, limb reduction defects, gastroschisis, omphalocele and Down syndrome. Authority for this surveillance system exists under Notifiable Conditions – Washington Administrative Code (WAC) 246-101.

Birth defects have a significant public health impact, and result in increased morbidity and mortality, long-term disability, the need for developmental services and special education, and economic and emotional impacts on the family. Birth defects are a leading cause of infant death and accounted for 22 percent of infant deaths in 2018.

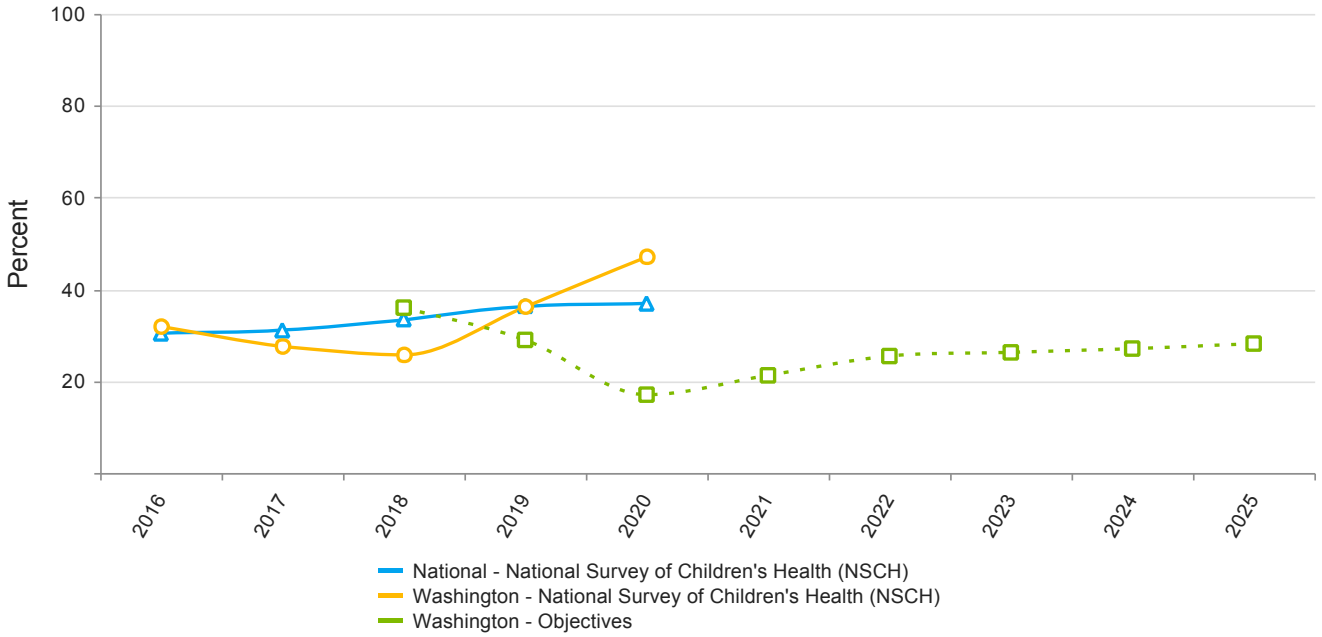
The current BDSS data system is 19 years old and has never been fully functional. The development of a new BDSS data system will provide more timely and complete birth defects data for Washington, integrate the use of health information exchange (HIE), and be interoperable with the UDS system being developed. The new system will incorporate data from vital statistics, including birth, death, fetal death, and hospital discharge data. Within the new BDSS data system, vital statistics data will be matched to the data provided by the priority facilities reporting to BDSS. The matching of data will allow for more complex analyses and a better understanding of the risk factors associated with birth defects in Washington. We anticipate that vital statistics data may also identify a small number of children with birth defects who were born in a facility that does not regularly report to BDSS.

The new data system will help us meet the goals of Washington BDSS, which include the ability to: (1) assess demographic distribution and trends over time, (2) monitor emerging or unusually high occurrences of birth defects and evaluate clusters, (3) examine potential risk factors, (4) plan, implement, and evaluate preventive strategies to prevent select birth defects, and (5) inform and educate policymakers and the public. The goal of the BDSS is to decrease or mitigate the impact of birth defects on children, families, and communities.

Child Health

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		36	29	17.1	21.3
Annual Indicator	31.9	27.7	25.6	36.2	46.9
Numerator	60,624	55,326	53,459	65,908	83,492
Denominator	190,110	199,961	209,028	182,179	177,879
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	25.5	26.3	27.1	28.2

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Number of ASQs provided by WithinReach to callers

Measure Status:	Inactive - Replaced				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		381	1,135	904	1,113
Annual Indicator	529	1,113	834	785	546
Numerator					
Denominator					
Data Source	WithinREACH	WithinREACH	WithinREACH	WithinREACH	WithinREACH
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

ESM 6.2 - Number of children reported by HCA as receiving developmental screening

Measure Status:	Inactive - Replaced				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			700	43,478	44,782
Annual Indicator			42,625	39,071	49,206
Numerator					
Denominator					
Data Source			Washington State Health Care Authority	Washington State Health Care Authority	Washington State Health Care Authority
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

ESM 6.3 - Percentage of children screened by Home Visiting/MIECHV programs

Measure Status:	Inactive - Measure will be discontinued and replaced with another ESM.

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	61	
Numerator		
Denominator		
Data Source	Home Visting Services Account Annual Report	
Data Source Year	2019	
Provisional or Final ?	Final	

ESM 6.4 - Number of developmental screens completed through Help Me Grow Washington.

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	707.0	778.0	856.0

State Performance Measures

SPM 4 - Percentage of sixth grade students who have an adult to talk to when they feel sad or hopeless

Measure Status:	Inactive - Replaced	
State Provided Data		
	2020	**2021**
Annual Objective		
Annual Indicator	75.3	68.6
Numerator		
Denominator		
Data Source	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2021
Provisional or Final ?	Final	Final

SPM 5 - Ease of receiving mental health treatment or counseling

Measure Status:	Active	
State Provided Data		
	2020	**2021**
Annual Objective		
Annual Indicator	53.9	
Numerator		
Denominator		
Data Source	NSCH	
Data Source Year	2018/2019	
Provisional or Final ?	Final	

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	55.0	56.0	57.0	58.0

SPM 6 - Social and emotional readiness among kindergarteners

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	74	74.4	77	77	78
Annual Indicator	70.2	76.7	76.7	79	77.4
Numerator					
Denominator					
Data Source	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids
Data Source Year	2016-2017	2017-2018	2017-2018	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	78.0	79.0	79.0	79.0

SPM 12 - Percent of families showing 4 or more factors indicating high resilience to challenges.

Measure Status:		Active	
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	88.0	90.0	92.0

State Action Plan Table

State Action Plan Table (Washington) - Child Health - Entry 1

Priority Need

Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course.

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

By September 30, 2025, increase the number and proportion of families with children (ages 0-3) who receive information about developmental screening, developmental milestones, and resources to support healthy child development.

By September 30, 2023 and ongoing, increase the number of pediatric health care practices who are using the Strong Start statewide universal developmental screening and referral data system as part of their practice.

By September 30, 2023, identify improved methods to track the proportion of children who are receiving timely developmental screenings

Through September 2025, increase the proportion of children who receive timely well-child visits and are up-to-date on recommended vaccination

Strategies
Provide leadership, staffing, and funding support for the ongoing development and implementation of the statewide Help Me Grow WA system and related collaborative statewide initiatives that include explicit focus on connecting families to developmental screening and resources.
Communicate developmental screening and developmental milestones information through a variety of social media and virtual/live modalities.
Incorporate Vroom™ brain building tips and other child development resources in Watch Me Grow Washington mailings.
Complete soft launch of new Strong Start Universal Developmental Screening data system (Strong Start) with two provider practices (beginning in summer 2022) and one Help Me Grow sub-affiliate county.
Promote Strong Start with additional health care provider practices. Identify and provide technical assistance to interested providers.
Promote Strong Start with state and local partners that work closely with families of children birth through age five, and provide training and technical assistance, as well as information about resources and supports related to early childhood development.
Continue coordination between Strong Start and Help Me Grow WA to ensure alignment of developmental screening data systems and services.
Encourage the coordination of pediatric screening efforts, results, and referrals among clinical care settings, medical homes, child-care settings, schools, and other organizations.
Explore options to improve availability and usability of Medicaid data provided through HCA-DOH mutual data share agreement.
Explore data agreements with other insurers or other sources to track developmental screening rates.
Incorporate developmental screening data from Strong Start UDS data system.
Promote routine well-child visits and recommended preventive care in early and middle childhood (birth to age 11). Activities include Patient/Parent education (communications campaign, social media posts, school flyers, public education ads, etc), and provider education (webinars, communications, clinic collaborations, etc.).
Partner with pediatric and primary care clinic systems to engage over-due or unestablished members/children into the practice to receive well-child visits.
Establish partnerships with early learning focused organizations and school-based health centers to identify and deploy collaborative activities to improve well-child visits.
Analyze claims data from all MCOs to identify children without completed well-child visits

ESMs	Status
ESM 6.1 - Number of ASQs provided by WithinReach to callers	Inactive
ESM 6.2 - Number of children reported by HCA as receiving developmental screening	Inactive
ESM 6.3 - Percentage of children screened by Home Visiting/MIECHV programs	Inactive
ESM 6.4 - Number of developmental screens completed through Help Me Grow Washington.	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Washington) - Child Health - Entry 2

Priority Need

Promote mental wellness and resilience through increased access to behavioral health and other support services.

SPM

SPM 5 - Ease of receiving mental health treatment or counseling

Objectives

Through January 2023, develop an early childhood comprehensive systems strategic plan in collaboration with state partners and families.

Through September 2025, increase the number of health care providers who have received training and are incorporating focus on early relational health and screening for social and economic needs in routine care.

From January 2021 through January 2025, work with partners to expand access to behavioral health and other support services for children ages 11 and under and families.

Strategies

Partner with pediatric and family medicine organizations to promote focus on strengthening parent-child relational health in well-child visits.

Support training for clinical and community health workforce on early relational health concepts, promotion of parent and child social-emotional skill development.

Promote routine use of social determinants of health screening tools. such as evidence-based Safe Environment for Every Kid (SEEK) tool in pediatric health care settings.

Participate in state efforts to expand access to infant, early childhood and child behavioral health services and supports, including the efforts of the state Child and Youth Behavioral Health Work Group.

Promote standardized depression, anxiety, and substance use screening for children and their parents per the AAP Bright Futures, school-based health center models, and specific needs of communities.

Support interventions to address suicide ideation among children, especially among children who are involved in child welfare systems, LGBTQ+, BIPOC.

Identify and support evidence-based practices to prevent and reduce the harmful impacts of bullying and social media on children, especially in the middle childhood period.

Support efforts to address and mitigate effects of parental substance use on children and prevent early initiation in children. Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges.

Increase knowledge, visibility of and access to parent and child behavioral health resources and services available locally. Promote linkages to services that meet unique client or subpopulation gaps in care.

Work with HCA and other state partners to identify ways to increase diversity of child and family behavioral health service providers in order to better serve unique needs of BIPOC, immigrant, rural, and other populations

Support the development and implementation of anti-racist, trauma-informed and healing-centered policies and practices within behavioral health, health care, and other service settings serving children and families.

Build networks and resources in communities to enable and enhance community and peer support.

State Action Plan Table (Washington) - Child Health - Entry 3

Priority Need

Promote mental wellness and resilience through increased access to behavioral health and other support services.

SPM

SPM 6 - Social and emotional readiness among kindergarteners

Objectives

Through January 2023, develop an early childhood comprehensive systems strategic plan in collaboration with state partners and families

Through September 2025, increase the number of health care providers who have received training and are incorporating focus on early relational health and screening for social and economic needs in routine care.

Strategies

Provide state leadership and coordination for development of an integrated and comprehensive early childhood system of services and supports through the Early Childhood Comprehensive System project and other related state initiatives.

Identify and implement effective, equity focused strategies to engage parents, caregivers and those with lived experiences in decisions about the development and improvement of the early childhood system of services and support.

Collaborate with state partners to increase health care provider engagement in state coordinated access and referral network through state Help Me Grow and local efforts.

Work with families and state partners to identify and address ongoing structural barriers within state systems that impact the ability of families to access supports for themselves and their children.

Support the development and implementation of anti-racist, trauma-informed and healing-centered policies and practices within health care and other service settings serving children and families.

Advocate for investment in prevention services for parents. Implement and promote fatherhood inclusion opportunities and support resources. Promote inclusion of additional people taking parenting roles, such as foster parents, grandparents, kinship care.

Partner with pediatric and family medicine organizations to promote focus on strengthening parent-child relational health in well-child visits.

Support training for clinical and community health workforce on early relational health concepts, promotion of parent and child social-emotional skill development.

Promote routine use of social determinants of health screening tools. such as evidence-based Safe Environment for Every Kid (SEEK) tool in pediatric health care settings.

State Action Plan Table (Washington) - Child Health - Entry 4

Priority Need

Optimize the health and well-being of children and adolescents, using holistic approaches.

SPM

SPM 12 - Percent of families showing 4 or more factors indicating high resilience to challenges.

Objectives

By September 2025, increase community-based primary prevention programs, practices, policies, and systems to reduce childhood adversity and promote child and family well-being.

By August 30, 2023, develop a sustainability plan to continue progress on strategies and actions identified in collaboration with Essentials for Childhood partners.

By September 30, 2023, develop a positive community norms campaign or educational awareness campaign focused on child well-being in the context of their families and communities.

By September 2025, advance program, policy, and system changes that increase the proportion of families with children who have sufficient household income plus concrete supports to meet basic needs.

By September 30, 2023, develop an approach to measure and monitor community resilience and correlation with child and family well-being outcomes

By September 30, 2023, complete a needs assessment focused on middle childhood health (ages 6-11 years), including examining existing state and local initiatives and opportunities improvement.

Strategies

Collaborate with Essentials for Childhood and other partners to promote state leadership, commitment, and investment in the vision of all children in WA State thriving in safe, stable, nurturing relationships and environments.

Adopt and share concepts, tools, trainings, and practices aligned with the Healthy Outcomes from Positive Experiences (HOPE) Framework in state Essentials for Childhood initiative and other settings.

Promote evidence-informed programs and policies to prevent and reduce adverse childhood experiences and promote positive experiences statewide through local health jurisdictions, community-based home visiting programs, and other prevention programs sponsored by DOH, HCA and DCYF.

Promote school- and community-based health strategies for early and middle childhood to increase accessibility of services for children where they are, informed by parents of diverse races/ethnicities.

Support community-led resilience building initiatives in communities with higher rates of child maltreatment and other adversity. Connect with DOH Health Equity Zones and other related initiatives.

Continue to build out Inventory of What Works to reduce maltreatment and promote family resilience.

Work with EfC partners to identify ongoing priorities and resources, and the most appropriate structure to support ongoing collaboration.

Complete feasibility study of positive community norms campaign.

Develop and test messaging and marketing approaches.

Coordinate campaign development with EfC partners and parents representing diverse communities.

Collaborate with EfC partners and statewide initiatives (i.e., Governor's Dismantling Poverty Strategic Plan) to expand access to economic and concrete supports, through development and implementation of evidence-based policies, such as guaranteed basic income, and simplification of enrollment in state benefits programs.

Use a racial equity lens to prioritize economic stability strategies that address economic inequities experienced by BIPOC children and families.

Participate in statewide efforts to expand access to affordable, high-quality child-care and evidence-based home visiting as strategies to support family financial well-being, reduce family stress, and promote healthy child development.

Continue work with state and local partners to improve access to and navigation of family supports and services (including economic supports) through development of state and local coordinated access and referral networks (Help Me Grow WA and related local efforts).

Work with Surveillance and Evaluation section and other partners to identify valid and reliable measures for ACEs/PCEs incidence and promising strategies at the state and community levels.

Engage with academic partners to research potential community resilience questions, possible inclusion in existing survey tools, or other approaches to measurement. Pursue funding sources to implement recommended approach.

Define future data needs to measure child and family health and well-being. Support current data collection activities in this population, such as the oral health basic screening survey. Advocate for additional resources to expand availability of child health and well-being data, such as through state roll-out of the Best Starts for Kids Child Survey.

Collaborate with other DOH sections, units, and state/local partners to identify existing data focused on middle childhood health.

Develop and implement methods to assess current state and local assets and identify gaps and opportunities related to middle childhood health.

III.E.2.b.v.c. State Action Plan Narrative by Domain

Child Health Domain Narrative

Overview

The Child Health unit at the Department of Health (DOH) is managed within the Thriving Children and Youth section of the Office of Family and Community Health Improvement (OFCHI) in the Division of Prevention and Community Health (PCH). This section also includes the Adolescent Health unit and the Children and Youth with Special Health Care Needs unit.

Child health is viewed holistically through a life course development perspective, encompassing the physical, mental, emotional, behavioral, and spiritual aspects of child well-being in alignment with the phases of development. Child health is also considered in the context of the socio-ecological model, recognizing the influence of family, community, societal and systemic factors on children's well-being. Child health strategies include both universal approaches (e.g., promotion of developmental screening, comprehensive system development) and more targeted approaches to address the needs of children and families who are furthest from opportunity due to social, economic, or geographic factors. Identifying and addressing the historical and ongoing impacts of systemic racism on children's health is a central focus. We continue to promote the importance and availability of well-child visits, increasing and tracking the rate of developmental screenings, and COVID-19 vaccinations (ages 5-11). We work to reduce barriers to well-child health visits, increase connection to services, and improve provider billing practices. Through our many partnerships with state agencies, local health jurisdictions, community-based organizations, and other entities, we promote relational health and other positive childhood experiences (PCEs) and work towards the prevention and mitigation of child maltreatment and other adverse childhood experiences (ACEs).

Our child-health-focused initiatives and programs are funded by a variety of sources, including the Title V Maternal and Child Health Block Grant (MCHBG), Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), administrative Medicaid match, state funds, and foundation funding.

Our section works together with other workgroups in DOH to address the priority needs of the child population (ages 0-11). In addition to the work done within OFCHI, several other sections of DOH contribute toward meeting our Title V child health objectives, strategies, and performance measures. The Injury and Violence Prevention program works on initiatives to promote child safety and prevent injuries. The Healthy Eating Active Living program works to reduce the burden of obesity and chronic disease, increase the proportion of children with a healthy weight, and promote breastfeeding/chestfeeding for a healthy start. The Immunizations and Watch Me Grow Health Promotion System

manages a universal vaccine program and sends child health and safety information to all families with young children in Washington by mail and e-mail. The Oral Health program promotes access to oral health care and prevention of dental disease and oversees the Smile Survey to collect data on the oral health of children in Washington. Collectively, these programs contribute toward our shared vision of safe, healthy, and thriving children.

In 2020, the Washington population of children 1 to 11 was estimated to be 1,037,834 or about 22.2% of the total state population. The population of children ages 1 to 5 was estimated at about 4.4% of the total; ages 6 to 11 were about 9.4%. In general, Black, Indigenous, and people of color (BIPOC) populations have a proportionally larger population of young children than the white, non-Hispanic population. See table below for 2020 population estimates broken out by age groups and race/ethnicity.

Washington CY2020 Child Population Estimates by Race/Ethnicity						
Race/Ethnicity	Total Population (1-11 Yrs.) N	1-11 Yrs. %	1- 5 Yrs. N	1-5 Yrs. %	6-11 Yrs. N	6-11 Yrs. %
American Indian/Alaska Native	14,205	1.4%	6,065	1.3%	8,140	1.4%
Asian	85,762	8.3%	37,782	8.3%	47,980	8.3%
Black/African American	45,836	4.4%	20,309	4.4%	25,527	4.4%
Hispanic	246,872	23.8%	114,155	25.0%	132,717	22.9%
Multi-Racial	99,756	9.6%	46,875	10.2%	52,881	9.1%
Pacific Islander	9,952	1.0%	4,461	1.0%	5,491	0.9%
White	535,451	51.6%	227,867	49.8%	307,584	53.0%
All	1,037,834	-	457,514	-	580,320	-

While Washington has one of the lowest rates of uninsured children between birth and age 5, families report barriers to accessing coverage, including difficulties navigating the enrollment process. Over 34% of children are only covered by public health insurance (such as Medicaid, Children's Health Insurance Program [CHIP], or other federal or state plan, with no private insurance) (KIDS COUNT), which can make it more difficult for families to find a doctor who accepts their health insurance, make an appointment, and obtain specialist care (Medicaid and CHIP Payment and Access Commission [MACPAC]).

In 2019-2020, an estimated 46.9% of children in Washington ages 9 to 35 months received a developmental screening, nearly 10% higher as compared to the national 2019-2020 rate and the 2018-2019 Washington state rate (National Survey for Children's Health [NSCH]). In 2019-2020, approximately 68% of families needing care coordination in Washington received it, compared with the national rate of 69% (NSCH).

In calendar year 2020, the rates for children having received the full recommended vaccine series is listed in the table below.

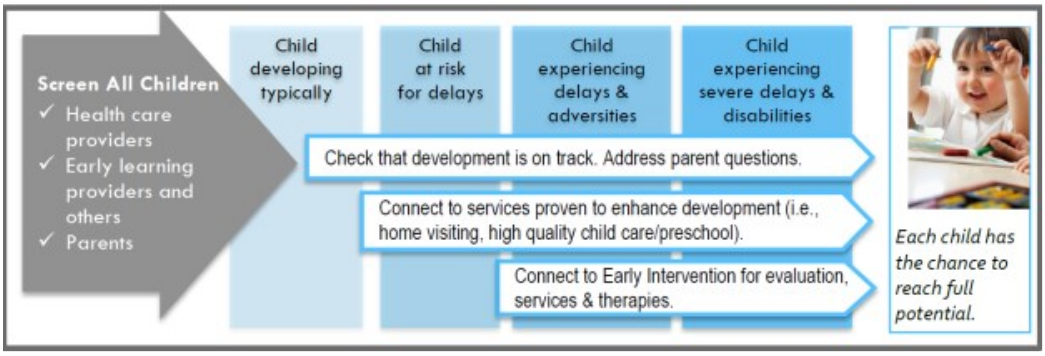
Age group	Recommended series	% complete
19-35 months	4:3:1:3:3:1:4	58.4
4-6 years	5:3:4:2:4:4:2	42.6
11-12 years	1:1:1	33.4
13-17 years	1:1:UTD	41.5

Washington's Title V program served 1,585,143 children, adolescents, and young adults; ages 1 to 21 in 2020. We promoted the health and wellness of children through policies and programs that support safe, stable, nurturing relationships and environments; universal developmental screening; early and ongoing learning and development; culturally appropriate, responsive supports; and services and systems improvements that support the whole child, whole family, and whole community. We also pivoted our work on many of our MCHBG objectives to meet the immediate needs created by the COVID-19 pandemic.

National Performance Measure 6 – Developmental Screening
Percent of children, ages 9 to 35 months, receiving a developmental screening using a parent-completed screening tool in the last year.

The NSCH combined survey of 2019-2020 indicates that 46.9% of children ages 9 to 35 months received a developmental screening using a parent-completed screening tool. This is up from 36.4% reported in 2018-2019.

Universal Developmental Screening in Washington
UDS and Connection to Responsive Services: A DOH Priority
Universal developmental screening (UDS) is included in the DOH Strategic Plan. Two objectives related to UDS are to: (1) promote data integration, data sharing, and data analysis necessary to support better health outcomes; (2) ensure equitable access to services, programs, opportunities, and information.



We developed and finished contracts that facilitated implementation of UDS, including autism identification and evaluation work within the University of Washington Medical Home Partnerships Project (MHPP) contract. The Essentials for Childhood (EfC) grant, which identified policy priorities related to UDS, Help Me Grow Washington, and home visiting; and partnership with the state's Medicaid administrative agency, the Health Care Authority (HCA) and several managed care organizations (MCOs). Our aim with this work is to reduce barriers to well-child visits, track and increase rates of developmental screening, and increase connection to responsive services. MCHBG funding was used to provide oversight and direction for many of these partnership grants, to align and leverage opportunities and outcomes, and to lend content expertise as needed.

Key partners in our UDS efforts in Washington have included other programs within DOH; the Department of

Children, Youth, and Families (DCYF); families; health care providers; community-based organizations; university researchers; MCOs; and local health jurisdictions.

Medical Home Partnerships Project and School Medical Autism Review Teams
About most of the state's counties participate in the Medical Home Partnerships project to promote and improve access to screening, referrals, and interventions, including primary care coordination and development of new services. This work establishes coordinated and accessible systems of care, enabling families to receive timely and appropriate developmental screening and support through the diagnostic process for developmental concerns. Most of this work is focused on enhancing communities' ability to diagnose and refer CYSHCN for autism through the School Medical Autism Review Team (SMART) model. The SMART process brings community providers together with school and medical resources to provide a comprehensive diagnosis of autism spectrum disorder (ASD) for a child.

All participating counties are doing UDS systems work to varying extents. Additional details about the CAM and SMART activities are included in the *CYSHCN Annual Report*.

Title V UDS-Related Activities
The statewide, non-profit agency WithinReach provides resource information, health care referrals, and developmental screening tools for children. Title V funding supports their work.

Operating our state's MCH toll-free hotline, WithinReach received and responded to 13,204 calls in FFY 2021. WithinReach's ParentHelp123.org website data showed that in calendar year 2021, they had 26,627 page views with 20,624 total unique page views. WithinReach's hotline and website resources are described further in the *Women/Maternal Health Annual Report*.

WithinReach is also the Help Me Grow (HMG) state affiliate for Washington. DOH continued to work with WithinReach on HMG WA expansion through partnerships on three platforms: (1) as our state's HMG affiliate, connecting with other HMG states on best practices for the promotion of the Ages and Stages Questionnaire (ASQ) and other screening systems, (2) as a key strategy of the Essentials for Childhood collective impact initiative for the prevention of child abuse and neglect and building of family resilience, focused on children birth to 5 years of age, (3) as an approach of the Early Childhood Comprehensive Systems (ECCS) initiative to increase involvement of health care providers (e.g., perinatal, pediatric, primary care) by which access to regionally and culturally relevant services and supports for families is improved.

Additionally, DOH coordinated with HMG WA in the planning and development of a statewide data system to track developmental screening of children birth to age five. The data system project was funded by a Centers for Medicare and Medicaid Services (CMS) Health Information Technology for Economic and Clinical Health (HITECH) award, with 10% matching state funds authorized by the Washington State Legislature. DOH continues to collaborate with HMG WA on the initial implementation phase of the UDS data system.

We have two evidence-based strategy measures (ESMs) for national performance measure (NPM) 6 related to UDS.

Our first ESM is to track the number of Ages and Stages Questionnaires provided by WithinReach to callers. A total of 546 ASQs were completed by parents in 2021 through WithinReach, which was a decrease from the previous year and far short of our objective of 1,113 for 2021. It is possible that the pandemic was part of the cause for the decrease in parent screenings, as many parents prioritized finding solutions to financial challenges, such as loss of

housing and employment. This ESM measures the number of ASQ and ASQ:SE (Social-Emotional) screenings completed, rather than number of children screened using these tools, due to the reporting available from WithinReach. Some children are screened multiple times, as the Bright Futures Guidelines recommend, which creates a discrepancy between what we wish to measure (number of children screened) and what we actually measure (number of screens completed). Our new UDS data system (described below which went live in fall of 2021), is designed to collect these data more precisely as we move forward. We will, of course, only be able to report on data entered into the system; however, the data we collect will show both the total number of screenings and the number of individual children screened.

Our second ESM is the number of children reported by HCA as receiving developmental screening. DOH negotiated a data-sharing agreement with HCA in 2016, which added annual developmental screening reporting for Medicaid billing. Data from the first full year of billing in 2016 began to be compiled in 2017. In 2018 and 2019, DOH worked to amend and refine the agreement, and renamed it a Mutual Information Sharing Agreement (MISA). Additional data requirements were added to the MISA in order to obtain population denominators to be able to understand the uptake of developmental screening by age group, as well as by other indicators such as managed care versus fee-for-service, provider type, by county, etc. DOH epidemiology staff will provide the analyses of the data. Reporting on this ESM, in calendar year 2021, 49,206 developmental screenings were completed for children, adolescents, and young adults ages 0 to 21. This exceeded our objective of 44,782.

In 2019, the Washington State Legislature approved 10% state matching funds to support a 90% federal technology grant from the Centers for Medicare and Medicaid Services (CMS) to develop a statewide data system to track developmental screening of children birth through age 5, not limited to those who have Medicaid coverage. As a result, an internal project team and UDS Steering Committee were established to develop project and implementation plans for the statewide UDS system. Key collaborators continued to be engaged including leaders from DCYF, HMG WA, the Washington Chapter of the American Academy of Pediatrics (WCAAP), Local Health Jurisdictions (LHJs), and Tribal health through regular meetings at which participants received updates and provided input.

The UDS project experienced delays, primarily due to the multiple layers of oversight and the impact of the COVID-19 pandemic on DOH resources. The UDS Steering Committee approved going forward with a minimally viable product initially in order to meet the September 2021 launch deadline. The minimally viable product enables health care providers and parents to access and enter data, with the intent that future versions will expand access to child-care providers and staff from early childhood entities, including HMG WA affiliates. The system went live in fall 2021, and the DOH has begun a focused soft launch with a HMG WA sub-affiliate county. DOH is also contracting with the WCAAP to include UDS system training in an upcoming Bright Futures Learning Collaborative with two community health centers. In its 2021 session, the legislature approved additional funding for maintenance and operation, including staffing a dedicated UDS program within OFCHI.

In addition to the statewide work described above, eight of 35 LHJs planned to use Title V funds in FFY 2021 to expand UDS in their communities. Primary areas of focus included provision of training and technical assistance to cross-sector partners, engaging in policy and systems change efforts, and increasing awareness of the statewide UDS system. Pandemic response activities continued to impact progress on planned work.

Additional Work Supporting Children's Health

Increasing Alignment between HMG and UDS Data Systems Development

Two data systems are currently being developed in coordination with one another. Key leaders working on the HMG WA data system, which supports an information and referral network, presented on progress to the UDS Stakeholders Group in May 2021, and the WithinReach/HMG director provided an additional update in June. The

DCYF HMG lead serves on the UDS Steering Committee and is actively engaged in implementation of the UDS system. We are working together to establish unique milestones for the UDS and HMG systems to determine how the systems will work together, and not create duplicative work for providers and parents. Additionally, we are working with a HMG sub-affiliate on a focused soft launch of the new system.

Enhancing Health Systems

DOH created flyers and social media content to remind parents of the value and importance of well-care visits. The flyers and social media posts included additional information of "behavior health support" as a benefit of getting well-care visits. The flyers were distributed in Fall 2020 and Spring 2021 to families of infants, children, and adolescents, and were available in English, Spanish, Russian, and Vietnamese. They were provided to all school nurses statewide for distribution to parents and children.

DOH also engaged 16 clinic organizations to participate in the Fall 2020 and Spring 2021 Statewide Children's Health Promotion Initiative (SCHPI) clinic project. The project focused on the following five tasks and had a potential impact on 20,599 children.

- Collecting and reporting well-care visit rates for the three months prior to the clinic project.
- Learning about the well-care visit Healthcare Effectiveness Data and Information Set (HEDIS) measures and how the results are determined and shared with other clinic staff.
- Reconciling the list of Managed Care Organization (MCO)-assigned patients and the list of patients from the Electronic Health Record (EHR) covered by the partnering MCO.
- Contacting unestablished and overdue patients, reminding them about the value of a well-care visit and reminding them to schedule an appointment.
- Completing two Plan, Do, Study, Act improvement cycles using new strategies from the Tip Sheet that the partnering MCO provides to encourage well-care visit completion.

At the conclusion of the project, DOH invited participating clinics to attend a "Clinic to Clinic" meeting to share the lessons learned, what worked, what did not, and what might work if it were modified. Plans are underway to spread the impact statewide.

In February 2021, DOH hosted an online seminar, "Well Visits 2020 – Changes and Opportunities," about the (HEDIS) well-care visit measure changes announced by the National Committee for Quality Assurance (NCQA) in July 2020. Dr. Beth Harvey, one of our pediatric provider partners, presented information about well-child visits and immunization promotion to an audience of more than 100, which was evenly split over two presentation times, one before clinic hours, and the other over the typical clinic lunch hour. A panel of physicians and clinic quality staff answered questions about their strategies to improve engagement with parents and patients, as well as questions from the audience. Reviews were positive, and attendees included clinic staff as well as business office staff. Continuing Medical Education (CME) credits were provided through the American Academy of Family Physicians (AAFP). The online seminar follow-up email included a copy of the presentation slide deck, a "Tips to Improve Well Visit Rates" handout, and a list of links to our parent flyers.

Increasing Family Resilience, Adverse Childhood Experiences Prevention

Since 2018, DOH Child Health staff in collaboration with Essentials for Childhood partners have convened a statewide ACEs and Resilience Community of Practice (CoP), a network of leaders from across the state who are putting innovative practices to work on the ground in communities and learning from research. Participants work in fields including health services and public health, child welfare, early learning, education, behavioral health, and community organizing. During 2021, the CoP was put on hiatus while DOH contracted with a consultant to conduct an assessment of needs and interests and create a "Roadmap" for the future of the group. The contractor conducted a

series of interviews and focus groups with participants to gather input on how the CoP can best support local community practitioners. Key findings were categorized into four areas including:

- Tangible Supports: Communities and local initiatives are sometimes challenged with access to tangible supports ranging from multiple forms of funding, data support, and technology and equipment to effectively implement and sustain activities.
- Baseline Knowledge: Communities require access to free, relevant training on the topics of ACEs, resilience, healing centered approaches, and parenting and personal skill building/application.
- Shared Power: There is a strong call to move beyond top-down initiatives and traditional forms of power and implement processes and mechanisms that balance power and influence leaders and those served. Local practitioners seek community driven initiatives that are adaptive and responsive with support and navigation at the state level.
- Clear Communication: Local professionals do not have clear understanding of the connection between state and local work, unless there is a specific grant, need, or relevant opportunity. Clear messaging about the CoP is needed, but the larger ask is around messaging campaigns to build community resilience.

Through their MCHBG contracts, 26 of the 35 LHJs focused on work related to ACEs. Activities centered on collaborations with community partners (e.g., schools, youth serving community coalitions, child-care providers etc.) to support training and implementation of practices/policies that are trauma informed and promote resilience. For example, the Spokane Regional Health district facilitated a series of presentations on ACEs prevention and the use of the Healthy Outcomes from Positive Experiences framework to share strengths-based opportunities to serve families with young children and build community resilience.

From October to December 2020, DOH worked with the Association of State and Territorial Health Officials (ASTHO) to design, facilitate, and complete two partner events and a survey designed to assess statewide capacity for ACEs prevention work and use of evidence-based practice. An objective was to build collaboration for renewed focus on family resiliency, in the context of this time of the pandemic and renewed efforts to address systemic racism. These two events were well attended, with 17 partners attending one event, and 25 partners attending the other, representing most geographic areas and partnering state agencies. Forty-four community partners and their networks completed a survey focused on quantitative and qualitative measures of the level of community partnerships, capacity for ACEs prevention work, and the use of evidence-based practices. These data will be used to assess statewide capacity and plan for future funding opportunities.

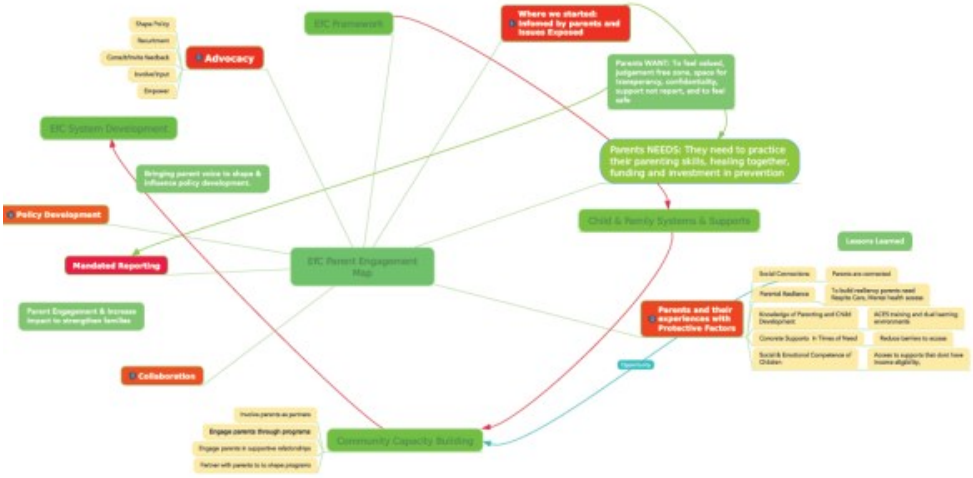
Essentials for Childhood

The Essentials for Childhood (EfC) initiative is continuing our second, five-year CDC grant (2018-2023). Our EfC program is primarily funded through the CDC, MCHBG, and private foundations. For 2021-2026, we have also been awarded an ECCS grant, which will strengthen systems development work. We leverage the MCHBG with EfC funding to address child wellness, prevention of child maltreatment, and to streamline child-focused prevention services statewide. EfC brings a public health approach to reducing child abuse and neglect, ending systemic racism, and increasing family and community resilience, focusing on risk and protective factors. We approach this work with an equity lens, adamantly believing that all children should have the opportunity to achieve their optimal life course. EfC continues to adapt to an ever-changing landscape, which in this period included the COVID-19 pandemic.

EfC is led by a Steering Committee of over 30 cross-sector partners invested in promoting the health and well-being of children and families. Members represent families and community, state and local government agencies, health care, non-profit organizations, and philanthropy. We regularly review membership and recruit new members doing aligned work. We are also working to expand the diversity of our group and assure representation of groups

impacted by historical and structural racism and other traumas. Currently, we are using the *Racism as a Root Cause: A New Framework* (Malawa, Gaarde, & Spellen, 2020) model to guide our anti-racist work. During this period, new membership included a father with lived experience in the child welfare system, three community-based partners from diverse regions of the state, added representatives from our state's Medicaid/Medicare department, and a new private foundation attendee. Our father representative works at the state and national levels to strengthen and support families and improve outcomes for families who are at risk of being or are involved with the child welfare system.

In April 2021, we planned and launched a comprehensive effort to incorporate parent representatives into our EfC Steering Committee, through the consultation of a parent policy leader with lived child welfare system experience. Starting in June 2021, the consultant recruited and facilitated 3 meetings with a group of diverse parents (Parent Leadership Group). The consultant presented preliminary themes that emerged from the meetings to the EfC Steering Committee in September. A final report capturing key findings, recommendations, and proposed next steps was completed in September 2021. The report included a parent engagement map (see below image), capturing lessons learned and best next steps to collaborate with parents throughout policy and systems development initiatives.



The EfC Steering Committee met virtually four times during FFY 2021. Additionally, an EfC Leadership Group was formed in December 2020, and met four times to shape our policy and Steering Committee agendas. They updated the EfC framework document, a snapshot of our vision, fundamentals, priority strategies and actions, overall goals, and long-term outcomes. The EfC Steering Committee also provided input into the needs assessments that informed the statewide Early Learning Coordination Plan and the MCHBG state action plan.

Other topics covered by the Steering Committee included the disparate racial and economic impacts of the COVID-19 pandemic on families with young children and exploring COVID-19 infection and death rates by racial group and geography. The Steering Committee committed to continuing this focus, working on policies and system changes to address disparities in access to programs, services, and community development that builds family resiliency.

In June 2021, EfC Steering Committee revisited its policy agenda development process and accomplishments. The final policy agenda consisted of evidence-based polices to promote child and family mental, emotional, behavioral health, and family/community resilience. The Leadership Group and Steering Committee used a multi-step process to gather information and assess policies. As a first step, key informant interviews were conducted with EfC Leadership Group and Steering Committee members as well as with policy partners. The interviews were conducted

to gather feedback on EfC's role in reviewing policies including how existing partnerships could be leveraged to: (1) reinforce each other's policy agendas, (2) support community engagement, and (3) build on existing local/state work. The interview data informed the criteria used to assess and prioritize policies and involved:

- determining the extent to which polices aligned with the EfC theory of change;
- comparing polices to the Prenatal-3 Policy Roadmap Washington State scorecard produced by the University of Texas at Austin to identify policy gaps;
- examining if policies included changes to address systemic racial inequities; and
- identifying polices with a clear relationship to helping families and communities respond to the impacts of the pandemic.

Related to the policy work, EfC launched an *Inventory of What Works* in June 2021. It consists of promising, evidence-based, and community-driven strategies (i.e., programs, policies, practices) for building family resiliency and preventing child abuse and neglect. These efforts are designed to eventually increase access to "what works" in our state to promote child and family wellness and resilience. With a focus on families with children ages birth to 5, we will assess the availability of strategies effective with different racial and ethnic groups, to the degree possible. Accordingly, a set of equity definitions were developed and used to determine the extent to which strategies addressed racial, geographic, and economic equity. The forthcoming inventory work will further examine strategies using the equity definitions and determine alignment with key documents including the state's *Early Learning Coordination Plan*, *Preschool Development Grant Needs Assessment, and Governor's Poverty Reduction Work Plan.* Additionally, information collected as part of a pilot project with four LHJs will be integrated into the inventory. As part of the pilot project, LHJs identified strategies at the county/regional level to assess local assets and gaps.

In August 2021, the EfC Steering Committee discussed state level child maltreatment data, including examining racial disproportionality. The data sharing generated rich discussion about opportunities to strengthen state systems. Committee members also considered a variety of factors associated with child maltreatment including economic insecurity, substance use, and access to mental health services/supports. Additionally, committee members identified opportunities to work more collaboratively with state agency and community-based partners to promote primary prevention strategies to reduce and prevent child maltreatment.

Advocacy and support for the development of a Help Me Grow (HMG) system in Washington State has been a part of the EfC initiative since early in its existence. The HMG WA movement continues to gain momentum and support. The vision is for HMG WA to put families at the center of an information and referral network that will make it easy for families to access resources and services to address all their health and well-being needs. During this period, HMG WA revisited its governance structure to advance opportunities to coordinate with local partners and broaden representation of the leadership team. In addition to the state HMG affiliate at WithinReach, work has focused on development of HMG sub-affiliates in 5 local/regional areas of the state to improve coordination and access to localized resources. HMG coordinates closely with EfC, presenting updates and getting input at each EfC Steering Committee meeting. Strengthening the HMG WA resource and referral network is also a primary strategy of the ECCS program.

Since 2019, DOH has partnered with the Bezos Family Foundation to share Vroom Brain Building messages and tools in Washington State. Vroom is a set of asset-based, tested messages and tips for parents and caregivers of children from birth to age 5. Content is deployed in a variety of ways, including a mobile application, text, website, and printed materials. Vroom messages promote positive adult-child relationships, back-and-forth interactions that create neural pathways in developing brains, and life skills that promote executive function. Vroom is intended to help children benefit from parent/caregiver interactions that promote brain building.

Vroom is part of our EfC strategy of promoting parent and caregiver knowledge of parenting skills, child development, and community social environments that support and empower families. We provide technical assistance, learning opportunities, and some funding to support Vroom promotion, prioritizing families furthest from opportunity and impacted by historic inequities.

Key activities during this period include:

- In February 2021, EfC began collaborating with seven community-based subcontractors to incorporate Vroom into their work with families of young children. We continued to host a learning community among these partners, where participants shared and learned from each other.
- Two subcontractors developed and launched virtual training courses that are now online.
  - Early Relational Health in the Primary Care Office Visit is a free, virtual self-paced course designed for pediatric medical providers. Dr. Aaron Grigg, MD, FAAP teaches this course and shares Vroom and other resources that are available for parents and caregivers to engage with their young children in ways that enhance brain development. The e-course launched in September 2021.
  - Brain Building Moments with Vroom, teaches early learning providers about Vroom and how they can use it to promote brain development among the children in their care. The course was developed by the Snohomish Health District and launched in August 2021.
- EfC provided starter sets of Vroom materials and technical assistance to organizations across the state including a tribal prevention program, substance use prevention program, early learning programs, First Steps Medicaid providers, and LHJs.
- In collaboration with partners, three introductory webinars were conducted to promote Vroom. The webinars were designed to strengthen parenting skills, promote healthy child development, and increase awareness of services available to parents/caregivers and families. On average, 93.5% of evaluation survey respondents agreed or strongly agreed with statements about increasing knowledge as a result of participating in the webinars.
- Vroom information cards were included in Watch Me Grow Washington health promotion mailings in 2021. During the calendar year, 83,227 Washington families received a Vroom information card in the mail near their child's 2½ year birthday, along with other health promotion information. Of the total mailings, 4,007 were requested to be provided in Spanish language. These Vroom information cards were printed in English on one side and Spanish on the other, making the same card appropriate for families that read either or both languages.

State Performance Measure 1 – Social/Emotional Readiness for Kindergarten

One of our state performance measures (SPMs) enables us to better understand current status of healthy child development. We are monitoring the percent of incoming kindergarteners who demonstrate the social and emotional characteristics appropriate to their age. We are also using the data to identify disparities associated with social and economic factors, such as race/racism, low income, homelessness, disability, and English Language Learner status. We recognize that while our work is informed by and contributes to this measure overall, we are not solely responsible for improvements or changes to this measure.

Data are from the Office of Superintendent of Public Instruction's Washington Kindergarten Inventory of Developing Skills (WaKIDS). At the start of the 2021-2022 school year, 58,488 of 75,556 (77.4 %) children entering kindergarten were developmentally ready in the social-emotional (SE) domain. This encompasses children who met both expected 4-year-old milestones and 5-year-old/kindergarten age milestones. Further examination showed that 49.2% of children meet SE milestones for 5-year-old/kindergarten age and up, and there are significant differences between SE readiness based on race/ethnicity, low income, homeless, English Language Learner (ELL), and disability status. See table below for a breakdown of these readiness differences.

SE Readiness for K-age and up

Category		Numerator	Denominator	%
Race/ Ethnicity	American Indian/Alaska Native	299	791	37.8
	Hispanic/Latino of any race	7,876	18,861	41.8
	Black/African American	1,480	3,378	43.8
	Native Hawaiian/Other Pacific Islander	446	1,019	43.8
	Two or more races	3,576	6,971	51.3
	White	19,208	36,309	52.9
	Asian	3,295	5,918	55.7
Income Status	Low income	9,399	23,539	39.9
	Non-low income	27,706	51,944	53.3
Housing Status	Homeless	503	1,494	33.7
	Non-Homeless	36,602	73,989	49.5
Disability Status	Students with disabilities	1,562	6,653	23.5
	Students without disabilities	35,543	68,830	51.6
English Language	English Language Learner (ELL)	2,402	5,724	42
	Non-ELL	34,703	69,759	49.7
Sex	Male	16,271	37,851	43
	Gender X	58	125	46.4
	Female	19,917	35,436	56.2

Additional Work Supporting Child Health at the Local Level

COVID-19 and Local Health Jurisdictions

Despite the demands of the continuing COVID-19 pandemic on LHJ staff, eight of the LHJs continued to conduct activities related to child health. Many LHJ staff were required to assist with the response to the pandemic and away from their usual work on MCH activities.

Local Health Jurisdiction Work on Child Health

As a Universal Developmental Screening system is being developed by the state, partners are waiting for that structure to be in place. For the 2020-21 contract year, 8 of the 35 MCHBG local programs have selected a UDS strategy. From the list of possible strategies, they could choose one or more.

- **Assessment**: Assess current UDS services in the county and report the findings to partners and the Department of Health (DOH) - selected by 2
- **Partner Engagement**: Develop with community partners, a UDS Action Plan for the county – selected by 2
- **Provider Capacity**: Increase the number of early learning and healthcare providers trained on developmental screening tools and a community referral system – selected by 3
- **Community Implementation**: Increase the percent of children ages 10 - 71 months (end of 5th year) receiving a developmental screening using a parent completed screening tool and/or getting screened by professionals – selected by 1

- **Snohomish -** The LHJ focused its efforts on the development of a Help Me Grow network in their community that is connected to the statewide Help Me Grow initiative sponsored by Department of Children Youth and Families.

The Help Me Grow initiative is closely tied with the statewide UDS efforts and the two programs have worked closely together during the development and rolling out of the statewide UDS data system. This LHJ is part of Early Leaning Coalition that is charged with standing-up a Help Me Grow network that will provide referral services for families based on screening results or statements of need from the families.

- **Sea-King -** LHJ Staff collaborated with University of Washington and other partners, including teammates, to create a three-part training series for childcare providers to address developmental screening, assessment, and responses to children with autism spectrum disorders. This process involved roughly 40 hours of time during this three-month period, included 8 collaborators, and reached 183 providers in September

In Summary
Title V staff in the child health domain continued to promote statewide UDS, well-child exams, and appropriate follow-up and referral for intervention services. We addressed system-level reform with the development and communication of a policy agenda and began to build an *Inventory of What Works*. We gathered key data through a comprehensive ACEs prevention survey, in partnership with ASTHO. The survey focused on ACEs prevention work, specifically evidence-based practice, community partnerships, and capacity needs, mid-pandemic, from communities across Washington. These data surfaced family mental health and substance use disorder treatment needs, informing our system change efforts to work with our state partners to build access to effective behavioral health care services. These data will help us to better plan our ACEs prevention and mitigation efforts.

In partnership with a private foundation, we accelerated our dissemination and the development of a learning network for the in-demand Vroom Brain Building Tools and Messaging for parents. This was one of many ways we responded directly to the pandemic needs of families, when preschool and child-care centers were forced to close. The need for science-based activities for young children continued uninterrupted for parents using Vroom.

This year, we retained our longstanding “whole child, whole family, whole community” focus of systems reform. Our objectives and strategies were aimed at family and community resiliency for all populations, especially for those who continued to face health inequities. In addition, Title V efforts in this domain were aimed at reducing child abuse and neglect through state and local level work.

III.E.2.b.v.c. State Action Plan Narrative by Domain

Child Health Domain Plan for FY2023

Priority:

Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course.

National Performance Measure:

Percent of children ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

National Outcome Measures

Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Percent of children, ages 0 through 17, in excellent or very good health

Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Percent of children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3:3:1:4)*

Background:

Work in this priority area is supported by several different units within DOH OFHCI and other DOH offices. The primary focus of work is on improving utilization and quality of preventive health care for children, including early identification and intervention for developmental needs.

Objective:

By September 30, 2025, increase the number and proportion of families with children (ages 0-3) who receive information about developmental screening, developmental milestones, and resources to support healthy child development.

Strategies:

Provide leadership, staffing, and funding support for the ongoing development and implementation of the statewide Help Me Grow WA system and related statewide initiatives that include explicit focus on connecting families to developmental screening and resources (e.g., Pritzker Children's Initiative).

Communicate developmental screening and developmental milestone information through a variety of social media and virtual/live modalities, such as site visits with local health jurisdictions, Watch Me Grow Washington, DOH Facebook and other social media, and referrals.

Document promotion efforts including the supports and barriers identified in the communication process.

Incorporate Vroom™ brain building tips and other child development resources in Watch Me Grow Washington

mailings.

Status of this Objective
Ensuring early identification of child developmental needs, connecting children with developmental concerns to early intervention resources, and general promotion of healthy early child development remain high priorities for Child Health, particularly for children experiencing social and economic adversity. In addition to working with health care providers on developmental screening practices and data collection (see next Objective), DOH staff participate in leadership groups for statewide initiatives, such as the Pritzker-funded Children's Initiative/Prenatal-to-3 Coalition that includes increasing participation in developmental screening for young children in low-income families through the Help Me Grow WA system as one of four primary goals. DOH is also using a variety of communication channels to increase parent/caregiver awareness of developmental milestones and ideas for promoting healthy brain development, including sharing science-informed tips and tools such as those available through Bezos Family Foundation (BFF)'s Vroom initiative. With funding support from BFF, DOH has served for the past several years as the statewide hub for activating Vroom in communities throughout Washington State, resulting in Vroom resources being available to providers and families in a wide variety of settings including early learning centers, health care clinics, home visiting programs, libraries, and family resource centers. As of April 2022, DOH is working with BFF to transition the statewide activation role to a community-based partner to sustain the Vroom work. DOH will continue to promote Vroom and similar resources though incorporation in Watch Me Grow Washington mailings to families of toddlers, as well as providing technical assistance and support throughout the transition. DOH will also continue to support and monitor integration of developmental screening into state home visiting services, including those supported with federal MIECHV and MCHBG funds.

Objective:
By September 30, 2023 and ongoing, increase the number of pediatric health care practices using the Strong Start statewide universal developmental screening and referral data system as part of their practice.

Strategies:
Complete soft launch of new Strong Start Universal Developmental Screening data system (Strong Start) with two healthcare provider practices (beginning in summer 2022) (and one Help Me Grow sub-affiliate county.

Promote Strong Start with additional health care provider practices. Identify and provide technical assistance to interested providers.

Promote Strong Start with state and local partners that work closely with families of children birth through age five. Parents and legal guardians can access and enter developmental screening information about the child and share the information with childcare and early learning providers. DOH will provide training and technical assistance, as well as information about resources and supports related to early childhood development.

Continue coordination between Strong Start and Help Me Grow WA to ensure alignment of developmental data systems and services.

Encourage the coordination of pediatric screening efforts, results, and referrals among clinical care settings, medical homes, child-care settings, schools, and other organizations.

Status of this Objective
As of June 2022, the Strong Start Universal Developmental Screening data system is operational, with plans for an initial soft launch of the system with 2 pediatric provider groups and one Help Me Grow sub-affiliate county over the

summer/fall of 2022 to identify and address any system challenges and ensure the system can be integrated into clinic workflows with minimal disruption. The UDS program is currently bringing on additional staff to roll out the system more broadly, as well as to continue coordination efforts with Help Me Grow WA, health care provider organizations, and state and local early childhood partners including local public health jurisdictions and tribal health partners.

Objective:
By September 30, 2023, identify improved methods to track the proportion of children who are receiving timely developmental screenings

Strategies:
Explore options to improve availability and usability of Medicaid data provided through HCA-DOH mutual data share agreement.

Explore data agreements with other insurers or other sources to track developmental screening rates.

Incorporate data from Strong Start UDS data system.

Status of this Objective
Availability of accurate data about the proportion of children in WA State receiving timely developmental screening and referral remains challenging. This makes it difficult to determine if there are particular populations or geographic areas to concentrate outreach efforts. DOH has developed a data share agreement with the HCA that provides the number of children screened every year. Work to update this agreement to include more information on Medicaid covered children who have had developmental screenings is ongoing. Currently, the UDS is in a testing/approach phase. The UDS team is actively working with Care Coordination Services to get this system up and running. While the Strong Start data system may assist with this challenge over time, DOH staff will explore options to get more meaningful data from health care provider billing information.

Objective:
Through September 2025, increase the proportion of children who receive timely well-child visits and are up-to-date on recommended vaccinations

Strategies:
Promote routine well-child visits and recommended preventive care in early and middle childhood (birth to age 11). Activities include Patient/Parent education (communications campaign, social media posts, school flyers, public education ads, etc.), and provider education (webinars, communications, clinic collaborations, etc.).

Partner with pediatric and primary care clinic systems to engage over-due or unestablished members/children into the practice to receive well-child visits.

Establish partnerships with early learning focused organizations and school-based health centers to identify and deploy collaborative activities to improve well-child visits.

Analyze claims data from all MCOs to identify children without completed well-child visits
Track methods and effectiveness of well-child visit promotion against trends of well-child visitation, vaccination completions with actual well-child visits, and vaccination rates.

Status of this Objective
As of June 2022, DOH developed and began seeking solicitations from organizations via a formalized RFP (Request for Proposal) to plan, implement, and evaluate a social marketing/communications campaign to increase awareness of the importance and value of scheduling a well-care visit. The campaign will include Google ads, social media, and digital ad buys, and media production campaign videos. Educational promotional materials developed from this campaign will be promoted statewide for 6 months (September 2022 – February 2023).

DOH will continue to plan strategies to engage and re-engage parents and caregivers in preventative care for their children through FFY23. Anticipated activities include:

- Surveys to update our understanding of factors influencing parents to postpone or avoid preventative care.
- DOH/MCO Clinic partnership project with a large clinic system partnering with all five MCOs using proven strategies to increase well-child visits.
- Messaging to parents through early learning centers
- Messaging to parents of school age children through public school nurses/ESDs, and
- Working with school-based health clinics to expand the availability of well visits.

Priority:
Promote mental wellness and resilience through increased access to behavioral health and other support services.

State Performance Measures*:*
Social and emotional readiness among kindergarteners.

Ease of receiving mental health treatment or counseling.

National Outcome Measures*:*
Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Background
Work under this priority is focused on improving the system of services and supports for children and families, including (1) early childhood comprehensive system planning and supports, and (2) increasing access to specific behavioral health services and supports for children and their families.

Objective:
Through January 2023, develop an early childhood comprehensive systems strategic plan in collaboration with state partners and families

Strategies:
Provide state leadership and coordination for development of an integrated and comprehensive early childhood system of services and supports through the Early Childhood Comprehensive System project and other related state initiatives, such as Essentials for Childhood, State Early Learning Coordination Plan, and Pritzker's Prenatal-to-3 Children's Initiative.

Identify and implement effective, equity focused strategies to engage parents, caregivers and those with lived experiences in decisions about the development and improvement of the early childhood system of services and

support.

Collaborate with state partners to increase health care provider engagement in state coordinated access and referral network through state Help Me Grow and local efforts.

Work with families and state partners to identify and address ongoing structural barriers within state systems that impact the ability of families to access supports for themselves and their children. Prioritize efforts to eliminate barriers for families who identify as Black, Indigenous, People of Color, immigrant, or LBGTQ+ members; families of children with special health care needs; families who live in rural or geographically isolated areas; and families who experience trauma of parental incarceration, child welfare system involvement, homelessness, substance use disorder and mental illness, and other adverse experience.

Support the development and implementation of anti-racist, trauma-informed and healing-centered policies and practices within health care and other service settings serving children and families.

Advocate for investment in prevention services for parents. Implement and promote fatherhood inclusion opportunities and support resources. Promote inclusion of additional people taking parenting roles, such as foster parents, grandparents, kinship care.

Status of this Objective
In late summer 2021, DOH was awarded a 5-year HRSA Early Childhood Comprehensive Systems grant. Through this funding source, DOH is providing support for Help Me Grow WA to expand health care provider engagement in the coordinated access and referral network as well as support for integration of local resource information into the centralized state resource database at WithinReach. Key deliverables of this initiative are an Early Childhood Comprehensive Systems Strategic Plan, and meaningful parent/family engagement in systems change. DOH staff will continue to leverage ECCS and MCHBG resources to support the development of the strategic plan in partnership with families and other state partners, and in coordination with the variety of existing early childhood initiatives, such as the WA State Early Learning Coordination Plan to avoid duplication.

Objective:
Through September 2025, increase the number of health care providers who have received training and are incorporating focus on early relational health and screening for social and economic needs in routine care.

Strategies:
Partner with pediatric and family medicine organizations to promote focus on strengthening parent-child relational health in well-child visits.

Support training for clinical and community health workforce on early relational health concepts and promotion of parent and child social-emotional skill development.

Promote routine use of social determinants of health screening tools such as evidence-based Safe Environment for Every Kid (SEEK) or Survey of Well-being of Young Children (SWYC) tool in pediatric health care settings, with referrals to resources through Help Me Grow WA or local coordinated access and referral programs.

Status of this Objective
Safe, stable, and nurturing relationships and environments are essential for healthy child development. Health care providers are in a unique position to promote early relational health and identify social and economic challenges

facing families that may be causing stress and negatively impacting parent-child relationships and environments. This may include identification of parental stress, mental health and substance use concerns. DOH will work with health care provider organizations, including the WA Chapter of American Academy of Pediatrics “First Year Families” initiative to assess existing practices and opportunities to expand focus on relational health and identification of social and economic factors impacting child and family well-being. In addition, DOH staff will explore other opportunities, such as partnering with Bezos Family Foundation’s Mind in the Making initiative to increase awareness and promotion of early executive function development in young children.

Objective:
From January 2021 through January 2025, work with partners to expand availability and access to behavioral health services for children ages 11 and under and families.

Strategies:
Participate in state efforts to expand access to infant, early childhood and child behavioral health services and supports, including the efforts of the state Child and Youth Behavioral Health Work Group.

Promote standardized depression, anxiety, and substance use screening for children and their parents per the AAP Bright Futures, school-based health center models, and specific needs of communities.

Support interventions to address suicide ideation among children, especially among children who are involved in child welfare systems, LGBTQ+, BIPOC

Identify and support evidence-based practices to prevent and reduce the harmful impacts of bullying and social media on children, especially in the middle childhood period.

Support efforts to address and mitigate effects of parental substance use on children and prevent early initiation in children. Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges.

Increase knowledge, visibility of, and access to parent and child behavioral health resources and services available locally. Promote linkages to services that meet unique client or subpopulation gaps in care.

Work with HCA and other state partners to identify ways to increase diversity of child and family behavioral health service providers in order to better serve unique needs of BIPOC, immigrant, rural, and other populations.

Support the development and implementation of anti-racist, trauma-informed and healing-centered policies and practices within behavioral health, health care, and other service settings serving children and families.

Build networks and resources in communities to enable and enhance community and peer support.

Status of this Objective
Access to behavioral health services and supports for children and their families remain an extremely challenging issue, particularly in the face of growing mental and behavioral health needs through the COVID-19 pandemic. These issues are being prioritized within DOH and at the broader state level and with legislative support for a cross-sector Children and Youth Behavioral Health Workgroup, and significant investments in expanded behavioral health services in schools and inpatient facilities. Funding for School-Based Health Centers, including expanded access to behavioral health services was prioritized in 2021 and 2022 legislative sessions. DOH has convened an Agency

Behavioral Health Workgroup to articulate the public health role in mental illness and SUD prevention, including focus on children and youth. DOH staff will participate in the development of the legislatively mandated statewide behavioral health strategic plan for children and youth. DOH Child Health staff coordinate with other programs in the Office of Family and Community Health Improvement and across DOH on child behavioral health issues, including connections with the Perinatal, Adolescent Health, CYSCHN and Injury and Violence Prevention units. The Perinatal Health Unit reviews plans around depression screening and support of infants with Neonatal Abstinence Syndrome and parents with substance use disorder. The Adolescent Health Unit is managing the School Based Health Center program, including SBHC behavioral health expansion. The CYSCHN Unit is supporting a Pediatric Mental Health Care Access grant and expansion of the Partnership Access Line (PAL) at Seattle Children's Hospital offering remote pediatric mental health consultation for primary care providers across the state. The Injury and Violence Prevention programs in the Office of Safe and Healthy Communities are working on suicide prevention and the roll out of the 988 behavioral health crisis system.

DOH Child Health staff will continue to participate in cross-agency and cross-sector efforts to expand access to behavioral health services, while bringing the upstream prevention perspective to these conversations. Two areas of particular concern that we will focus on in FY23 include: bullying behaviors in middle childhood given the significant correlations between bullying and mental health problems, and access to culturally specific services to better meet needs of BIPOC, immigrant, and rural children, especially those who also identify as LGBTQI+ or have been involved in child welfare system/foster care.

Priority:
Optimize the health and well-being of children and adolescents, using holistic approaches.

State Performance Measure
Family resilience composite measure (NSCH)

Background:
Work in this priority area focuses on supporting community and system-level approaches to reduce child and family adversity, promote family and community resilience, particularly in the early childhood period. During FFY23, we plan to increase focus on middle childhood (ages 6-11), by assessing current state and local initiatives and opportunities for enhancement.

Objective:
By September 2025, increase community-based primary prevention programs, practices, policies, and systems to reduce childhood adversity and promote child and family well-being

Strategies:
Collaborate with Essentials for Childhood and other partners to p*romote state leadership, commitment, and investment in the vision of all children in WA State thriving in safe, stable, nurturing relationships and environments.*

Adopt and share concepts, tools, trainings, and practices aligned with the Healthy Outcomes from Positive Experiences (HOPE) Framework in state Essentials for Childhood initiative and other settings.

Promote evidence-informed programs and policies to prevent and reduce adverse childhood experiences (ACEs) and promote positive childhood experiences (PCEs) statewide through local health jurisdictions, community-based home visiting programs, schools and early learning settings, and other prevention programs

sponsored by DOH, HCA and DCYF.

Support community-led resilience building initiatives in communities with higher rates of child maltreatment and other adversity. Connect with DOH Health Equity Zones and other related initiatives.

Continue to build out an Inventory of What Works to reduce maltreatment and promote family resilience, for use in state and local prevention planning.

Continue to convene the ACEs and Resilience Community of Practice to promote shared learning and increase connections between community and state partners working on ACEs, PCEs, and resilience.

Status of this Objective
During 2021, as part of the first phase of the Essentials for Childhood Inventory of What Works project, DOH partnered with 4 local health jurisdictions to identify promising, evidence-based, and community-driven strategies (i.e., programs, policies, practices) for building family resiliency and preventing child abuse and neglect. An aim of this work is to assess community assets and gaps related to reducing child maltreatment and promoting family resiliency. One finding of note was a call for more leadership commitment and local resources to support families. This was also echoed in the ACEs and Resilience Community of Practice Roadmap, with a request for more state leadership, awareness and tangible resources to support community-based solutions. During FY23, we will leverage several key opportunities to support community-based primary prevention work including the roll out of Foundational Public Health Services funding to local health jurisdictions to create capacity for Maternal, Child, and Family Health prevention planning, ongoing support and learnings from DCYF Strengthen Families Locally initiative in 4 communities with higher rates of child maltreatment, and potential connections with communities through DOH's Health Equity Zones initiative. In addition, we will actively support sharing "positive" messages through the dissemination of materials from the Tufts HOPE framework, which includes numerous family- and community-friendly resources and ideas. After an 18 month hiatus due during pandemic, we will reconvene the ACEs and Resilience Community of Practice, bringing together diverse state and local partners to lift up effective and innovative community approaches to: reduce and mitigate adversity; promote resilience; and strengthen the network of upstream prevention practitioners.

Objective:
By September 30, 2023, develop a positive community norms campaign or educational awareness campaign focused on child well-being in the context of their families and communities

Strategies:
Complete feasibility study of positive community norms campaign.

Develop and test messaging, identify message dissemination strategies to support related areas of interest (e.g., ACEs, trauma-informed/healing centered services).

Coordinate campaign development and implementation strategies with EfC partners and parents representing diverse communities.

Status of this Objective
As of June 2022, after some contracting delays, plans are in place to contract with The Montana Institute to conduct a feasibility study of a positive community norms campaign (identified as a key strategy in the CDC's Technical Package on Preventing Child Abuse and Neglect). TMI will determine if there is enough current state data related to

perceptions about parenting to move forward with a campaign. If feasible, we will pursue additional resources to develop the campaign in FY23.

Objective:
By September 30, 2023, develop an approach to measure and monitor community resilience and correlation with child and family well-being outcomes

Strategies:
Work with Surveillance and Evaluation section and other partners to identify valid and reliable measures for ACEs/PCEs incidence and promising strategies at the state and community levels.
Engage with academic partners to research potential community resilience questions, possible inclusion in existing survey tools, or other approaches to measurement. Pursue funding sources to implement recommended approach.

Define future data needs to measure child and family health and well-being. Support current data collection activities in this population, such as the oral health basic screening survey. Advocate for additional resources to expand availability of child health and well-being data, such as through state roll-out of the Best Starts for Kids Child Survey.

Status of this Objective:
The lack of available data to guide work in advancing child and family well-being has created challenges in bringing attention to the issues and being able to measure and monitor success of child health-related interventions at the population level. In addition to understanding and measuring child and family resilience factors, community partners and state policymakers have expressed interest in exploring measurement of factors within communities (e.g., community cohesion, caring for others, presence of high levels of unmitigated trauma, etc.) that impact the risk of childhood adversity and both positive and negative outcomes. DOH has identified funding to partner with a research entity to recommend a potential methodology (e.g., survey questions) for measuring community contextual resilience, likely beginning early fall 2022. In addition, DOH is working with state and local governmental public health system partners through the state's Foundational Public Health Services initiative to move forward a recommendation to fund statewide roll-out of King County's Best Starts for Kids Child Survey, which would serve to fill a key gap in data related to children 0-11 years and their families.

Objective:
By September 2025, advance program, policy and system changes that increase the proportion of families with children who have sufficient household income plus concrete supports to meet basic needs.

Strategies:
Collaborate with EfC partners and statewide initiatives (i.e., Governor's Dismantling Poverty Strategic Plan) to expand access to economic and concrete supports, through development and implementation of evidence-based policies, such as guaranteed basic income, and simplification of enrollment in state benefits programs.

Use a racial equity lens to prioritize economic stability strategies that address economic inequities experienced by BIPOC children and families.

Participate in statewide efforts to expand access to affordable, high-quality child-care and evidence-based home visiting as strategies to support family financial well-being, reduce family stress, and promote healthy child development.

Continue work with state and local partners to improve access to and navigation of family supports and services (including economic supports) through development of state and local coordinated access and referral networks (Help Me Grow WA and related local efforts)

Status of this Objective

Reducing family stress, including economic stress is essential to improving well-being and promoting optimal health. State school readiness data reveal significant differences between low income and non-low-income children entering kindergarten. Low-income children are more likely to be behind on reaching milestones across all developmental domains, including social-emotional development. In a 2016 study of the effects of economic hardship on family functioning and child outcomes, researchers found that economic hardship led to economic pressures which were associated with parental emotional distress and couple conflict (Neppl, T., Senia J., Donnellan, M.B. (2016). *The Effects of Economic Hardship: Testing the Family Stress Model over Time*. J Fam Psychol, 30(1):12-21.). This conflict in turn led to child behavioral concerns. A recent review of research on poverty and child maltreatment concluded that addressing economic hardship is key to preventing child welfare system involvement. (Weiner, D. A., Anderson, C., & Thomas, K. (2021). *System transformation to support child and family well-being: The central role of economic and concrete supports.* Chicago, IL: Chapin Hall at the University of Chicago.) Strengthening economic supports for families is identified as a key strategy in the Centers for Disease Control and Prevention (CDC) Technical Package on preventing child abuse and neglect as well as a primary lever in reducing harms to child well-being associated with structural racism and advancing more equitable well-being outcomes.

Key work in this area is connected to the Essentials for Childhood Initiative, which receives funding support from both CDC and MCHBG. In particular, EfC partners have identified opportunities to improve family well-being and reduce child adversity through current state efforts to study and potentially pilot a guaranteed basic income approach, and other strategies aligned with the Governor's Dismantling Poverty Strategic Plan (2020). DOH staff will work with partners to support development of policy agendas, while ensuring compliance with federal, state, and agency rules for policy advocacy. In addition, DOH staff will continue to participate in state efforts to expand access to supportive services, such as home visiting and child care, and will continue to prioritize efforts to eliminate barriers for families who identify as Black, Indigenous, People of Color, immigrant, or LBGTQ+ members; families of children with special health care needs; families who live in rural or geographically isolated areas; and families who experience trauma of parental incarceration, child welfare system involvement, homelessness, substance use disorder and mental illness, and other adverse experiences.

Work related to increasing access to services and supports through Help Me Grow WA has been addressed in other areas of this plan.

Objective*:*

By August 30, 2023, develop a sustainability plan to continue progress on child and family well-being strategies and actions identified in collaboration with Essentials for Childhood partners.

Strategies*:*

Work with EfC partners to identify ongoing priorities and resources, and the most appropriate structure to support ongoing collaboration.

Status of this Objective

Our current 5-year grant from CDC for the Essentials for Childhood initiative ends in August 2023. Over the past 4 years, we have leveraged a variety of funding sources including MCHBG to support strategies aligned with this initiative. We will work with our Steering Committee to identify priorities going forward and explore new funding opportunities to advance that work.

Objective:
By September 30, 2023, complete a needs assessment focused on middle childhood health (ages 6-11 years), including examining existing state and local initiatives and opportunities for improvement.

Strategies:
Collaborate with other DOH sections, units, and state/local partners to identify existing data focused on middle childhood health.

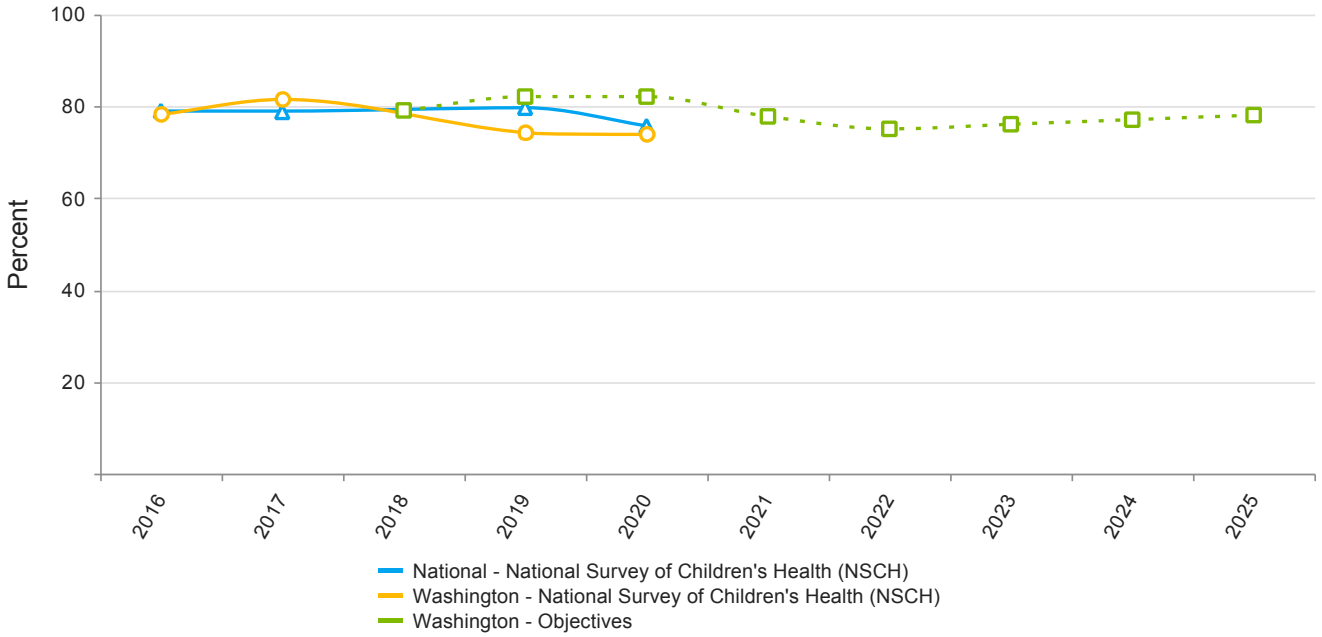
Develop and implement methods to assess current state and local assets and identify gaps and opportunities related to middle childhood health.

Status of this Objective:
To date, DOH Child Health has largely focused efforts on the critical early childhood period, while recognizing a need to ensure the needs of children in the middle childhood period (age 6-11) are considered. Concerns about increasing behavioral health needs including suicidal ideation, as well as key opportunities for health promotion in this time period, indicate a growing urgency to attend to middle childhood health more explicitly. During FY 23, DOH Child Health staff will launch an assessment of middle childhood health needs, including engagement with key state and community partners and families of children in this age range.

Adolescent Health

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		79	82	82	77.7
Annual Indicator	78.1	81.3	81.3	74.0	73.8
Numerator	424,264	432,006	432,006	405,716	407,557
Denominator	543,052	531,119	531,119	548,292	552,011
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	75.0	76.0	77.0	78.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			50
Annual Indicator	68.4	68.4	69.2
Numerator			
Denominator			
Data Source	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2018	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	69.9	70.6	71.3	72.0

State Performance Measures

SPM 7 - Percentage of tenth grade students who have an adult to talk to when they feel sad or hopeless

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	59.9	60.4
Numerator		
Denominator		
Data Source	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	60.5	60.6	60.7	60.8

SPM 8 - Percentage of tenth grade students who report having used alcohol in the past 30 days

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			15.8
Annual Indicator		18.8	8.4
Numerator			
Denominator			
Data Source		Healthy Youth Survey	Healthy Youth Survey
Data Source Year		2018	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	14.8	13.8	12.8	11.8

SPM 9 - Adolescents reporting at least one adult mentor

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			74.4
Annual Indicator		69.8	65.3
Numerator			
Denominator			
Data Source		Healty Youth Survey	Healthy Youth Survey
Data Source Year		2018	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	66.5	68.0	69.0	70.0

State Action Plan Table

State Action Plan Table (Washington) - Adolescent Health - Entry 1

Priority Need

Identify and reduce barriers to quality health care.

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By September 30, 2025, develop and provide technical assistance for school-based health centers and adolescent health providers so they report the ability to appropriately bill insurance for 50 percent of services delivered.

By September 30, 2023, have a sustainable comprehensive sexual health network focused on youth from historically underserved communities.

By September 30, 2023, conduct an Adolescent Health needs assessment to learn more about adolescent experiences with health care; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.

By September 30, 2023, discuss key health topics with the Youth Advisory Council to learn more about their thoughts, ideas and recommendations for health needs and gaps. By September 30, 2023, identify/develop strategies and interventions to increase access to healthcare services for young people that are based on the ideas and recommendations of the Youth Advisory Council.

By September 30, 2023, partner with youth volunteers to develop and implement an adolescent health promotional campaign using social media.

Strategies

In collaboration with payers and health coverage organizations, understand and mitigate issues related to financial eligibility for health care and other support services.

Through partnerships, understand and mitigate issues related to financial eligibility for health care and other support services for adolescents and young adults.

Conduct needs assessment to identify existing strengths and gaps in data, as well as top barriers for adolescents and young adults in seeking health care services.

Ensure all adolescents and young adults, regardless of race, ethnicity, sexual orientation, and gender identity, have a full range of education, access, and ability to utilize health services that meet their individual needs.

Support and enhance efforts to increase health literacy among adolescents and young adults.

ESMs	Status
ESM 10.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Washington) - Adolescent Health - Entry 2

Priority Need

Optimize the health and well-being of children and adolescents, using holistic approaches.

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By September 30, 2022, form youth advisory council and hold at least one initial meeting and by September 30, 2023 discuss adolescent well visits and adolescent and young adult care and services.

By September 30, 2023, conduct an Adolescent Health needs assessment to learn more about adolescent experiences with adolescent and young adult well visits, and transition care; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.

By September 30, 2023, partner with the Washington School Based Health Alliance and the Health Systems Transformation Team to present information about School-Based Health Centers, and their importance in improving access to health care and well visits for adolescents.

By September 30, 2022, award grants to plan, start, and improve school-based health centers throughout Washington, primarily in communities that have been historically underserved.

Strategies

Include adolescents in this work through strategies such as building and supporting a youth advisory council, and identify other meaningful ways to engage the population to be served.

Collaborate with internal and external partners to identify and implement solutions that support accessible, affordable, and quality childcare, including care that meet the needs of families with CYSHCN.

Promote school-based health strategies to serve adolescent populations where they are.

ESMs	Status
ESM 10.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Washington) - Adolescent Health - Entry 3

Priority Need

Promote mental wellness and resilience through increased access to behavioral health and other support services.

SPM

SPM 7 - Percentage of tenth grade students who have an adult to talk to when they feel sad or hopeless

Objectives

By September 30, 2023, conduct an Adolescent Health Provider needs assessment to learn more about provider experiences with behavioral health screenings and risk assessments; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.

By September 30, 2022, award nine or more grants to SBHCs for behavioral health services.

By September 30, 2023, partner with youth volunteers to develop and implement an adolescent behavioral health awareness campaign using social media.

By September 30, 2022, provide accessible trainings for SBHC providers on trauma informed care, adolescent friendly services, and discussing sensitive topics. By September 30, 2023, implement efforts to expand trainings to additional adolescent and young adult friendly providers.

By September 30, 2022, discuss mental and behavioral health with the Youth Advisory Council to learn more about their thoughts, ideas and recommendations for behavioral health needs and gaps, including stigma around BH care and suicide prevention.

By September 30, 2023, identify/develop behavioral health interventions for young people based on the ideas and recommendations of the Youth Advisory Council.

Strategies

Improve the knowledge and ability of health care professionals to deliver comprehensive evidence-based/informed services, including integrated mental health and chemical dependency screening and interventions for adolescents and young adults.

Promote standardized depression, anxiety, and substance use screening that are adolescent and young adult-friendly.

Take action to reduce stigma surrounding adolescent and young adult behavioral health conditions and implement trauma-informed services specific to adolescents and young adults in community services and health care systems.

Expand access to and the quality of behavioral health services in SBHCs.

Support interventions to address suicide ideation among youth, especially among those marginalized by mainstream society.

State Action Plan Table (Washington) - Adolescent Health - Entry 4

Priority Need

Promote mental wellness and resilience through increased access to behavioral health and other support services.

SPM

SPM 8 - Percentage of tenth grade students who report having used alcohol in the past 30 days

Objectives

By September 30, 2025, increase the number of school-based health centers with licensed mental health services by 5 percent.

By September 30, 2023, hold at least 10 Youth Advisory Council meetings, where behavioral and mental health care – including substance use among youth– are discussed.

By September 30, 2022, collaborate with internal and external partners (including OSPI and S/E) to identify strengths and gaps in data, and define strategies to address them.

By September 30, 2023, provide funding to support health campaigns in SBHCs that promote awareness/reduce stigma around adolescent substance use.

Strategies

Support efforts to address and mitigate individual and community effects of substance use among adolescents and young adults.

Build on efforts to identify scope of impacts of substance use, including inequities among adolescents and young adults from priority populations.

State Action Plan Table (Washington) - Adolescent Health - Entry 5

Priority Need

Improve the safety, health, and supportiveness of communities.

SPM

SPM 9 - Adolescents reporting at least one adult mentor

Objectives

By September 30, 2025, reduce the percentage of 10th grade students receiving our interventions who reported that someone they were dating limited their activities, threatened them, or made them feel unsafe by 10 percent (from 9.5 to 8.5 percent).

By September 30, 2025, continue to work to align violence prevention efforts with partners, including DOH Injury and Violence Prevention and the Office of the Superintendent of Public Instruction (OSPI)

By September 30, 2025, continue to promote resources and information about, and support projects that promote healthy relationships for young people.

By September 30, 2025, continue to participate in OSPI's monthly School Safety and Student Wellbeing Workgroup to align efforts with agency partners.

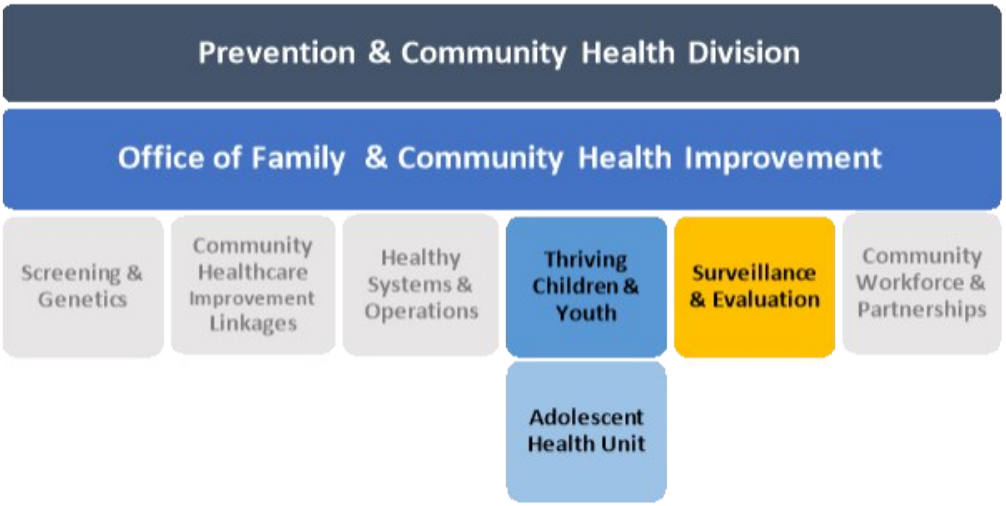
Strategies

Support violence prevention efforts and promote healthy relationships among adolescents and young adults.

Align violence prevention efforts with partners, including DOH Injury and Violence Prevention and the Office of the Superintendent of Public Instruction (OSPI)

Build networks and resources in communities to enable and enhance community and peer support.

III.E.2.b.v.c. State Action Plan Narrative by Domain



Adolescent Health Domain Annual Report

Overview

The Adolescent Health unit at the Department of Health (DOH) resides in the Thriving Children and Youth section of the Office of Family and Community Health Improvement in the Division of Prevention and Community Health. The Adolescent Health unit works to ensure equitable opportunities for improved social, emotional, and physical health and well-being for adolescents and young adults where they live, learn, work, and play. We use a health equity lens to address social determinants of health, disparities, and other barriers to optimum health for adolescents and young adults, specifically priority populations.

Program goals include providing access to quality age-appropriate health services; ensuring safe and supportive environments at home, school, and in the community; increasing sexual health services and information; and planning and developing policies to promote new knowledge and competence in adolescent health. We strive to be human-centered, collaborative, inclusive, data-driven, and innovative.

Our state action plan for adolescent health focuses on the following priorities: sexual and reproductive health, access to appropriate health care services, support for pregnant and parenting teens, and sexual health education. In mid-June 2021 we hired a Title V Adolescent Health Coordinator in a new position to focus on well-adolescent visits and on the overall Title V plan.

To address the unit's priorities, the Adolescent Health Team implements several programs with specific focuses and collaborates other DOH programs and key partners. The following report describes those efforts as they relate to our MCHBG priorities, objectives and strategies.

Priority:

Promote mental wellness and resilience through increased access to behavioral health and other support

services.

State Performance Measures:
Percentage of 10th grade students who have an adult to talk to when they feel sad or hopeless.
Percentage of 10th grade students who report having used alcohol in the past 30 days.

Objective:
By September 30, 2025, increase the number of school-based health centers with licensed mental health services by 5 percent.

Respondents to the maternal and child health needs assessment noted that young people have difficulty finding providers (including behavioral health providers), and the health care system needs to be easier to navigate and include better coordination, linkages, and referrals. Respondents also consistently identified concerns related to suicide and youth mental health, like the need for providers to screen for mental health and substance use risk when seeing young patients and clients. These data and the MCH needs assessment highlight the need for systems-level improvements so that adolescents can access and experience patient-centered medical and mental health care.

School-based health centers (SBHC) are a key strategy we use to increase access to youth-friendly services for young people. SBHCs provide integrated and comprehensive medical and behavioral healthcare in convenient locations for young people - which increases access and utilization and promote the development of trust between young people and their healthcare professionals. Over the reporting period, the Adolescent Health Team and DOH leadership established the new SBHC program in accordance with SHB 1225: Concerning School-Based Health Centers (codified at RCW 43.70.825) to expand and sustain SBHCs that provide comprehensive and integrated medical and behavioral health care throughout the state, and which prioritize students from communities or populations that are historically underserved.

In addition, the Adolescent Health Team and leadership submitted an agency request decision package for additional and complementary funding to expand behavioral health services in school-based health centers. The request was part of a larger Young Adult Behavioral Health Improvement (ESSB 5693) package included in the 2022 operating budget. The new budget allocates additional funds and directives to complement SHB 1225 and allowing us to fund between eight and 10 grants to increase access to or improve behavioral health services in existing SBHCs. Many of the goals of this funding will remain the same as the original SBHC grant program, with the focus shifted to behavioral health. To implement this legislation, over the reporting period we:

- Expanded our partnership with the Washington School-Based Health Alliance to assist DOH with development of SBHC grant funding criteria for the behavioral health focused grants. This was formalized through a contract amendment for their services.
- Collaborated with the Alliance to identify key partners and stakeholders to participate in SBHC behavioral health grant development and selection activities.
- Recruited and hired staff, including the SBHC Behavioral Health Grant Program Coordinator to assist with program development, grant application creation and to monitor and manage grants (formalized as contracts with DOH).
- Partnered with the Alliance to provide training and technical assistance to SBHCs to increase access to or improve behavioral health services.

- Released a Request for Applications (RFA) for the SBHC behavioral health grant. In July, we will select around nine existing or startup SBHC sites to fund up to $90,000 for behavioral health improvement projects.

Strategy:
Improve the knowledge and ability of health care professionals to deliver comprehensive evidence-based/informed services, including integrated mental health and chemical dependency screening and interventions for adolescents and young adults.

We want to strengthen SBHC providers' ability to care for students with behavioral health needs. To do this, we want to provide learning resources for adolescent providers that cover key topics like healing-centered care, adolescent-friendly care, and how to discuss sensitive topics with young people. Over the reporting period, we partnered with Cardea Services to develop online trainings on each of these topics. The trainings will be available for adolescent health providers (advanced practice clinical providers and behavioral health providers) in SBHCs. For convenience and ease of access, the trainings will be available online and will include an audio-only component. In addition, providers will be able to apply for continuing education credits. In the future, we hope to expand these trainings (funding dependent) to adolescent health providers, state-wide.

Strategy:
Take action to reduce stigma surrounding adolescents' and young adults' behavioral health conditions, treatment, and related challenges.

As the need for mental health care among young people rises – especially over the course of the COVID-19 pandemic – stigma impedes access to needed care and can make it less likely youth will seek services. According to the U.S. Department of Health and Human Services, National Institute of Mental Health, 32% of 13- to 18-year-olds experience anxiety disorders. Depression occurs in approximately 13% of 12- to 17-year-olds; attention deficit-hyperactivity disorder (ADHD) occurs in approximately 9% of 13- to 18-year-olds. However, stigma and misperceptions about youth with mental health diagnoses are an ongoing problem and have a profound impact on whether youth will get the care they need. This is compounded by the fact that people with mental health conditions report experiencing discrimination and prejudice, which is one of the primary reasons people do not seek the care they need when they need it.

Over the reporting period, we learned from our partners that families and caregivers of young people are also being impacted by stigma around behavioral health conditions. We have heard our partners share stories about parents who do not want mental health screenings for their children out of a belief that they will result in "false positives", and that some families do not want mental health care or services for their young people, at all.

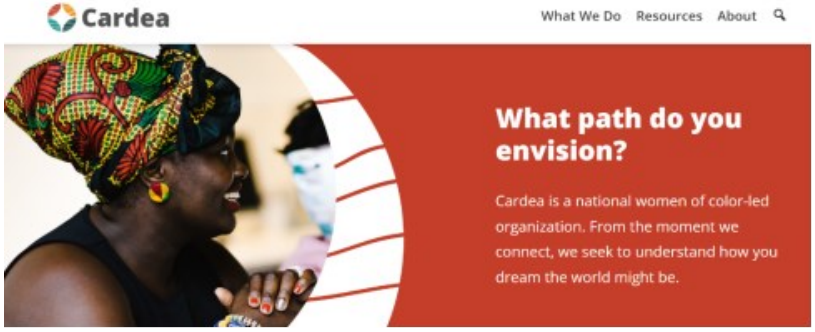
The Adolescent Health Team has laid the foundation for work to address stigma and behavioral health. This includes much of the work and resources that have contributed to the SBHC behavioral health grant program. In addition, we have also been working on the following:

- We recruited two new Youth Voice volunteers to help us create and carry out communications campaigns using social media to increase knowledge of behavioral health and reduce stigma. We hope to implement some of those plans over the rest of the reporting period.
- We collaborated with and provided funding for the Alliance to support SBHCs to carry out health promotion activities in and with the schools they serve. Taking place over the next school year, these activities will cover topics like mental and behavioral health, stigma around mental health, and substance use.

Strategy:
Implement trauma-informed services specific to adolescents and young adults into community services, health care systems, and the public sector.

The goal of DOH and key partners like HCA and DCYF is to move Washington toward a statewide culture of trauma-informed – or healing centered - approaches. According to a study by Darnell, Flaster, Hendricks, Kerbrat, & Comtois (2019), among adolescents between the ages of 13 and 17, 62% have been exposed to one or more traumatic events throughout their lifetimes. Recent data from the Washington State Healthy Youth Adverse Childhood Experiences Score (2021) found that while youth tended to most frequently report 0-1 ACEs, many young people are reporting 4 or more: 14.6% of 12th graders, 11.4% of 10th graders, and 12.4% of 8th graders reported four or more ACEs. In addition, trauma-related events impact young people at different rates depending on their socioeconomic and racial/ethnic backgrounds. For example, the same survey shows that lesbian, gay, and bisexual 10th graders were 3 times more likely to report 4+ ACEs than heterosexual youth, and transgender 10th graders were 7 times more likely to report 4+ ACEs than boys. The data varied across race and ethnicity, with Asian/Asian American and white youth reporting the lowest WAH-ACEs scores compared to their peers. And, 10th graders who moved with their families for seasonal, temporary, or agricultural work were more likely (15.0%) than those who didn't (10.7%) to have WAH-ACEs scores of 4+ or more.

These numbers make it critical for those serving young people to incorporate healing-centered approaches in their programs. Understanding the impact of trauma on youth development, and how to engage youth to be resilient, is an essential part of care for adolescents and young adults. To continue toward this goal, we completed the following activities over the reporting period:

- 

We collaborated with Cardea Services to create trauma-informed trainings for SBHC providers that will be available online, and for which providers will be able to receive continuing education credits. We expect to release these trainings during the rest of the reporting period and hope to expand access to them in the future.

- Given severe provider shortages, we supported the DOH COVID-19 Behavioral Health Group pilot effort to increase the school and community-based workforce qualified to provide adolescent behavioral health screening,

assessment, and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) treatment through our Youth Behavioral Health Improvement decision package. This package included funds for universal screening and the SBHC behavioral health grants.

- Over the rest of this reporting period and into the next, we plan to continue this work to expand access to the trainings, to work with partners within DOH and with other state agencies to promote policies and programs related to youth behavioral health care that include a trauma-informed approach.

Strategy:
Support interventions to address suicide ideation among youth, especially among those marginalized by mainstream society.

The 2021 Healthy Youth Survey indicates that thirty eight percent of 8th, 10th and 12th graders reported depressive feelings. Among female students, it was 50%. White students were more likely to report depressive feelings than their Asian classmates, but less likely than Hispanic, American Indian/Alaska Native and classmates who identified as more than one race. All females, no matter which race/ethnicity they identified as, reported higher rates of depressive feelings than males of any race/ethnic group. Approximately twice as many respondents who identified as not heterosexual reported having depressive feelings as did those identifying as heterosexual, 62% and 30%, respectively. 65% of students reported they did have an adult in the community they could talk to if they felt sad or depressed (HYS 2021)

Suicide is the second leading cause of death for Washington youth between the ages of 15 and 19. In 2017, nearly four youth killed themselves on average in each week, and two youth ages 10 to 24 were hospitalized because of intentional self-injuries, which included suicide attempts. Responses to the 2018 Washington Healthy Youth Survey showed that 23% of 10th grade students considered attempting suicide in the past year. Ten percent of 10th grade students reported making a suicide attempt in the 12 months prior to the survey. In addition, preliminary data and anecdotal evidence suggests that COVID-19 related stressors are having a significant impact on rates of youth depression and suicide during 2020 and beyond.

To strengthen our work to address mental health and suicide risk among youth, we continue to support the work of our colleagues. This includes:

- Support and implement recommendations made by the Children and Youth Behavioral Health Workgroup. This workgroup is facilitated by the Health Care Authority (WA Medicaid Agency): Children and Youth Behavioral Health Work Group (CYBHWG) | Washington State Health Care Authority.
- School-based mental health care: Last year we submitted a decision package to request funds to strengthen behavioral health services in the school systems, specifically through school-based health centers through $720,000 in grant funding. More information can be found here: School-Based Health Center Program | WaPortal.org
- We convened a new Youth Advisory Council so we can learn more about the ideas and recommendations of young people around behavioral health and suicide prevention. We plan to take what we learn from the Council to guide our MCHBG program and project planning in future years. This Council has 40-members comprised of young people age 13-21. You can learn more here: Youth Engagement and the Youth Advisory Council | WaPortal.org
- Our partners in Injury and Violence Prevention are the lead participants in the Children and Youth Behavioral Health workgroup on behalf of our Division. We continued to support and promote their work and align our work with theirs. Some of their more recent projects include:
    - The suicide prevention team released the *Native and Strong Campaign* last year – it's a sister campaign

to HCA's WA Tribal Opioid Solutions: www.nativeandstrong.org. The original campaign was developed for tribal audiences age 12 – 24 and Elders. They hope to expand to also reach two-spirit individuals, tribal veterans, and younger children to age 6.

- They are also doing youth suicide prevention in schools through Sources of Strength, a peer-based youth suicide prevention program to reduce bullying and sexual violence in high schools. More general information can be found here: Sources of Strength

Strategy:
Promote standardized depression, anxiety, and substance use screening for adolescents and young adults.

The effectiveness of risk screening is dependent on ensuring confidentiality. Research shows that adolescents are more likely to share risk behaviors and answer screenings honestly if they believe their care is confidential. The Washington Youth Sexual Health Survey demonstrated that teens in Washington have significant concerns about their privacy and confidentiality when accessing services, and more work is needed in Washington to implement best practices using innovative interventions to incorporate these tools into clinical workflows. And although screening and counseling adolescents on risk behaviors is universally recommended by the Society for Adolescent Health and Medicine, American Medical Association, American Academy of Pediatrics, American Academy of Family Physicians, and American College of Preventive Medicine; it is not universally followed, and rates of use range from only 15 to 50%.
One of our key strategies is to work with partners to ensure providers have the tools they need to provide age-appropriate, evidenced based, and youth-friendly services for young people. To do this, we support the use of the Bright Futures Guidelines for clinical service. However, last fall, we learned that the Washington Chapter of the American Academy of Pediatrics (WCAAP) was not actively promoting the use of Bright Futures.

As such, we wanted to learn more about the experiences of providers delivering care to young people – including their experiences with screenings and risk assessments. Over the reporting period, we worked with the Surveillance and Evaluation Team to plan an Adolescent Health Needs Assessment to learn more about providers' experiences and needs when caring for adolescent and young adults. The needs assessment includes a survey geared to adolescent and young adult healthcare providers and consists of open-ended questions around the services they provide, including screening and risk assessments, well-visits, adolescent-friendly care, telehealth, general barriers/challenges, billing/reimbursement and more. Over the rest of this reporting period, we will finalize the survey, work with several pediatric providers recommended by the WCAAP and others to help frame survey questions so they are relevant and meaningful and identify a dissemination strategy. We anticipate releasing the survey in the fall and reporting the findings in our next MCHBG report.

Similarly, we also want to learn more about young people's experiences and perspectives with adolescent and young adult healthcare. The needs assessment will include a survey geared to young participants age 13-22 and will also have open-ended questions about adolescent and young adult health topics like well-visits and preventive care, adolescent-friendly services, and youth experiences with their healthcare providers. We recruited a Youth Voice Intern to collaborate with and to help us ensure the survey and distribution plan are youth-friendly and relevant. We are also preparing for IRB exemption. Depending on the outcome of the review, we hope to release the survey in either early fall or after the holidays, so it doesn't conflict with the Healthy Youth Survey.

Strategy:
Support efforts to address and mitigate individual and community effects of substance use among adolescents and young adults.

The Healthy Youth Survey from 2021 shows that drinking within the past 30 days was related to grade level. It was also down considerably from 2018. In 2021, 20 percent 12th graders and 8 percent of 10th graders reported drinking. In comparison in 2018, 28 percent of 12 graders and 18 percent of 10th graders reported drinking. The most common source of alcohol was from friends, while the second most common source was from parents with their permission. Attitudes of parents and peers does seem to influence adolescent drinking, with those who report more disapproval by either group less likely to report drinking. As the degree of disapproval increases, the likelihood of drinking decreases in a "dose-response" model.

Cannabis use in the prior 30 days was, like alcohol, inversely related to grade level with 16% of 12th graders, 7% of 10th graders, 3% of 8th graders and 1% of 6th graders reporting use. There was a very strong inverse relationship between use and perception of acceptability of use from both peers and the general community in which students lived. Fourteen percent of 10th graders and 27% of 12 graders reported that it would be very easy to obtain cannabis if the wanted to.

During this reporting period, the Adolescent Health Team implemented the following strategies and activities to mitigate the effects of substance use:

- Securing funding for SBHCs to improve access to and the quality of behavioral health services in SBHCs, including substance use care
- Promoting the Washington State Tobacco Quitline and tobacco cessation smartphone app, with emphasis on each program's tailored pregnancy programs
- Promoting and supporting the Tobacco, Vaping and Marijuana Prevention Teams at DOH. The Adolescent Health Team has also collaborated with the Tobacco and Marijuana Prevention Team on engaging the Youth Advisory Council around mental and behavioral health. Members from the Tobacco Prevention Team provided insight and best practices on youth engagement for the Adolescent Health Team; they also attended on of the Youth Advisory Council meetings to listen and learn from young people.
- As mentioned above, conducting a needs assessment to learn more about the types of substance use/risk behaviors screenings providers are using, and challenges and successes, therein.
- Adolescent Program Manager has been in discussion with the tobacco unit within DOH to provide a letter of support for the five-year cessation grant as a way to determine the best way to leverage resources to further our shared goals for youth prevention and cessation of tobacco use.
- Supporting the work of the newly formed Opioid Prevention Team at DOH (in Injury and Violence Prevention) to address opioid use among young people. This includes supporting their work to carry out the "Laced and Lethal" project in Seattle/King County to spread awareness about substances laced with fentanyl. We hope to collaborate with this team to expand this project in the future.

Strategy:
Build on efforts to identify scope of impacts of substance use, including inequities among adolescents and young adults from priority populations.

Health disparities continue to be evident in rates of youth and young adult substance use. To better understand how youth are impacted by substance use, and the inequities that exist, we continued work to assess existing data to identify gaps in services and underlying socioeconomic factors playing into substance use. We also examined structural issues through a lens that acknowledges systemic racism, sexism, and homophobia, and their effects on health inequities.

Due to limited capacity, we were not able to form a cross-agency workgroup to align substance use reduction and prevention strategies and efforts among internal programs. However, the Adolescent Health Team has been

participating in the state-level opioid prevention workgroup to learn more about the programs and projects in the state that impact youth substance use. The Team also hopes to revisit a plan to form an internal workgroup to align substance use prevention strategies. Potential partners include Injury and Violence Prevention; TVPPCP; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Immunizations; Heart Disease, Stroke, and Diabetes Prevention unit; and Healthy Eating and Active Living (HEAL).

Priority:
Identify and reduce barriers to quality health care.

Objective*:*
By September 30, 2025, develop and provide technical assistance for school-based health centers and adolescent health providers so they report the ability to appropriately bill insurance for 50 percent of services delivered.

Over the reporting period, we formalized our partnership with the Alliance to provide support, training and technical assistance to SBHCs, statewide. Because SBHCs face a number of challenges related to sustainability, part of this work includes ensuring SBHCs are able to receive reimbursement for services. The Alliance provides tremendous support to SBHCs to ensure they are able to properly bill for services. We also learned there are misunderstandings among insurers around school-based health centers and how they differ from fee-for-service school-based health services managed by the Health Care Authority. To begin work to remedy this misunderstanding, during the reporting period, we collaborated with the Alliance and our Health Systems Transformation Team (HST) to increase awareness of SBHCs in Washington, and to continue to build support networks for SBHCs. DOH and the Alliance delivered a presentation to the Medicaid Managed Care Organizations (MCOs) on the fundamentals of SBHCs and some of the funding challenges they face. DOH and the Alliance will be working with the HST team again to plan and carry out another presentation geared to providers about how SBHCs can be utilized as an access point for youth to receive well-visits and preventive care that is complementary to pediatric and family practice. That presentation will take place during the next reporting period.

Strategies:
Conduct needs assessment to identify top barriers for adolescents and young adults in seeking health care services.

Ensure all adolescents and young adults, regardless of race, ethnicity, sexual orientation, and gender identity, have a full range of education, access, and ability to utilize health services that meet their individual needs.

In 2019, the Washington Youth Sexual Health Survey findings highlight issues for Adolescent and Young Adult (hereafter AYA) with access to and experience with health care visits. Seventy-five percent of respondents reported they have a health care provider that they have seen more than once, yet only 18 percent reported having had a sexual health wellness exam. Respondents also reported barriers associated with going to see a health care provider, such as the hours of the clinic do not work with their schedule (37%), not understanding how insurance works (38%), feeling judged (39%), and being afraid that their parent or caregiver will find out (48%).

To learn more about barriers to care, we have been working on a revised Adolescent and Young Adult Health Needs Assessment to learn more about the experiences of providers and young people with adolescent and young adult healthcare services. Over the reporting period, we outlined our plan for the needs assessment and completed documentation and applications for IRB exemption. The needs assessment will include two surveys with open ended questions that focus on key adolescent health topics, like mental and behavioral health, well visits, barriers to

accessing and utilizing healthcare, and comfort-level with providers. We also recruited a Youth Voice intern to provide a youth perspective on the survey, distribution plan, and communications materials. Over the rest of the reporting period and into next year, we will carry out the survey and use what we learn to guide Adolescent Health programming – including our MCHBG strategies and activities.

Strategy:
Through partnerships, understand and mitigate issues related to financial eligibility for health care and other support services for adolescents and young adults.

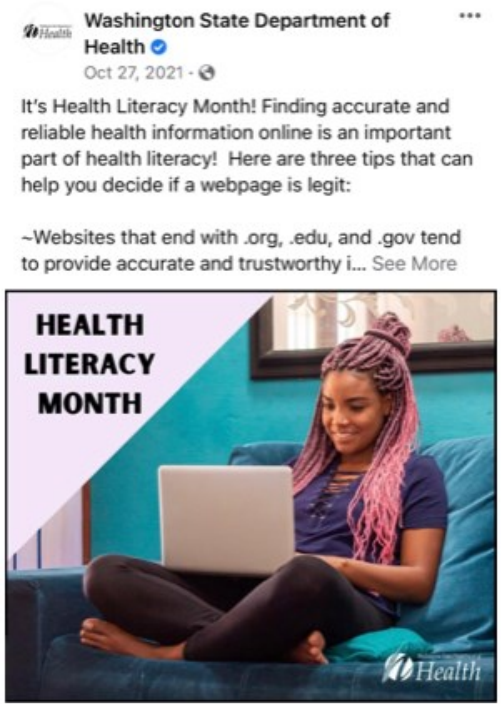
A number of adolescents eligible for Medicaid coverage are yet to be enrolled. We focused our energy and effort for the first part of the reporting period on the new SBHC Grant Program. Over the rest of the reporting period, we will form a small advisory group comprised of state-level representatives that will meet regularly to identify barriers and challenges to healthcare access among young people and troubleshoot and solve the issues identified. This work will have a focus on ensuring SBHCs can bill appropriately so they are reimbursed, and also strategies to increase insurance coverage among young people. HCA and other state agencies are working to increase knowledge of and offer training opportunities on billing and reimbursement for providers, specifically for school-based health centers and adolescent and young adult healthcare providers.

The Adolescent Health Consultant continues to participate on the Healthy Students, Promising Futures (HSPF) Learning Collaborative. This national collaborative is co-convened by the Healthy Schools Campaign and Trust for America's Health. Washington is one of 15 states participating in this project, and has cross-agency representation, including HCA, Office of the Superintendent of Public Instruction (OSPI) and DCYF, along with DOH. The HSPF focuses on federal and state polices that impact school-based health services for children in Medicaid, models for delivering school-based health services, and cross-state collaboration. The purpose of this collaborative is to increase access to school-based health services through Medicaid reimbursement. The HCA recently released a draft resource guide to help schools understand Medicaid reimbursement for school-based health services, how to contract with managed care organizations, and how to bill for qualifying services. DOH's role on this workgroup is to provide insight and feedback from the Department's perspective and ensure activities contribute to increased access to healthcare services for students.

Strategy:
Support and enhance efforts to increase health literacy among adolescents and young adults.

According to the Health Resources and Services Administration (HRSA), low health literacy can cause individuals difficulty in locating providers and services, sharing their medical history with providers, seeking preventive health care, managing chronic health conditions, and understanding directions on medicine. Evidence demonstrates that addressing health literacy at an early age can help develop one's ability to understand health information and improve interactions with the health care system, leading to positive health outcomes later in life.

Over the reporting period, we promoted health literacy using social media during health literacy month. We also recruited two Youth Voice volunteers to help us create and implement social media campaigns promoting adolescent well-visits, behavioral health wellness and health literacy among youth in Washington. Over the rest of the reporting period and into the next, we will collaborate with the volunteers to develop health literacy and adolescent well-visit promotional campaign for social media based on existing campaign materials from the CDC, HRSA and other federal sources. The youth volunteers will create the content, ensure they are youth-friendly and will help us develop a dissemination plan to release the materials on social media so that it will reach young people. We anticipate rolling out the first campaign this summer. We hope to continue this activity into the next reporting period.



We also approached OSPI and the Health Care Authority about partnering to promote health literacy in schools and in healthcare documents. However, competing activities delayed this partnership. Over the next reporting period, we hope to revisit this partnership and promote the inclusion of health literacy education in school curriculum (including comprehensive sexual health education) using strategies like those proposed in this Youth Health Literacy Toolkit, and with entities like HCA and managed care organizations, to make sure that health statements and documents are user-friendly and available in multiple languages to increase accessibility. Prior to promotion activities, steps in this process include learning how OSPI and the regional Educational Service Districts have assessed needs and identified gaps in this area of student learning. Since OSPI recommendations are based on accommodation of all public-school boards and communities, health literacy curriculum needs to be broad in scope.

Priority:
Improve the safety, health, and supportiveness of communities.

State Performance Measure*:*
Adolescents reporting at least one adult mentor.

Objective:
By September 30, 2025, reduce the percentage of 10th grade students receiving our interventions who reported that someone they were dating limited their activities, threatened them, or made them feel unsafe by 10% (from 9.5 to 8.5%).

Strategy:
Support violence prevention efforts and promote healthy relationships among adolescents and young adults.

In 2021, bullying in the previous 30 days was reported by 21% of students in the Healthy Youth Survey across all surveyed grades. There was a tendency for younger students to report more bullying, 6th grade 3%, 9th grade 23%,

and both 10th and 12th grade 13%. Thirty four percent of 10th graders who were bullied reported low grades compared with twenty five percent of those who hadn't. Among 10th graders individuals who identified as either gay or lesbian or as bisexual were much more likely to have reported as having been bullied, 24% and 23% vs. 10% respectively.

The Adolescent Health Team continues to support and promote the work of the Injury and Violence Prevention Team. Among the many programs supported by the team, Injury and Violence Prevention (IVP) Team has been implementing several projects to reduce violence among school-aged youth, specifically among middle and high schoolers. The first is through the Sources of Strength program. This is a peer-based program, geared to high-school aged young people and focuses on youth suicide prevention, and reducing bullying and sexual violence. For middle schoolers, the IVP Team has implanted the "It's About Respect" campaign in middle schools around the state. Over the reporting period, they increased the number of schools the campaign reaches.

We will continue working with key partners to support efforts to promote healthy relationships among youth in our state, including providing resources, training and support to adolescent health providers to recognize signs of dating and abuse. To do this, we purchased "In Her Shoes" trainings from the Washington State Coalition Against Domestic Violence (WSCADV) for all sixty School-Based Health Centers in the state. The curriculum can be found at In Their Shoes: Teens and Dating Violence (CLASSROOM EDITION) | WA State Coalition Against Domestic Violence – WSCADV. Over the rest of the reporting period, we will promote those to the SBHCs in hopes of having them utilize the tools in those locations.

Our Personal Responsibility Education Program will continue to provide education on adult preparation topics such as healthy relationships, including positive self-esteem, relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions; parent-child communication; and healthy life skills, such as goal-setting, decision making, negotiation, communication, and interpersonal skills and stress management.

Priority:
Optimize the health and well-being of children and adolescents, using holistic approaches.

National Performance Measure*:*
Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

In 2021 68% of 10th grade students reported seeing a health care provider for a check-up in the past year. This was down from 2018 when 77% reported seeing a health care provider in the prior year. Non-Hispanic White and non-Hispanic Asian students were more likely to have seen a provider than were students of other races or ethnicities. Hispanic students, non-Hispanic Black/African American and students identifying as more than one race all reported as less likely to have a checkup as non-Hispanic White or non-Hispanic Asian students. Students identifying as gay or bisexual, or any sexual orientation other than straight were as likely to report having a checkup in the prior 12 months as those identifying as heterosexual [HYS]).

By 2020, 54% of all adolescents in Washington had completed the full 1:1:1 immunization series. The state goal is 80 percent. That same year, 42% of 13-17-year-olds were up to date with the appropriate number of HPV shots. 62% of adolescents 16-17 years of age have completed the initial COVI-19 vaccine series. That percentage among those aged 12-15 years is 54.6%.

We want to ensure adolescents have access to health care services that meet their needs in the communities where they live. The Health and Human Services Office of Adolescent Health defines this as "youth-friendly health care

services," which includes "those that attract young people, respond to their needs, and retain young clients for continuing care." These services are based on a comprehensive understanding of what young people want and need (rather than being based only on what providers believe youth need).

Over the reporting period, we carried out a number of activities to implement this strategy:

- We partnered with OSPI, the Northwest Portland Area Indian Health Board (NPAIHB), and others to implement the new Washington Youth Sexual Health Survey to understand and improve youth access to and experience with sexual health services holistically, and to learn about what works, how, for whom, and why.
- We partnered with OSPI, CYSHCN, the Health Systems Transformation team, and the NPAIHB to plan, recruit and select a new Youth Advisory Council (YAC). The planning and selection team was comprised of DOH staff from TPP, CYSHCN, Health Systems Transformation, COVID-19 Youth Equity, and the Northwest Portland Area Indian Health Board. The new 40-member council is made up of young people aged 13-21 from all over Washington State, and who have diverse backgrounds, identities, abilities, and experiences. The main purpose of the YAC is to create a structure to regularly engage with young people on adolescent health programming and to create opportunities for young people to contribute to public health. Over the rest of the reporting period and into next year, we will gather with the YAC every other month to discuss key health topics related to adolescent and young adult health services (and our MCHBG activities). Topics will include well visits, behavioral health, and youth-friendly care to learn more about young people's thoughts, ideas, opinions and recommendations. We will organize feedback to share with our partners, including here at DOH, as well as use to plan MCHBG activities moving forward.
- We carried out several social media communications promoting well visits. We also recruited two Youth Voice volunteers to help us create and implement social media campaigns promoting adolescent well-visits, behavioral health and health literacy among youth in Washington. Over the rest of the reporting period, we will collaborate with the volunteers to develop health literacy and adolescent well-visit promotional content for social media based on existing campaign materials from the CDC, HRSA and other federal sources. The youth volunteers will create the content, ensure they are youth-friendly and will help us develop a dissemination plan to release the materials on social media so that it will reach young people. We anticipate rolling out the first campaign this summer. We hope to continue this activity into the next reporting period.

Strategy:

Promote the use of evidence-based practice guidelines, like Bright Futures, among adolescent health providers.

One of our key strategies is to work with partners to ensure providers have the tools they need to provide age-appropriate, evidenced based youth-friendly services for young people. To do this, we continued to support the use of the Bright Futures Guidelines for clinical service. Last fall, we learned that the Washington Chapter of the American Academy of Pediatrics (WCAAP) was not actively promoting the use of Bright Futures. As such, we wanted to learn more, and find out whether clinical providers are using the Bright Futures guidelines and what their experiences with it (or other screening tools) have been. Over the reporting period, we have been working with the Surveillance and Evaluation Team to plan for an adolescent and young adult health needs assessment to learn more about clinical providers' experiences and needs when caring for adolescent and young adults. The needs assessment will include a survey questionnaire for adolescent and young adult healthcare providers comprised of open-ended questions about adolescent and young adult healthcare services. Survey topics include screening and risk assessments, well-visits, adolescent-friendly care, telehealth, general barriers/challenges, billing/reimbursement and more. Over the rest of this reporting period, we will finalize the survey, work with several pediatric providers recommended by the WCAAP and others who will help us frame the questions, so they are relevant and meaningful, and figure out the best dissemination strategy. We anticipate releasing the survey in the fall and reporting the findings in our next MCHBG report.

Similarly, we also want to learn more about young people's experiences and perspectives with adolescent and young adult healthcare. The same needs assessment will include a survey for participants age 13-22 that will also be comprised of open-ended questions about adolescent and young adult health topics. This survey will cover topics like well-visits and preventive care, adolescent-friendly services, and youth experiences with their healthcare providers. To develop the survey geared to youth, we are collaborating with a Youth Voice Intern to ensure the survey and distribution plan are youth-friendly and relevant. Because of this survey will be geared to youth, we are also currently preparing for IRB review in hopes of obtaining an exemption this summer. Depending on the outcome of the review, we hope to release the survey in either early fall or after the holidays, so it doesn't conflict with the Healthy Youth Survey.

Strategy:
Promote preventive care screening and wellness visits for adolescents and young adults.

We continued to create and promote communications strategies to youth and parents about the importance of well visits, including social media posts such as the "Well Child Wednesdays" and "National Adolescent Health Month".

We also will continue our partnership with the Immunization program to promote and improve access to human papillomavirus (HPV) vaccine. We will continue to explore how best to provide information and training to providers about ways to discuss the HPV vaccine with youth and parents.

Strategy:
Increase the proportion of Washington adolescents who receive age-appropriate, evidence-based clinical preventive services.

The Adolescent Health program conducted a survey of youth in 2017 on AYA-friendly care, and developed a list of best practices for clinicians based on the results. The MCHBG Epidemiologist and the Adolescent Health Program Manager used this survey data to identify why youth may not be seeking care, and gaps in youth-friendly services. Over the next reporting period, we will use results of this project to work with providers to develop technical assistance, training, and ways to help youth navigate the health care system and advocate for themselves as end users and consumers of services, including promoting health literacy. We also hope to follow up with qualitative data collection and analyses to understand individual experiences and factors around accessing health care services.

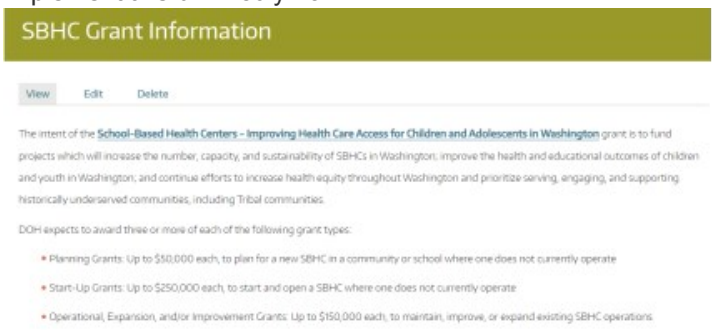
Another strategy we have been working on is to provide more learning resources for adolescent providers in the state and which cover key topics like healing-centered care, adolescent-friendly care, and how to discuss sensitive topics with young people. To do this, over the reporting period, we partnered with Cardea Services to develop online trainings on each of these topics that can be delivered online and like a podcast. The trainings will be available for adolescent health providers (advanced practice clinical providers and behavioral health providers) in School-Based Health Centers. For convenience and ease of access, the trainings will be available online and will include a podcast-like component. In addition, SBHC providers will be able to apply to receive CME/CEU's for them. In the future, we hope to expand these trainings (funding dependent) so they are available to adolescent health providers state-wide.

Strategy:
Foster measurable quality improvements in preventive care across the health system to increase adolescent and young adult-friendly care.

As mentioned previously, we have bene planning a needs assessment to assess what quality improvement (QI) practices are already in place, and then develop measures for QI based on our findings to ensure optimal AYA-friendly care.

Strategy:
Promote school-based health strategies to serve adolescent populations where they are.

Over the reporting period, the Adolescent Health Team worked with partners to implement Substitute House Bill 1225: Concerning School-Based Health Centers. The legislation was passed by the Washington State Legislature in 2021 and directs DOH to establish a SBHC program office with the objective to expand and sustain the availability of services to students with a focus on historically underserved populations. It also providers about $1.35 million in for SBHC grants to help build infrastructure and capacity. The Adolescent Health team began work with partners to implement this bill in July 2021.



Implementation activities completed over the reporting period included the SBHC-related activities mentioned earlier in the report as well as:

- Participated in and contributed to plans to bring on vendors to establish a state-wide SBHC data platform.
- Explored a new partnership with the Northwest Portland Area Indian Health Board to assist DOH with training about Tribal healthcare and education systems and facilitating support and learning for Tribal communities currently starting or potentially starting a SBHC.
- We participated in a collaborative to develop health and education information-sharing resources related to legality of Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) rules as they relate to SBHCs. That work will result in examples, toolkits, and resources about the

laws that can be disseminated to SBHC providers and sites. This work is ongoing.

Strategy:
Identify and develop methods to monitor systems and data gaps and improvements needed in adolescent health.

In Washington State, we have access to many different data from several data sources from our programs like PREP and GRADS, our survey activities like WYSH, and data that are publicly available like the Healthy Youth Survey. As we gear up to learn more from gaps in data, we partnered with the Surveillance and Evaluation Team to plan for a new Adolescent Health Data Dashboard and resource tool. The Dashboard will be a one-stop place for DOH staff (and ultimately, the public) to go to for key adolescent health data for Washington State – including data from our programs, survey activities and that is publicly available, as well as links and resources to more comprehensive and granular data. This will ultimately help us learn more about what data gaps exist so we can prepare to fill those gaps. During the reporting period, we began work to outline the plan for the Dashboard, including what key data we want to include, how we want to visualize the data, where it will be housed and what resources we want to include. For the rest of the reporting period and into next year, we will finalize our plans and create the content. We will also work with our internal communications teams to make sure the content is ready for the public and identify the best platform for publication. We hope the Dashboard is live by the time we report out, next year and will be a useful tool for the Adolescent Health Team, and other DOH and partners' programs whose work impacts young people.

Objective:
By September 30, 2022, form youth advisory council and hold at least one initial meeting.

Strategy:
Include adolescents in this work through strategies such as building and supporting a youth advisory council and identify other meaningful ways to engage the population to be served

We recognize the importance of getting input from a variety of youth voices on our programs and programmatic needs. As we've mentioned before, one of the ways we will obtain this perspective is to partner with OSPI and others to create and convene a youth advisory council.

Adult professionals promoting healthcare for young people is not going to be as effective as young people promoting healthcare services for young people. As such, we have increased efforts to engage more young people in more of our work. Engaging youth and ensuring their perspectives are reflected in our work has always been a priority; but

internal challenges have made it difficult to engage with young people on a regular basis. As discussed earlier, we created a statewide Youth Advisory Council, which met for the first time in April 2022.

In April 2022, we hosted our first meeting with our new Council to discuss online activities to do during zoom, and health topics they think are important to young people. They had a lot to share with us using our Jamboard (image below) and we had a great time.

Having a youth advisory council will enable us to better represent the individuals we serve, and to expand our reach to more of the community. Our goal is to have four quarterly meetings by September 2023.

Additional Work Supporting Adolescent Health
The Adolescent Health Unit houses several programs that contribute to larger efforts to improve access to and the quality of adolescent and young adult healthcare services, in general.

Sexual Health: Rates of chlamydia infection in 2019 were highest among female 15- to 24-year-olds (3,200 cases per 100,000 population) and male 15- to 24-year-olds (1,200 cases per 100,000 population), with 52% of all cases occurring to those under 24 years of age. Chlamydia cases and rates have increased each of the past 10 years. This is in contrast with gonorrhea and syphilis, the second and third most common sexually transmitted infections in Washington, which occur more frequently among 25- to 34-year-olds.

Proviso for STI Prevention:
Over the reporting period, the Washington State Legislature passed ESSB 5092 which includes a proviso that directs DOH to provide recommendations for funding and policy initiatives to address the spread of sexually transmitted illnesses (STIs). The Adolescent Health Team, along with several programs at DOH, submitted recommendations, including the inclusion of youth in all activities related to STI prevention at DOH, and additional funding from the legislature to ensure young people are involved in STI prevention work in all state agencies.

Teen Pregnancy Prevention:
Washington has made considerable progress in decreasing statewide teen birth rates with a steady decline since 2011. However, there are still significant disparities across geographic, economic, racial, and ethnic lines. To address these disparities, several activities are underway. The Adolescent Health program has well-established and collaborative relationships with other DOH programs, other government agencies, and community partners.

The state Family Planning program has focused on the use of long-acting reversible contraception (LARC) and emergency contraceptives for teens. LARC methods provide continuous contraception for three to 10 years. This time period covers most, if not all, of the adolescent years, and is recommended for sexually active teens by both the American Academy of Pediatrics and the American College of Gynecology.

The Adolescent Health program works closely with OSPI on a number of projects. Staff continue to participate on OSPI's Exemplary Sexual Health Education steering committee and provide technical assistance for the review of sexual health education curricula for medical and scientific accuracy. OSPI is an active member of the PREP collaboration. Another example of partnership with OSPI is to partner with them in implementation of the Teen Pregnancy Prevention grant, described below.

The focus of our Teen Pregnancy Prevention grant is to build a multidisciplinary network committed to improving youth access to and experience with sexual health care and increase youth engagement at the network coordination and implementation site levels, with an intentional focus on equity and priority populations. The goal of what we have called the Washington Youth Sexual Health Innovation and Impact Network (WYSHIIN) is to build a multi-disciplinary network committed to improving youth access to and experience with sexual health care across the state of Washington. The Northwest Portland Area Indian Health Board (NPAIHB), a partner from the inception of the program, was involved in the planning and development of the application. Together, we intentionally co-coordinate a network inclusive of tribal and non-tribal entities. We have 11 implementation sites, both tribal and nontribal, to develop and test innovations for youth.

We are developing a system where large organizations and government entities connect and work with local community-based nonprofit agencies with equity at the center of our vision. We want as much cross-collaboration, sharing resources, shared learning as possible across all levels of agencies. Our key priority is to increase access and experience with sexual health for youth. Goals of the network are to:

- Increase youth engagement at the network coordination and implementation site levels to inform the work
- Implementation sites working with historically underserved populations to conduct community needs assessments and implement interventions that are designed and tested with youth input.
- Ensure that clinics and providers engaging in youth-serving community partnerships, trainings for staff, youth-friendly policy changes, and referrals for youth.

Ultimately, our goal is that adolescents see an increase in capacity to make their own appointments, receive a sexual wellness visit, and increase their likelihood of having a positive experience while accessing services. Partners from the first year include Planned Parenthood of the Northwest and Hawaii, SeaMar Community Health Clinics, Seattle-King County Public Health and a first-time partner to federal and state funding, Greater Destiny Church.

In creating our second round RFP for our set of partners this past year, our goal was to enlist more nontraditional partners like Greater Destiny and serve more geographically diverse populations, specifically those from eastern Washington. We asked our first-year partners to help us with the RFP and give us input on what had been challenging so we could possibly eliminate those aspects, or at least make the application less daunting. We were very successful in inviting partners that are very new to this type of partnership on board with three of four new partners are from eastern Washington and new to federal and state funding. New partners in this second year of the WYSHIIN grant are:

- Domestic Violence Sexual Assault Services, Whatcom
- Latino Leadership Northwest, Clark
- Washington State University, Stevens
- Room One, Okanogan-social media campaign with youth engagement

Thus far, the 18 interventions implemented by the 11 network partners have resulted in over 3,500 youth engaged as well as 372 caregivers and 753 community members.

WA PREP:

The Adolescent Health Team supports schools in the state to implement Comprehensive Sexual Health Education (CSHE) in accordance to law through the Washington State Personal Responsibility Education Program (PREP). WA PREP promotes preventive visits for young people as it relates to sexual health and provides teen pregnancy, sexually transmitted infections (STI) prevention, and adult preparation curriculum at high schools, middle schools,

juvenile rehabilitation facilities, and other youth-serving agencies.

The Washington State Personal Responsibility Education Program (WAPREP) provides teen pregnancy, sexually transmitted infections (STI) prevention, and adult preparation curriculum training at high schools, middle schools, juvenile rehabilitation facilities, and other youth-serving agencies. There are currently five Intervention Partners in various stages of implementing WAPREP, and five possible sites for the next cycle. The sites are all school districts this cycle and WAPREP is working with the Office of the Superintendent of Public Schools to provide extra support to school districts with implementation of new legislation that requires schools to implement comprehensive sexual health education. WAPREP has also started providing support to school districts, regardless of their participation in WAPREP, through the Comprehensive Sexual Health Education Network. Meetings are held every other month and subject matter is based on requests from school districts. Other partners include OSPI, Department of Social and Health Services, and Cardea Services.

The WAPREP team recruited several new intervention partners during the current reporting year and continues to support sustainability partners by providing technical assistance and training as needed. WAPREP is funded through the 2010 Affordable Care Act. The program goal is to prevent teen pregnancy and STIs among youth 10 to 19 years old, using evidence-informed and evidence-based curricula. WAPREP serves school districts, youth serving community-based organizations, and system-involved youth. WAPREP recruitment prioritizes schools in counties with the highest rates of teen pregnancy, STIs, and poverty, with a focus on equity and inclusion. In FFY 2018, WAPREP served 2,511 youth; 1,914 youth in FFY 2019; and 824 youth in FFY 2020.

An interactive map of Washington with information on STIs and teen pregnancy rates is located on the WAPREP website. WAPREP focuses on youth and young adults who are homeless, in foster care, who live in rural areas, and who live in areas that have high teen birth rates, as well as pregnant and parenting youth, and minority youth (including sexual minorities). Consequently, five additional school districts are now implementing evidence-based curricula that are proven to increase good decision-making skills and help youth make healthy choices.

Facilitating Comprehensive Sexual Health Education (CSHE) effectively requires teachers to create safe and supportive environments and support student learning. One- and two-day training programs equip teachers with the skills to effectively implement CSHE in the classroom. Additionally, training is provided on a variety of evidence-based/informed interventions, such as:

- FLASH, Middle School and High School
- Draw the Line/Respect the Line
- Native Voices, Native Stand and Native It's Your Game
- Making Proud Choices
- Respect, Rights and Responsibility (3Rs), Middle School and High School

Additional Work Supporting Adolescent Health at the Local Level

COVID-19 and Local Health Jurisdiction

The COVID-19 pandemic has had many impacts of both LHJs and on adolescents. Many LHJ staff members worked on pandemic response throughout this program year and many adolescents were significantly impacted by infections in their homes, isolation, and school closures. The LHJs, despite these challenges, continued to make adolescent health a priority through the following activities.

Local Health Jurisdiction Work on Adolescent Health

LHJs have an option to engage with Adolescent Health strategies, which includes supporting and improving local school-based health initiatives. Activities in this Domain could include mental wellness, nutrition, family support,

holistic wellness, preventative care, and community resources. In some counties, MCHBG funds are being used to support COVID efforts, including COVID response among the adolescent population.

- **Spokane -** Spokane County is implementing the 'Handle with Care' behavior management program in Spokane Public Schools (SPS) and has initiated a responsive evaluation plan alongside the roll-out of the trainings associated with the intervention. Handle with Care information was included as part of SPS yearly mandatory reporter training, and the feedback received from school staff throughout the implementation will inform next steps.

- **Snohomish -** In an ACEs quarterly meeting, Snohomish County arranged speaker Brenda Newell, LICSW speaking on the topic: LGBTQ+ Children and Youth: We each have a role in providing safe, supportive and inclusive communities.' This discussion focused on awareness and learning, including identifying risk factors for LGBTQIA2S+ youth, and identifying community resources to support these youth and their families. Schools remain an opportunity for adolescent health improvement, particularly about LGBTQIA2S+ youth.

- **Adams -** Adams County is partnering with 4 school districts in efforts to manage the Covid-19 pandemic impacts. The collaboration is set up for school staff to notify the LHJ of youth who are sent home due to COVID-like illness, who are quarantined due to ill family members or other exposures, and any possible school related exposures or outbreaks. The LHJ in turn keep schools up to date on the status of quarantines staff and students and provide release from quarantine or isolation letters to verify when return to the school setting is approved by the LHJ.

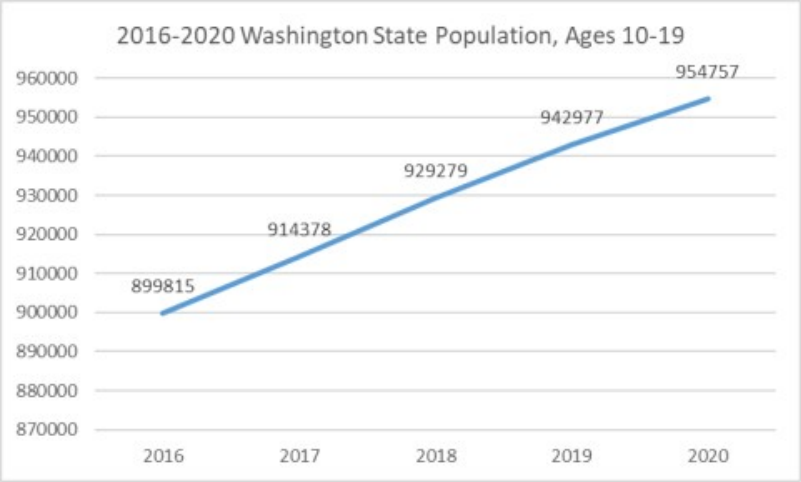
Adolescent Health - Application Year

III.E.2.b.v.c. State Action Plan Narrative by Domain

Adolescent Health Domain Application Year

Overview of priority MCHBG Projects and Activities

Washington State has an increasing population of adolescents and there are more young people living here than ever before. The health status of adolescent and young adults in Washington State is reflected across several data sources including those that indicate teen pregnancy rates, repeat teen pregnancy rates, and sexually transmitted infections are lower than the national average for some demographic groups and higher for others. Educational and social outcomes, such as graduation rates, housing, childcare, and healthcare access also differ for under-resourced groups and historically marginalized populations.



Our vision is to serve as a state-wide leader in optimizing the health, well-being, and development of all adolescents and young (AYA) adults, and our mission is to provide programs that promote the health and wellbeing of adolescents where the live, learn, work, and play.

We selected MCHBG performance measures, priorities and strategies that reflect the activities and programs for their impact on improving healthcare services and access for young people and will also contribute to our efforts to health equity for all.

Priority:

Promote mental wellness and resilience through increased access to behavioral health and other support services.

State Performance Measures:

Percentage of 10th grade students who have an adult to talk to when they feel sad or hopeless.
Percentage of 10th grade students who report having used alcohol in the past 30 days.

Objective:

By September 30, 2023, conduct an Adolescent and Young Adult Health Needs Assessment, to learn more about adolescent health provider experiences with behavioral health screenings and risk assessments; by September 30, 2024, follow up on the need's assessment with recommendations and actions for improvement.

Strategies:
Improve the knowledge and ability of health care professionals to deliver comprehensive evidence-based/informed services, including integrated mental health and chemical dependency screening and interventions for adolescents and young adults.

Promote standardized depression, anxiety, and substance use screening that are adolescent and young adult friendly.

Our goal is to ensure young people can participate in youth friendly and confidential screenings for mental and behavioral health needs, by promoting the use of a youth-friendly standardized risk behavior screening tool among providers who serve youth and young adults – like the one created by the Adolescent Health Initiative (AHI) at the University of Michigan.
The Washington Youth Sexual Health (WYSH) Survey demonstrated that teens in Washington have significant concerns about their privacy and confidentiality when accessing services, and more work is needed in Washington to implement best practices using innovative interventions to incorporate these tools into clinical workflows. And although screening and counseling adolescents on risk behaviors is universally recommended by the Society for Adolescent Health and Medicine, American Medical Association, American Academy of Pediatrics, American Academy of Family Physicians, and American College of Preventive Medicine; it is not universally followed, and rates of use range from only 15 to 50%.

Over the last year, we have been connecting with partners, including the Washington Chapter of the American Academy of Pediatrics (WCAAP), the University of Washington's Leadership Education in Adolescent Health (UW LEAH), and the Washington School Based Health Alliance (WSBHA) to learn more about the screening and assessment tools providers are using and what support providers need to use these tools. We learned that there are several tools being used for risk assessments and mental health screenings, and there isn't one tool being promoted. We realized we need to learn more about the tools providers are already using, what's working and what's not, and what the best practice is.

Over the reporting period, we collaborated with the Surveillance and Evaluation Team to plan an Adolescent Health Needs Assessment to learn more about providers' adolescent and young adult healthcare delivery and practice. The needs assessment will include releasing two online surveys comprised of mixed question types – one for youth age 13-22 and one for adolescent and young adult health providers – to collect qualitative and quantitative data and information around needs, experiences and perspectives of adolescent healthcare services, practice and delivery.

Over the last few months, we planned the project and started IRB processes; over the rest of the reporting period and into the next, we will finalize survey tools and outline a dissemination plan. We hope to work with several pediatric and family care providers to help ensure the survey makes sense and so we can get it to adolescent and young adult-serving providers. We will also release the survey, collect, and analyze the findings and hope to learn more about where we need to focus our program efforts and funds. We expect to report on the findings in the 2023 report.

In the meantime, we continue to support the use of the Bright Futures Guidelines for best practices in adolescent care. Bright Futures was officially recognized in the Patient Protection and Affordable Care Act (ACA) as the blueprint for all visits to the health care provider for health supervision (often referred to as well-child visits). Bright Futures Guidelines for provider visits include priority issues that should be addressed, recommended tools and schedules for screenings and assessments, and is available to providers through downloads or physical kits using the link above.

Objective:
By September 30, 2023, conduct an Adolescent Health needs assessment among youth to learn more about adolescent experiences with medical and behavioral health care; by September 30, 2024, follow up on the need's assessment with recommendations and actions for improvement.

In addition to learning about provider perspectives, we also want to learn more about young people's experiences and needs around adolescent and young adult healthcare delivery and practice. The needs assessment will include releasing two online surveys comprised of mixed question types – one for youth age 13-22 and one for adolescent and young adult health providers – to collect qualitative and quantitative data and information around needs, experiences and perspectives of adolescent healthcare services, practice and delivery. To ensure the project is youth-friendly and relevant to young people, we recruited a Youth Voice Intern to help us with this project. The intern will provide insight from their experience and expertise as a young person in Washington on the entire project, including project planning, survey creation and distribution, communications materials, data analysis and recommendations made for programmatic improvement.

Strategies:
Take action to reduce stigma surrounding adolescent and young adult behavioral health conditions, treatment, and related challenges, and implement trauma-informed services specific to adolescents and young adults in community services and health care systems.

Mental and behavioral health needs among young people have increased dramatically as a result of COVID-19. The 2021 Healthy Youth Survey shows 38% of 8th, 10th and 12th graders reported depressive feelings. Among female students, it was 50%. According to the U.S. Department of Health and Human Services, National Institute of Mental Health, 32% of 13- to 18-year-olds experience anxiety disorders. Depression occurs in approximately 13% of 12- to 17-year-olds; attention deficit-hyperactivity disorder (ADHD) occurs in approximately 9% of 13- to 18-year-olds.

As mental health needs rise for young people, we've heard from partners and young people that mental illness and stigma still impede access to needed care and make it less likely youth will seek services. Our partners have shared concerns with a rise in stigma stemming from the parents and caregivers of young people. For example, partners have said parents and families have been refusing mental and behavioral health screenings and interventions for several reasons, including lack of confidence in the tools and thoughts that the behavioral health needs among youth is over estimated. Stigma and misperceptions about youth with mental health diagnoses are an ongoing problem and have a profound impact on whether youth will get the care they need.

Over the reporting period, we convened a Youth Advisory Council to regularly engage on topics like stigma around behavioral healthcare. We brought on two Youth Voice interns to integrate the youth perspective into educational campaigns and communications materials, including stigma reduction around behavioral health. And we provided funding to the Washington School-Based Health Alliance to carry out a mini grant project for SBHCs to conduct educational campaigns in the schools around behavioral health topics, including stigma reduction.

Over the next reporting period, we will continue working to address stigma in the community. Some of our activities will include:

- Collaborate with the Youth Voice volunteers to conduct a social media campaign around stigma reduction. Research has shown that social media campaigns focused on stigma reduction around mental health and treatment have been an effective tool to increase the use of mental health services among adults. The communications campaign will focus on disseminating evidence-based information related to stigma reduction among youth, youth-serving providers, agencies and community organizations.

- We will discuss ideas and recommendations for strategies to reduce stigma around behavioral health care and treatment with the Youth Advisory Council. We will identify key strategies and share those with our internal and external partners and integrate them into our MCHBG program planning.
- We will track progress on the SBHC health education campaigns to learn more about their project and the impact.

Objective:
By September 30, 2022, award nine or more grants to SBHCs for behavioral health services.

Strategies:
Expand access to and the quality of behavioral health services in SBHCs.
Support efforts to address and mitigate individual and community effects of substance use among adolescents and young adults.

Respondents to the 2020 maternal and child health needs assessment noted that young people have difficulty finding providers, and the health care system needs to be easier to navigate – including enhanced coordination, linkages, and referrals. Respondents also consistently identified concerns related to suicide and youth mental health, including the need for providers to screen for risk when seeing adolescent patients and clients. The MCH needs assessment highlights the need for systems-level improvements so that adolescents can access and experience user-centered medical and mental health care. Increasing the number of places where young people can access youth-friendly and welcoming care, not just to family planning and sexual health services, but also behavioral and more general physical health, benefits all. Promoting, supporting and expanding school-based health centers is a key strategy we implement to increase access to youth-friendly healthcare services.

Over the reporting period, the Adolescent Health team worked with key partners, including the Washington School-Based Health Alliance (WSBHA), the Office of the Superintendent of Public Instruction (OSPI), and the Health Care Authority (HCA), among others, to implement two pieces of legislation (SHB 1225 and ESSB 5693 Section 222) geared to expanding and sustaining SBHCs throughout the state, increasing access to comprehensive and integrated medical and behavioral health services to young people in Washington, and prioritizing funds and activities in communities that were historically underserved. In spring, we released two grant requests for applications (RFAs) to plan, start or operate an SBHC that provides integrated medical and behavioral healthcare; and one to increase access to and improve the quality of behavioral health services in existing and start-ups SBHCs.

During the second half of the reporting period, we will convene a committee comprised of community members, partners, and experts to help us select 18-20 applications to award $2 million dollars. Grants will be awarded for a mixture of planning, start up, operations/expansion, and behavioral health projects in a mixture of rural, urban, suburban and Tribal communities, and all awards will go to projects that serve a high proportion (at least 60%) of students that are historically underserved as outlined in our RFAs. For more information, please see our grant page at: School-Based Health Center Program | WaPortal.org

To support this expanded SBHC program, we will be hiring additional staff to manage Behavioral Health Grants and complete the SBHC Grant Program Team. The SBHC Team will formalize grant awards through 18-20 new contracts with grantees to carry out activities and tasks outlined in the RFA and in grant applications. Activities will include carrying out unique SBHC projects, developing sustainability and health equity plans to ensure ongoing access to the SBHC, convening advisory councils/steering committees and engaging youth and communities around healthcare needs, and completing educational campaigns around key adolescent health topics like mental health and substance use. The SBHC Team will also work with grantees to identify and address challenges and barriers,

and connect them to resources, training and technical assistance provide by the Washington School-Based Health Alliance

Objective:
By September 30, 2022, provide accessible trainings for SBHC providers on trauma informed care, adolescent friendly services, and discussing sensitive topics. By September 30, 2023, implement efforts to expand trainings to additional adolescent and young adult friendly providers.

The goal of DOH and partners like HCA and DCYF is to move Washington toward a statewide culture of trauma-informed approaches. According to a study by Darnell, Flaster, Hendricks, Kerbrat, & Comtois (2019), among adolescents between the ages of 13 and 17, 62% have been exposed to one or more traumatic events throughout their lifetimes. It is critical for those serving young people to incorporate trauma-informed approaches in their programs, and to ensure behavioral health services are accessible. Understanding the impact of trauma on youth development, and how to engage youth to be resilient.

Over the reporting period, we worked with WSBHA to identify gaps in SBHC provider trainings on key topics that support youth-friendly and healing-centered care and services. We then worked with our partners at Cardea Services to outline plans to create new trainings on healing centered care, youth-friendly services, and discussing sensitive topics. The trainings will cover the evidence-based practices and will be available to providers through online courses that can be completed on a computer or by listening to the audio. Once completed, providers (including advanced practice providers and behavioral health providers) will be able to access continuing education credits for participating in the trainings.

In addition, we will work with community organizations and other state agencies to promote, support, and facilitate education and training for health providers and youth-serving organizations around trauma-informed services for youth. This will include:

- One or more media campaigns to promote existing and available resources like these trauma-informed approaches for adolescent and young adult behavioral health care, including in SBHCs.
- Facilitate access to the Cardea trainings on trauma-informed approaches to adolescent health care for SBHC providers and explore options to expand access to those trainings for adolescent and young adult healthcare providers in the state.
- Support efforts at DOH, the HCA and OSPI to increase the school and community-based workforce that are qualified to provide adolescent behavioral health screening, assessment, and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) treatment through our SBHC work. This is a recommendation made by the Children's Behavioral Health Workgroup facilitated by the HCA and is a priority among our state partners.
- Work with partners within DOH and with other state agencies to promote policies and programs related to youth behavioral health care that include a trauma-informed approach.

Objective:
By September 30, 2022, discuss mental and behavioral health with the Youth Advisory Council to learn more about their thoughts, ideas and recommendations for behavioral health needs and gaps, including stigma around behavioral health care and suicide prevention. By September 30, 2023, identify/develop behavioral health interventions for young people that are based on the ideas and recommendations of the Youth Advisory Council.

Strategies:

Support interventions to address suicide ideation among youth, especially among those marginalized by mainstream society.

Over the past year, we worked to convene a Youth Advisory Council in the Adolescent Health Unit. We sought insight from partners at DOH, OSPI and the Northwest Portland Area Indian Health Board and others who work with youth, to identify best practices for recruitment and retention of youth partners. We then formed a planning committee comprised of internal programs for which youth voice was essential and outlined the plan for our new youth engagement group. In late December 2021, we recruited for the new Youth Advisory Council, and by the end of January, we received over 300 applications from young people around the state. Of the applicants, we selected 40 young people from diverse backgrounds and unique experiences and identities.

Our goal is to meet with the Council every other month through March 2023. Each time we meet, we will discuss key adolescent and young adult health topics that intersect with our MCHBG priorities and listen to Council Members' ideas, opinions, recommendations and feedback on the topics. Topics will include general adolescent health; mental and behavioral health (including substance use and suicide prevention); youth-friendly care; and well visits/transitional care. After each meeting, we will organize the Council's feedback into high-level themes and subthemes and share it back with the Council. We will also share their feedback with relevant partners and report back to the Council about any activities that occur as a result. We also anticipate working with the Council to plan for the next generation YAC for which we will recruit in December 2022/January 2023. In April 2022, we held our first (virtual) Youth Advisory Council Meeting. For more information go to our webpage by clicking on the image below:

Suicide is a leading cause of death for Washington youth between the ages of 15 and 19. In 2020 the state rate for suicide among 15–19-year-olds was 12.5/100,000. Responses to the 2021 Washington Healthy Youth Survey showed that 20 percent of 10th grade students considered attempting suicide in the past year. Eight percent of 10th grade students reported making a suicide attempt in the 12 months prior to the survey. In addition, preliminary data and anecdotal evidence suggests that COVID-19 related stressors are having a significant impact on rates of youth depression and suicide during 2020 and beyond.

Our primary strategy to address the behavior health needs of young people is to support, promote, expand, and sustain SBHCs throughout Washington, including promotion of integrated medical and behavioral care in SBHCs.

We also want to learn more from young people about their ideas, recommendations, opinions and needs as it relates to behavioral health and suicide prevention. To do this, we will integrate discussions around mental and behavioral health into our Youth Advisory Council activities, and into our Adolescent Health Needs' Assessment. As mentioned before, we will use what we learn from these youth community engagement activities to plan our MCHBG programming, identify new and innovative strategies to support young people's needs around suicide prevention,

and share what we learn with internal and external partners.

We will also continue to learn from the Washington State Children's Behavioral Health Workgroup. Over the last reporting period, the workgroup identified several strategies that agencies and partners can implement to address the youth behavioral health crisis exacerbated by COVID-19. Recommendations that we have pursued have included trauma informed care training and education for healthcare providers (as described above), expanding the behavioral health workforce through the SBHC BH Grant, and conducting population-level screening for students and strengthening regional response teams (both of which are agency-level efforts that were part of our Young Adult Behavioral Health Improvement Decision Package).

As always, we will continue to support and promote the suicide prevention work carried out by our partners in Injury and Violence Prevention. Their work includes contracting with 8-10 schools throughout the state for Sources of Strength; launching the Native and Strong Campaign in partnership with the Healthcare Authority; and working with Tribal communities to launch the Washington State Indian Behavioral Health Hub. Future work will include reviewing suicide prevention data for adolescents to begin work to tease apart culturally relevant interventions.

Objective:
By September 30, 2023, partner with youth volunteer to develop and implement an adolescent behavioral health awareness campaign using social media.

Over the last reporting period, we brought on two Youth Voice volunteers to partner with on creating and disseminating health education campaigns and communications materials for key adolescent health topics. During the next reporting period, we will work with the volunteers on a social media campaigns around mental/behavioral health stigma reduction. For example, California's social media marketing campaign to reduce mental health stigma (see Collins et. al, 2019) has shown that social media campaigns focused on stigma reduction have been an effective tool to increase the use of mental health services among adults. We plan to apply this strategy and implement social medial campaigns to reduce stigma related to behavioral health conditions among youth to increase access to behavioral health care. The communications campaign will focus on disseminating evidence-based information related to stigma reduction among youth, youth-serving providers, agencies, and community organizations. We hope to couple this with the coordination of behavioral health stigma-reduction trainings for youth-serving providers throughout the state.

State Performance Measure*:*
Percentage of 10th grade students who report having used alcohol in the past 30 days

Objectives:
By September 30, 2025, increase the number of school-based health centers with licensed mental health services by 5 percent.

As mentioned before, SBHCs is a key project we implement to address many healthcare needs for young people – including, behavioral health. Engrossed Second Substitute Bill 5693 Section 222 was passed in 2022 and provides additional funding for behavioral health services in SBHCs. The legislation allocates $720,000 in additional grant funds to DOH to award to SBHCs to improve or expand behavioral health services. As mentioned above, we released a RFA to for grants to increase access to behavioral health services in existing and start-ups SBHCs. SBHCs will be able to use this funding to increase behavioral health staffing to better meet the needs of the young people they serve, increase awareness and knowledge of school and community members, and engage young people around behavioral health conditions to reduce stigma.

During the second half of the reporting period, DOH will convene a review committee comprised of partners and experts to review grant applicants and help us select grantees for behavioral health improvement projects in SBHCs. Grants will be awarded in a mixture of rural, urban, suburban and Tribal communities, and all awards will go to grantees who serve a high proportion (at least 60%) of students that are historically underserved as outlined in our RFA. For more information, please see our grant page at: School-Based Health Center Program | WaPortal.org

Objectives:
By September 30, 2023, provide funding to support health campaigns in SBHCs that promote awareness/reduce stigma around adolescent substance use.

As part of our formal partnership/contract with the WSBHA, we will provide funding and guidance to the Alliance to support SBHCs to carry out health campaigns on key adolescent health topics, including stigma reduction around behavioral and mental health care and needs, health literacy, and substance use among youth. The Alliance will submit their plan for implementation in June 2022 and will begin implementing that plan in September of the same year. After the project has completed, we will assess the impact and whether to expand the project to additional SBHCs and schools.

Objectives:
By September 30, 2023, hold at least 10 Youth Advisory Council meetings, where behavioral and mental health care – including substance use among youth– are discussed.

As mentioned before, we successfully convened a new Youth Advisory Council to provide insight and expertise about adolescent and young adult healthcare. One of the key discussion topics will include behavioral health care; we anticipate an organic discussion around youth substance use during this time. We have invited internal partners whose work intersects with youth substance use prevention to participate in these discussions. We will integrate what we learn from our young council members into our programming, including MCHBG strategies.

Strategies:
Build on efforts to identify scope of impacts of substance use, including inequities among adolescents and young adults from priority populations.

We will continue to participate in the cross-agency State Overdose and Response workgroup to align substance use reduction and prevention strategies and efforts among internal programs. We will continue to support and promote the work of the Opioid Prevention Program at DOH, including exploring partnerships around an awareness campaign geared to youth focused on addressing ACEs and using a trauma informed approach.

While the rates of tobacco use and exposure have significantly declined in our state, we are particularly concerned with the youth vaping epidemic because substance use is a risk factor for teen pregnancy. Over the last reporting period, we invited our partners in Youth Cannabis and Commercial Tobacco Prevention Program (formerly Tobacco and Vapor Product Prevention and Control Program (TVPPCP)) to participate in the Youth Advisory Council meetings that are focused on behavioral health ideas and recommendations. We have also been promoting the team's own youth-engagement activities through our youth-serving and youth networks. This includes their *You Can* campaign. The campaign is a youth assessment project for youth, ages 12 to 17 to better understand attitudes towards substance use, explore how they are coping with stress, anxiety, boredom, and loneliness, and gauge awareness of the resources available to support those who are struggling. The assessment will be conducted using an online discussion board and we hope to learn more about substance use among youth from this project. Over the

next five years, the DOH Adolescent Health program will continue to collaborate with the Youth Cannabis and Commercial Tobacco Prevention team.

Over the last few months, we worked with the Surveillance and Evaluation team to inventory key data sources we use for our public health work and identify ways to organize those data sources in a way that contributes to our adolescent health work. Over the next reporting period, we will formalize our work to assess existing data to identify gaps in services and underlying socioeconomic factors playing into substance use through the creation of an Adolescent Health Data Dashboard. The Dashboard will be a one-stop place for relevant and state-level adolescent and young adult health data (including data relates to substance use among young people). It will also include key resources so more detailed data on key topics can easily be found. Once the Dashboard goes live, we will collaborate with internal partners, including the Opioid Use Prevention Team and Injury and Violence Prevention, to examine structural issues through a lens that acknowledges systemic racism, sexism, and homophobia, and their effects on health inequities.

Priority:
Optimize the health and well-being of children and adolescents, using holistic approaches.

Objectives:
By September 30, 2022, form a youth advisory council and hold at least one initial meeting and by September 30, 2023 discuss adolescent well visits and adolescent and young adult care and services.

Strategies:
Include adolescents in this work through strategies such as building and supporting a youth advisory council and identify other meaningful ways to engage the population to be served.

We recognize the importance of getting input from young people on our projects and programs. As we've mentioned earlier, we've been increasing our efforts to engage with young people, including starting a new Youth Advisory Council. We plan to spend dedicated meeting time discussing adolescent well visits and preventive care to hear more about the ideas, recommendations, and opinions to improve care for young people. We will share what we learn from the Council with relevant partners – including those working to increase well visits among youth - to improve access to and the quality of adolescent and young adult preventive care.

We are also engaging young people directly in several areas of our work:

- We recruited two new Youth Voice volunteers to help codesign and implement social media campaigns and redesign communications materials, so they are youth-friendly
- The youth-focused survey of the Adolescent Health Needs Assessment will help us better understand where young people are at and what they need. The youth portion of the needs-assessment was done in partnership with a new Youth Voice intern.
- We will continue to partner with Surveillance and Evaluation, OSPI and the Northwest Portland Area Indian Health Board to continue dissemination, and later data analyses, of the Washington Youth Sexual Health Survey to understand and improve youth access to and experience with sexual health services holistically, and to learn about what works, how, for whom, and why.

Objectives:

By September 30, 2023, partner with the Washington School Based Health Alliance and the Health Systems Transformation Team to present information about School-Based Health Centers, and their importance in improving access to health care and well visits for adolescents.

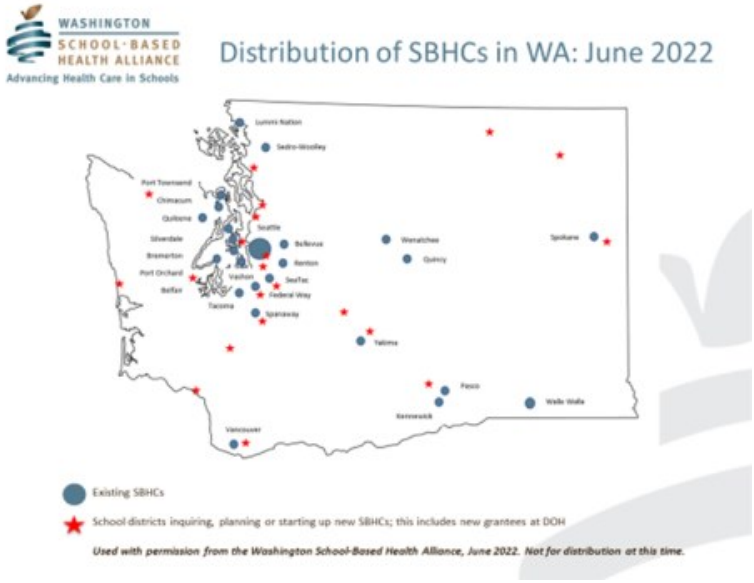
Strategies:
Collaborate with internal and external partners to identify and implement solutions that support accessible, affordable, and quality childcare, including care that meet the needs of families with CYSHCN.

Over the last reporting period, we partnered with our Office's Health Systems Transformation team and the WSBHA to present to the Medicaid Managed Care Organizations (MCOs) about SBHCs as an access point for well visits for school-aged youth. This presentation garnered a lot of interest from the MCOs who shared they wanted to learn more about SBHCs, and how to support them.

We also learned there is some confusion about SBHCs among insurers and pediatric providers. Over the rest of this reporting period, we will work with the same partners to plan for an additional presentation to promote and spread awareness about well visits in SBHCs geared to pediatric providers who do not work in SBHCs. We hope to carry out the presentation(s) in the next reporting period, and plan to do more with through this collaboration.

Objectives:
By September 30, 2022, award grants to plan, start, and improve school-based health centers throughout Washington, primarily in communities that have been historically underserved.

Strategies:
Promote school-based health strategies to serve adolescent populations where they are.



We will continue to work with the WSBHA and others to expand and sustain SBHCs throughout the state, including:

- We will convene a SBHC Advisory Group to help us make decisions about grant funding criteria and performance metrics, and how we can recognize success
- We will partner with internal programs and state agencies to convene a work group to find solutions to challenges

and barriers faced by school-based health care, including school-based health centers. This group will include internal partners at DOH, like the K-12 Education Director, as well as OSPI and HCA. We hope to also include the Office of the Insurance Commissioner and others whose work impacts SBHCs and healthcare services in schools.

- We will partner with the Northwest Portland Area Indian Health Board to help us better support Tribal communities that want to start SBHCs, and to help us engage Tribes and Tribal/Urban Indian communities in the SBHC work. We will formalize this partnership through a direct-buy contract for training on Tribal education and health systems for DOH staff, and to plan a learning space for Tribal communities to hear from Tribal-led SBHCs in Washington and elsewhere. We hope to secure sustainable funding for this partnership on an ongoing basis using MCHBG and other funds.

Objectives:
By September 30, 2023, conduct an Adolescent Health needs assessment to learn more about adolescent experiences with adolescent and young adult well visits, and transition care; by September 30, 2024, follow up on the need's assessment with recommendations and actions for improvement.

Strategies:
Promote the use of evidence-based practice guidelines, like Bright Futures, among adolescent health providers.

Promote preventive care screening and wellness visits for adolescents and young adults.
Foster measurable quality improvements in preventive care across the health system to increase adolescent and young adult-friendly care.

Collaborate with internal and external partners to identify and implement solutions that support accessible, affordable, and quality childcare, including care that meet the needs of families with CYSHCN.

As mentioned before, we have been planning an Adolescent Health Needs Assessment to learn more about the perspectives of young people and adolescent and young adult health providers around specific aspects of adolescent and young adult healthcare and services. Part of the needs assessment will include surveys with open-ended questions about well visits, transition care (for participants over 18), and the use of recommended/evidence-based tools and assessments by AYA providers. Over the next reporting period, we will release and distribute survey materials, collect, clean, and analyze data, and use findings to inform MCHBG activities moving forward.

Strategies:
Increase the proportion of Washington adolescents who receive age-appropriate, evidence-based clinical preventive services.

We want to ensure adolescents have access to health care services that meet their needs in the communities where they live, work and play. The Health and Human Services Office of Adolescent Health defines this as "youth-friendly health care services," which includes "those that attract young people, respond to their needs, and retain young clients for continuing care." These services are based on a comprehensive understanding of what young people want and need (rather than being based only on what providers believe youth need). All activities and projects in the Adolescent Health Unit contribute to increasing access to and the quality of age appropriate and evidence-based clinical preventive services, including:

- The SBHC Grant Program works to expand and sustain SBHCs throughout the state with funding and activities prioritized in communities historically underserved. Through the SBHC model we continue to support and promote includes comprehensive and integrated medical and behavioral healthcare that is age-appropriate and

youth friendly, and follows evidence-based recommendations, is community responsive, and is grounded in healing centered care.

- Over the next reporting period, we hope to convene key partners, including the Youth Advisory Council, to begin discussing needs and plans for an Adolescent and Young Adult Health Care Center of Excellence program at DOH. We hope to convene the group and hold at least one meeting by September 1, 2023.
- WA PREP works with schools, juvenile rehabilitation facilities, and youth serving agencies statewide to implement sexual health education effective in reducing adolescent pregnancy, sexually transmitted diseases, and HIV. Programs teach abstinence, contraception, and condom use, as well as adult preparation topics, including parent/child communication, healthy relationships, and healthy life skills. WA PREP teaches youth ages 11-21 with age-appropriate and culturally relevant curricula for the groups and communities where they are implemented. For more information on the state's comprehensive sexual health education law, see RCW 28A.300.475: Comprehensive sexual health education (wa.gov).
- The Family Planning program will continue to provide teen-friendly services in communities across the state. They will also continue to partner with state and local programs on community-based intervention and education programs to prevent teen pregnancy, such as the PREP program.

Objectives:
By September 30, 2022, collaborate with internal and external partners (including OSPI and S/E) to identify strengths and gaps in data, and define strategies to address them

Strategies:
Identify and develop methods to monitor systems and data gaps and improvements needed in adolescent health.

Promote and support culturally and linguistically responsive strategies to connect children and families to comprehensive medical care and community resources.

Identify existing strengths and gaps in data on barriers to quality health care. Develop plan to consolidate and improve accessibility to existing data, and explore and propose potential methods to address identified gaps

Over the next reporting period, we will begin work to realize the Dashboard. One of our first activities will be to assess and catalog data already available, including data collected through the PREP and GRADS programs, which serve adolescents and young adults through existing projects in the Adolescent Health unit. For example, PREP program surveys evaluate adult preparation subjects, including healthy relationships, parent-child communication, and healthy life skills. We will also work with partners to identify communities that are disproportionately impacted and find possible solutions to data gaps. As mentioned before, another useful source of data will be the new Washington Youth Sexual Health survey from OSPI; we will continue to support development, distribution, and evaluation of this survey. In 2019, OSPI conducted a statewide youth survey to update the Washington Youth Sexual Health Plan. This effort was done collaboratively with stakeholders, including those from our Adolescent Health program, and was inclusive of youth in Washington state. The process honored the voices of youth, and their input was received through the survey as well as through engagement on the written goals in the Washington Youth Sexual Health plan. We have partnered with OSPI and others to update and redistribute the survey. We will also review and assess data from surveys related to COVID-19 completed in 2020. Some details from the COVID-19 Student Survey, conducted instead of the 2020 Healthy Youth Survey, are included in the *Needs Assessment Update* section under the heading, “Impacts of COVID-19 Pandemic.”

Over the rest of this reporting period and into the next, we will also begin collecting data from SBHCs for grant

purposes. We will partner with the WSBHA to determine the best methods for gathering data from and on SBHCs and using that data to improve and guide our SBHC Grant Program work. We will also collaborate with Surveillance and Evaluation and the WSBHA and Public Health Seattle King County to discuss the need and possible plan for a SBHC needs assessment to learn more about the challenges and barriers SBHCs face, and work with partners to address those needs and identify feasible solutions. Finally, we will support the WSBHA and Public Health Seattle-King County (PHSKC) to bring a data platform vendor for the SBHCs to access and use to collect and report data. We will determine funding needs for the platform to allow all DOH SBHC grantees to also access the system and to report data to DOH.

We also hope to learn from OSPI's Behavioral Health Navigator Surveys of behavioral health needs of school-aged youth in Washington. The surveys were completed by the Behavioral Health navigators with leadership in Educational Service Districts over the last reporting period and will be analyzed this summer. We have already been able to use preliminary data to inform some of our key projects, including the SBHC Behavioral Health grant. We hope to work with OSPI to learn more about the findings and identify strategies to address the needs and challenges identified.

Priority:
Identify and reduce barriers to quality health care.

Objective:
By September 30, 2025, develop and provide technical assistance for school-based health centers and adolescent health providers so they report the ability to appropriately bill insurance for 50 percent of services delivered.

Strategies:
In collaboration with payers and health coverage organizations, understand and mitigate issues related to financial eligibility for health care and other support services.

Through partnerships, understand and mitigate issues related to financial eligibility for health care and other support services for adolescents and young adults.

Over the last reporting period, we formalized our partnership with the WSBHA to provide support, training, and technical assistance to SBHCs, statewide. The Alliance provides many tools and resources to SBHC providers and healthcare sponsors to help them reach optimal operations and sustainability. We also collaborated with the Alliance and our internal Health Systems Transformation team to present on SBHCs to the state's Managed Care Organizations (MCOs). This was an attempt to spread awareness about the SBCHs and to begin building networks for DOH and the Alliance to reach out to for billing and reimbursement related issues that the SBHCs may encounter.

We will continue our partnership with the WSBHA to provide training, support and technical assistance to SBHCs, statewide; we will continue to provide support, training and technical assistance to adolescent health providers, and to learn more about the success, challenges and needs of SBHCs around billing and reimbursement. We will use what we learn to plan technical assistance and support to ensure providers are able to bill for services.

In addition, we will continue to participate in key workgroups and partnerships to learn more about how we can best support SBHCs and adolescent and young adult health providers:

- In collaboration with the WSBHA, we will convene a workgroup comprised of key state agencies – including the HCA, the Office of the Insurance Commissioner, and the Medicaid Managed Care Organizations - to meet with regularly to troubleshoot and identify solutions to barriers and challenges experienced by students and providers

in SBHCs – including billing and reimbursement issues.

- We will continue to participate on the Healthy Students, Promising Futures (HSPF) Learning Collaborative. This national collaborative is co-convened by the Healthy Schools Campaign and Trust for America's Health. The purpose of this collaborative is to increase access to school health services through Medicaid reimbursement. The HSPF collaborative focuses on federal, and state polices that impact school-based health services for children in Medicaid, models for delivering school-based health services, and cross-state collaboration.
- Promote and support the Health Care Authority's toolkit on school-based health services billing guide (in progress now) and which includes recommendations for schools to seek SBHCs to provide healthcare services in the schools. We will work to help promote and disseminate these materials and promote strategies that make it easier for schools to provide healthcare services for young people.

Objective:
By September 30, 2023, discuss key health topics with the Youth Advisory Council to learn more about their thoughts, ideas and recommendations for health needs and gaps. By September 30, 2023, identify/develop strategies, and interventions to increase access to healthcare services for young people that are based on the ideas and recommendations of the Youth Advisory Council.

Strategies:
Ensure all adolescents and young adults, regardless of race, ethnicity, sexual orientation, and gender identity, have a full range of education, access, and ability to utilize health services that meet their individual needs.

We will work with the new Youth Advisory Council to learn about the challenges and barriers young people face when trying to access and use healthcare services. We will organize the information we learn and share this information with our relevant partners. In addition, we will integrate their ideas and recommendations into our MCHBG strategies to reduce barriers to care for young people.

Objective:
By September 30, 2023, have a sustainable comprehensive sexual health network focused on youth from historically underserved communities.

In 2019, the Washington Youth Sexual Health Survey findings highlight issues for AYA with access to and experience with health care visits. Seventy-five percent of respondents reported they have a health care provider that they have seen more than once, yet only 18 percent reported having had a sexual health wellness exam. Respondents also reported barriers associated with going to see a health care provider, such as the hours of the clinic don not work with their schedule (37%), not understanding how insurance works (38%), feeling judged (39%), and being afraid that their parent or caregiver will find out (48%).

In 2020, the Adolescent Health team, in collaboration with the Surveillance and Evaluation unit, was awarded one new grant for the next round of Teen Pregnancy Prevention funding from the Office of Population Affairs (OPA). We are the only state agency awarded this funding, and one of only 13 grantees total. We will continue our partnership with the Office of Superintendent of Public Instruction and the Northwest Portland Area Indian Health Board to coordinate the Washington Youth Sexual Health Innovation and Impact Network (WYSHIIN) to understand and improve youth access to and experience with sexual health services holistically, and to learn about what works, how, for whom, and why. The interventions range from the clinic setting to social media campaigns, and the partners are from all sectors who have bidirectional impact on youth sexual health care. As described in the report, we are working with 11 implementation partners and have to date served over 3500 youth, 372 caregivers and 753 community members. More information can be found here: Washington Youth Sexual Health Innovation and Impact

Network | WaPortal.org.

Pivots and program expansion into Year 3 of the project include the utilization of a youth advisory committee to provide feedback on program impact and youth-led presentation opportunities of their recommendations, culminating in a report of recommendations to share with implementation partners, lead agencies, OPA, and the communication results to the youth.

Sustainability planning will be an integral part of year 3 activities among implementation partners. In the second half of year 2, we reported on the development of collaborative alliances among cohort 1 and 2 implementation partners. We will expand these opportunities in year 3 through:

- Promotion of the communications plan activities, providing additional activities and opportunities for cohort 1 and 2 to connect and collaborate
- Key informant interviews with partners to ask about project goals, process measures for each organization, and evaluation themes.

Objective:
By September 30, 2023, conduct an Adolescent Health Needs Assessment to learn more about adolescent experiences with medical and behavioral health; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.

Strategies:
Conduct needs assessment to identify existing strengths and gaps in data, as well as top barriers for adolescents and young adults in seeking health care services.

As we've mentioned, we will continue to collaborate with the Surveillance and Evaluation team to conduct an Adolescent Health Need's Assessment to learn more about the perspectives and experiences of young people and their providers around adolescent and young adult healthcare services. This will include disseminating two surveys (one for providers and one for young people) comprised of open-ended questions about challenges and barriers to accessing and utilizing adolescent and young adult healthcare services, as well as providing those healthcare services. Over the next reporting period, we will release the survey, collect data, clean and analyze data, and organize findings to share. We will also work with partners to troubleshoot and find solutions through programmatic changes and improvements to ensure young people can access healthcare services when they need them.

Objective:
By September 30, 2023, partner with youth volunteers to develop and implement an adolescent health promotion campaign using social media.

Strategies:
Support and enhance efforts to increase health literacy among adolescents and young adults.

Over the last reporting period, we recruited two Youth Voice Volunteers to help us plan, create and carry out health promotion campaigns using social media and other methods covering key topics. Over the next reporting period, we will collaborate with these volunteers to plan health promotion campaigns, including one on health literacy. We will work with these youth partners to design and create content for the campaigns; outline dissemination plans that are relevant to youth; and carry out those plans. We will also spend time reflecting on the process and identifying ways to improve it through the perspective of our Youth Volunteers. We will work with our volunteers to learn about the projects they and other youth might be interested in so we can create opportunities that are youth friendly.

Priority:
Improve the safety, health, and supportiveness of communities.

State Performance Measure*:*
Adolescents reporting at least one adult mentor.

Objective:
By September 30, 2025, reduce the percentage of 10th grade students receiving our interventions who reported that someone they were dating limited their activities, threatened them, or made them feel unsafe by 10 percent (from 9.5 to 8.5 percent).

Objective:
By September 30, 2025, continue to work to align violence prevention efforts with partners, including DOH Injury and Violence Prevention and the Office of the Superintendent of Public Instruction (OSPI)

Objective:
By September 30, 2025, continue to promote resources and information about, and support projects that promote healthy relationships for young people.

Strategy:
Support violence prevention efforts and promote healthy relationships among adolescents and young adults.

Build networks and resources in communities to enable and enhance community and peer support

Data shows interpersonal violence, including bullying, is an issue for young people in Washington. In 2021, occurrences of bullying in the previous 30 days was reported by 21 percent of students in the Healthy Youth Survey across all surveyed grades. Among 10th graders individuals who identified as either gay or lesbian or as bisexual were much more likely to have reported as having been bullied, 24% and 23% vs. 10% respectively.

Interpersonal violence in the past 12 months among dating couples was reported at about 7 percent across 8th, 10th and 12th grades. Individuals not identifying as heterosexual were twice as likely to have experienced partner violence in the preceding year, 10% vs. 5%.

We will continue working with partners to support efforts to promote healthy relationships among youth in our state, especially those led by our partners in Injury and Violence Prevention. In addition, we will:

- Collaborate with internal and external partners – like Injury and Violence Prevention and the NPAIHB - to identify initiatives and efforts geared to youth and provider education about health relationships, disseminate information about these resources to key partners and communities, and identify areas where we can address any gaps in information.
- Promote training and information on healthy relationships created by the Washington State Coalition Against Domestic Violence for SBHCs to better respond to young people's needs around healthy relationships. To do this, we will provide online training kits called "*In Their Shoes: Teens and Dating Violence*" to all the SBHCs in the state, including those we will support and fund through our SBHC grant program.
- Partner with OSPI to review and support materials in the education sphere that promote and teach healthy relationships.

- Provide or support trainings to health care providers (including SBHCs) to recognize signs of dating abuse, partner violence, and trafficking through screenings.
- Our Personal Responsibility Education Program (PREP) will continue to provide education on adult preparation topics such as healthy relationships, including positive self-esteem, relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions; parent-child communication; and healthy life skills, such as goal setting, decision making, negotiation, communication, and interpersonal skills and stress management.

Objective:
By September 30, 2025, continue to participate in and contribute to key agency-level workgroups, including OSPI's monthly School Safety and Student Wellbeing Workgroup to align efforts with agency partners.

Strategy:
Build networks and resources in communities to enable and enhance community and peer support.

During the last reporting period, we spent time participating and contributing to several workgroups as mentioned throughout this plan including meeting with DOH staff and OSPI staff who participate in OSPI's School Safety and Student Wellbeing Advisory Committee. The purpose of School Safety and Student Well-Being Advisory Committee (SS-SWAC) is to advise the superintendent, the office of the Superintendent of Public Instruction's School Safety Center, the school districts, and public and private schools on all matters related to comprehensive school safety and student well-being. Representatives from state agencies and community organizations attend and make decisions about student safety topics. Over many years, the representative had DOH has been from the Division of Environmental Public Health. However, with the shift of student safety moving from physical and environmental aspects of safety more to social, emotional and psychological elements of safety, the DOH contact has asked that the Adolescent Health Unit help to represent DOH at the meeting, and help identify a new decision maker for the

In addition, the Injury and Violence Prevention Team at DOH are hoping to convene a gender-based violence prevention workgroup for internal partners at DOH. This is something we hope to partner on during the next reporting period.

Priority:
Optimize the health and well-being of children and adolescents, using holistic approaches.

National Performance Measure:
Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

ESM 10.1*: Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year*

Objective:
By September 30, 2022, form Youth Advisory Council and hold at least one initial meeting and by September 30, 2023 discuss adolescent well visits and adolescent and young adult care and services.

Strategies*:*
Include adolescents in this work through strategies such as building and supporting a youth advisory council and identify other meaningful ways to engage the population to be served.

As mentioned earlier, we will work with the Youth Advisory Council to learn more about ideas and recommendations to increase access and use of well visits by adolescents and young adults. We will integrate their feedback and

ideas into our programming – including MCHBG activities – and will share with relevant partners.

We will also partner with our Youth Voice Volunteers and the Health Systems Transformation team to devise a social media communications plan to promote well visits during the late summer months.

Objective:
By September 30, 2023, conduct an Adolescent and Young Adult Health needs assessment to learn more about adolescent experiences with adolescent and young adult well visits, and transition care; by September 30, 2024, follow up on the need's assessment with recommendations and actions for improvement.

Strategies:
Promote the use of evidence-based practice guidelines, like Bright Futures, among adolescent health providers.

Increase the proportion of Washington adolescents who receive age-appropriate, evidence-based clinical preventive services.

Collaborate with internal and external partners to identify and implement solutions that support accessible, affordable, and quality childcare, including care that meet the needs of families with CYSHCN.

As we have reported, we have been planning for an Adolescent and Young Adult Needs Assessment to learn more about young people's experiences with youth healthcare providers and services.

We want to learn more about what tools providers are already using, and what has worked for them and what has not worked for them. To do this, we will be including several questions about mental health screening and risk behavior assessments in the healthcare provider aspect of our Adolescent and Young Adult Needs Assessment. Over the last reporting period, we focused on project planning and IRB; over the rest of the reporting period, we will flush out the provider survey and outline a dissemination plan. We hope to work with several pediatric and family care providers to help ensure the survey makes sense and so we can get it to adolescent and young adult-serving providers. Over the next reporting period, we will release the survey, collect and analyze the findings, then work with partners and several providers to outline recommendations for us moving forward.

When we know more about how and what types of tools we want to promote and support, we will utilize internal communications resources – like social media, listservs, and adolescent-focused webpages – to disseminate information about preferred tools and toolkits, and we will work with partners to spread awareness about the toolkit and how it is used through communications and webinars. We will also work specifically with SBHCs to promote use of the toolkit in SBHC settings.

In addition
We will continue to learn from our partners at WSBHA and Public Health Seattle King County about the screening and assessment tools they are supporting for SBHCs. They will be working to bring on a new vendor for SBHC data – the project will include an electronic screening and assessment tool that will be made available to SBHCs in King County. Their goal is to standardize screenings and assessment processes and tools in the SBHCs they support so they can begin learning from the data, and to promote universal processes. We hope to learn from that process.

As reported earlier, we will also convene key partners, including the Youth Advisory Council, to begin discussing needs and plans for an Adolescent and Young Adult Health Care Center of Excellence program at DOH.

Objective:
By September 30, 2023, partner with the Washington School Based Health Alliance and the Health Systems Transformation Team to present information about School-Based Health Centers, and their importance in improving access to health care and well visits for adolescents.

Over the last reporting period, we partnered with our Office's Health Systems Transformation team and the Washington School Based Health Alliance to present on SBHCs to the Medicaid Managed Care Organizations (MCOs) to spread awareness about SBHCs as an access point for well visits for school-aged youth. This presentation garnered a lot of interest from the MCOs who shared they wanted to learn more about SBHCs, and how they can support them. We also learned there are many misconceptions about SBHCs among insurers and pediatric providers.

Over the rest of this reporting period, we will work with the same partners to plan for an additional presentation to promote and spread awareness about well visits in SBHCs geared to pediatric providers who do not work in SBHCs. We hope to carry out the presentation(s) in the next reporting period, and plan to do more with through this collaboration.

Strategies:
Promote school-based health strategies to serve adolescent populations where they are.
Promote and support culturally and linguistically responsive strategies to connect children and families to comprehensive medical care and community resources.

In addition to our work to implement a new SBHC Grant Program, we will also continue to build relationships and networks to increase the reach of SBHCs throughout this state. This work will include:

- We will continue our partnership with the WSBHA to provide expertise and ongoing consultation to us around SBHCs, the SBHC model, and grant criteria; and to provide support, training and technical assistance to SBHCs, statewide, including our grantees.
- We will work with the WSBHA to identify members for and convene an advisory group to help us make decisions about SBHC grant funding criteria and performance metrics, and how we can recognize success. This group will include key partners and experts around SBHCs and will meet on a quarterly or semi-annual basis.
- We will partner with key state agencies to convene a work group to find solutions to challenges and barriers faced by SBHCs. This group will include internal partners at DOH, like the K-12 Education Director, as well as OSPI and HCA. We hope to also include the Office of the Insurance Commissioner and others whose work impacts SBHCs and healthcare services in schools.
- We will partner with the Northwest Portland Area Indian Health Board to help us better support Tribal communities that want to start SBHCs, and to help us engage Tribes and Tribal/Urban Indian communities in the SBHC work. We will formalize this partnership through a direct-buy contract. We hope to secure sustainable funding for this partnership on an ongoing basis using MCHBG and other funds.

Strategies:
Identify and develop methods to monitor systems and data gaps and improvements needed in adolescent health.

Identify existing strengths and gaps in data on barriers to quality health care. Develop plan to consolidate and improve accessibility to existing data, and explore and propose potential methods to address identified gaps

As mentioned throughout our reports and plans, we collaborated with partners internally and externally to identify ways to learn more about gaps and barriers in the data we have and identify data we need to understand more. A

quick recap of activities includes:
We want to learn more from providers in SBHCs about their experiences and needs as it relates to adolescent healthcare and services. We will spend the next reporting period working with partners to determine the best methods for gathering data from and on SBHCs and using that data to improve and guide our SBHC Grant Program work. We will also collaborate with Surveillance and Evaluation and the WSBHA and Public Health Seattle-King County (PHSKC) to develop and implement a plan for an SBHC needs assessment to learn more about the challenges and barriers SBHCs face, and work with partners to address those needs and identify feasible solutions.

We will support the WSBHA and PHSKC to bring a data platform vendor for the SBHCs to access and use to collect and report data. We will determine funding needs for the platform to allow DOH SBHC grantees to also access the system and report data to DOH.

The Adolescent Health Team and Surveillance and Evaluation will collaborate to carry out plans for the Adolescent Health Data Dashboard.

We will continue work with OSPI and others to update and redistribute the WYSH survey. We will also review and assess data from surveys related to COVID-19 completed in 2020. Some details from the COVID-19 Student Survey, conducted instead of the 2020 Healthy Youth Survey, are included in the *Needs Assessment Update* section under the heading, “Impacts of COVID-19 Pandemic.”

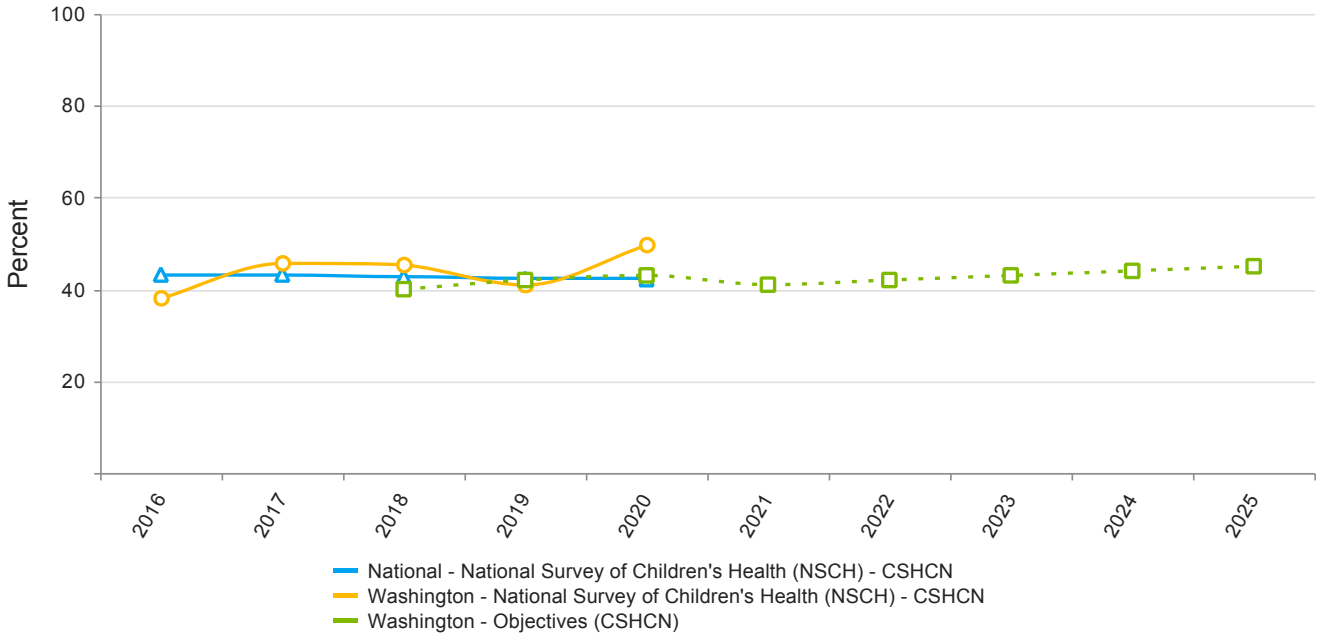
We hope to learn from OSPI’s Behavioral Health Navigator Surveys of behavioral health needs of school-aged youth in Washington. The surveys were completed by the BH navigators with leadership in Educational Service Districts over the last reporting period and will be analyzed this summer. We have already been able to use preliminary data to inform some of our key projects, including the SBHC Behavioral Health grant. We hope to work with OSPI to learn more about the findings and identify strategies to address the needs and challenges identified.

Children with Special Health Care Needs

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		40	42	43	41
Annual Indicator	38.1	45.7	45.3	40.8	49.5
Numerator	113,841	138,232	141,032	131,960	161,798
Denominator	299,109	302,213	311,138	323,785	327,035
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	42.0	43.0	44.0	45.0

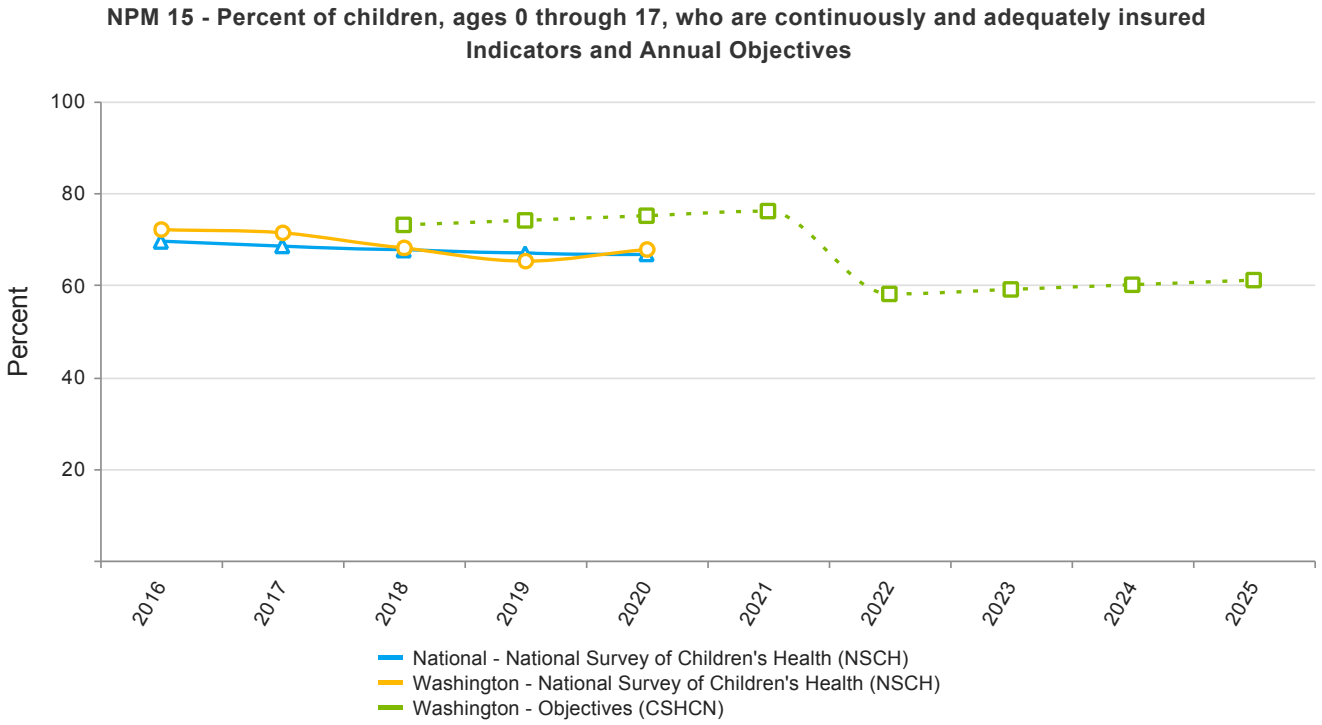
Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			80
Annual Indicator		87.5	88.6
Numerator		14	39
Denominator		16	44
Data Source		University of Washington LEND ECHO-Autism Program	University of Washington LEND ECHO-Autism Program
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.0	91.0	92.0	93.0



NPM 15 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		73	74	75	76
Annual Indicator	72.0	71.2	67.9	65.1	67.6
Numerator	1,154,504	1,148,124	1,107,284	1,068,524	1,116,228
Denominator	1,603,905	1,613,555	1,630,587	1,642,095	1,652,168
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective		73	74	75	76
Annual Indicator					55.4
Numerator					
Denominator					
Data Source					NSCH
Data Source Year					2019-2020
Provisional or Final ?					Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	58.0	59.0	60.0	61.0

Evidence-Based or –Informed Strategy Measures

ESM 15.1 - 15.1 Increase the percentage of CYSHCN who report having insurance when receiving services

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	99.2	99.2
Numerator	19,268	19,268
Denominator	19,424	19,424
Data Source	Washington State Child Health Intake Form	Washington State Child Health Intake Form
Data Source Year	2020	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	99.3	99.4	99.5	99.6

State Performance Measures

SPM 10 - Suicide ideation among youth with special health care needs

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	40	38.2
Numerator	422	421
Denominator	1,055	1,103
Data Source	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	38.0	37.5	37.0	36.0

State Action Plan Table

State Action Plan Table (Washington) - Children with Special Health Care Needs - Entry 1

Priority Need

Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

By September 2022, explore opportunities to work with the Community Health Worker (CHW) program to increase CHW knowledge of developmental screening and milestones. Implement the Autism and Developmental Disabilities module as part of broader training curriculum for CHWs. Develop strategies for linking trained CHWs to autism diagnostic network.

By September 2022, update provider training needs assessment and plan for at least two trainings to address provider training needs related to working with CYSHCN populations.

By September 30, 2025, increase the number of dietitian members of the Nutrition Network with CYSHCN training and the number of community-based feeding teams working with CYSHCN. Prioritize training and support given to those in counties with limited resources and those with ability to provide services via telehealth.

By September 30, 2025, increase the percentage of CYSHCN ages 0-17 who receive care in a well-functioning system by 5 percent.

Strategies
Improve overall awareness of the complex needs of the children and youth with special health care needs (CYSHCN) population as a demographic identity, with distinctive cultural needs for access to communities and systems of care.
Partner with the Medical Home Partnerships Project to provide state-level subject matter expertise and technical assistance, and coordinate with the UW LEND program and Seattle Children's Hospital to support communities in workforce development, resource development, and ongoing training on family-centered, comprehensive systems of care for CYSHCN.
Provide targeted subject matter expertise to contractors and providers, including CYSHCN Coordinators, on areas of expertise such as complex nutrition for CYSHCN, children and youth with clinical and behavioral complexity, including autism, navigating state systems and policy, care coordination, family navigation, and community referral systems and clinical linkages.
Identify and develop methods to establish baseline data on CYSHCN, systems of care, gaps, and barriers to equitable, quality care. Make data accessible via a CYSHCN dashboard and other dissemination efforts. Utilize data to identify referral opportunities and strategies, and community needs for local health care resources and equitable service delivery.
Provide services to family members of CYSHCN so they can be trained, engaged, supported, and involved at all levels of program planning and implementation of services for CYSHCN. Implement and promote inclusion opportunities and support resources for fatherhood, foster parents, grandparents, kinship care.
Partner with the Washington Statewide Leadership Initiative collaborative and community-based organizations to elevate family voices and provide connections so family voices can effectively influence the development of systems and services for CYSHCN.
Promote and facilitate successful transitions including transition from hospital to home, from Birth to 3 into school and community-based services, and from pediatric to adult specialty services.
Through partnerships, address the need for improved access to affordable services, and increased availability of CYSHCN service providers, quality healthcare, access to insurance, and adequate health care financing, particularly in rural communities and remote areas regardless of language spoken, gender identity, race and ethnicity, immigration status, or insurance status of families.
Through partnerships, facilitate innovative programming and technology solutions such as telehealth and remote services to address gaps in rural and remote areas and other barriers to access to care.
Enhance and maintain health systems and improve financing options to improve care coordination and family navigation.

ESMs	Status
ESM 11.1 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Washington) - Children with Special Health Care Needs - Entry 2

Priority Need

Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

NPM

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured

Objectives

By September 30, 2025, increase the percentage of CYSHCN ages 0-17 who receive care in a well-functioning system by 5 percent.

Strategies

Provide services to CYSHCN and family members of CYSHCN so they can be trained, engaged, supported, and involved at all levels of program planning and implementation of services for CYSHCN. Implement and promote inclusion opportunities and support resources for fatherhood, foster parents, grandparents, kinship care.

Partner with the Washington State Leadership Initiative collaborative and community-based organizations to elevate family voices and provide connections so family voices can effectively influence the development of systems and services for CYSHCN.

Promote and facilitate successful transitions including transition from hospital to home, from Birth to 3 into school and community-based services, and from pediatric to adult specialty services.

Through partnerships, address the need for improved access to affordable services, and increased availability of CYSHCN service providers, quality healthcare, access to insurance, and adequate health care financing, particularly in rural communities and remote areas regardless of language spoken, gender identity, race and ethnicity, immigration status, or insurance status of families.

Through partnerships, facilitate innovative programming and technology solutions such as telehealth and remote services to address gaps in rural and remote areas and other barriers to access to care.

Enhance and maintain health systems and improve financing options to improve care coordination and family navigation.

ESMs	Status
ESM 15.1 - 15.1 Increase the percentage of CYSHCN who report having insurance when receiving services	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Washington) - Children with Special Health Care Needs - Entry 3

Priority Need

Promote mental wellness and resilience through increased access to behavioral health and other support services.

SPM

SPM 10 - Suicide ideation among youth with special health care needs

Objectives

By September 30, 2025, decrease the percentage of 10th grade CYSHCN who report they have considered attempting suicide by 5 percent.

By September 30, 2025, create and disseminate health education publications specific to autism and other developmental disabilities that are adopted by the suicide prevention program as part of their health education resources and curricula for the state-level suicide prevention plan.

Strategies

Take action to reduce stigma surrounding behavioral health, treatment and related challenges.

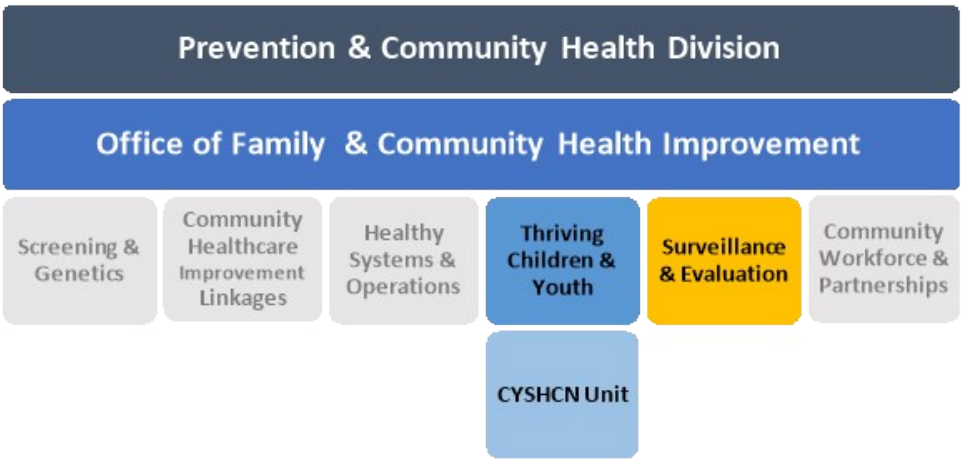
Support interventions to address suicide ideation among CYSHCN.

Identify opportunities to infuse trauma-informed care into working with CYSHCN.

Collaborate with surveillance and epidemiology Healthy Youth Survey leads to advocate for including questions about special health care needs in all Healthy Youth Surveys.

Identify and disseminate data for analysis on risk of suicide ideation for CYSHCN, including focus on youth with autism and other developmental disabilities. In the evidence base, increase representation of youth with disabilities as a complex disparate group with a high intersectionality between other known populations vulnerable to high risk factors.

III.E.2.b.v.c. State Action Plan Narrative by Domain



Children and Youth with Special Health Care Needs Domain Annual Report

Overview

The Children and Youth with Special Health Care Needs (CYSHCN) unit at the Department of Health (DOH) resides in the Thriving Children and Youth section of the Office of Family and Community Health Improvement in the Division of Prevention and Community Health. The CYSHCN program works to promote a system of care that is family-centered, integrated, collaborative, coordinated, and equitably accessible to all CYSHCN and their families. In our work on the overall system of care, particular areas of focus are equitable access, funding strategies, concrete supports for the well-being of CYSHCN and their families, family navigation, and care coordination.

The Washington State CYSHCN program endeavors to serve the broad population of CYSHCN in Washington state and adopts the federal definition of CYSHCN in determining eligibility for services. An estimated 327,000 children and youth with special health care needs (CYSHCN) ages 17 and younger reside in Washington state; this is an estimated 20% of the population of this age group (National Survey of Children's Health [NSCH] 2019-20). This is a similar percentage of CYSHCN as the U.S. (19%). The Washington CYSHCN program serves this population through:

- Grants to local health jurisdictions for local CYSHCN coordinators that work on systems improvement for CYSHCN in their local communities as well as offering some enabling and direct services to children and their families.
- Technical assistance to providers via CYSHCN Communication Network meetings and other trainings as well as contracts with the University of Washington Center for Human Development and Disability's Medical Homes Partnership Project and Nutrition Network.
- Support for family engagement and leadership through the Washington State Leadership Initiative (WSLI), and contracts with family led and family serving organizations.
- Collaboration with other state agencies and providers on statewide systems enhancements to improve the system of care and care coordination for CYSHCN
- Utilizing state funding to support a network of neurodevelopmental centers and maxillofacial review boards
- Supporting education and outreach on Medicaid services for CYSHCN through an interagency agreement with our state Medicaid agency, the Health Care Authority (HCA)

The Child Health Intake Form (CHIF) system, which tracks CYSHCN who receive services through MCHBG and Neurodevelopment Center of Excellence (NDC) funding, increased from 12,486 children in 2014 to 19,424 children in 2019, a 56% increase over this period. Although the number served falls far short of the total number of CYSHCN estimated for the state, this reflects the fact that the vast majority of funded services fall higher up on the health impact pyramid than the direct and enabling services counted here.

The CYSHCN program at DOH works to increase access to comprehensive, coordinated, family-centered and culturally responsive health care and related services needed for CYSHCN and their families. To accomplish this, we must address the gaps and weaknesses in the primary and specialty care systems that directly impact if and when a child gains access to needed services and supports. In FY 2021, we concentrated much of our work on the medical home national performance measure (NPMs) for CYSHCN. When we created the new five-year state action plan in 2020, we had not originally included NPM 15 – Adequate Insurance for 2021-2025. However, last year we decided to re-include NPM 15. There is much overlap between our and our partners' work on medical home and our work to improve coverage and families' use of available coverage for services.

50% of CYSHCN in Washington state had a medical home. This percent has remained relatively stable for the last four years. The percent is not statistically significantly different from the percent of children without a special health care need, (53%). In addition, 55% of CYSHCN had adequate insurance, less than the percent of non-CYSHCN at 71%. 24% of parents of CYSHCN reported that obtaining specialist care was "somewhat difficult". Often parents describe barriers related to access to skilled providers. In the most recent Washington Five Year Needs Assessment, it was reported that services for complex medical or behavioral health needs were limited or nonexistent in certain locations, making access for families difficult. Necessary travel to a distant provider location can result in additional expense and is sometimes impractical for families. This often creates bottlenecks in clinics that serve CYSHCN from a large region of the state.

There is also limited access to Medicaid Home and Community Based Waiver Services in the state, which makes obtaining adequate coverage for CYSHCN whose families are over Medicaid income limits difficult and often impossible for those without intellectual disabilities. *Sixteen percent of Washington families raising CYSHCN stopped working or reduced working hours to provide care, compared with 3% who did not have a child/youth with special health care needs*. This represents an apparent improvement over 2018-19 numbers where 25% of Washington families reported stopping or reducing work hours, but there is still a significant gap between families raising CYSHCN and those who did not have a child with special health care needs. The complexities of health care financing create an added barrier to both families and providers. The work in the CYSHCN program to support adequate insurance has shifted away from an enrollment focus to a focus on health care financing in general, to adequately meet the needs of CYSHCN and their families without unreasonable out-of-pocket expenses or financial barriers to accessing needed services.

The state action plan for the CYSHCN population domain was designed to address these barriers and is aligned with the evidence-based and -informed national Standards for Systems of Care for CYSHCN. Training and support on medical homes and community-based supports are needed for primary care practices and other providers, especially for those serving medically underserved populations. Families and providers need training, tools, and supports to build strong family-professional partnerships and address cultural and linguistic barriers to effective partnerships and care. Greater coordination and collaboration are needed among state agencies and organizations, local community agencies and organizations, families, and other stakeholders to assure quality and increase access to needed services. The financing strategies of the health care system need to carve out a pediatric model that provides CYSHCN and their families enhanced care coordination services such as those offered to adults with chronic diseases, with providers incentivized for successful outcomes.

The following sections describe progress made and programmatic highlights during FFY 2021 for Medical Home and Adequate Insurance priority areas.

National Performance Measure 11 – Medical Home
Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Care Coordination and Identification of CYSHCN
The Department of Health's Title V staff continued to work closely with Washington State Health Care Authority (HCA), the state Medicaid administrative agency, on improved identification of CYSHCN through changes in data-sharing processes, as well as improvement of data and information sharing among other key system partners. Medicaid's Predictive Risk Intelligence SysteM (PRISM) database, used by contracted managed care organizations (MCOs), identifies patients who could benefit from comprehensive services in a "health home" with care coordination, based on risk factors associated with high claims and high utilization of specialty services.

With a shift in thinking around health care transformation efforts and work to incorporate value-based care and alternative payment models, there is an increasing awareness of cost-based risk models shifting more focus on adult care needs and chronic disease. While care coordination of CYSHCN increases the optimization of developmental outcomes, there are little data to show long-term impact on overall cost savings on the already overburdened health care system. Due to design characteristics of the current PRISM system, CYSHCN are largely under-identified, as their overall claims are significantly lower than adults with chronic disease, and the data are not focused on long-term financial savings over the life course.

DOH has partnered with the Department of Social and Health Services (DSHS) and HCA to add a "flag" (indicator) in PRISM that identifies any child who receives services through our Title V CYSHCN program, which is indicated in our CYSHCN Child Health Intake Form database. The addition of this CYSHCN indicator to PRISM allows the MCOs to sort client data specifically to identify CYSHCN; MCOs can then use the CYSHCN "flag" as a single data point that alerts care management staff of the increased need for these children to have coordinated and comprehensive services through their health plans. Prior to this enhancement, MCOs had no way to reliably identify CYSHCN in their data systems.

Our redesign of the CHIF database began in September 2018 and the new system launched in spring 2020. DOH worked with Medicaid to help fund this database build using 90/10 Health Information Technology for Economic and Clinical Health (HITECH) Implementation Advanced Planning Document (IAPD) funding. The CYSHCN program continues quality improvement activities to ensure the ongoing quality assurance and success of data matching between the CYSHCN program and HCA to address any errors and to sustain high match rates. During FFY 2021 we developed and piloted Health Information Exchange (HIE) integration so providers that submit data to the CHIF system can do so more seamlessly from their electronic medical record (EMR).

Autism Identification, Diagnosis, and Connection to Services System Development
The CYSHCN program, through a partnership with the University of Washington (UW), has long supported technical assistance on Community Asset Mapping (CAM) to local communities to build capacity for early childhood systems. This work has identified a common community need around the state to improve the continuum of supports and services related to the screening, identification, diagnosis, and intervention of autism spectrum disorders and other developmental disabilities (ASD/DD). Therefore, much of our medical homework has focused on improving medical home for children with autism. However, enhancing medical home for children with autism also helps to support practices to better provide a medical home to other CYSHCN. This work enhances the understanding of local

services and statewide resources for CYSHCN and additional staffing that can support the needs of additional subpopulations of CYSHCN beyond those with autism. It also brings historically siloed systems that serve CYSCHN (e.g., health care, schools, public health, and social services) together to collaborate on a more coordinated and integrated system of care.

The CYSHCN program contracted with the Washington State Medical Home Partnerships Project (MHPP) for CYSHCN to support the medical home NPM. The MHPP is co-located and works closely with the UW Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program. The MHPP is a Washington state Title V-funded technical assistance center for medical home for CYSHCN and for promotion and replication of comprehensive coordinated systems of care in communities for CYSHCN with autism and their families. They provide support and workforce development to pediatricians, developmental clinicians providing habilitative services, as well as child and family advocates who work collaboratively to develop medical homes, integrated within their medical home "neighborhood."

MHPP provides small grants to communities to enhance systems of care for autism through autism task forces. They also maintain a website, MedicalHome.org, for medical home resources to support providers, families, and CYSHCN partners statewide. The Director of UW MHPP is funded by Title V CYSHCN dollars, as well as part of an FTE for an advanced registered nurse practitioner (ARNP) with developmental pediatric expertise. They have public health, nursing, and developmental behavioral pediatric expertise on staff, and collaborate closely with many state and local partners, including the Washington Chapter of the American Academy of Pediatrics (WCAAP); Partnerships for Action, Voices for Empowerment (PAVE), the Title V Family to Family Health Information Center (F2F); Medicaid; and the DOH CYSHCN program, to support and leverage local initiatives that improve care and decrease health inequities.

MHPP has led the state in enhancing communities' ability to diagnose and refer CYSHCN for autism through Community Asset Mapping and the School Medical Autism Review Team (SMART) model. The SMART model was created with Washington's first autism grant (2008-2011), sustained with MCHBG funds after the completion of the grant, and then expanded and enhanced with the 2016 CARES autism grant. This program continues to be sustained through Title V funding now that the CARES autism grant has ended.

The SMART model was developed in one CAM county and has been replicated in eleven additional counties. Nine other counties have been developing teams, and an additional two counties have expressed interest in the model. The SMART process brings community providers together with school and medical resources to provide a comprehensive diagnosis of autism spectrum disorder (ASD) for a child. It provides a close link between a child's primary care provider and school team, which sees the child regularly and engages with the family. The SMART tool, available online, and customized to each community, is available in English and Spanish.

CYSHCN partners led technical assistance projects all over the state and were instrumental in the development of a robust sustainability plan for much of the work accomplished during our previous autism grant. A key accomplishment was the collaboration between many of our CYSHCN grant partners in expanding autism diagnostic training to community providers. Many primary care providers are hesitant to diagnose or care for children with special needs, especially autism, because they feel they do not have the necessary skills or support. HCA began contracting with Seattle Children's Autism Center in 2013 to provide Autism Center of Excellence (COE) certification training to interested community primary care providers in rural and other underserved areas to increase access to an ASD diagnosis for children with Medicaid.

Participation in this training allows primary care physicians to assess and diagnose children with autism, bill for the assessment, and refer to Applied Behavior Analysis (ABA) therapy that will be covered by Medicaid. In more recent

years, Seattle Children's faculty also promoted the SMART model as a practical strategy to help primary care physicians access interdisciplinary evaluation expertise and provide technical assistance to SMART teams.

MHPP staff helped Seattle Children's Autism Center faculty organize the regional trainings in 2018, drawing in CAM leaders and other community partners for recruitment and logistical support. This increased regional recruitment and attendance at the trainings. However, many qualifying providers still did not diagnose after going through the autism COE training because they reported still feeling unconfident of their skills.

To address this, Seattle Children's Autism Center used Autism Cares funds from the CYSHCN program through the MHPP and brought in Dr. Kristin Sohl, the originator of Project ECHO (Extension for Community Healthcare Outcomes) Autism in Missouri in August 2018 to help partners figure out how to provide ongoing, deeper assistance to providers willing to evaluate and diagnose children if they had more resources and support. Seattle Children's and UW LEND leaders, in partnership with community leaders statewide, were successful in getting funding from the state legislature through the HCA for a two-year Project ECHO Autism Washington pilot in 2019-2021.

When enhanced with the ECHO model, COE training provides a collaborative space for the primary care providers to staff cases, receive ongoing education, and develop their expertise in diagnosing and supporting CYSHCN with autism. This was a key workforce development effort in response to the lack of diagnostic services available in many communities.

In 2020, the COE and ECHO trainings became much more integrated with the SMART model, with many SMART teams participating in COE and ECHO training**.** The active interest and concrete support of HCA and Seattle Children's Autism Center to collaborate with and expand the SMART team model in conjunction with COE trainings is an exciting step toward bringing comprehensive, reliable evaluation for autism spectrum disorder closer to home for every child and family that needs it.

The program continued to grow and increase integration in 2021. There are now 2 cohorts of the Autism ECHO with one focused on younger children and one on the lifespan. The MHPP lead is part of the hub team for Project ECHO as the public health Community Connector. Project ECHO meets twice a month for 90 minutes. The hub team includes 10 interdisciplinary faculty (including a self-advocate and two parent advocates/resource navigators) and 72 community primary care provider/psychologist "spokes." At each meeting they discuss a patient case presented by a spoke and listen to a short didactic lecture. Many spokes are also currently part of SMART teams, other spokes have been part of Great MINDS (Great Medical Homes Include Developmental Screening) and other DOH/MHPP initiatives in the past, so MHPP involvement helps to support the ongoing Title V public health connection. MHPP is working with family leaders, self-advocates and LEND faculty to identify community and other resources for ECHO participants. This will help with community resource efforts for the Collaborative for Improvement and Innovation Network (CoIIN) for children with medical complexity, medical home, and other MHPP activities, and builds on earlier Pediatric Transforming Clinical Practice Initiative (P-TCPI) work.

COE trainings moved online due to COVID-19 in 2020 and engaged many new providers across the state due to the virtual format. The virtual COE trainings in February, May and September 2021 had over 160 participants, with over 120 potential COEs and other representatives from public health, schools, early intervention, and other community partners. 45-50% of trainees have already followed through to be added to the official HCA COE list. Many also signed up for the 2021 ECHO cohort. Existing CAM communities and SMART teams are helping lead the way for more colleagues in new communities to join them and state partners, including DOH, HCA, Seattle Children's, Medicaid MCOs, UW, and more. Many separate strands are coming together to form an accessible system of diagnosis and support for children and youth with autism and their families. MHPP staff have provided technical

assistance to support new and current community coalitions.

Although federal autism grant funds previously supported much of this work with communities on improving care for children and youth with autism, MCHBG funds also provided substantial program management support and maintenance of the programs starting September 1, 2019, as part of the grant sustainability plan.

The Project ECHO Autism Washington training sent a detailed survey to all identified 100+ COEs this year asking for their confidence levels around a variety of topics including serving as a medical home for children with autism. This survey will be repeated yearly with COEs going through Project ECHO as well as all other COEs. The MHPP secured agreement from the UW LEND program, where Project ECHO is based, and the COE training lead at Seattle Children's to share the data about the medical home question over the next five years. These data are the basis of our ESM: *Percent of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients*. Data from the 2021 ECHO Autism combined cohorts focused on 1) children and youth and/or more experienced diagnosticians, and 2) young children/new diagnosticians. 89% of all medical providers who participated in the trainings, indicated that they were confident in their ability to provide a medical home for their patients with autism. This is up from 82% in the 2020 cohort. When the two 2021 cohorts were looked at individually, the cohort of those who were serving all age and/or had more experience in diagnosing autism were uniformly confident in their ability, with 100% of participants reporting confidence in providing a medical hoe. Those in the cohort working specifically with younger children and/or who had less experience in diagnosing autism, still had high levels of confidence, with 81% reporting that they were confident in their ability to provide a medical home.

Nutrition Support, Workforce Development, and Systems Improvements

It is the position of the Academy of Nutrition and Dietetics (AND) that nutrition services provided by registered dietitian nutritionists (RDNs) and dietetic technicians, registered (DTRs) are essential components of comprehensive care for all people with developmental disabilities and special health care needs (AND 2015). To reiterate the importance of an RDN's role in CYSHCN, the ACEND proposed 2022 Educational Standards Included learning activities that must prepare students to implement the Nutrition Care Process with various populations and diverse cultures including infants, children, adolescents, adults, pregnant/lactating females, older adults and *people with disabilitie*s. We continue to promote infrastructure and capacity building, including community based RDN skill development and building of interdisciplinary models of care (maxillofacial review boards, neurodevelopmental centers, feeding teams, and early intervention). This work was supported through a variety of contracts and partnerships.

Of note, onboarding of the new Nutrition Consultant began in March of 2021 with a vacancy in the position three months prior.

The Local Health Jurisdiction (LHJ) MCH Action Plans for 2020-21 often involved nutrition as a focus area in many of the counties. Early in the pandemic, a gap was identified that food insecurity was prevalent and a community implementation of ways to support innovative strategies to improve nutrition was a priority. King County focused on the 13 regions with low supermarket accessibility. All but one of these regions are in South King County areas with the lowest income and highest racial diversity. Several LHJ's developed strong partnerships with schools and pediatricians that were initiating conversations about social-emotional health, nutrition, and access to care beyond the COVID-19 pandemic. Partner engagement was another important consideration for LHJs and one community decided to coordinate monthly Feeding Team meetings to allow for agency resource sharing and care coordination among service and therapy providers (Benton-Franklin). In addition, they developed formal and informal agreements between the health systems, including Medicaid Managed Care Plans, and various agencies serving CYSHCN throughout the county. Lastly, a reoccurring theme was promoting practices and policies that support breastfeeding in early learning programs.

The Assessment of Nutrition Services for CYSHCN completed in the fall of 2019 and published online in early 2020

identified that families and health care providers value pediatric dietitians as an important part of the interdisciplinary care of CYSHCN. It also identified that Washington's well-established CYSHCN Nutrition Network of dietitians is an advantage as we work to improve nutrition services for the CYSHCN population.

Four recommendations to address gap areas emerged from the needs assessment:

- Expand hospital and community nutrition coordination systems and referral processes
- Address nutrition workforce shortages and development needs
- Create methods for quantifying and tracking the statewide population of CYSHCN with nutritional needs
- Facilitate innovative solutions for nutrition access (telehealth and medical home models)

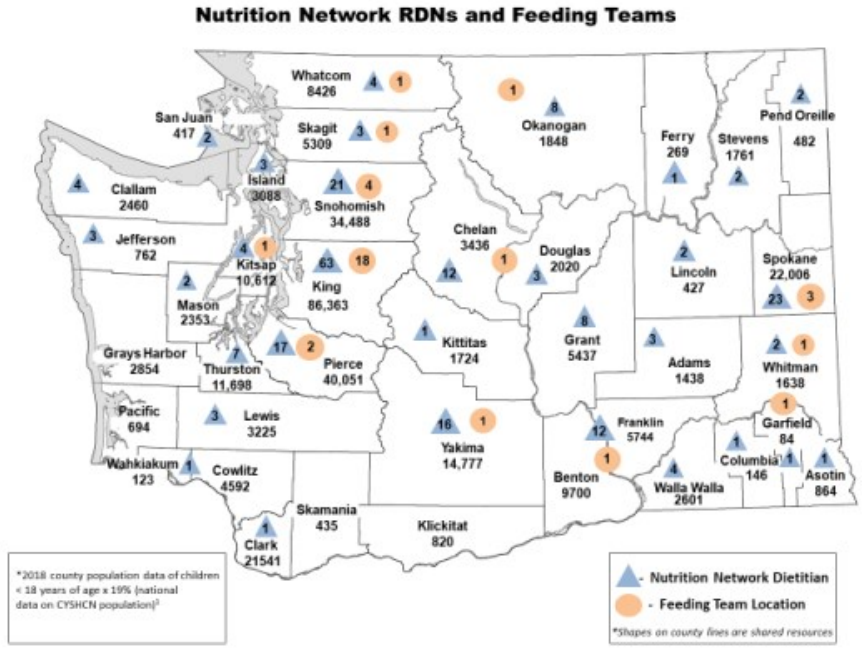
A key finding of the report was that based on existing data on nutrition risk factors, up to 26% (46,574 of 180,689) of infants and children participating in Washington's WIC program in 2018 have a special health care need. This speaks to the benefit of CYSHCN training for WIC dietitians. It also highlights the need for coordination and communication across systems of care as CYSHCN transition from hospital to home and are seen in community settings. In fall of 2021, the nutrition consultant began brainstorming ideas with WIC staff on strategies to meet this need and implemented 'WIC Office Hours' in early 2022. In April of 2021, the nutrition consultant met with 3 epidemiologists to discuss a comparison of Self-Reported Medical Conditions of Infants and Children Participating in WIC 2017-2018 from WIC's old system to the new updated system (Cascades). We began to discuss better ways of tracking CYSHCN nutrition diagnoses in Cascades.

We partner with the UW Center on Human Development and Disability Nutrition program and provide MCHBG funding by contract as well. Our statewide Nutrition Network for CYSHCN is supported by this contract. In January 2021, a two-day virtual training in CYSHCN nutrition was conducted, with attendance by 9 RDNs. This capacity-building work increased the number of RDNs with training in CYSHCN as part of a statewide network to, 240 with at least one member serving 35 of the 39 counties. In May 2021 the Spring Nutrition Network series covered the diagnosis topics of Eosinophilic Esophagitis and Celiac by two dietitians from Seattle Children's Hospital as well as 'Anxious Eaters, Anxious Mealtimes' presented by Marsha Dunn Klein OTR/L, MED, FAOTA to provide ongoing refinement of specialized nutrition skills and resources, and an opportunity to network and collaborate on relevant projects. A subgroup of the CMC CollN Hospital to Home workgroup developed and provided a 3-day training in spring of 2021 on supporting infant feeding and nutrition and caregiver perinatal mental health during the hospital to home transition process. The training was attended by 6 WA State feeding teams, totaling 45 attendees including RDNs, feeding therapists, family resource coordinators, and infant mental health specialists. A virtual journal club, which included Nutrition Network RDNs and feeding team members, was offered on the impact of race and immigration status on quality of care. The findings suggested that providing patient-centered communication may mitigate racial and cultural differences between providers and patients and is key to reducing disparities and improving immigrant patients' satisfaction level with medical care.

In spring of 2020, the Nutrition contract conducted a needs assessment among Nutrition Network dietitians about challenges in providing nutrition services via telehealth to WA state's CYSHCN. There were many requests for a webinar on a "how-to" on tele-nutrition, which was then provided in fall of 2020. UW contract holders researched and met with a membership management company to improve process of keeping Nutrition Network member information up-to-date. They purchased a plan that would help build member database as well as manage conference registration and a discussion board that would allow members to network with each other.

In the CYSHCN feeding team network, there are 36 interdisciplinary feeding teams with an RDN participating, with 13 counties having at least one feeding team. The figure below is a state map showing where Nutrition Network

RDNs and feeding teams serve CYSHCN in Washington. The UW Nutrition program provides technical assistance to these teams, identifies areas of need, and helps support the development of new feeding teams. For example, the UW Nutrition contract holders met with the RDN and feeding therapists from an early intervention program to learn about how they function as a feeding team. Feedback was provided on how they can further improve their teaming as well as formalize the nutrition assessment process. The team was then added to the WA State Feeding Teams roster and to the CYSHCN Nutrition website's "Locate a Feeding Team" page. Discussions on how to integrate the RDN better into their team was also provided to new forming teams.



Partnership work through the nutrition contract includes an interdisciplinary workgroup of providers, hospitals, family, and early intervention specialists to address ways to provide feeding supports for fragile infants transitioning from hospital to home. With support from the hospital to home workgroup, the Department of Children, Youth, and Families (DCYF), the lead agency for Washington's Part C program, has created an enhanced list of diagnoses that automatically qualify a child for early intervention services. Representatives from DCYF were also invited to present at the spring Nutrition Network meeting to facilitate further collaboration between feeding teams and early intervention. Collaboration between the nutrition contract, LEND leadership and faculty, and faculty at a university preterm follow-up clinic started in the fall of 2019 to discuss development of a training curriculum for community feeding teams on fragile infant feeding. In 2021, the CMC CoIIN was approved for an extension year of funding. The nutrition contract contributes by researching recruitment strategies to attract dietitians serving underserved locations and populations to join the Nutrition Network.

Three of four maxillofacial review boards (MFRB) in Washington receive CYSHCN program funding (state funds) to provide interdisciplinary care to children with oral facial anomalies such as cleft lip and/or palate. Our funding supports the three teams that operate outside of a pediatric regional medical center. Our CYSHCN Nutrition Consultant supports these contracts and provides technical assistance to the MFRBs. Technical assistance included discussions of DOH funding exploring such as Targeted Case Management, involvement of streamlining MFRB work/data collection into the new CHIF database and onboarding new staff. Each of the three teams serves children from nine to ten counties in the eastern, central, and southwestern portions of Washington. Typically, their caseload of around 200 children is 75% or more Medicaid-insured.

The maxillofacial team coordinator supported by these funds is an allied health professional who coordinates individualized treatment plans developed by the review board team for children who require a combination of medical, surgical, feeding/occupational, and behavioral interventions. They frequently coordinate care among several community providers dispersed throughout their region that have maxillofacial expertise, and often volunteer their time and services on these review boards. Data for each child served by these three MFRBs are included in our CYSHCN CHIF database for tracking to ensure they are identified as a CYSHCN by Medicaid and have access to Medicaid services, and to help identify gaps in service.

Our Nutrition Consultant, in partnership with our UW Nutrition contractors, is also in the process of updating our "Nutrition Interventions for CSHCN" publication. This is a textbook for CYSHCN dietitians on the nutritional needs of children with different health conditions. Work in FFY 2020-21 involved making author assignments, getting updated chapters from authors, and editing completed chapters. We hope to finalize this publication during FFY 2022-23.

Critical Partnerships with Other Programs

The CYSHCN program continues to meet with UW MHPP and UW LEND to discuss ways to better leverage Title V dollars to benefit CYSHCN in our state. As the CYSHCN program continues to identify workforce development needed to increase expertise in our state to address the needs of CYSHCN, LEND is exploring expanding their program to reach more parts of the state. LEND is increasingly involved in CAM and SMART activities, providing support to the teams, along with the Project ECHO Autism Washington work. Our Title V Clinical Nutrition consultant also was accepted to the LEND program for the 2021-22 program year.

Washington's CYSHCN program is one of 10 states participating in a HRSA-funded Collaborative Improvement and Innovation Network to Advance Care for Children with Medical Complexity (CMC CoIIN). This grant offers great opportunities to leverage work already done through DOH-funded activities to support medical home coordination for babies with complex nutritional follow-up needs exiting the neonatal intensive care unit (NICU).

The focus of the grant is on families who have a medically complex infant with a nutrition need such as a nasogastric (NG) tube or gastrostomy tube (G-tube), and the purpose is to help them access and navigate community services after leaving the hospital. The federal funders have added a large data emphasis on medical home impact. This project was aligned with ongoing work of the CYSHCN program and our community partners. The CoIIN grant has worked to address major care coordination gaps identified by Title V between NICU discharge and establishing primary care, early intervention, and community supports. Through ongoing communication with the CYSHCN coordinators in each local health jurisdiction (LHJ), we hope to build on their initial findings and solutions. The CMC CoIIN focuses on a clinical pilot, so the HRSA funds were awarded directly to Seattle Children's Hospital as the principal investigator. During the 2021-22 extension year PAVE, our F2F has taken over the contract to work on dissemination and sustainability. The CYSHCN program provides in-kind staff support. In addition, the majority of the partners outside of the hospital receive Title V CYSHCN funding, such as UW MHPP; UW LEND Nutrition; and PAVE, our F2F. Feedback from these partners indicates that the CYSHCN Title V program funds allow them to have the capacity to support the CoIIN work and increases sustainability for the program as the grant is wrapping up in 2022. We have also been researching with the HCA on potential options for Medicaid funding to continue and expand the critical care coordination and family navigation components of this project.

LHJs provide case management and care coordination, and participate in, convene, and manage systems-level partnerships and activities to improve local and regional systems of care for CYSHCN and their families. Many of the LHJ care coordinators participate in community-level initiatives, such as the SMART team autism work, the CMC CoIIN work, or resource development efforts to align with universal developmental screening (UDS) work in communities.

National Performance Measure 15 – Adequate Insurance
Percent of children, ages 0 through 17, who are continuously and adequately insured.

The NSCH 2018-2019 shows that the percentage of children with adequate insurance in Washington state is 67.3%. However, among CYSHCN it is only 55.9%, demonstrating disparities for CYSHCN. Washington is a Medicaid expansion state, which affords many families the opportunity to access insurance coverage. However, for many CYSHCN, having high out-of-pocket expenses continues to make their insurance inadequate for their needs.

Medicaid Access, Payment, and Reimbursement
DOH has a Medicaid interagency administrative reimbursement contract with HCA to cover staffing hours for CYSHCN program staff to assist families and providers in navigating insurance and billing issues for Medicaid. DOH maintains a log to track individual assistance provided to families whose CYSHCN are Medicaid clients. In general, the CYSHCN program continues to experience fewer direct requests for assistance from families, and more requests for assistance from community providers who are directly assisting families. This appropriately reflects the goal to “move down the pyramid” to support enabling services, population health, and systems building activities.

Over the course of the year, CYSHCN program team members provided assistance to families regarding access to and coverage for metabolic formulas. The most typical outcome continues to be referral back to the DOH Newborn Screening Program and the Biomedical Genetics Clinic for individual assistance.

One ongoing issue for providers of these metabolic foods is navigating reimbursement processes through MCOs, which limits consistent access to necessary metabolic formula. The administrative processes surrounding the provision of these formulas is inefficient and somewhat arbitrary. These products meet the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria for medical necessity and should therefore be covered by the Medicaid state plan under the EPSDT benefit.

The CYSHCN Director re-initiated a conversation with the Medicaid agency Enteral Foods and EPSDT Manager to discuss the possibility of providing Medicaid reimbursement for these products. After exploration with coverage parameters at the HCA, we were given permission to continue to explore Medicaid coverage for these products. This process is complex. The CYSHCN program worked with the UW Center on Human Development and Disability Biomedical Genetics Clinic to determine if data can be made available to demonstrate the cost offset to substitute metabolic low-protein foods in place of liquid formulas, which do have current coverage. Understanding the billing codes to be used for successful billing and the means of distribution of these specialty products is another challenge that will determine if coverage can be provided with existing resources, or if there will need to be a legislation decision package request to cover anticipated cost matches to the Medicaid covered service. This work was delayed due to COVID-19 and staff outages. It is currently a work in progress and is a great example to study for deriving a policy solution to a complex problem.

The CYSHCN Director is our DOH-delegated representative to the Developmental Disabilities Council (DDC) and has participated in regular meetings. Much of the work this year focused on the development of the five-year plan for the DDC.

CYSHCN program team members have helped multiple provider types with understanding Medicaid EPSDT rules and how these impact client access to Developmental Disabilities Administration (DDA) waiver services. The CYSHCN program provided technical assistance to neurodevelopmental centers.

Most of the CYSHCN program's assistance to providers this year was about helping providers with billing questions, licensing, and credentialing with Medicaid managed care organizations. What seems most helpful is to use a variety of ways to provide technical assistance, such as quarterly meetings with newborn screening/metabolic clinics, Nutrition Network member trainings, SMART team meetings, COE trainings, and individual provider technical assistance. The CYSHCN program has made some progress in helping providers understand billing and new billing guidelines. There is an ongoing need to help providers understand the process to reduce the number of denied claims.

A barrier is understanding the different rules and procedures with the five different managed care organizations and the different roles played in licensing, credentialing, and billing by DOH, HCA, and the MCOs. It is helpful for them to understand the criteria to reduce the billing error rate. Over the years, the CYSHCN program has assisted in solving billing problems, but there continue to be challenges for providers in this area. The CYSHCN program has started to strategize with HCA on a more systems-based approach to addressing this clearly systemic barrier, rather than providing individual technical assistance with no lasting resolution to these billing issues. We have also created information for providers to clarify whom to contact when they need assistance with a particular type of issue. The MHPP program has created a billing guide for autism screening, evaluation, and diagnosis to support providers to maximize billing so they can continue to offer this important service throughout the state. This further reinforces our program goal to address health care financing as a key barrier to CYSHCN and their families – one that often keeps them from getting access to skilled providers.

There seems to be an increasing awareness by state agencies, medical providers, and families of EPSDT efforts in Washington; however, there is not as much understanding from families of CYSHCN regarding what EPSDT is and why it is needed. They often see it as a barrier to getting services through Medicaid home and community-based services (HCBS) waivers. State agencies working to promote EPSDT seem to make parallel efforts and work in silos. The CYSHCN program will continue to work across systems and attempt to support better integration and coordination of services.

Maximize Implementation of Federal and State Health Reform

Title V staff continued to work with multiple partners and stakeholders to seek, identify and address issues as they surfaced. We have educated and provided support for coverage of care coordination for children through efforts aimed at the regional Accountable Communities of Health (ACHs).

Our grant partners have worked with schools to ensure children with ASD/DD receive services outlined in their individualized education programs (IEPs), and to explore opportunities for ABA to be covered for school-based health services. We have worked with our grant partners and with the licensing division of DOH to ensure that licenses are processed in a timely way in order for children to have access to services, and to initiate continuous quality improvement activities around improving the ABA licensing process.

Additional Work Supporting CYSHCN

Family Professional Partnerships and Family Engagement

The Family Engagement Coordinator continues to support the Washington Statewide Leadership Initiative (WSLI), alongside Partnerships for Action, Voices for Empowerment, our state affiliate Family-to-Family Health Information Center. Together they serve as the backbone support for WSLI, providing funding and staff time to set up, facilitate, and follow up on meetings and decisions made, along with providing website and social media support for the group. WSLI is a collaborative that uses a collective impact model to better enable and enhance partnership connections between family-led organizations and their community- and state-level partners.

For more information on family professional partnerships and family engagement, see the *Family Partnership* section.

System Coordination and Collaboration

The need for coordination and collaboration across systems of care for CYSHCN is diverse and varied. The CYSHCN program hosted quarterly Communication Network meetings in FFY 2021. More than 45 people attended each meeting, representing geographically diverse CYSHCN partners from each of the Medicaid-contracted MCOs, medical and community groups and providers, multiple state and local agencies, and family-led organizations.

The meeting topics, chosen with stakeholder input, included mental health and wellness supports for CYSHCN and their families, family navigation, peer supports, school-based services and supports, equity, and strategic planning. These meetings are opportunities to meet with partners and solve problems people experience in addressing the needs of families. They provide opportunities to hear updates on the variety of work that is happening on behalf of CYSHCN around the state, receive training and information on changes and emerging issues, and network to better partner and replicate successful practices across the state. These meetings are typically full-day, in-person meetings, but were transitioned to a shorter, virtual format in 2020 due to COVID-19 and have continued in the virtual format during FFY2021.

Additional Work Supporting CYSHCN at the Local Level

Work in the area of CYSHCNs is required of all LHJ partners. Most of the work done by our LHJ partners in this area continues to be care coordination, resource and referral activities and systematic change efforts. The main focus for most of our LHJ partners is in the arena of increasing the number of families that are connected to a medical home to provide holistic, individualized care for these families. Additionally, our LHJ partners work to increase access to health insurance and provide those services that may not be covered by that insurance, most specifically access to respite services for family care givers. Our LHJ leads serve as the connecting point for families in their county with the available resources and assist in navigating complex systems of care. In addition to this continued work, our LHJ partners have also undertaken the task of understanding the impact that the pandemic has had on children with special health care needs and their families to better assist in helping families recover from the pandemic. Some of these impacts have emphasized some flaws in our systems of care and their ability to weather changing health environments.

Benton-Franklin- The LHJ staff participated in a call with a local branch of one of our state universities Washington State University (WSU) having them look at providing a Board-Certified Behavior Analyst degree and certification process at WSU. With the help of staff members from Discovery Behavior Solutions, a private firm that partners with this LHJ to provide applied behavior analysis services to CYSHCN families, staff from this LHJ were able to convey the local need and the shortages throughout the state for this type of degree

Clark - An example of care coordination offered by this LHJ is best demonstrated by the story of a family in need of services. The child, a recent arrival from Mexico was diagnosed with autism. With collaborative support of the child's pediatric provider, the RN from this LHJ, the child's guardian, and school, the child was able to have their needs met. This included being evaluated in both English and Spanish, referred for dental and vision exams, referred to ABA, speech, OT, and caught up on vaccines.

Kitsap - Staff from this LHJ continued to work on creating a CYSHCN extended resource list which includes resources for Mental and Behavioral Health services, Respite Care, and Sensory Friendly entertainment. As

resources began to reopen with COVID precautions, the list was a helpful summary of what is available, and it supported families in navigating community-based systems of care.

Sea King - The CSHCN team in this LHJ has identified a shared definition of Medical Home and figured out a system for tracking Medical Homes through Epic, one of the electronic health record systems that is used throughout the state. Once in place, the LHJ staff will be able to run reports that identify clients and communities in need.

Additionally, staff at this LHJ have worked with the King County Help Me Grow to develop and expand the network of service linkages available to CYSHCN clients. Staff from this LHJ and from Help Me Grow have completed development of a line of two-way communication that will benefit both programs. This system will continue to develop as the Help Me Grow program expands. This successful partnership will expand referral resources and access to care for marginalized CYSHCN families across King County

Whatcom - This LHJ convened multiple partner groups to discuss and strategize solutions for care services effected by the pandemic, including organizing focus groups of families, child-care providers and housing service providers.

Walla Walla - Staff of this LHJ have been working with a multidisciplinary team, which includes the Walla Walla Valley Disability Network, in preparation to present an “Inclusion Benefits Everyone” free webinar and Childcare Provider Training (with STARS accreditation) which will be held on November 12th & 13th. This webinar training session will help caregivers feel more comfortable and confident caring for children (from birth to 6 years old) with challenging behaviors, sensory issues, mobility, and motor challenges in the childcare setting.

Thurston - This county was chosen for a mini grant from DOH for the Essentials for Childhood, Inventory of What Works project. Staff of this LHJ collected information from throughout the county using a survey to develop a landscaped asset inventory to capture evidence based, trauma informed, promising practices, policies, and programs to prevent child abuse and neglect and strengthen family resiliency. This LHJ was able to identify policy strategies with strong focus on early childhood intervention strategies that may improve the lives of CYSHCN families in Thurston County.

Tacoma-Pierce - Staff of this LHJ have on going meetings with Managed Care Organizations in order to help educate and inform their care coordinators about resources available to CYSHCN within Tacoma-Pierce County. Additionally, they provide outreach to local providers to help them stay informed on services available and the referral processes for those services.

Spokane - LHJ staff have had an approximate 140% increase in connections with families in one quarter and have increased connections with more community stakeholders through trying to find resources for families. Some of these connections are: Informing Families, local parent/community advocates, local food/clothing banks, housing resources, autism resources, a newly formed Parents Empowering Parents group, Kindering Joy Coaching, and a Facebook group for families with children with special needs. More families are reaching out through the phone number found on the website, while some are learning about services by word of mouth and reaching out.

Skagit - This county works with a promotora, specifically to do outreach to their Mixteco population. This individual has been making connections with the local farmworker communities and utilizing those connections in order to provide health navigation services for children with complex needs that may not otherwise be in a system of care

Overall Effectiveness of Program Strategies and Approaches

Many of the strategies and activities used to increase access to the medical home model of care and adequate insurance for Washington's CYSHCN seem to be effective (e.g., family leadership training, resource, and information sharing; and UW MHPP technical assistance contract activities around medical home and autism systems of care). We are still working to increase and strengthen our capacity to evaluate the impact of some state program activities, including projects led by CYSHCN program staff, as well as other contract activities. As this capacity grows, so does our understanding of what is working and what is not.

We continue to leverage our role as a convener to create connections between communities and between agencies and programs. Providing training on evidence-based decision making, public health priorities and initiatives, and elevating the work of our community and statewide partners has helped us to continue to expand our meaningful partnerships and leverage our resources.

III.E.2.b.v.c. State Action Plan Narrative by Domain

Children and Youth with Special Health Care Needs Application Year

Priority:

Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

National Performance Measures:

Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Percent of children, ages 0 through 17, who are continuously and adequately insured.

Objective:

By September 2022, explore opportunities to work with the Community Health Worker (CHW) program to increase CHW knowledge of developmental screening and milestones. Implement the Autism and Developmental Disabilities module as part of broader training curriculum for CHWs. Develop strategies for linking trained CHWs to autism diagnostic network.

Strategy:

Improve overall awareness of the complex needs of the CYSHCN population as a demographic identity, with distinctive cultural needs for access to communities and systems of care.

General Status on this Objective to Date:

Community health workers are increasingly seen as essential workers in our state for effective outreach to families with young children, even more so in the mid- and post-pandemic environment. Curriculum is under development that allows for community flexibility and standardized learning components, with specific attention to learning needs most suited to each community's race, ethnicity, language needs, and geography.

CYSHCN specific curriculum was completed in June 2020, as part of the broader CHW training curriculum. The CYSHCN team served as subject matter experts on autism for the creation of a two-part module, "Understanding Autism Spectrum Disorder." The initial pilot of this experimental module, conducted in summer 2020, generated extremely positive feedback from CHWs. The module was incorporated into the regular training schedule for 2021.

Ongoing funding was allocated this legislative session to provide statewide leadership, training, and integration of community health workers with insurers, health care providers, and public health systems. DOH plans to work closely with early childhood services to support education and outreach to partners who facilitate developmental screenings, including patient navigators, home visiting programs, and CHWs. We also work with the MHPP to increase access to CHWs through the medical home as part of our autism systems work. The CYSHCN team has been collaborating with HCA on enhancing Medicaid funding options for care coordination for CYSHCN including options for funding CHWs.

Objective:

By September 2022, update provider training needs assessment and plan for at least two trainings to address provider training needs related to working with CYSHCN populations.

General Status on this Objective to Date:

Currently families with children who have developmental delays and disabilities have long wait times and limited provider options when seeking ASD/DD diagnosis. Early intervention has been shown to increase development potential for these CYSHCN and their families but wait times to receive the initial diagnosis are months long in many parts of the state. Increasing provider confidence in their abilities and resources available to diagnose and care for CYSHCN is key to meeting the needs of communities. We will continue to partner with the University of Washington and on Autism Center of Excellence (COE) and ECHO trainings for providers around the state. The next COE training is scheduled for September 2022. Evaluation of trained providers' confidence levels in providing a medical home for children with autism is conducted on an ongoing basis.

CYSHCN training for WIC dietitians, particularly on the nutrition needs and common feeding difficulties of preterm birth or very low weight CYSHCN children, has been identified as a need and is in the planning process. Bi-monthly "office hours" to consult with the clinical nutrition consultant about client case studies, ongoing questions and issues continue to be useful and have identified further areas of support that is needed such as autism, feeding difficulties and gastrointestinal disorders. We will evaluate the impact of these trainings on WIC providers' confidence levels and use office hours sessions to identify topics for further training.

Strategy:
Partner with the Medical Home Partnerships Project to provide state-level subject matter expertise and technical assistance, and coordinate with the UW LEND program and Seattle Children's Hospital to support communities in workforce development, resource development, and ongoing training on family-centered, comprehensive systems of care for CYSHCN.

We plan to continue our contract with MHPP and include this work as a deliverable. The *CYSHCN Annual Report* section provides details about this contract and work.

Objective:
By September 30, 2025, increase the number of dietitian members of the Nutrition Network with CYSHCN training and the number of community-based feeding teams working with CYSHCN. Prioritize training and support given to those in counties with limited resources and those with ability to provide services via telehealth.

Strategies:
Provide targeted subject matter expertise to contractors and providers, including CYSHCN Coordinators, on areas of expertise such as complex nutrition for CYSHCN, children and youth with clinical and behavioral complexity, including autism, navigating state systems and policy, care coordination, family navigation, and community referral systems and clinical linkages.

Identify and develop methods to establish baseline data on CYSHCN, systems of care, gaps, and barriers to equitable, quality care. Make data accessible via a CYSHCN dashboard and other dissemination efforts. Utilize data to identify referral opportunities and strategies, and community needs for local health care resources and equitable service delivery.

General Status on this Objective to Date:
The report on our nutrition needs assessment, Assessment of Nutrition Services for CYSHCN, was published in early 2020. In FFY 2022 work will continue to address the gaps it identified, listed in the *CYSHCN Annual Report*. Two new feeding teams have been added in the past six months and another one is in development. A key strength of our

CYSHCN program is our Nutrition Consultant's ability to work at the state level to identify and address gaps through policy change, training, network and coalition building, and health education around the specialized nutrition needs of CYSHCN. Our new Nutrition Consultant is engaging in planning with the Nutrition Network on increasing membership and technical assistance for members. Further outreach and more targeted recruitment to increase Nutrition Network involvement was conducted in 2021. The goal is to address the gaps in the current network (geographic, ability to take referrals, language/cultural diversity, etc.). Parent voice interviews will continue to be conducted to assess the importance racial diversity in providers, use of telehealth, and cold calls within communities with no dietitian involvement.

We plan to continue our contract with UW Center on Human Development and Disability Nutrition program to support an interdisciplinary workgroup of providers, hospitals, family, and early intervention specialists to address ways to provide feeding supports for fragile infants transitioning from hospital to home. We will continue discussions on development of a training curriculum for community feeding teams on fragile infant feeding, and to support community based RDN skill development. We will work with the UW Nutrition program and LEND to implement recommendations that arose from the nutrition needs assessment.

Through the quarterly CYSHCN Coordinators meetings we will continue to include nutrition topics as education and discussion items. The Nutrition Consultant and the CYSCHN Coordinator of Pierce Co are working together to create a workgroup to address the gap in care for newly diagnosed type 1 diabetic youth. A resource platform through PAVE is in progress in addition to working towards obtaining WA specific data around diabetic ketoacidosis (DKA) admits and CPS calls for poorly managed blood sugars. The CYSHCN Nutrition Specialist will work with the Nutrition Network and the CYSHCN Epidemiologist to collect relevant and meaningful data on nutrition risk factors and co-morbidities for CYSHCN.

Subject matter expertise around adolescent transitions for youth with disabilities will take form in training modules for communities whom are interested in creating culinary classes. The Nutrition Consultant has partnered with a new community center and a local university to pilot the cooking classes and create modules for WA state. This program also supports workforce development for RDN students in working with individuals with disabilities by partnering with university programs.

Objectives:
By September 30, 2025, increase the percentage of CYSHCN ages 0-17 who receive care in a well-functioning system by 5 percent.

General Status on These Objectives to Date:
The CYSHCN program supports and promotes the Standards for Systems of Care for CYSHCN, which emphasize integrated, coordinated, family-centered, and culturally and linguistically competent systems of care.

Strategies:
Provide services to CYSHCN and family members of CYSHCN so they can be trained, engaged, supported, and involved at all levels of program planning and implementation of services for CYSHCN. Implement and promote inclusion opportunities and support resources for fatherhood, foster parents, grandparents, kinship care.

Partner with the Washington State Leadership Initiative collaborative and community-based organizations to elevate family voices and provide connections so family voices can effectively influence the development of systems and services for CYSHCN.

Promote and facilitate successful transitions including transition from hospital to home, from Birth to 3 into school and community-based services, and from pediatric to adult specialty services.

Through partnerships, address the need for improved access to affordable services, and increased availability of CYSHCN service providers, quality healthcare, access to insurance, and adequate health care financing, particularly in rural communities and remote areas regardless of language spoken, gender identity, race and ethnicity, immigration status, or insurance status of families.

Through partnerships, facilitate innovative programming and technology solutions such as telehealth and remote services to address gaps in rural and remote areas and other barriers to access to care.

Enhance and maintain health systems and improve financing options to improve care coordination and family navigation.

Our continuing work with the Medical Home Partnerships Project directly addresses access to medical home and other aspects of the system of care, including provider training and technical assistance to support access. Their work includes:

- Promote integration of care through effective and timely information sharing and family-professional partnerships.
- Promote inter- and multidisciplinary care.
- Promote awareness of developmental milestones and evidence-based well child care.
- System coordination: leverage strategic partnerships to encourage the coordination of pediatric screening efforts, results, and referrals among all screening and referral entities, including but not limited to clinical care settings, medical homes, child-care settings, and schools.
- Provide and participate in forums for infrastructure and systems development for CYSHCN.
- Provide technical assistance to support development of the medical home model.
- Coordinate and build the Medical Home Leadership Network for CYSHCN interdisciplinary community resource teams and community coalitions.
- Identify, adapt, develop, and disseminate CYSHCN medical home tools, best practices, and timely information through multiple communication strategies to family organizations, providers, and statewide partners who impact families with CYSHCN.
- Continue providing information and resources on medical homes and systems integration to family organizations for CYSHCN through the medicalhome.org website.
- Collaborate with Project ECHO Autism Washington and Autism Center of Excellence training to develop capacity of medical homes and community partners to provide early identification, evaluation, and successful referral to treatment for children and youth with autism.
- Partner with DOH program staff to continue supporting Community Asset Mapping communities' activities and School Medical Autism Review Teams, with emphasis on supporting rural and frontier communities.

We will continue to provide opportunities for community-based family navigators to work with clinical professionals to support family-centered care in a medical home. An exploratory workgroup of family navigators is working to create a toolkit to promote evidence-based practices for family navigation. This toolkit will be designed to allow for and encourage individualization based upon geographical, cultural and linguistic needs. This has been on pause, as many of the partners involved have been busy doing COVID-19-related work. As the response winds down, this workgroup will resume its work on this project.

As the new CHIF database was launched in spring 2020 and participants continue to catch up on a backlog of data

entry caused by the transitions between systems and COVID related staffing shortages. We continue to work on systems enhancements, supporting users, updating the manual, and training materials, and identifying ways to use the data to best support the needs of children. We will also continue to troubleshoot and resolve issues with the data system and user experience.

We intend to work with CHIF data to identify frequently utilized services, referral pathways, and quality improvement opportunities that are data informed. We expect to share CHIF access with additional clinical partners in order to evaluate different service models, settings, and services provided. We are looking for ways to expand CHIF and our use of the data to provide better overall surveillance. For example, can we identify children not being fully served; or can we identify children being served, but data have not been collected?

We will continue to assist families with CYSHCN with clinical medical and behavioral complexity to access needed services, both at the state and local levels. The CYSHCN program will also work with the licensing division in DOH to address issues related to licensing and scope of practice for services provided to CYSHCN and their families, such as Applied Behavior Analysis (ABA), therapies, nutrition services, facility, and respite provider licensing. We also have been working closely with HCA to support providers that are experiencing delays or other challenges with credentialing and/or billing for Medicaid services through our state's managed care organizations. Our partners at the Medical Home Partnerships Project have also created billing guides for common services related to autism evaluation and diagnosis so providers can understand the appropriate codes to use to maximize reimbursement for necessary components of the autism evaluation.

We will work with Seattle Children's Hospital, PAVE, LEND, and HCA to develop recommendations around alternative payment models for family-centered care coordination for children. We will work with community-based providers who are exploring implementation of alternative payment models for care of children with medical complexity by identifying opportunities to influence billing and contracting policies with managed care.

We will work with self-advocate partners in our autism work and from the Developmental Disabilities Council to learn from their lived experience and identify opportunities to inform pediatric interventions based on these lived experiences. We are participating in the DDC Equity workgroup to ensure that the perspectives of self-advocates and families of underserved populations are represented.

Through partnerships with PAVE, Parent to Parent, the Washington State Fathers Network, and others, we will continue to promote trainings, webinars, and educational resources to families of CYSHCN to empower and promote family leadership and engagement at all levels of services and systems.

The CYSHCN program will continue to partner with PAVE and other family-led, community-based organizations to form the backbone of the Washington Statewide Leadership Initiative collaborative. The Family Engagement Coordinator will convene the Steering Committee, explore best practices, and support and promote trainings and resources put together by the various organizations who are part of the collaborative.

The CYSHCN program will promote successful and intentional transition to adulthood services for youth with special health care needs and will include transition support activities in our work with local CYSHCN coordinators, our provider training and technical assistance contractors at UW, and our family engagement contractors. We have been able to hire a new staff person focused on adolescent transition and behavioral health work for CYSHCN.

We recognize that many CYSHCN are also part of other underserved groups who face health disparities. By increasing surveillance methods and promoting CYSHCN awareness and inclusion in health reforms focused on health equity, we will positively affect the health of CYSHCN and their families. This will also help us better identify

areas that need more focused work or more frequent monitoring.

We will work within DOH and with other state agencies to influence existing databases to include autism and other developmental disabilities as a demographic dataset, recognizing that the autism and developmental disability community has a distinctive cultural identity that impacts their health, their community access, and self-determination.

Priority:
Promote mental wellness and resilience through increased access to behavioral health and other support services.

State Performance Measure:
Suicide ideation among youth with special health care needs.

Objectives:
By September 30, 2025, decrease the percentage of 10th grade CYSHCN who report they have considered attempting suicide by 5 percent.

By September 30, 2025, create and disseminate health education publications specific to autism and other developmental disabilities that are adopted by the suicide prevention program as part of their health education resources and curricula for the state-level suicide prevention plan.

General Status on These Objectives to Date:
Data collected through the Healthy Youth Survey (HYS) and other sources indicate that CYSHCN, including those with ASD/DD, have higher rates of suicidal ideation and attempts than their typically developing peers. Mental health and suicidal ideation are assessed biennially through the Healthy Youth Survey, administered to middle and high school youth throughout the state. Previously, disability demographic questions were included within the core data set every other time the HYS was administered. Data collected through the HYS and other sources indicate that CYSHCN, including those with ASD/DD, have higher rates of suicidal ideation and attempts than their typically developing peers. This underlines the importance of making the CYSHCN demographic questions part of the base data set, as the consistent collection of this information is vital to measure risk for behaviors and risk factors for suicide and other behavioral health concerns, and to develop appropriate interventions. We have worked with the HYS team to include these questions on all future HYS administrations. We also were able to include a CYSHCN demographic question in the related COVID-19 student survey that was administered to students this spring. Following up on these successes, we have proposed a change to the HYS disability screener that will enable us to better differentiate the responses of individuals with different types of disabilities. This is currently under review and will hopefully be included in next year's HYS survey. We will analyze those responses for disparities in mental health for those with disabilities.

The CYSHCN program has initiated conversations with the DOH suicide prevention program about the need to provide appropriate educational material to address this disproportion. The program has also been awarded a Pediatric Mental Health Care Access award that will focus on providing mental health consultation to primary care providers and mental health services to families experiencing crisis in rural areas of our state. We have recently hired a new CYSHCN adolescent and behavioral health consultant to support this work as well as our work on adolescent transition.

Strategies:
Take action to reduce stigma surrounding behavioral health, treatment, and related challenges.

Support interventions to address suicide ideation among CYSHCN.

Identify opportunities to infuse trauma-informed care into working with CYSHCN.

Collaborate with surveillance and epidemiology Healthy Youth Survey leads to advocate for including questions about special health care needs in all Healthy Youth Surveys.

Identify and disseminate data for analysis on risk of suicide ideation for CYSHCN, including focus on youth with autism and other developmental disabilities. In the evidence base, increase representation of youth with disabilities as a complex disparate group with a high intersectionality between other known populations vulnerable to high risk factors.

The CYSHCN program will provide subject matter expertise within the agency and across state systems of care to highlight the unmet behavioral health needs of children and youth with ASD/DD. Data will be used from the HYS and other sources to demonstrate the need for health education that specifically addresses the risk factors leading to increased behavioral health needs and decreased resilience. Known protective factors, including access to community, peer support, and self-determination, are key concepts in promoting resilience, and the CYSHCN program and our partners will promote and share this information.

The CYSHCN program will work with the suicide prevention program to find or create health education publications specific to suicide prevention in ASD/DD populations. These are to be adopted as part of the health education resources and curricula for the state-level suicide prevention plan.

We will promote educational opportunities for primary care, mental health, school-based and other providers regarding the need for behavioral health supports that include expertise working with individuals with ASD/DD.

The CYSHCN program will promote awareness of behavioral health needs and increased access for CYSHCN, especially those who have thoughts of suicidal ideation, through partnerships with the Family, Youth, and System Partner Round Tables (FYSPRT).

We will work with the DCYF infant behavioral health program to identify opportunities to carve out interventions for young children with or at risk for ASD/DD to receive support in early learning settings that support social and emotional learning objectives. DCYF has prioritized social and emotional learning and development as a key part of strategies that promote kindergarten readiness. One such strategy is to implement infant mental health reflective supervision into Early Achievers licensed early learning settings with a goal of reducing behavior-related expulsions by 50 percent over five years. It is known that children with ASD/DD are over-represented in these expulsions. Interventions prioritizing social and emotional learning environments that can address sensory integration needs, social skill development, and group dynamics of inclusive learning settings can reduce trauma experienced by children with ASD/DD. This can improve behavioral outcomes and potentially reduce expulsions from care settings.

The CYSHCN program will partner with the Injury and Violence Prevention unit to provide subject matter expertise on efforts to reduce bullying and the disproportion of students with developmental disabilities who experience bullying and lack of social connection. We will work with community-based organizations such as School's Out Washington and YMCA to develop inclusive out-of-school learning opportunities that are accessible, and that promote social connection and access to community, to address barriers to resilience.

The CYSHCN program will work with autistic self-advocates who are interested in sharing their lived experience to

identify the long-term outcomes of therapies and interventions commonly used in young children, and to identify alternative trauma-informed strategies. The CYSHCN program will facilitate collaborative spaces that welcome the lived experience of autistic individuals as a necessary component of person-centered care for CYSHCN with autism.

Strategy:
The CYSHCN program will promote the collection and analysis of data on behavioral health needs and suicide ideation of CYSHCN, and specifically of those with ASD/DD, from the HYS and other sources. The team will serve as subject matter experts in promoting awareness of the unique cultural values, strengths, and needs of this population.

We will work with other offices, such as Injury and Violence Prevention, to ensure that the increased risk factors for CYSHCN related to injury, such as wandering, bullying, etc. and risk for suicide are acknowledged and included as an important demographic at-risk group.

Cross-Cutting/Systems Building

State Performance Measures

SPM 11 - Five-year maternal and child health needs assessment process for 2026-2030 plan is initiated by September 30, 2021

Measure Status:	Inactive - Completed		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			Yes
Annual Indicator			Yes
Numerator			
Denominator			
Data Source			Title V Program
Data Source Year			2022
Provisional or Final ?			Final

SPM 13 - Percentage of adults who did not get health care because of cost

Measure Status:	Inactive - This measure will be discontinued as it does not relate to work being done by Washington State's Title V program.		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			13
Annual Indicator		13.2	10.1
Numerator			
Denominator			
Data Source		BRFSS	BRFSS
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

SPM 14 - Develop outreach plan to support COVID-19 vaccination campaign efforts by March 31, 2021

Measure Status:	Inactive - Completed		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			Yes
Annual Indicator			Yes
Numerator			
Denominator			
Data Source			WA Title V Program
Data Source Year			2022
Provisional or Final ?			Final

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

III.F Public Input

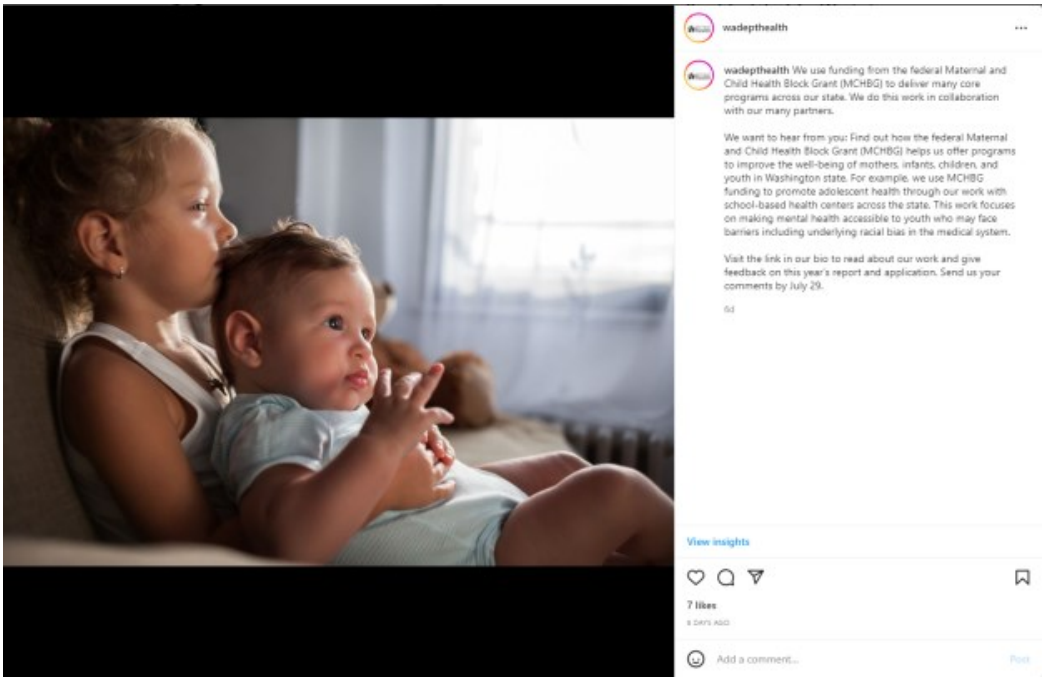
The Washington Title V program seeks ongoing input on priorities and programs from partners and stakeholders, including the public who fund and benefit from our work. We do this through advisory groups, workgroups, direct meetings with partners, working with parent and advocacy organizations, and surveying parents, providers, community organizations and the general public.

The Department of Health (DOH) maintains a website with pages that include maternal and child health information, reports, and publications. Most of our web pages include staff contact links to provide the ability to reach us for program-related questions or discussion.

We make regular use of social media to connect and engage with the public, including Facebook, Twitter, YouTube, Instagram, and Medium, a blogging platform.

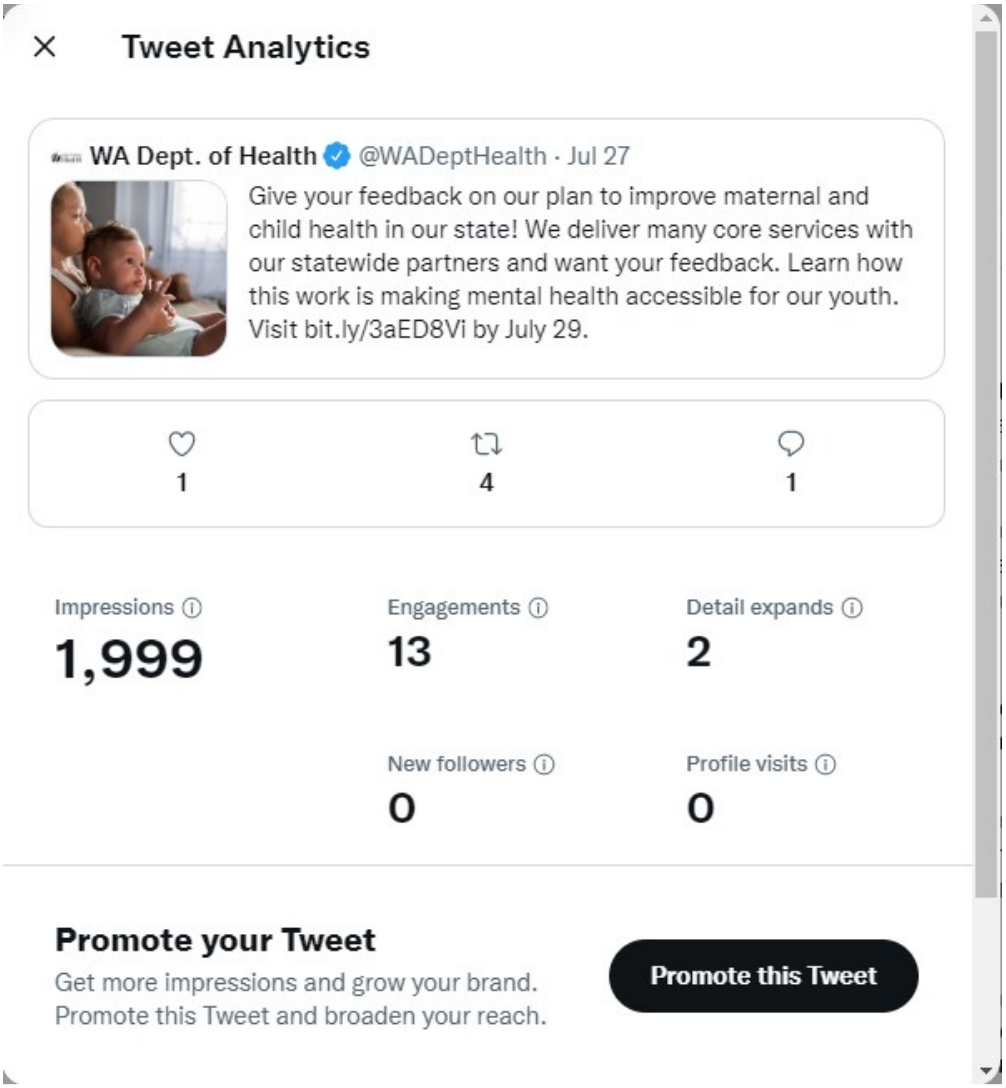
Input on the Maternal and Child Health Block Grant Application and Report

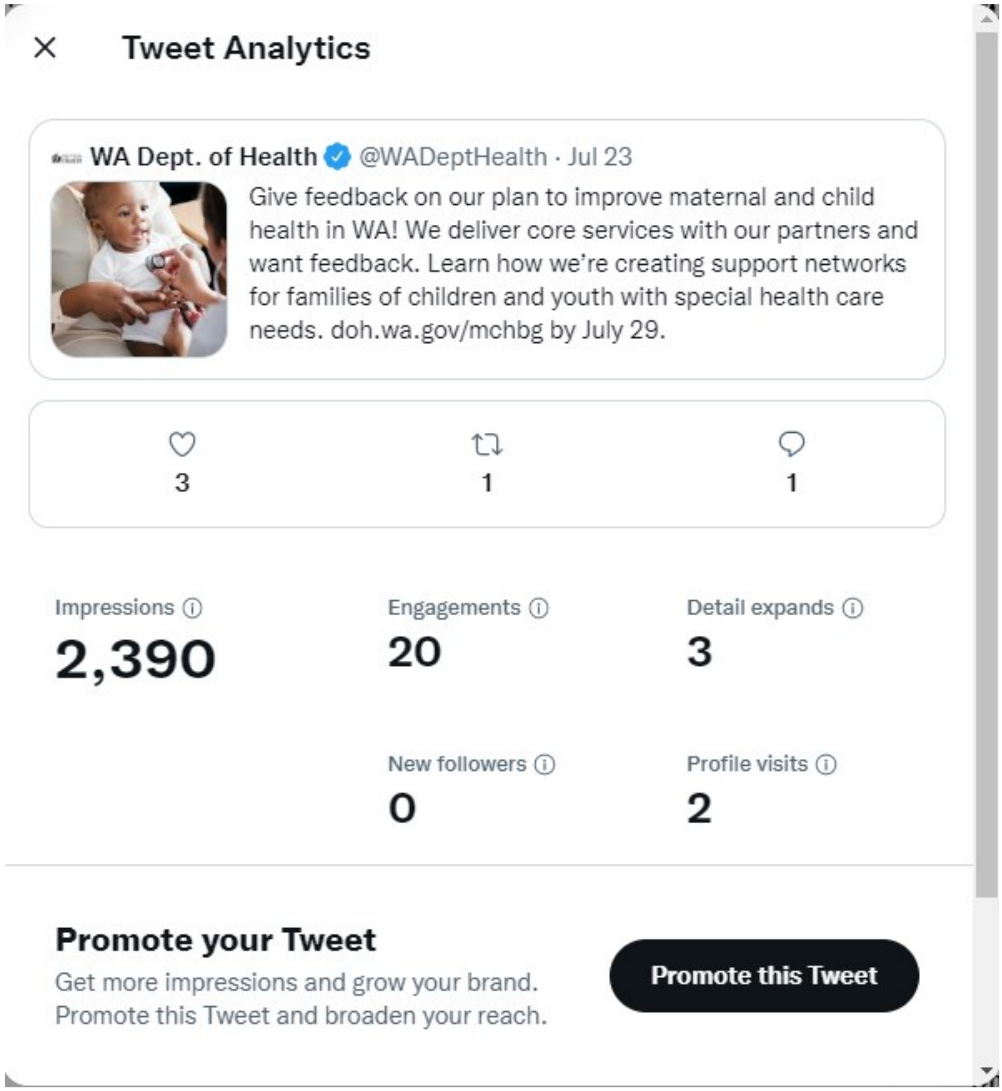
To inform people about the MCHBG application and report, we prepared an MCHBG Overview document based on the grant application's executive summary overview. We used the DOH Facebook and Twitter social media and email messages to groups such as representatives of local health jurisdictions to broadcast the availability of this material and to encourage comments and discussion, as shown below.

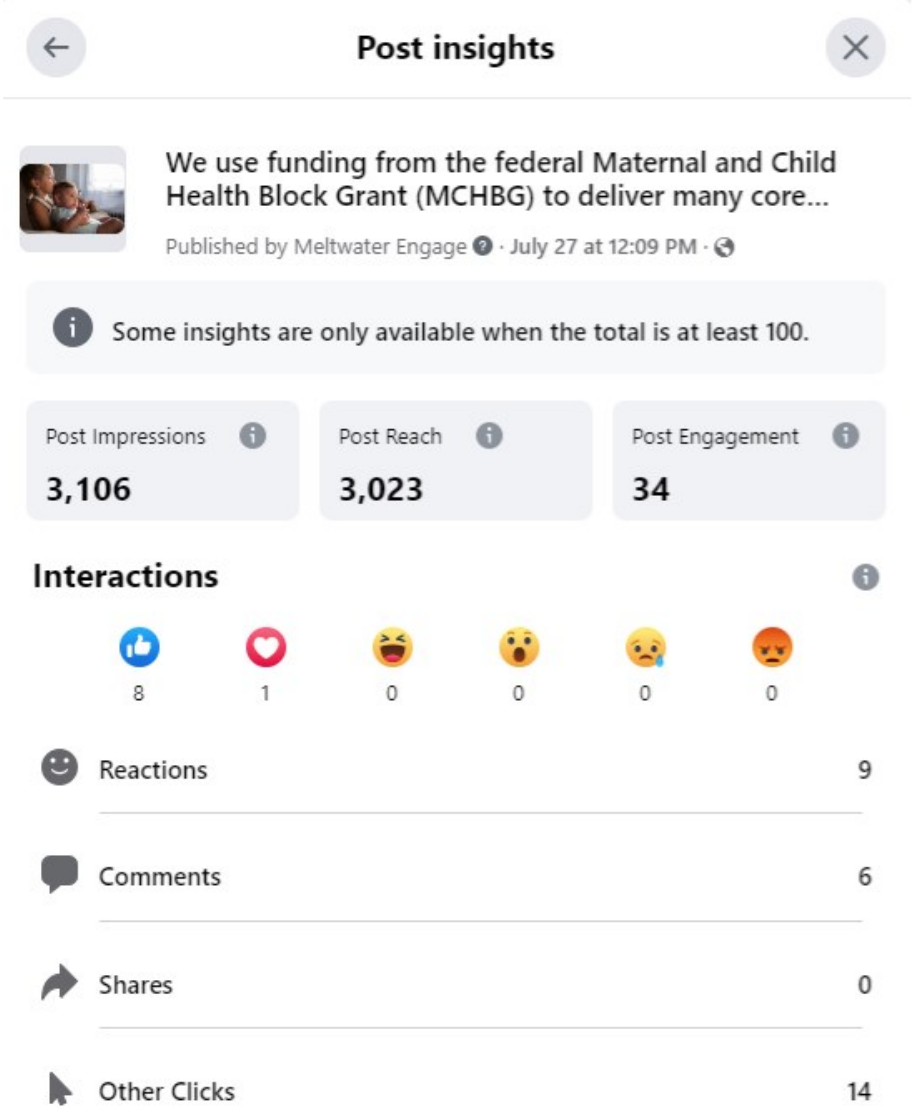


The link in the social media messages took viewers to our MCHBG web page, which included a brief program description, links to the overview document and a full print version of the draft application, and a contact email and phone number for comments. The public comment period was announced as July 18-29, 2022.

The social media postings were successful at reaching members of the public as detailed in the analytics pages shown below:


Tweet Analytics
WA Dept. of Health @WADeptHealth · Jul 27
Give your feedback on our plan to improve maternal and child health in our state! We deliver many core services with our statewide partners and want your feedback. Learn how this work is making mental health accessible for our youth. Visit bit.ly/3aED8Vi by July 29.
1
4
1
Impressions
1,999
Engagements
13
Detail expands
2
New followers
0
Profile visits
0
Promote your Tweet
Get more impressions and grow your brand. Promote this Tweet and broaden your reach.
Promote this Tweet


Tweet Analytics
WA Dept. of Health @WADeptHealth · Jul 23
Give feedback on our plan to improve maternal and child health in WA! We deliver core services with our partners and want feedback. Learn how we're creating support networks for families of children and youth with special health care needs. doh.wa.gov/mchbg by July 29.
3
1
1
Impressions
2,390
Engagements
20
Detail expands
3
New followers
0
Profile visits
2
Promote your Tweet
Get more impressions and grow your brand. Promote this Tweet and broaden your reach.
Promote this Tweet



We received 7 substantive comments on the MCHBG annual report and application this year. All of these comments were received via email to the dedicated email address established for this purpose. Comments received on the DOH Facebook page were not substantive. The comments received ranged from general comments on the structure of the programming such as a request for DOH to provide additional supports for fathers through the MCHBG and a request for DOH to improve its partnerships with external and community-based organizations, to specific feedback on Medication Assisted Treatment for pregnant individuals. All these comments were provided to the appropriate DOH staff for review.

DOH has been working to improve accessibility to our written material by increasing the availability of our documents and communications in languages other than English. Spanish versions of our MCHBG web page and MCHBG Overview were created in summer 2021.

We had the MCHBG Overview translated into additional languages as well. The Overview document was translated into multiple languages including Russian, Vietnamese, Ukrainian, Somali, Korean, Tagalog, Arabic, Punjabi, and Cantonese. This will be available on our website for public comment and will remain after the grant submission and shared with community partners as an educational piece about the program and Washington's use of the grant

funding.

Tribal Engagement

This year we also held a Tribal Listening Session to gather input on the report and application from Tribes and Tribal serving organizations. The Tribal Listening Session was held on August 3, 2022. Participation from Tribes and Tribal serving organizations was lower than had been hoped. We were not able to gather any substantive feedback from this session. However, MCH staff have begun the planning process for outreach to Tribes and Tribal serving organization that will, hopefully, be more successful in gathering feedback that will inform the design of the program moving forward and will allow DOH to serve the needs of American Indian/Alaska Native families.

Advisory Groups

Throughout this application and report, we mention several advisory groups and committees that inform our work and priorities. These include the Washington Statewide Leadership Initiative collaborative, the statewide Children with Special Health Care Needs Communication Network, the Essentials for Childhood (EfC) program's Steering Committee and workgroups, the Washington State Perinatal Collaborative, and meetings of the local health jurisdictions' maternal and child health and CYSHCN specialists. We also plan to organize a youth advisory council.

Our efforts to get input on the Title V program, priorities, and activities are a continuous process as we engage with partners and stakeholders, including the public, throughout the year. During this next year we want to improve our efforts to engage with a broader range of community voices to ensure our programs serve all populations well.

III.G. Technical Assistance

III.G. Technical Assistance

We have had several enriching technical assistance opportunities as a state in the past year or so. Both our MCH and CYSHCN Directors participated in the leader-to-leader cohort through the Association of Maternal and Child Health Programs and in addition to focused leadership training, were assigned a mentor and small group to process challenges and opportunities with our MCHBG and public health work. This was supplemented by national topical sessions focused on shared learning around equity in practice, uplifting community leadership, and centering anti-racism in our MCH work. We also benefited from a convening that the California MCHBG team facilitated focused on how to administer the block grant in decentralized states. Many of these themes continue to be areas we seek additional guidance and technical assistance, particularly envisioning findings models that maximize statewide impact while honoring localized solutions. Other states have gone before us in changing their funding structures to be more responsive to the five-year needs assessment and changing political and fiscal environments.

Looking at this next year, we would welcome the opportunity to explore technical assistance around a few pertinent areas:

- Continued shared learning about using the block grant wisely within a decentralized public health system. What are best practices? What are learnings from states who have tried varied models of fund distribution over time?
- Partnership in exploring child health outcome measures. What are other states using as state performance measures? How could we do a better job capturing work around primary prevention?
- Continued guidance and additional learning opportunities related to identifying appropriate state performance measures, state outcome measures, and selection and use of evidence-based strategy measures that are directly connected with our work.
- On the heels of the overruling of Roe versus Wade, what are implications for populations served by the block? What resources can we access to understand the impact of this removal of a national human liberty?
- How can we be more gender inclusive in our work? Are any States pursuing legislation, policy or systems changes focused on gender inclusive services?
- Guidance on better framing and formatting our State Action Plan and connecting Objectives with Strategies

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - WA DOH IV Title V-Medicaid IAA MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - WA DOH Appendix A Abbreviations And Acronyms.pdf

Supporting Document #02 - WA DOH Appendix B MCHBG Local Work.pdf

Supporting Document #03 - WA DOH Appendix C MCHBG State Action Plan Table 2023.pdf

Supporting Document #04 - WA DOH Appendix D Program Materials.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - WA DOH Organizational Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Washington

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 9,242,405	
A. Preventive and Primary Care for Children	$ 3,176,278	(34.3%)
B. Children with Special Health Care Needs	$ 3,291,505	(35.6%)
C. Title V Administrative Costs	$ 743,990	(8.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 7,211,773	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 7,573,626	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 7,573,626	
A. Your State's FY 1989 Maintenance of Effort Amount $ 7,573,626		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 16,816,031	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 13,831,634	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 30,647,665	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,059,994
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Colorectal Cancer Control Program (CRCCP)	$ 779,403
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Essentials for Childhood	$ 255,600
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 3,100,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 333,807
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,019
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 375,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 1,577,811
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 700,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 445,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 4,550,000

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 8,900,000 (FY 21 Federal Award: $ 8,811,411)		$ 7,569,106	
A. Preventive and Primary Care for Children	$ 2,949,524	(33.1%)	$ 2,144,447	(28.3%)
B. Children with Special Health Care Needs	$ 3,093,599	(34.8%)	$ 2,474,858	(32.6%)
C. Title V Administrative Costs	$ 721,461	(8.1%)	$ 495,465	(6.6%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,764,584		$ 5,114,770	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 7,573,626		$ 7,573,626	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 7,573,626		$ 7,573,626	
A. Your State's FY 1989 Maintenance of Effort Amount $ 7,573,626				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 16,473,626		$ 15,142,732	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 12,716,080		$ 12,719,080	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 29,189,706		$ 27,861,812	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Essentials for Childhood	$ 453,857	$ 456,857
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 209,299	$ 209,299
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 235,000	$ 235,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000	$ 160,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,107,164	$ 1,107,164
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 5,700,000	$ 5,700,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 1,675,032	$ 1,675,032
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 324,234	$ 324,234
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 375,000	$ 375,000
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Teen Pregnancy Prevention	$ 1,859,770	$ 1,859,770
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Cancer Genomics Program	$ 516,724	$ 516,724

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: These are expenditures through July 1, 2022. We anticipate an increase in grant expenditures by the end of the grant budget period 9/30/2022.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: These are expenditures through July 1, 2022. We anticipate an increase in grant expenditures by the end of the grant budget period 9/30/2022.	
3.	**Field Name:**	**2. Subtotal of Lines 1A-C**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: These are expenditures through July 1, 2022. We anticipate an increase in grant expenditures by the end of the grant budget period 9/30/2022.	
4.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: These are expenditures through July 1, 2022. We anticipate an increase in grant expenditures by the end of the grant budget period 9/30/2022.	
5.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: These are expenditures through July 1, 2022. We anticipate an increase in grant expenditures by the end of the grant budget period 9/30/2022.	

Data Alerts:

- The value in Line 1A, Preventive and Primary Care for Children, Annual Report Expended is less than 30% of the Federal Allocation, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Washington

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 933,840	$ 1,227,168
2. Infants < 1 year	$ 933,841	$ 1,227,168
3. Children 1 through 21 Years	$ 3,176,278	$ 2,144,447
4. CSHCN	$ 3,291,505	$ 2,474,858
5. All Others	$ 162,951	$ 0
Federal Total of Individuals Served	$ 8,498,415	$ 7,073,641

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	$ 0	$ 0
2. Infants < 1 year	$ 2,524,542	$ 2,524,542
3. Children 1 through 21 Years	$ 2,524,542	$ 2,524,542
4. CSHCN	$ 2,524,542	$ 2,524,542
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 7,573,626	$ 7,573,626
Federal State MCH Block Grant Partnership Total	$ 16,072,041	$ 14,647,267

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: State dollars to used to purchase vaccines for children accounts for our State Match allocation.	
2.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: State dollars to used to purchase vaccines for children accounts for our State Match allocation.	
3.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2023**
	Column Name:	**Application Budgeted**
	Field Note: State dollars to used to purchase vaccines for children accounts for our State Match allocation.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Washington

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 94,723	$ 21,937
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 48,650	$ 9,331
B. Preventive and Primary Care Services for Children	$ 4,416	$ 1,171
C. Services for CSHCN	$ 41,657	$ 11,435
2. Enabling Services	$ 545,808	$ 208,661
3. Public Health Services and Systems	$ 8,601,874	$ 7,338,508
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 11,937
Laboratory Services		$ 10,000
Direct Services Line 4 Expended Total		$ 21,937
Federal Total	$ 9,242,405	$ 7,569,106

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 7,573,626	$ 7,573,626
3. Public Health Services and Systems	$ 0	$ 0
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 7,573,626	$ 7,573,626

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Washington

Total Births by Occurrence: 83,254 **Data Source Year: 2021**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	83,155 (99.9%)	196	195	195 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect	Citrullinemia, Type I
Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Cystic Fibrosis	Glutaric Acidemia Type I
Glycogen Storage Disease Type II (Pompe)	Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease
Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	S, ßeta-Thalassemia
S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy			

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Early Hearing Detection, Diagnosis and Intervention (EHDDI)	81,189 (97.5%)	1,042	160	143 (89.4%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Washington State does not have the resources for long-term follow-up of all conditions. For conditions on which we have the ability to follow up, the information and duration of the monitoring depends on the condition under consideration.

Form Notes for Form 4:

In 2021, 52 Washington State resident infants were diagnosed with and received surgical intervention for Critical Congenital Heart Disease (CCHD) after receiving a pulse oximetry screen which came back as symptomatic for CCHD.

Data reported here for the EHDDI program are from CY 2020.

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2021**
	Column Name:	**Core RUSP Conditions**
	Field Note: Eligible births: 83,951 Washington State birth occurrences minus 87 neonatal deaths and 298 infants with valid parental refusals.	
2.	**Field Name:**	**Early Hearing Detection, Diagnosis and Intervention (EHDDI) - Total Number Referred For Treatment**
	Fiscal Year:	**2021**
	Column Name:	**Other Newborn**
	Field Note: The 17 confirmed cases who did not receive treatment include those who declined services, were considered too medically fragile for treatment or moved out of the jurisdiction.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Washington

Annual Report Year 2021

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	773	62.0	2.0	5.0	1.0	30.0
2. Infants < 1 Year of Age	80,819	46.0	1.5	49.4	3.1	0.0
3. Children 1 through 21 Years of Age	361,164	51.0	0.0	45.9	3.1	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	5,477	74.0	4.0	19.0	2.0	1.0
4. Others	161	53.0	14.0	18.0	4.0	11.0
Total	442,917					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	83,086	No	83,096	100.0	83,096	773
2. Infants < 1 Year of Age	82,821	No	80,819	100.0	80,819	80,819
3. Children 1 through 21 Years of Age	1,936,588	No	1,997,659	20.0	399,532	361,164
3a. Children with Special Health Care Needs 0 through 21 years of age^	398,545	Yes	398,545	100.0	398,545	5,477
4. Others	5,670,543	Yes	5,670,543	1.0	56,705	161

^Represents a subset of all infants and children.

Form Notes for Form 5:

Data used to complete Forms 5a and 5b
Form 5a:
Data on counts of pregnant women, CSHCN and “Other” are obtained from local health jurisdiction annual reports on numbers of clients served.

Data counts of infants comes from the First Steps program, housed in the Department of Social and Health Services.

Data on counts of children served come from a combination of local health jurisdiction report data and health promotion

Mailings conducted by the Watch Me Grow Washington (formerly Child Profile) program housed in the Washington State Department of Health.

Data on primary sources of coverage were obtained from various sources including local health jurisdiction annual reports, the Washington State Health Care Authority, the American Community Survey and the Medicaid Management Information System (MMIS).

Form 5b:
The count of pregnant resident Washington State women comes from the Washington State Birth Certificate for the year 2020, the most recent year for which we have data. Plural gestation is accounted for in the total.

The count of infants comes from the First Steps Database.

The count of children 1-21 comes from Washington State's Office of Financial Management official estimates of population for 2020.

The count of CSHCN come from the estimated population derived from the 2019-2020 NSCH.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2021**
	Field Note: This is the total number of women local health reported as having served.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2021**
	Field Note: The percent with no insurance coverage comes from the American Community Survey and is the rate fror the population 0-17 years of age.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: This total includes all children 1-6 years of age who received a Watch Me Grow Washington (formerly Child Profile) mailing from the Washington State Department of Health as well as half the children served by local health jurisdictions. The percent with no insurance overage comes from the American Community Survey and is the rate for the population 0-17 years of age. Coverage from Title XIX comes from DSHS Client Services Database and is for 2017, the most recent year provided.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2021**
	Field Note: This is the total number of CSHCN served by local health.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2021**
	Field Note: This is the total number reported as having been served by local health.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2021**
	Field Note: Due to educational work and information on healthy pregnancies, Washington State reaches close to 100% of pregnant women with programs or campaigns funded in part by Title V funds.	
2.	**Field Name:**	**Pregnant Women Denominator**

	Fiscal Year:	**2021**
	Field Note: Due to educational work and information on healthy pregnancies, Washington State reaches close to 100% of pregnant women with programs or campaigns funded in part by Title V funds.	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2021**
	Field Note: Through Washington State's Universal Vaccine coverage initiative al children 1-18 years of age in Washington State have access to vaccines regardless of ability to pay. This initiative is paid for by state matching funds for Title V funds.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2021**
	Field Note: Through Washington State's Universal Vaccine coverage initiative al children under one year of age in Washington State have access to vaccines regardless of ability to pay. This initiative is paid for by state matching funds for Title V funds.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**
	Field Note: Through Washington State's Universal Vaccine coverage initiative all children 1-18 years of age in Washington State have access to vaccines regardless of ability to pay. This initiative is paid for by state matching funds for Title V funds. the remaining 20% of individuals were over 18 years of age.	
6.	**Field Name:**	**Children 1 through 21 Years of Age Denominator**
	Fiscal Year:	**2021**
	Field Note: Through Washington State's Universal Vaccine coverage initiative all children 1-18 years of age in Washington State have access to vaccines regardless of ability to pay. This initiative is paid for by state matching funds for Title V funds. the remaining 20% of individuals were over 18 years of age.	
7.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2021**
	Field Note: Through Washington State's Universal Vaccine coverage initiative all children 1-18 years of age in Washington State have access to vaccines regardless of ability to pay. the initiative is paid for by state matching funds for Federal Title V funds. Washington State has a very high percent of CSHCN enrolled Medicaid. These two factors combined to contribute to virtually all CSHCN in Washington State having access to services which Title V has contributed to.	

8.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2021**

Field Note:
This count is the same as was reported from form 5a, having received a service from a local health jurisdiction.This count represents a minimum served in Washington State.

Data Alerts:

1.	Infants Less Than One Year, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.
2.	Children 1 through 21 Years of Age, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Washington

Annual Report Year 2021

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	80,819	15,761	44,510	3,846	1,018	8,526	1,252	3,865	2,041
Title V Served	1,118	218	616	53	14	118	17	53	29
Eligible for Title XIX	36,815	11,609	15,920	2,572	778	1,735	961	2,068	1,172
2. Total Infants in State	82,083	15,993	45,236	3,937	1,026	8,622	1,265	3,922	2,082
Title V Served	82,389	16,004	45,438	3,955	1,031	8,660	1,271	3,940	2,090
Eligible for Title XIX	37,306	11,726	16,156	2,624	784	1,755	972	2,100	1,189

Form Notes for Form 6:

These data are for CY2020

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Washington

A. State MCH Toll-Free Telephone Lines	2023 Application Year	2021 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 322-2588	(800) 322-2588
2. State MCH Toll-Free "Hotline" Name	Help Me Grow Washington Hotline	Help Me Grow Washington Hotline
3. Name of Contact Person for State MCH "Hotline"	Mary Myhre	Mary Myhre
4. Contact Person's Telephone Number	(360) 236-4626	(360) 236-4626
5. Number of Calls Received on the State MCH "Hotline"		13,169

B. Other Appropriate Methods	2023 Application Year	2021 Annual Report Year
1. Other Toll-Free "Hotline" Names	N/A	N/A
2. Number of Calls on Other Toll-Free "Hotlines"		0
3. State Title V Program Website Address	https://doh.wa.gov/public-health-healthcare-providers/public-health-system-resources-and-services/local-health-resources-and-tools/maternal-and-child-health-block-grant	https://doh.wa.gov/public-health-healthcare-providers/public-health-system-resources-and-services/local-health-resources-and-tools/maternal-and-child-health-block-grant
4. Number of Hits to the State Title V Program Website		611
5. State Title V Social Media Websites	N/A	N/A
6. Number of Hits to the State Title V Program Social Media Websites		0

Form Notes for Form 7:

The number of calls to the hotline is from 10/01/2020 to 9/30/2021.

Form 8
State MCH and CSHCN Directors Contact Information

State: Washington

1. Title V Maternal and Child Health (MCH) Director	
Name	Katie Eilers
Title	Director, Office of Family and Community Health Improvement
Address 1	P.O. Box 47855
Address 2	
City/State/Zip	Olympia / WA / 98504
Telephone	(360) 236-3687
Extension	
Email	katie.eilers@doh.wa.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Monica Burke
Title	Children and Youth with Special Health Care Needs Director
Address 1	P.O. Box 47855
Address 2	
City/State/Zip	Olympia / WA / 98504
Telephone	(360) 236-3504
Extension	
Email	monica.burke@doh.wa.gov

3. State Family or Youth Leader (Optional)	
Name	Nikki Dyer
Title	Family Engagement Coordinator
Address 1	P.O. Box 47855
Address 2	
City/State/Zip	Olympia / WA / 98504
Telephone	(360) 236-9353
Extension	
Email	nikki.dyer@doh.wa.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Washington

Application Year 2023

No.	Priority Need
1.	Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course.
2.	Identify and reduce barriers to quality health care.
3.	Improve the safety, health, and supportiveness of communities.
4.	Promote mental wellness and resilience through increased access to behavioral health and other support services.
5.	Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.
6.	Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.
7.	Optimize the health and well-being of children and adolescents, using holistic approaches.
8.	Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Increase capacity of the local public health workforce to strategically identify, plan for, and address the needs of women and children throughout the state.	New
2.	Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course.	Revised
3.	Identify and reduce barriers to quality health care.	New
4.	Improve the safety, health, and supportiveness of communities.	Revised
5.	Promote mental wellness and resilience through increased access to behavioral health and other support services.	New
6.	Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.	New
7.	Improve infant health outcomes and reduce inequities that result in infant morbidity and mortality.	New
8.	Optimize the health and well-being of children and adolescents, using holistic approaches.	New
9.	Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.	New
10.	Identify and respond to emerging priority needs associated with public health emergencies and their effects on the maternal and child populations.	New

Form 10
National Outcome Measures (NOMs)

State: Washington

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

NPM 15 is being used as a measure for work being done with CYSHCN. The data shown in the table is for all children and not specific to CYSHCN. As such we have added data from the NSCH for this measure specific to CYSHCN in the State Data section. Targets are based on these data.

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	78.8 %	0.2 %	59,426	75,417
2019	78.5 %	0.2 %	61,029	77,738
2018	78.5 %	0.2 %	62,327	79,394
2017	78.5 %	0.1 %	64,698	82,452
2016	77.5 %	0.1 %	66,763	86,123
2015	77.5 %	0.1 %	65,652	84,691
2014	76.7 %	0.2 %	64,163	83,705
2013	74.1 %	0.2 %	60,342	81,406
2012	73.5 %	0.2 %	60,755	82,625
2011	72.5 %	0.2 %	59,485	82,030
2010	72.4 %	0.2 %	59,216	81,838
2009	69.8 %	0.2 %	59,133	84,682

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	68.2	3.0	525	76,938
2018	66.8	2.9	519	77,695
2017	60.6	2.8	486	80,220
2016	58.7	2.7	482	82,103
2015	56.6	3.1	341	60,270
2014	56.8	2.7	449	79,074
2013	55.9	2.7	427	76,367
2012	51.5	2.6	394	76,573
2011	48.2	2.5	376	77,968
2010	49.8	2.5	389	78,132
2009	46.7	2.4	376	80,570
2008	41.8	2.3	344	82,254

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2020	17.6	2.0	76	432,133
2015_2019	15.8	1.9	69	438,037
2014_2018	14.7	1.8	65	441,727

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.7 %	0.1 %	5,558	82,984
2019	6.4 %	0.1 %	5,456	84,778
2018	6.6 %	0.1 %	5,690	85,986
2017	6.6 %	0.1 %	5,776	87,479
2016	6.4 %	0.1 %	5,792	90,427
2015	6.4 %	0.1 %	5,730	88,909
2014	6.4 %	0.1 %	5,705	88,511
2013	6.4 %	0.1 %	5,547	86,483
2012	6.1 %	0.1 %	5,347	87,288
2011	6.1 %	0.1 %	5,340	86,831
2010	6.3 %	0.1 %	5,464	86,388
2009	6.3 %	0.1 %	5,580	89,111

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	8.6 %	0.1 %	7,167	82,946
2019	8.5 %	0.1 %	7,172	84,719
2018	8.3 %	0.1 %	7,147	85,959
2017	8.4 %	0.1 %	7,334	87,454
2016	8.1 %	0.1 %	7,364	90,430
2015	8.1 %	0.1 %	7,216	88,923
2014	8.1 %	0.1 %	7,125	88,490
2013	8.1 %	0.1 %	7,023	86,321
2012	8.3 %	0.1 %	7,262	87,164
2011	8.2 %	0.1 %	7,107	86,602
2010	8.5 %	0.1 %	7,304	86,286
2009	8.5 %	0.1 %	7,553	89,026

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	25.3 %	0.2 %	20,971	82,946
2019	25.3 %	0.2 %	21,419	84,719
2018	24.0 %	0.2 %	20,669	85,959
2017	23.8 %	0.1 %	20,837	87,454
2016	22.9 %	0.1 %	20,681	90,430
2015	22.5 %	0.1 %	19,987	88,923
2014	22.5 %	0.1 %	19,870	88,490
2013	22.2 %	0.1 %	19,196	86,321
2012	22.5 %	0.1 %	19,600	87,164
2011	22.3 %	0.1 %	19,339	86,602
2010	23.8 %	0.1 %	20,512	86,286
2009	24.4 %	0.1 %	21,689	89,026

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020/Q3-2021/Q2	2.0 %			
2019/Q4-2020/Q3	2.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	1.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	2.0 %			
2013/Q4-2014/Q3	2.0 %			
2013/Q3-2014/Q2	2.0 %			
2013/Q2-2014/Q1	2.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.6	0.2	390	85,104
2018	4.6	0.2	397	86,276
2017	4.4	0.2	390	87,783
2016	4.6	0.2	418	90,718
2015	4.8	0.2	432	89,190
2014	4.8	0.2	428	88,799
2013	5.2	0.3	451	86,813
2012	5.2	0.2	452	87,662
2011	5.5	0.3	478	87,256
2010	5.3	0.3	463	86,794
2009	4.8	0.2	434	89,544

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	4.3	0.2	362	84,895
2018	4.7	0.2	404	86,085
2017	3.9	0.2	340	87,562
2016	4.3	0.2	391	90,505
2015	4.9	0.2	434	88,990
2014	4.5	0.2	397	88,585
2013	4.5	0.2	392	86,577
2012	5.3	0.3	460	87,463
2011	4.6	0.2	396	86,976
2010	4.5	0.2	388	86,539
2009	4.9	0.2	439	89,313

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	2.9	0.2	248	84,895
2018	3.1	0.2	271	86,085
2017	2.4	0.2	209	87,562
2016	2.8	0.2	251	90,505
2015	3.3	0.2	291	88,990
2014	3.0	0.2	263	88,585
2013	3.0	0.2	264	86,577
2012	3.6	0.2	311	87,463
2011	2.9	0.2	248	86,976
2010	3.1	0.2	265	86,539
2009	2.9	0.2	256	89,313

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	1.3	0.1	114	84,895
2018	1.5	0.1	133	86,085
2017	1.5	0.1	131	87,562
2016	1.5	0.1	140	90,505
2015	1.6	0.1	143	88,990
2014	1.5	0.1	134	88,585
2013	1.5	0.1	128	86,577
2012	1.7	0.1	149	87,463
2011	1.7	0.1	148	86,976
2010	1.4	0.1	123	86,539
2009	2.0	0.2	183	89,313

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	126.0	12.2	107	84,895
2018	145.2	13.0	125	86,085
2017	116.5	11.5	102	87,562
2016	118.2	11.4	107	90,505
2015	155.1	13.2	138	88,990
2014	160.3	13.5	142	88,585
2013	157.1	13.5	136	86,577
2012	173.8	14.1	152	87,463
2011	119.6	11.7	104	86,976
2010	135.2	12.5	117	86,539
2009	138.8	12.5	124	89,313

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	70.7	9.1	60	84,895
2018	67.4	8.9	58	86,085
2017	76.5	9.4	67	87,562
2016	72.9	9.0	66	90,505
2015	75.3	9.2	67	88,990
2014	68.9	8.8	61	88,585
2013	79.7	9.6	69	86,577
2012	78.9	9.5	69	87,463
2011	83.9	9.8	73	86,976
2010	76.3	9.4	66	86,539
2009	95.2	10.3	85	89,313

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	7.7 %	1.0 %	6,213	80,228
2019	7.4 %	0.9 %	6,065	81,797
2018	8.0 %	1.0 %	6,645	82,837
2017	7.9 %	1.0 %	6,581	83,373
2016	9.7 %	1.1 %	8,433	86,552
2015	14.0 %	1.2 %	11,851	84,870
2014	11.4 %	1.2 %	9,706	84,823
2013	9.8 %	1.2 %	8,149	82,814
2012	12.1 %	1.4 %	10,022	82,842
2011	9.3 %	1.1 %	7,740	83,644
2010	7.6 %	0.9 %	6,286	83,234
2009	7.3 %	0.9 %	6,253	85,862
2008	9.8 %	1.1 %	8,440	86,426
2007	11.0 %	1.1 %	9,293	84,446

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	8.2	0.3	636	77,628
2018	9.7	0.4	754	77,963
2017	9.6	0.4	772	80,331
2016	8.9	0.3	737	82,820
2015	9.4	0.4	569	60,830
2014	9.5	0.4	752	79,405
2013	8.1	0.3	603	74,505
2012	7.0	0.3	543	77,768
2011	6.8	0.3	534	79,002
2010	5.8	0.3	460	78,933
2009	4.5	0.2	365	81,829
2008	3.7	0.2	307	83,450

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	9.5 %	1.2 %	150,732	1,586,520
2018_2019	11.0 %	1.5 %	173,321	1,576,641
2017_2018	10.4 %	1.5 %	161,216	1,555,296
2016_2017	11.1 %	1.3 %	169,068	1,529,985
2016	12.0 %	1.4 %	181,386	1,517,733

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	11.7	1.2	98	835,231
2019	12.2	1.2	102	837,158
2018	12.8	1.2	107	838,955
2017	11.9	1.2	99	831,015
2016	13.0	1.3	107	823,889
2015	15.2	1.4	124	813,509
2014	13.0	1.3	105	807,568
2013	14.2	1.3	114	802,857
2012	14.7	1.4	117	794,091
2011	13.8	1.3	109	787,588
2010	15.6	1.4	122	782,518
2009	13.1	1.3	101	772,537

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	34.5	1.9	317	918,183
2019	28.6	1.8	262	915,053
2018	32.5	1.9	296	909,851
2017	29.5	1.8	265	897,967
2016	27.9	1.8	248	887,344
2015	29.0	1.8	255	880,358
2014	25.4	1.7	223	878,349
2013	26.3	1.7	231	877,199
2012	28.8	1.8	253	879,611
2011	26.4	1.7	234	887,880
2010	25.9	1.7	233	900,361
2009	31.6	1.9	285	901,564

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	8.3	0.8	111	1,342,603
2017_2019	8.4	0.8	112	1,339,754
2016_2018	9.7	0.9	129	1,335,278
2015_2017	9.3	0.8	124	1,328,930
2014_2016	9.4	0.8	124	1,324,549
2013_2015	9.6	0.9	127	1,320,457
2012_2014	9.1	0.8	120	1,321,272
2011_2013	8.6	0.8	114	1,329,906
2010_2012	8.2	0.8	111	1,352,543
2009_2011	9.9	0.9	136	1,376,712
2008_2010	10.5	0.9	147	1,393,455
2007_2009	13.3	1.0	185	1,392,780

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	13.9	1.0	187	1,342,603
2017_2019	15.7	1.1	210	1,339,754
2016_2018	15.7	1.1	210	1,335,278
2015_2017	15.0	1.1	199	1,328,930
2014_2016	12.5	1.0	165	1,324,549
2013_2015	12.4	1.0	164	1,320,457
2012_2014	11.4	0.9	150	1,321,272
2011_2013	11.8	0.9	157	1,329,906
2010_2012	10.2	0.9	138	1,352,543
2009_2011	9.8	0.8	135	1,376,712
2008_2010	8.7	0.8	121	1,393,455
2007_2009	8.8	0.8	123	1,392,780

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	19.7 %	1.4 %	327,035	1,657,953
2018_2019	19.6 %	1.6 %	323,785	1,648,387
2017_2018	19.0 %	1.6 %	311,138	1,633,551
2016_2017	18.7 %	1.4 %	302,213	1,616,285
2016	18.6 %	1.6 %	299,109	1,606,451

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	12.4 %	1.9 %	40,660	327,035
2018_2019	14.1 %	3.2 %	45,552	323,785
2017_2018	21.3 %	4.5 %	66,378	311,138
2016_2017	21.2 %	3.9 %	63,925	302,213
2016	14.6 %	2.7 %	43,780	299,109

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	2.4 %	0.5 %	34,345	1,417,362
2018_2019	2.6 %	0.6 %	36,105	1,399,350
2017_2018	1.8 %	0.6 %	24,131	1,366,434
2016_2017	1.4 %	0.4 %	19,240	1,358,071
2016	1.5 %	0.4 %	20,417	1,351,429

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	6.3 %	0.8 %	88,246	1,410,242
2018_2019	7.2 %	1.0 %	99,775	1,383,262
2017_2018	7.2 %	1.1 %	96,700	1,350,305
2016_2017	6.9 %	0.9 %	93,781	1,349,694
2016	7.9 %	1.1 %	105,766	1,346,100

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	56.9 %	4.8 %	136,633	240,131
2018_2019	59.1 %	5.2 %	127,835	216,155
2017_2018	52.4 %	6.2 %	94,622	180,665
2016_2017	49.6 %	5.4 %	86,561	174,353
2016	47.0 %	5.6 %	90,026	191,685

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	91.3 %	1.2 %	1,513,153	1,657,131
2018_2019	91.5 %	1.3 %	1,505,380	1,645,610
2017_2018	90.0 %	1.5 %	1,469,085	1,631,596
2016_2017	89.7 %	1.4 %	1,446,187	1,612,130
2016	90.6 %	1.4 %	1,448,487	1,598,140

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	13.8 %	0.1 %	8,443	61,000
2016	13.3 %	0.1 %	9,264	69,870
2014	13.6 %	0.1 %	10,399	76,564
2012	14.3 %	0.1 %	11,609	81,082
2010	14.9 %	0.1 %	11,651	78,336
2008	14.9 %	0.1 %	10,092	67,801

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	13.2 %	2.2 %	89,177	676,908
2018_2019	11.9 %	2.2 %	74,617	628,629
2017_2018	11.0 %	2.2 %	71,025	644,485
2016_2017	10.1 %	1.9 %	66,886	664,149
2016	8.7 %	1.7 %	55,307	637,589

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	3.0 %	0.2 %	50,328	1,661,312
2018	2.6 %	0.2 %	43,106	1,659,567
2017	2.5 %	0.2 %	40,714	1,646,050
2016	2.4 %	0.2 %	39,403	1,624,757
2015	2.8 %	0.2 %	44,789	1,611,780
2014	4.4 %	0.3 %	70,932	1,600,541
2013	6.3 %	0.3 %	99,643	1,592,511
2012	5.5 %	0.4 %	87,433	1,580,454
2011	6.1 %	0.4 %	96,436	1,577,275
2010	6.4 %	0.3 %	100,888	1,582,129
2009	7.0 %	0.3 %	109,873	1,571,164

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	72.7 %	2.8 %	66,000	90,000
2016	65.1 %	4.2 %	60,000	92,000
2015	61.3 %	4.4 %	57,000	92,000
2014	71.7 %	3.5 %	66,000	92,000
2013	70.3 %	3.5 %	63,000	90,000
2012	69.8 %	4.0 %	62,000	89,000
2011	69.1 %	4.2 %	62,000	90,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	65.4 %	1.8 %	1,014,780	1,551,652
2019_2020	66.9 %	1.6 %	1,045,249	1,562,405
2018_2019	63.8 %	1.7 %	981,394	1,538,476
2017_2018	61.3 %	1.8 %	923,632	1,505,667
2016_2017	56.7 %	1.8 %	854,661	1,507,339
2015_2016	60.9 %	1.8 %	907,341	1,489,887
2014_2015	57.2 %	2.0 %	850,483	1,485,820
2013_2014	57.3 %	2.1 %	853,456	1,489,875
2012_2013	58.4 %	2.7 %	860,850	1,475,399
2011_2012	46.9 %	2.5 %	685,858	1,461,885
2010_2011	48.4 %	3.4 %	697,849	1,441,836
2009_2010	40.1 %	2.1 %	566,535	1,412,806

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	74.6 %	3.1 %	345,022	462,798
2019	72.0 %	3.4 %	328,726	456,290
2018	71.3 %	3.4 %	322,524	452,137
2017	71.9 %	2.9 %	322,727	448,849
2016	64.8 %	3.1 %	288,296	444,994
2015	56.1 %	3.0 %	248,735	443,688

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	91.1 %	2.0 %	421,594	462,798
2019	89.8 %	2.0 %	409,584	456,290
2018	82.0 %	3.1 %	370,936	452,137
2017	88.6 %	2.1 %	397,478	448,849
2016	86.8 %	2.3 %	386,222	444,994
2015	85.3 %	2.3 %	378,574	443,688
2014	88.5 %	2.1 %	392,380	443,358
2013	86.2 %	2.5 %	381,483	442,689
2012	86.0 %	2.6 %	380,318	442,300
2011	75.0 %	3.2 %	334,615	446,367
2010	70.6 %	2.7 %	309,347	438,428
2009	60.2 %	3.2 %	264,685	440,072

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	88.1 %	2.3 %	407,668	462,798
2019	83.3 %	2.8 %	380,007	456,290
2018	83.7 %	2.8 %	378,547	452,137
2017	82.6 %	2.5 %	370,830	448,849
2016	75.1 %	3.0 %	334,269	444,994
2015	75.4 %	2.6 %	334,333	443,688
2014	82.1 %	2.5 %	364,126	443,358
2013	79.0 %	2.9 %	349,775	442,689
2012	71.2 %	3.4 %	314,934	442,300
2011	69.4 %	3.3 %	309,700	446,367
2010	67.6 %	2.8 %	296,176	438,428
2009	55.8 %	3.2 %	245,424	440,072

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	11.3	0.2	2,478	219,345
2019	12.7	0.2	2,788	219,326
2018	12.7	0.2	2,762	218,148
2017	14.8	0.3	3,191	216,216
2016	16.6	0.3	3,584	215,482
2015	17.7	0.3	3,773	213,738
2014	19.2	0.3	4,092	213,071
2013	20.5	0.3	4,386	213,860
2012	23.3	0.3	5,017	214,894
2011	25.4	0.3	5,530	217,942
2010	26.9	0.4	6,002	223,140
2009	30.4	0.4	6,866	225,775

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	12.2 %	1.2 %	9,582	78,301
2019	12.9 %	1.1 %	10,350	80,359
2018	11.4 %	1.1 %	9,250	81,403
2017	11.3 %	1.2 %	9,337	82,399
2016	11.8 %	1.1 %	9,850	83,605
2015	11.1 %	1.1 %	9,165	82,941
2014	12.5 %	1.2 %	10,408	83,168
2013	11.1 %	1.2 %	9,064	81,419
2012	10.2 %	1.2 %	8,332	81,983

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	2.5 %	0.5 %	40,903	1,657,385
2018_2019	2.7 %	0.5 %	44,975	1,648,387
2017_2018	3.2 %	0.7 %	51,978	1,633,551
2016_2017	2.5 %	0.6 %	40,219	1,611,889
2016	2.1 %	0.7 %	34,305	1,597,659

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Washington

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective				47	59
Annual Indicator			69.7	69.3	66.5
Numerator			919,438	939,935	908,611
Denominator			1,318,605	1,355,481	1,366,228
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	67.2	67.8	68.5	69.2

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Discussions between program and epidemiology staff, taking into account recent trends in the data, set an annual target of a 1% per year increase through 2025. These targets may be subject to revision as more data comes available.

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	93	93	93	94	94
Annual Indicator	92.1	92.4	91.0	92.5	95.1
Numerator	81,019	80,672	71,525	75,591	76,014
Denominator	87,977	87,274	78,591	81,714	79,899
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	93	93	93	94	94
Annual Indicator	94.5	94.2	94.1	94.1	
Numerator	81,550	80,140	79,016	79,016	
Denominator	86,284	85,113	83,941	83,941	
Data Source	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate	
Data Source Year	2017	2018	2019	2019	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	94.0	94.0	94.0	94.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
2020 data are not yet available. 2019 data, the most recent available, are provided.

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	23.5	33.1	34.8	36.5	38.3
Annual Indicator	31.6	29.1	27.6	28.9	32.3
Numerator	27,184	24,761	20,413	23,021	24,865
Denominator	86,004	84,974	74,010	79,683	76,973
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2014	2015	2016	2017	2018

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	40.2	42.2	44.3	46.5

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		36	29	17.1	21.3
Annual Indicator	31.9	27.7	25.6	36.2	46.9
Numerator	60,624	55,326	53,459	65,908	83,492
Denominator	190,110	199,961	209,028	182,179	177,879
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	25.5	26.3	27.1	28.2

Field Level Notes for Form 10 NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		79	82	82	77.7
Annual Indicator	78.1	81.3	81.3	74.0	73.8
Numerator	424,264	432,006	432,006	405,716	407,557
Denominator	543,052	531,119	531,119	548,292	552,011
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2016_2017	2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	75.0	76.0	77.0	78.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
The expected rebound following COVD-19 closures of medical facilities was not seen. New targets were developed in light of these new data. A target of one percentage point per year is forecast through 2025. As new data become available targets may be revised.

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		40	42	43	41
Annual Indicator	38.1	45.7	45.3	40.8	49.5
Numerator	113,841	138,232	141,032	131,960	161,798
Denominator	299,109	302,213	311,138	323,785	327,035
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	42.0	43.0	44.0	45.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Due to factors such as a return to more standard care practices following the COVID-19 pandemic as well as anticipated federal funds and on-going work by the program and partners an anticipated increase from a baseline of 41% by one percentage point per year was identified. Surveillance and program staff will continue to monitor progress on this measure and update targets as needed.

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		73	74	75	76
Annual Indicator	72.0	71.2	67.9	65.1	67.6
Numerator	1,154,504	1,148,124	1,107,284	1,068,524	1,116,228
Denominator	1,603,905	1,613,555	1,630,587	1,642,095	1,652,168
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		73	74	75	76
Annual Indicator					55.4
Numerator					
Denominator					
Data Source					NSCH
Data Source Year					2019-2020
Provisional or Final ?					Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	58.0	59.0	60.0	61.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Discussions between program and epidemiology staff resulted in a decision to increase the target for this measure by a percentage point per year based on a commitment to make slow but sustained improvements in this measure to reduce the disparity between children with and without a special health care need.

Form 10
State Performance Measures (SPMs)

State: Washington

SPM 1 - Substance use during pregnancy

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	16.1	14.9
Numerator	180	176
Denominator	1,118	1,180
Data Source	PRAMS	PRAMS
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	15.0	15.0	15.0	15.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 2019 data has been revised since last grant submission. The new percentage reflects improved data capture techniques and is more accurate.	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Discussions between program and epidemiology staff resulted in a decision to keep the targets constant. Most work on this issue is being done post-partum so interventions may not have a direct effect on use before/during pregnancy.	

SPM 2 - Provider screening of pregnant women for depression

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	87.2	88.3
Numerator		
Denominator		
Data Source	Washington State PRAMS Survey	Washington State PRAMS Survey
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	88.3	88.3	88.3	88.3

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Rates for this measure are high and measurable significant improvement may be difficult to obtain. While the point estimate has increase from the prior year, 2019 to 2020 the increase is well within 95% confidence intervals. Discussions between program and epidemiology staff resulted in a flat rate through 2025. These targets may be revised as new data become available.

SPM 3 - Universal developmental screening system participation

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Data from the system are not yet available. It is expected that data collection will begin when the system "goes live" this fall, 2021.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data from the system are not yet available. Recently staff have been hired to guide the final stages of creation and the beginning of data on-boarding into the system. It is hoped that we will have screening data to report for next year's submission.	
3.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: When data become available targets will be set for this measure.	

SPM 4 - Percentage of sixth grade students who have an adult to talk to when they feel sad or hopeless

Measure Status:	Inactive - Replaced	
State Provided Data		
	2020	**2021**
Annual Objective		
Annual Indicator	75.3	68.6
Numerator		
Denominator		
Data Source	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2021
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Ease of receiving mental health treatment or counseling

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	53.9	
Numerator		
Denominator		
Data Source	NSCH	
Data Source Year	2018/2019	
Provisional or Final ?	Final	

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	55.0	56.0	57.0	58.0

Field Level Notes for Form 10 SPMs:

None

SPM 6 - Social and emotional readiness among kindergarteners

Measure Status:				Active	
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective	74	74.4	77	77	78
Annual Indicator	70.2	76.7	76.7	79	77.4
Numerator					
Denominator					
Data Source	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids
Data Source Year	2016-2017	2017-2018	2017-2018	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	**2023**	**2024**	**2025**
Annual Objective	78.0	79.0	79.0	79.0

Field Level Notes for Form 10 SPMs:

None

SPM 7 - Percentage of tenth grade students who have an adult to talk to when they feel sad or hopeless

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	59.9	60.4
Numerator		
Denominator		
Data Source	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	60.5	60.6	60.7	60.8

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
This measure is connected to the overall body of work the Adolescent Health program is undertaking, rather than any specific intervention. In the coming year work on social support will be undertaken by the program including supporting behavioral health in school based health centers, suicide prevention work, including through youth advisory councils. A needs assessment is planned on the topic of social support. It is hoped these initiatives will increase the percent reported in this measure.

SPM 8 - Percentage of tenth grade students who report having used alcohol in the past 30 days

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			15.8
Annual Indicator		18.8	8.4
Numerator			
Denominator			
Data Source		Healthy Youth Survey	Healthy Youth Survey
Data Source Year		2018	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	14.8	13.8	12.8	11.8

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Three year's data, 22.2% in 2014, 14.9% in 2016 and 18.8% in 2019 do not indicate a clear trend. Discussions between program and evaluation staff, taking into consideration work that will be undertaken on the issue, resulted in a decision to target a one percentage point decrease per year starting in with the data collected in 2018. The next collection of data is for Fall 2021, for which a target of 15.8% has been created, three years after 2018's collection. Each year after will decrease by one percentage point. As more data become available these targets may be revised.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Discussions between program and epidemiology staff acknowledged a large decrease in 2021 but felt the decrease was unique to conditions prevalent during the COVID-19 pandemic.While a short-term return to prior drinking percents is not unexpected in the near term, a decision was made to remain with preexisting targets as work being done is expected to decrease rates in a sustained manner over the longer term.	

SPM 9 - Adolescents reporting at least one adult mentor

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			74.4
Annual Indicator		69.8	65.3
Numerator			
Denominator			
Data Source		Healty Youth Survey	Healthy Youth Survey
Data Source Year		2018	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	66.5	68.0	69.0	70.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Talks between program and epidemiology staff led to an acknowledgement that previous targets may have been too optimistic and that COVID-19 may have impacted social connectivity more profoundly than previously imagined. As such targets were decreased to be more in line with current data. From 2023 to 2025 an increase of one percentage point per year was chosen as achievable. As more data become available these targets may be revised.

SPM 10 - Suicide ideation among youth with special health care needs

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	40	38.2
Numerator	422	421
Denominator	1,055	1,103
Data Source	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2021
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	38.0	37.5	37.0	36.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Past survey results for this indicator are as follows:
2002 45.2%
2004 44.9%
2008 45.0%
2012 50.1%

Regression modeling indicates an historical annual 1.2% increase in the rate since 2002.

2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Recent data have indicated a decrease in the rate. Work on this topic is expected to pick up in the next few years, specifically with autistic youth, and is expected to result in reductions. Therefore a baseline of 38 percent which represents a decrease of 0.2 of a percentage point is set for 2022 increasing to a decrease of 0.5 of a percentage point from 2022 to 2023, a further 0.5 decrease from 2023 to 2024, with the decrease moving to a full percentage point reduction from 2024 to 2025.

SPM 11 - Five-year maternal and child health needs assessment process for 2026-2030 plan is initiated by September 30, 2021

Measure Status:	Inactive - Completed		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			Yes
Annual Indicator			Yes
Numerator			
Denominator			
Data Source			Title V Program
Data Source Year			2022
Provisional or Final ?			Final

Field Level Notes for Form 10 SPMs:

None

SPM 12 - Percent of families showing 4 or more factors indicating high resilience to challenges.

Measure Status:	Active

Annual Objectives			
	2023	2024	2025
Annual Objective	88.0	90.0	92.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
This is a new measure for Washington State. Targets were estimated using the current average increase over the past five administrations of the survey, 2016-2020, of approximately 2.5% per year. As more data become available targets may be revised.

SPM 13 - Percentage of adults who did not get health care because of cost

Measure Status:	Inactive - This measure will be discontinued as it does not relate to work being done by Washington State's Title V program.

State Provided Data			
	2019	2020	2021
Annual Objective			13
Annual Indicator		13.2	10.1
Numerator			
Denominator			
Data Source		BRFSS	BRFSS
Data Source Year		2019	2020
Provisional or Final ?		Final	Final

Field Level Notes for Form 10 SPMs:

None

SPM 14 - Develop outreach plan to support COVID-19 vaccination campaign efforts by March 31, 2021

Measure Status:	Inactive - Completed		
State Provided Data			
	2019	**2020**	**2021**
Annual Objective			Yes
Annual Indicator			Yes
Numerator			
Denominator			
Data Source			WA Title V Program
Data Source Year			2022
Provisional or Final ?			Final

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Washington

ESM 1.1 - Percentage of women reporting in PRAMS that they had a preventive medical visit in the prior year

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			43
Annual Indicator	67.3	66.4	67.2
Numerator			
Denominator			
Data Source	WA PRAMS	WA PRAMS	WA PRAMS
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	67.9	68.6	69.3	70.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
Discussions between program and epidemiology staff resulted in a one percent per year increase through 2025.

ESM 4.1 - Percentage of eligible facilities certified "Breastfeeding Friendly Washington" by Department of Health

Measure Status:	Inactive - Intervention measured in this ESM is being phased-out by hospitals in favor of a different breastfeeding promotion intervention.

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	26	46.1	57	58	60
Annual Indicator	43.4	55.3	57.9	59.2	22.4
Numerator	33	42	44	45	17
Denominator	76	76	76	76	76
Data Source	DOH	DOH	DOH	DOH	DOH
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: There are 76 total eligible facilities, including the 58 eligible (civilian) hospitals during the current year plus 18 birthing centers.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: There are 76 total eligible facilities, including the 58 eligible (civilian) hospitals during the current year plus 18 birthing centers	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: This measure will be retired as the Breastfeeding Friendly program is being replaced by the Lactation and Infant Feeding-Friendly Environment (LIFE) program by many Washington State birthing hospitals. A new measure will be developed relating to the new program/curricula being adopted.	

ESM 4.2 - Percentage of births taking place in facilities certified as Breastfeeding Friendly by Department of Health

Measure Status:	Inactive - Intervention measured by this ESM is being phased-out by participating facilities and replaced with a different breastfeeding promotion intervention.

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	59.2	
Numerator	50,259	
Denominator	84,918	
Data Source	WA Birth Certificate	
Data Source Year	2019	
Provisional or Final ?	Final	

Field Level Notes for Form 10 ESMs:

None

ESM 4.3 - Percentage of births taking place in facilities certified as compliant with LIFE by Washington State Department of Health.

Measure Status:	Active		
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	1.0	1.0	1.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: ESM 4.3 is a new measure covering a new accreditation program. In the first year of the adoption of the program data were not fully collected. With next year's Block Grant submission a full set of data will be collected and reported and associated targets will be set.	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: This measure is new. Current objectives have not been created for it yet. A placeholder value has been entered until next submission when targets will be reported.	

ESM 6.1 - Number of ASQs provided by WithinReach to callers

Measure Status:	Inactive - Replaced				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective		381	1,135	904	1,113
Annual Indicator	529	1,113	834	785	546
Numerator					
Denominator					
Data Source	WithinREACH	WithinREACH	WithinREACH	WithinREACH	WithinREACH
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The large increase in the number of ASQ's completed was due to a change in the way WithinREACH followed up on completion of the surveys.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The significant decrease in ASQs completed may have been due to the COVID-19 pandemic. Completions were down in the January-March quarter (216 completed) from the October-December quarter (272 completed). An even steeper decline was observed in the April-June quarter (118 completed). Also, in 2018 WithinREACH lost a CYSHCN coordinator position to reduced funding, which may have played a role in the decrease seen.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: A level steady state target was set for the next four years for this measure as it will be retired and replaced with a new ESM.	

ESM 6.2 - Number of children reported by HCA as receiving developmental screening

Measure Status:	Inactive - Replaced				
State Provided Data					
	2017	**2018**	**2019**	**2020**	**2021**
Annual Objective			700	43,478	44,782
Annual Indicator			42,625	39,071	49,206
Numerator					
Denominator					
Data Source			Washington State Health Care Authority	Washington State Health Care Authority	Washington State Health Care Authority
Data Source Year			2019	2020	2021
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: : 2019 was the first year we received data on this measure. Three years of data were made available to DOH, 2017 with 31,767 children screened, 2018 with 40,873 children screened and 2019 with 41,442 children screened. The numbers do indicate that the total may be increasing so epidemiology staff proposes a 3% per year increase over the next five years as an achievable goal. As more data become available targets may be revised. The lasting impact of COVID, if any, on this measure is, at this point, unknown.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Targets for this measure were set as constant for the next four years as this measure will be retired after this year and replaced with another measure.	

ESM 6.3 - Percentage of children screened by Home Visiting/MIECHV programs

Measure Status:	Inactive - Measure will be discontinued and replaced with another ESM.

State Provided Data		
	2020	**2021**
Annual Objective		
Annual Indicator	61	
Numerator		
Denominator		
Data Source	Home Visting Services Account Annual Report	
Data Source Year	2019	
Provisional or Final ?	Final	

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The Aligned Measures have been stable over the past two years. SFY 2018 had 63% receiving a developmental screen and SFY 2019 had 61%, Tends in the data are not apparent. It is expected that for 2020 and 2021 with the effects of COVID screenings may drop as other in-person interventions in other MCH fields dropped. It is hoped that by 2022, however, in-home visits will be more common and screening activities return to pre-pandemic levels. After this return to prior levels, it is unknown what the temporal trend will be. Program and epidemiological staff will revisit these objectives as more data become available.

ESM 6.4 - Number of developmental screens completed through Help Me Grow Washington.

Measure Status:			Active
Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	707.0	778.0	856.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data are collected from July to June. These data are from July 2020 to June 2021.	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: This measure is new. A proposed increase of 10% per year has been decided by program and epidemiology staff. This target may be revised as more data become available.	

ESM 10.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			50
Annual Indicator	68.4	68.4	69.2
Numerator			
Denominator			
Data Source	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2018	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	69.9	70.6	71.3	72.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
After missing a year in 2020, the Healthy Youth Survey was implemented in 2021. No large drop-off in medical check ups was noted due to COVID-19 as was expected. Given the nature of the measure and the indirect effects work by the Adolescent health program would have a modest one percent per year increase was targeted. As more data become available these targets may be revised.

ESM 11.1 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients

Measure Status:	Active

State Provided Data			
	2019	2020	2021
Annual Objective			80
Annual Indicator		87.5	88.6
Numerator		14	39
Denominator		16	44
Data Source		University of Washington LEND ECHO-Autism Program	University of Washington LEND ECHO-Autism Program
Data Source Year		2020	2021
Provisional or Final ?		Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	90.0	91.0	92.0	93.0

Field Level Notes for Form 10 ESMs:

None

ESM 15.1 - 15.1 Increase the percentage of CYSHCN who report having insurance when receiving services

Measure Status:	Active

State Provided Data		
	2020	2021
Annual Objective		
Annual Indicator	99.2	99.2
Numerator	19,268	19,268
Denominator	19,424	19,424
Data Source	Washington State Child Health Intake Form	Washington State Child Health Intake Form
Data Source Year	2020	2020
Provisional or Final ?	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	99.3	99.4	99.5	99.6

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data for 2021 not available by the time of submission.	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: Talks between program and epidemiology staff arrived at an annual increase in the target by 0.1 percentage point per year until a 100% rate is reached. This rate is understood to be aspirational.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Washington

SPM 1 - Substance use during pregnancy
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Reduce the percentage of pregnant women who use drugs during pregnancy
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of pregnant women answering the PRAMS survey who reported illegal substance use during their most recent pregnancy. **Denominator:** The total number of women answering PRAMS.
Healthy People 2030 Objective:	Related to HP2030 MICH-11 Increase abstinence from illicit drugs among pregnant women.
Data Sources and Data Issues:	The data will come from the drug use supplement in Phase 8 of the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS survey is an ongoing, population-based surveillance system sponsored by the Centers for Disease Control and Prevention (CDC) and the Washington State Office of Maternal and Child Health. PRAMS is designed to generate state-specific data for assessing health status and health care before, during, and after pregnancy. Selection is random, and participation is voluntary. Data issues: This survey makes use of self-reported data. The drug use supplement is at the end of a long survey and asks about illegal activities undertaken by pregnant women whose names and contact information are known to DOH. Many of the mothers answering are on government assistance and may fear termination of their participation in such programs if they admit drug use.
Significance:	Using drugs like cocaine, or heroin during pregnancy can lead to miscarriage, preterm birth, and low birth weight. It can also cause withdrawal symptoms in infants after birth. In addition, substance use disorders have been linked to maternal deaths.

SPM 2 - Provider screening of pregnant women for depression
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase the percentage of pregnant women who are screened by their providers for depression during their pregnancy.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of PRAMS respondents who indicated they were asked about feeling down or depressed by a doctor, nurse or other health care provider during one of their prenatal care visits. **Denominator:** The total number of respondents to the PRAMS survey.
Healthy People 2030 Objective:	Not related to any Objectives.
Data Sources and Data Issues:	The data will come from question 18.f in Phase 8 of the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS survey is an ongoing, population-based surveillance system sponsored by the Centers for Disease Control and Prevention (CDC) and the Washington State Office of Maternal and Child Health. PRAMS is designed to generate state-specific data for assessing health status and health care before, during, and after pregnancy. Selection is random, and participation is voluntary. Data issues: This survey makes use of self-reported data.
Significance:	Access to behavioral health resources was identified as a gap in large parts of Washington in the most recent Needs Assessment. This measure gives a state-level estimate of the percentage of pregnant women in Washington who are being screened for depression.

SPM 3 - Universal developmental screening system participation
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Increase the number of infants with at least one entry into the WA State Universal Developmental Screening system.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** The number of infants with at least one entry in the WA State Universal Developmental Screening system. **Denominator:**
Healthy People 2030 Objective:	Related to HP2030 MICH-17 Increase the proportion of children who receive a developmental screening
Data Sources and Data Issues:	The data will come from the Washington State universal developmental screening system run by the WA Department of Health. Data issues: The registry is still being set up. Limited data set will be available FY2022. For the first few years a simple count will be taken, with the intent of eventually calculating a percent with data entered.
Significance:	Access to developmental screening is seen as a key tool to identify developmental delays and get infants and children the care and services they need. Strategies to make sure more providers use standardized tools to screen patients at regular check-ups can help increase the proportion of infants and children who get developmental screenings and receive appropriate referrals and follow-up care.

SPM 4 - Percentage of sixth grade students who have an adult to talk to when they feel sad or hopeless
Population Domain(s) – Child Health

Measure Status:	Inactive - Replaced
Goal:	Increase the percentage of children in the sixth grade reporting they have and adult they can turn to for help when feeling sad or hopeless.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of sixth grade respondents to the Healthy Youth Survey who report having an adult to talk to when feeling sad or hopeless. **Denominator:** The total number of sixth grade respondents to the Healthy Youth Survey.
Healthy People 2030 Objective:	Does not relate to any Objectives.
Data Sources and Data Issues:	The data will come from the Healthy Youth Survey (HYS), administered by DOH in cooperation with other State Agencies. The survey is administered every other year to youth enrolled in public school, grades 6,8.10, and 12. Participation in the survey is voluntary on both the school and individual child level; however, a high percentage of schools participate. Data issues: This survey makes use of self-reported data.
Significance:	Behavioral health services were identified as a gap in large parts of Washington and among most populations, including children/youth, in the most recent Needs Assessment. This measure will provide an estimate of the percent of children in 6th grade who have an adult they can talk with.

SPM 5 - Ease of receiving mental health treatment or counseling
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of children who needed mental health care and did not have difficulty in getting it.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of respondents to WA NSCH who indicate that they did not have difficulty getting care. **Denominator:** The total number of respondents to WA NSCH.
Healthy People 2030 Objective:	Related to HP2030 AHS-6.2 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care.
Data Sources and Data Issues:	The data will come from question K4Q22_R on the National Survey of Children's Health. The National Survey of Children's Health (NSCH), funded and directed by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), is designed to provide annual national and state-level information on the health and well-being of children ages 0-17 years in the United States. Selection is random, and participation is voluntary. Data issues: This survey makes use of self-reported data. The NSCH makes use of a small sample size making sub-population analyses difficult or impossible.
Significance:	Access to mental/behavioral healthcare is a known barrier to preventative health, with known disparities among specific populations. This measure gives a state-level estimate of the percentage of Washington youth who are receiving all necessary medical services.

SPM 6 - Social and emotional readiness among kindergarteners
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of Washington children who arrive in kindergarten demonstrating the appropriate social and emotional characteristics of children of their age.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of entering kindergarteners who demonstrate appropriate characteristics in the social and emotional domain WaKIDS assessment. **Denominator:** Total number of entering kindergarteners who were administered the WaKIDS assessment.
Data Sources and Data Issues:	The data for this measure will come from the Washington Kindergarten Inventory of Developing Skills (WaKIDS) assessment. The assessment is a collaboration of the Office of the Superintendent of Public Instruction, the Washington State Department of Early Learning and Thrive Washington. It is administered to incoming kindergarteners in the fall of the year they start school.
Significance:	Being socially and emotionally ready for kindergarten is an indicator of appropriate preparation for success in school and other settings. Young children who fall behind and encounter achievement gaps and disparities are also more likely to encounter other social and health disadvantages which tend to stay with them throughout their lifetimes if appropriate interventions are not undertaken. This measure will indicate how successfully Washington is preparing its children for success and where disparities in that preparation exist so that interventions can be devised to address these disparities.

SPM 7 - Percentage of tenth grade students who have an adult to talk to when they feel sad or hopeless
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Increase the percentage of children in the sixth grade reporting they have and adult they can turn to for help when feeling sad or hopeless.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of tenth grade respondents to the Healthy Youth Survey who report having an adult to talk to when feeling sad or hopeless. **Denominator:** The total number of 10th grade respondents to the Healthy Youth Survey.
Healthy People 2030 Objective:	Does not relate to any Objectives.
Data Sources and Data Issues:	The data will come from the Healthy Youth Survey (HYS), administered by DOH in cooperation with other State Agencies. The survey is administered every other year to youth enrolled in public school, grades 6,8.10, and 12. Participation in the survey is voluntary on both the school and individual child level; however, a high percentage of schools participate. Data issues: This survey makes use of self-reported data.
Significance:	Behavioral health services were identified as a gap in large parts of Washington and among most populations, including children/youth, in the most recent Needs Assessment. This measure will provide an estimate of the percent of children in tenth grade who have an adult they can talk with.

SPM 8 - Percentage of tenth grade students who report having used alcohol in the past 30 days
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Decrease the percent of Washington youth reporting alcohol consumption.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of tenth grade respondents to the Healthy Youth Survey indicating alcohol use in the past 30 days., **Denominator:** The total number of grade 10 respondents to HYS.
Healthy People 2030 Objective:	Related to HP 2030 SU-04 Reduce the proportion of adolescents who drank alcohol in the past month.
Data Sources and Data Issues:	The data come from the Health Youth Survey, administered by DOH in cooperation with the Washington State Health Care Authority Division of Behavioral Health and Recovery, the Office of the Superintendent of Public Instruction, and the Liquor and Cannabis Board. The survey is administered every other year to youth enrolled in public school, grades 6, 8, 10, and 12. Participation in the survey is voluntary on both the school and the individual child level; however, a high percentage of schools participate. Data issues: The survey makes use of self-reported data.
Significance:	In addition to health outcomes associated with alcohol consumption, this is associated with overall substance abuse and behavioral health among youth and adolescents.

SPM 9 - Adolescents reporting at least one adult mentor
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Increase the percentage of youth in Washington who report having at least one adult mentor.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of students in grade 10 reporting that they have at least one adult mentor. **Denominator:** The total number of grade 10 respondents to HYS.
Data Sources and Data Issues:	The data come from the Health Youth Survey, administered by DOH in cooperation with the Washington State Health Care Authority Division of Behavioral Health and Recovery, the Office of the Superintendent of Public Instruction, and the Liquor and Cannabis Board. The survey is administered every other year to youth enrolled in public school, grades 6, 8, 10, and 12. Participation in the survey is voluntary on both the school and the individual child level; however, a high percentage of school participate. Data issues: The survey makes use of self-reported data.
Significance:	Having an adult mentor is a known protective factor, and is associated with hope, resilience, and positive school and health outcomes later in life.

SPM 10 - Suicide ideation among youth with special health care needs
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Reduce the percentage of 10th grade students with special health care needs who report having suicidal ideation.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Related to HP2030 MHMD-02 Reduce suicide attempts by adolescents. **Denominator:** The total number of 10th grade students who are identified as having a special need in the Healthy Youth Survey.
Healthy People 2030 Objective:	Related to HP2030 MHMD-02 Reduce suicide attempts by adolescents.
Data Sources and Data Issues:	The data will come from the Healthy Youth Survey (HYS), administered by DOH in cooperation with other State Agencies. The survey is administered every other year to youth enrolled in public school, grades 6,8.10, and 12. Participation in the survey is voluntary on both the school and individual child level; however, a high percentage of schools participate. Data issues: This survey makes use of self-reported data.
Significance:	Behavioral health was identified as a gap in large parts of Washington and among most populations, including children/youth with special needs, in the most recent Needs Assessment. This measure will provide an estimate of the percent of children in 10th grade who have suicidal ideation, a significant risk factor for making a suicide attempt.

SPM 11 - Five-year maternal and child health needs assessment process for 2026-2030 plan is initiated by September 30, 2021
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Inactive - Completed
Goal:	Conduct the next five year needs assessment as a continuous planning process that includes local health jurisdictions in all stages. Initiate new assessment activities by September 30, 2021.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** NA **Denominator:**
Data Sources and Data Issues:	Internal records of program and planning activities.
Significance:	This is a Block Grant requirement. During the most recent needs assessment DOH determined a more continuous process would serve the program and partners better.

SPM 12 - Percent of families showing 4 or more factors indicating high resilience to challenges.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	The goal is to determine the resilience of Washington State families.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The total number of respondents who indicated "yes" to four or more of the resilience measures used in the question's composition. **Denominator:** Total responses to these questions in the Washington State NSCH.
Healthy People 2030 Objective:	None
Data Sources and Data Issues:	Data will come from the National Survey of Children's Health Family Resilience measure as calculated and reported by the Child Health Data webpage. Data Issues: This survey makes use of self-reported data. The NSCH has a small sample size making sub-population analyses and year over year changes in trends, difficult to interpret.
Significance:	Having a strong family structure and communication can play important roles in a family's ability to successfully navigate difficult situations and challenges.This measure will help the Title V program assess the ability of Washington families to resist and overcome the stressors and challanges they encounter.

SPM 13 - Percentage of adults who did not get health care because of cost
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Inactive - This measure will be discontinued as it does not relate to work being done by Washington State's Title V program.
Goal:	Reduce the number and percentage of adults who do not have access to affordable health care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of adult respondents age 18-64 to WA BRFSS who indicate that they did not get health care because of cost. **Denominator:** The total number of adult respondents age 18-64 to WA BRFSS.
Data Sources and Data Issues:	The data will come from question C03.03 on the Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is a yearly cross-sectional survey that measures changes in the health of people in our state, and is the longest continuously running phone survey in the world. It is the only survey that collects population-level data on health factors like tobacco used and insurance coverage. Selection is random, and participation is voluntary. Data issues: This survey makes use of self-reported data, and the question composition is determined primarily by CDC.
Significance:	Access to affordable healthcare is a known barrier to preventative health, with known disparities among specific populations. This measure gives a state-level estimate of the percentage of Washington adults who are not receiving all necessary medical services due to financial barriers.

SPM 14 - Develop outreach plan to support COVID-19 vaccination campaign efforts by March 31, 2021
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Inactive - Completed
Goal:	Work with programs and partners to develop effective policies and methods to facilitate vaccination efforts to combat the COVID-19 pandemic.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** NA **Denominator:**
Data Sources and Data Issues:	Internal records of program and planning activities.
Significance:	The COVID-19 pandemic is the most significant public health emergency to hit Washington State in nearly a century. Developing an efficient and effective system of vaccination distribution is vital to its containment and eventual control.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Washington

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Washington

ESM 1.1 - Percentage of women reporting in PRAMS that they had a preventive medical visit in the prior year
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the percentage of women who access preventive health care.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of respondents to PRAMS who indicated that they had received a preventive health care visit in the year prior to becoming pregnant with their most recent child. **Denominator:** The total number of women completing the PRAMS survey.
Data Sources and Data Issues:	The data will come from question 6 in the Pregnancy Risk Assessment Monitoring System (PRAMS) survey. The PRAMS survey is an ongoing, population-based surveillance system sponsored by the Centers for Disease Control and Prevention (CDC) and the Washington State Department of Health. PRAMS is designed to generate state-specific data for assessing health status and health care before, during, and after pregnancy. Data issues: This survey makes use of self-reported data, there is a low response rate, the survey is only available in English and Spanish.
Significance:	Access to preventive health care is an important element to assure that women have their optimal health.

ESM 4.1 - Percentage of eligible facilities certified “Breastfeeding Friendly Washington” by Department of Health NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Inactive - Intervention measured in this ESM is being phased-out by hospitals in favor of a different breastfeeding promotion intervention.
Goal:	Track the certification of eligible facilities by DOH as Breastfeeding Friendly Washington
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of eligible facilities which have adopted Breastfeeding Friendly Washington **Denominator:** Total number of eligible facilities
Data Sources and Data Issues:	Data come from eligible facilities reporting that they are compliant with the program and have obtained their certification. These data are reported to DOH. One potential issue is inconsistencies in co-sleeping practice recommendations between the certification for Breastfeeding Friendly and the “Cribs for Kids” program.
Significance:	Breastfeeding has been shown to be extremely beneficial for both the mother and infant. The initiation of breastfeeding and its maintenance for as long as possible has been one of DOH’s core recommended practices. An increase in this measure will help to assure that new mothers are introduced to the practice with the greatest amount of support to achieve the longest maintenance of the behavior. In the long run, this will lead to healthier mothers and healthier infants.

ESM 4.2 - Percentage of births taking place in facilities certified as Breastfeeding Friendly by Department of Health
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Inactive - Intervention measured by this ESM is being phased-out by participating facilities and replaced with a different breastfeeding promotion intervention.
Goal:	Increase the percentage of births at Breastfeeding Friendly facilities.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of births to WA resident mothers in facilities certified as Breastfeeding Friendly **Denominator:** The total number of resident births in WA.
Data Sources and Data Issues:	The data will come from WA Birth Certificate. Breastfeeding Friendly facilities will be identified by DOH staff.
Evidence-based/informed strategy:	Breastfeeding Friendly is based on Baby-Friendly and WHO 10 steps, both or which are evidence based with studies to demonstrate effectiveness of each intervention step.
Significance:	Breastfeeding has been shown to be extremely beneficial for both the mother and infant. The initiation of breastfeeding and its maintenance for as long as possible has been one of DOH's core recommended practices. As such, its practice is highly recommended. An increase in this measure will help to assure new mothers are introduced to and educated about the practice with the greatest amount of support to achieve the longest maintenance of the behavior. In the long run, this will lead to healthier mothers and healthier infants.

ESM 4.3 - Percentage of births taking place in facilities certified as compliant with LIFE by Washington State Department of Health.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the percentage of births at LIFE participating facilities.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>The number of births to Washington resident mothers in facilities certified as LIFE program compliant.</td></tr><tr><td>**Denominator:**</td><td>Total number of resident births in Washington State.</td></tr></table>
Data Sources and Data Issues:	The birth data will come from Washington State Birth Certificate. LIFE compliant facilities will be identified and reported by Department of Health staff.
Evidence-based/informed strategy:	The LIFE program is based on the World Health Organization and Baby Friendly USA's "Ten Steps to Successful Breastfeeding". This program recognizes health care organizations that work to support, protect and promote lactation. The LIFE program teaches new mothers about the importance of breastfeeding, supports new moms in the initiation and maintenance of breastfeeding, teaches troubleshooting and problem solving skills to address common challenges to breastfeeding as well as coordinating with patients at discharge to facilitate timely access to ongoing support and care.
Significance:	This ESM will measure the percent of new mothers who are presented with evidence based information on the benefits of breastfeeding and given support in initiating and maintaining breastfeeding through the initial months of life. It is important to measure this as breastfeeding has been shown to be extremely beneficial for both the mother and infant. The initiation of breastfeeding and its maintenance for as long as possible has been one of the Department of Health's core recommended practices. As such, its practice is highly recommended. An increase in this measure will help to assure new mothers are introduced to and educated about the practice with the greatest amount of support to achieve the longest maintenance of the behavior. In the long run, this will lead to healthier mothers and healthier infants.

ESM 6.1 - Number of ASQs provided by WithinReach to callers
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - Replaced
Goal:	Report on the number of Ages and Stages Questionnaires (ASQs) completed through WithinReach
Definition:	**Unit Type:** Count **Unit Number:** 999,999 **Numerator:** Number of ASQs completed through WithinREACH **Denominator:**
Data Sources and Data Issues:	The data will come directly from WithinReach. The organization is presently collecting these data so there is no anticipation of difficulty in obtaining these data in the future.
Significance:	WithinReach is a major partner in many of the State's educational and outreach activities for the MCH population. Having a way to evaluate their work and the population's access to it will help efforts to offer services and referrals to children and families that need them. A change in the number of people accessing the service might indicate other changes affecting the MCH population in Washington.

ESM 6.2 - Number of children reported by HCA as receiving developmental screening
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - Replaced
Goal:	Report the unduplicated count of children receiving at least one developmental screen through Medicaid coverage.
Definition:	**Unit Type:** Count **Unit Number:** 999,999 **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	Data come from WA Health Care Authority. Issues: Data is being collected under a new data sharing agreement between DOH and HCA.
Significance:	This measure has significance because it relates to the efforts that the Office is engaged in to increase the number of developmental screens through provider/parent training and education.

ESM 6.3 - Percentage of children screened by Home Visiting/MIECHV programs
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Inactive - Measure will be discontinued and replaced with another ESM.</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of low-income or at-risk children who receive a developmental screen during Home Visiting encounters.</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of children given a developmental screen as part of HVSA’s Aligned Measures criteria.</td></tr>
<tr><td>Denominator:</td><td>Number of eligible children to be screened.</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The data are reported to DOH from the HV/MIECHV program run by DCYF for the State of Washington. The screens are part of the eight HVSA Aligned Measures collected during home visiting encounters.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>There is growing evidence that using home visiting sessions to encourage parents to use the Ages and Stages tool may increase developmental screening rates. While there are limited number of studies that examine this intervention, it appears to be effective in this setting.1

1 Green B, Tarte JM, Harrison PM, Nygren M, Sanders M. Results from a randomized trial of the Healthy Families Oregon accredited statewide program: early program impacts on parenting. Child Youth Serv Rev. 2014;44:288-298.</td></tr>
<tr><td>Significance:</td><td>This measure has significance because it relates to the efforts that the Office is engaged in to increase the number of developmental screens through provider/parent training and education.</td></tr>
</table>

ESM 6.4 - Number of developmental screens completed through Help Me Grow Washington.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase access to developmental screening.
Definition:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>999</td></tr><tr><td>**Numerator:**</td><td>Unique number of children receiving a developmental screening in the past 12 months through Help Me Grow Washington</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
Data Sources and Data Issues:	Help Me Grow Washington (including sub-affiliate) program data.
Evidence-based/informed strategy:	Help Me Grow is a nationally recognized resource and referral linkage system. Help Me Grow is included in the “Sample Strategies and Evidence-based or -informed Strategy Measures” document complied by the Strengthen the Evidence for Maternal and Child Health Programs Initiative. This new ESM is one way our program supports increasing related NPM 6 in WA State.
Significance:	Supporting Help Me Grow Washington activities to make developmental screening accessible helps families monitor the health and development of children and connect to resources to support child health and well-being. Measuring this ESM will enable us to determine if our activities are increasing the number of developmental screens completed through Help Me Grow Washington.

ESM 10.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of adolescents in school districts with active DOH-supported interventions who have accessed health care in the past year.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of adolescent respondents to HYS in school districts with DOH coordinated funding for adolescent health programs who indicate that they did get health care in the previous 12 months</td></tr>
<tr><td>Denominator:</td><td>The number of adolescent respondents to HYS in school districts with DOH coordinated funding for adolescent health programs</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The data come from the Health Youth Survey, administered by DOH in cooperation with the Washington State Health Care Authority Division of Behavioral Health and Recovery, the Office of the Superintendent of Public Instruction, and the Liquor and Cannabis Board. The survey is administered every other year to youth enrolled in public school, grades 6, 8, 10, and 12. Participation in the survey is voluntary on both the school and the individual child level; however, a high percentage of schools participate.
Data issues: The survey makes use of self-reported data from the HYS. Funding years for these programs do not always coincide with the Block Grant year. Additionally, some programs are defunded from time to time, and we receive new funding sources. As an example, Pregnancy Assistance Fund programs will be ending in December 2020, while we will be adding funding and programs associated with our new teen pregnancy prevention grant.</td></tr>
<tr><td>Significance:</td><td>Lack of access to healthcare is a known barrier to preventative health, with known disparities among specific populations. This measure gives estimates at a school district level to determine whether adolescent access to care is increasing in communities that are actively working to address this issue. The work tracked in this measure includes programs which implement curricula that is evidence informed and evidence-based while being culturally relevant and locally informed. Delivery of these programs is often in partnership with the OSPI and local youth serving organizations in order to be as culturally appropriate as possible.</td></tr>
</table>

ESM 11.1 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of providers who indicate they provide a medical home to patients with autism in the ECHO Projects survey.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of providers who rate themselves confident or very confident that they are able to provide a medical home for their patients with autism.</td></tr>
<tr><td>Denominator:</td><td>The total number of respondents who complete the question on the survey</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The ECHO Project uses a redcap survey based on the survey developed by the University of Missouri’s Project ECHO Autism. All primary care providers who have taken the Center of Excellence training and signed up to be COEs, and those COEs engaged in Project ECHO Autism are asked each year to complete the survey. This survey is repeated yearly, starting March 2020, to gauge increase in provider confidence in implementing their skills in diagnosing, treating and referring children with autism in a family- centered Medical Home.
Data Issues: Survey is self-administered. Terms are not independently defined.</td></tr>
<tr><td>Significance:</td><td>As communities around Washington work to meet the need of families with CYSHCN with autism, there have been gaps identified in diagnostic and referral process—particularly around who is recognized by Medicaid to provide billable diagnosis and referral services to CYSHCN with ASD/DD.
This places the burden on primary care providers who may not have the expertise to diagnose autism, or who are not recognized by Washington’s Medicaid agency as having the necessary expertise to diagnose and refer to autism specialty services. Often the providers themselves lack confidence in providing a medical home to children with ASD/DD when they lack access to consultations with qualified professionals to meet the often challenging needs of this population.
The Health Care Authority (HCA) funds a 1.5 day Center of Excellence training with faculty from Seattle Children’s and UW LEND to increase the number of PCPs who are recognized by the HCA to diagnose autism and refer children for HCA-covered treatment. COE PCPs interested in further developing their autism diagnostic and management skills can apply to join a UW LEND led year-long Project ECHO Autism WA cohort with twice a month Zoom videoconferencing case-based learning, consultation and didactics. The DOH-funded UW Medical Home Partnerships Project for CYSHCN participates in both the COE training and Project ECHO Autism helping connect providers to community colleagues and resources.</td></tr>
</table>

ESM 15.1 - 15.1 Increase the percentage of CYSHCN who report having insurance when receiving services
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
Goal:	Increase the percent of CYSHCN who have access to third party paid insurance.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>The number of CYSHCN who indicate they have insurance on their Child Health Intake Form.</td></tr><tr><td>**Denominator:**</td><td>The total number of CYSHCN who have a Child Health Intake Form filled out</td></tr></table>
Data Sources and Data Issues:	The data will come from the Child Health Intake Form (CHIF) a data collection instrument used in Washington State to track CYSHCN to assure they receive appropriate services. The form is filled out by county/local CYSHCN directors and/or neurodevelopmental centers.
Evidence-based/informed strategy:	The Child Health Intake Form (CHIF) is the standard reporting form used to ensure CYSHCN receive appropriate care.
Significance:	Adequate insurance is critical for CYSHCN to receive needed services that their families can afford. Tracking the percent of CYSHCN receiving services will help to ensure that this population continues to be able to access care.

Form 11
Other State Data

State: Washington

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Washington

Annual Report Year 2021

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Monthly	3		
2) Vital Records Death	Yes	Yes	Monthly	0	Yes	
3) Medicaid	Yes	No	Quarterly	3	No	
4) WIC	Yes	Yes	Annually	1	Yes	
5) Newborn Bloodspot Screening	Yes	Yes	Annually	3	Yes	
6) Newborn Hearing Screening	Yes	Yes	Monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	Monthly	2	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	10	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None