Application to the U.S. Health Resources & Services Administration

Maternal & Child Health Block Grant

2026 Application & 2024 Report

Washington State Department of HEALTH

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III.A.1. Program Summary

The Washington State Maternal and Child Health Block Grant (MCHBG) is a part of the Washington State Department of Health. The program operates in the Office of Family and Community Health Improvement in the Prevention and Community Health Division.

The mission of the Washington State Department of Health (DOH/department) is to work with others to protect and improve the health of all people in Washington. Our vision is 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 make sure our state is prepared for emergencies. We work with many partners daily to do this work. We center community-driven innovations and improvements in health care and public health systems in the state.

The MCHBG provides the state with essential financial and technical support to run programs and develop policies that improve the well-being of parents, infants, children, and youth—including children and youth with special health care needs (CYSHCN), and their families.

Title V efforts focus on community health and meeting the needs of mothers and families across the state. We support community-driven solutions and tailor system improvements to match what families actually need. In some areas like perinatal and genetic services in rural communities there's more demand than available services. So, we collaborate with health care providers, local public health, non-profit partners, the Tribal health system, and state agencies to improve how care is coordinated, strengthen policies that support families, and expand access and quality of care.

All MCHBG work is connected to state priorities. Between fall 2023 and spring 2025, the department conducted a statewide needs assessment to identify priority needs for maternal and child health services and set objectives and strategies for a 5-year period.

We identified **4 core principles** to shape our work:

1. Align services and policies with community need
2. Promote coordination and integration across public health and health care systems
3. Focus on prevention and early intervention, to promote strength and wellness across a person's life
4. Promote positive child, youth, and family experiences and wellness

The needs assessment helped set following **priorities for Washington**:

- Improve how we identify and prevent maternal health risks by expanding access to timely, high-quality care
- Enhance caregiver and infant well-being by strengthening social-emotional and economic support for new parents and caregivers
- Find and respond early to children's health challenges by improving access to family-centered health care

- Help children and families thrive by improving access to basic needs and community resources
- Promote positive youth development and well-being by making it easier to get health care and use resources that build healthy habits and relationships
- Improve the well-being of children and youth with special health care needs and their families by expanding access to comprehensive and coordinated health services and supports
- Strengthen maternal and child health systems of care through better coordination and collaboration between state, local, and Tribal partners and families

These state priority needs have helped us choose which **national performance** measures to focus on:

- Postpartum visits
- Breastfeeding (ever breastfed)
- Housing instability (during perinatal and percent children ages 0–11)
- Medical home (percent children ages 0-17)
- Adolescent well visit rate
- Care coordination for children and youth with special health care needs who have a medical home

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

- Prenatal care initiation
- Number of local health jurisdictions participating in system coordination for CYSHCN, prenatal-to-5 populations, or both

When possible, we braid the MCHBG funds with other funding to increase impact and support related work. We also participate in national technical assistance, communities of practice, and learning collaborative opportunities to learn about best practices in other states and improve the strategic quality improvement in our work.

Below we highlight a few examples of how we use MCHBG funding and how this program impacts communities:

- More than half of MCHBG funding goes to 32 local health jurisdictions (LHJs) and 1 local hospital in Washington. This helps ensure the grant supports local needs across the state. Over the past 5 years, all our local public health partners have used **at least 30%** of their funding for prevention, primary care, and family support services for CYSHCN. Many LHJs also use additional funding to support state priorities and strategies listed above. As we move into a new 5-year action plan, most LHJs will participate in 1 or both statewide strategies:
    - Improving the well-being of CYSHCN and their families by expanding access to comprehensive and coordinated health services and other supports
    - Strengthening maternal and child health systems of care by strengthening coordination and collaboration between state, local, and Tribal partners and families.

These 2 areas have become top priorities for Washington's public health system, with a goal of building stronger partnerships and increasing our collective impact.

- The block grant will continue to support coalitions and collaborations to improve access and quality of care for maternal, child and adolescent health populations. An example is the Perinatal Quality Collaborative (PQC), a voluntary group of public and private organizations, health care providers, state agencies and community members, and state agencies. The PQC implements initiatives to improve perinatal health outcomes for pregnant and postpartum women, their infants, and their families. Past projects include:
    - Promoting Smooth Transitions to improve safety during emergency transfers from home and birth center births to hospital delivery
    - Developing Perinatal and Neonatal Levels of Care Guidelines to help hospitals assess their facility's capabilities to provide the appropriate level of care for their pregnant women and newborns
    - Launching the Rural Obstetric Provider workgroup which focuses on the challenges faced by rural labor and delivery hospitals.

  Over the next 5 years, the PQC will launch the Washington Blue Band Initiative which helps identify and improve care for pregnant women with pre-eclampsia and postpartum women at risk of hypertension.

  Another important area of coalition work is the Health Care-Help Me Grow Collaboration. This work focuses on building stronger connections between health care providers and Help Me Grow Washington (MHG WA) or local resources and referral systems when appropriate. The department will continue providing funding and technical assistance to support these efforts.

  This work complements our broader focus on universal developmental screening in health care and child care settings. It also helps us better understand the basic needs of families. A key resource in this work is our family housing assessment, where we will investigate the housing gaps and opportunities for families.

  Washington works to prevent maternal deaths using a blend of state and federal funding. The department convenes a statewide Maternal Mortality Review Panel (MMRP) to review all maternal deaths. This panel determines contributing factors and develops recommendations to prevent future deaths.

  In 2023, the department issued a report to the legislature that summarized key findings and recommendations, based on data from 2014–2020. A report based on 2021–2023 data will be released in fall 2025. MCHBG funds help support the implementation of several MMRP recommendations, including increasing early prenatal care initiation rates and postpartum visit rates.

- In past years, MCHBG funding has helped expand access to comprehensive care for children and adolescents through the school-based health center initiative. Over the next 5 years, the department will launch the Youth Friendly Care Collective**.** This

project will bring health care providers together to create a community of practice focused on adopting youth-friendly care principles. We will also work with DOH's Youth Advisory Committee, other agency programs, community-based organizations, and partners. Together, these partners will support youth development through activities that build relationship and communication skills. They will also promote positive experiences and overall well-being through education and engagement in areas like sleep, nutrition, physical activity, healthy screen time, social media habits, family and peer connections, and community involvement.

Various state and federal funding sources support our overall Maternal and Child Health (MCH) program. We use MCHBG funds to pay part of the salaries of program managers who plan and lead strategic work to improve public health systems. These staff help make sure women and children receive the health benefits they are entitled to like preventive health services and screening. They also promote coordinated care in medical homes and address issues related to adequate insurance coverage.

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

MCHBG provides critical base funding to support maternal, child, and adolescent health services at both the state and local levels. Whenever possible, we use a braided funding model—combining MCHBG dollars with state general funds and other grant funding—to maximize impact.

More than half of Washington's Title V funding goes to LHJs, who use it to provide services based on a menu of options aligned with state priorities. About 10% of the grant supports contracts with health care and community service organizations working with the department on shared goals. The remaining funds support statewide maternal and child health services, surveillance and evaluation, needs assessments and planning, high priority policy initiatives, and work in underfunded areas.

Title V funding also helps sustain a robust state-level workforce with deep expertise in maternal and child health domains. It provides fiscal stability for the local public health MCH workforce and supports a statewide platform for connecting the MCH workforce across the governmental public health system.

During this reporting period, the department combined MCHBG funding with general state fund investments to support several strategic areas:

- Universal Developmental Screening Data System
- Birth Defects Surveillance
- School-Based Health Center Grant Program
- Early Hearing Detection for Infants and Newborn Screening
- Healthy Births
- Maternal Mortality Prevention

The Washington State Legislature has also invested in the Foundational Public Health Services (FPHS) account, which supports essential governmental public health services, including program, policy, and data and surveillance systems. Over time, this funding will strengthen work in specific maternal and child health, injury prevention, and access to care. Resources will also help with infrastructure for information systems, laboratory capacity, assessment, communication, emergency planning, policy and planning, community partnership development, and leadership development. Much of the state's FPHS MCH investments are dedicated to local governmental public health, providing much needed support to a deeply underfunded part of public health work.

Title V funding is also used alongside FPHS investments to strengthen statewide child fatality data collection, support new or re-invigorated child fatality reviews by LHJs, and help modernize child fatality state law.

III.A.3. MCH Success Story

Local health partners in Washington continue to show innovation and community collaboration in their MCH work.

In the past year, Clark County Public Health (CCPH) created a partnership between their Children and Youth with Special Health Care Needs (CYSHCN) team members, local Access to Baby and Child Dental (ABCD) staff, the Clark County Dental Hygiene Program director, and local dental care providers. Together, they reserved a dedicated time slot during the annual Children's Dental Day Clinic for children who need accommodations to receive dental care.

During the Children's Dental Day Clinic event, the Community Health Specialists at CCPH also organized a training for all dental hygienist students. An occupational therapist from the local Neurodevelopmental Center (NDC) led the training and shared best practices and strategies when working with CYSHCN. The goal was to help hygienists create a more positive and supportive experience for these children when visiting a dental clinic. Before this effort, the common approach was to sedate the children before any dental procedure could be done.

The NDC also provided an on-site Occupational Therapist to provide extra support during this event. Other coordinated efforts included:

- CCPH's Emergency Preparedness team gave families information and starter packs for sheltering in place or building grab-and-go emergency kits. These included resources focused on CYSHCN and their families.
- The ABCD Community Health Specialist helped families get referrals to DentistLink, a service that connects families with dental providers.
- A local quilting group donated "comfort quilts" to help reduce stress for children attending the Dental Day Clinic event and give them a cheerful gift to take home.
- Representatives from Educational Opportunities for Children and Families, a local organization providing early childhood education and family support programs in Southwest Washington, were present to offer information about early childhood education enrollment.
- A "Sensory Kit" developed for use in local dental clinics. These kits are designed to give clinics tools to help lower anxiety and improve the experience for children with special health care needs during dental visits.

Overall, this was a successful collaboration and there are plans to keep it going. CCPH and its partners are providing technical assistance about providing accommodations and working to expand CYSHCN participation and training. Since the event, 11 dental clinics have received sensory kits. Surveys from dental clinic staff and over 312 families of children show that the tools in the sensory kits make a big difference and help improve the experience for children with special needs during dental visits.

MCH State Action Plan Table

The following table describes the work that we will do over the next 5 years to improve maternal and child health in Washington.

Domain	Priorities	Five Year Objectives (2025-2030)	Strategies	Evidence Based Strategy Measures	National/State Performance Measures	National Outcome Measures
Women/Maternal	**1. Improve early identification, intervention, and prevention of maternal health risks by expanding access to timely, high-quality care**	1.1. Increase to 79% the percentage of mothers who receive prenatal care in their first trimester	**1.1.1. Maternity Care Access Collaborative(s):** Convene LHJs, WA State Perinatal Collaborative, State Medicaid Program, Rural Hospital Association and other partners to identify and implement at least 1 new strategy to improve access to prenatal and maternity care in areas with too few provider		SPM: Prenatal Care Initiation	**Severe Maternal Morbidity** (Rate per 10,000 delivery hospitalizations)- state rate
		1.2. Increase to 92% the percentage of mothers who attend postpartum visit within 12 weeks of delivery	**1.2.1. Maternal Hypertension Care:** Provide outreach, training, and technical assistance to health care providers and hospitals on maternal hypertension care, including the WA Blue Band Initiative (evidence-based maternal hypertension and preeclampsia care	Number and percent of hospitals with hypertension identification and treatment programs in place for pregnant and postpartum women (Blue Band Initiative).	**NPM: Postpartum Visit**	

			during and after pregnancy)			
			1.2.2. Perinatal Substance Use Care: Provide technical assistance to hospitals in implementing the Centers of Excellence for Perinatal Substance Use certification offered by WA DOH			
Perinatal/Infant	**2. Enhance caregiver and infant well-being by strengthening social-emotional and economic supports for new parents and caregivers**	2.1. Increase to 94% the percentage of infants who have ever breastfed	**2.1.1. Breastfeeding and Lactation Support:** Maintain breastfeeding and lactation support in community and hospital settings, including Human Donor Milk Banks	Number community and hospital settings that participate in human milk donor program	**NPM: Breastfeeding (ever breastfed)**	**Infant Mortality** (Number of deaths of infants from birth up to 1 year per 1000 live births) - state rate
			2.1.2. Universally offered Home Visiting/Newborn Outreach: Work with LHJs, DCYF, and other partners to design, pilot, and evaluate innovative community-based newborn outreach or home visiting models			

		2.2. Decrease to 35% the percent of parents reporting material hardship in at least one area of basic needs. (Rapid Survey)	**2.2.1. Family Housing Assessment:** Work with MCH interns and partners to conduct a family housing assessment and identify recommendations to address priority needs for pregnant and parenting families' infants. (See also Child Health)		**NPM: Housing Instability (perinatal)**	**Adverse Childhood Experiences**
			2.2.2. Statewide Resource and Referral System: Provide funding to support the statewide Help Me Grow WA system to connect families to concrete supports and resources like housing and other services	Number families with infants and young children connected to concrete support and resources like housing, food, childcare, health care through Help Me Grow		
Child	**3. Improve prevention and early intervention for child health challenges by expanding access to timely, family-centered health care**	3.1. Increase to 53% the percentage of children (0–17 years) with a medical home (NSCH)	**3.1.1. Rural Pediatric Access Collaborative:** Convene LHJs, state health care provider organizations, dental organizations, State Medicaid Program, ACHs, and other partners to assess		**NPM: Medical Home (Children 0–17) (percent children 0-17, who have a medical home)**	**Children in Good Health** (percent of children 0–17, in excellent or very good health)

	needs in areas with too few providers. Identify and implement at least 1 new strategy to address access challenges in pediatric primary care, oral health care and specialty care.			
	3.2.1. Pediatric Community Health Workers: Promote the inclusion of community health workers (CHW) in pediatric care teams by providing training and technical assistance to new CHWs, health care practices, and other organizations that hire Pediatric CHWs			
	3.3.1. Health Care-Help Me Grow Collaboration: Support stronger connections between health care providers and HMG WA (or local resource and referral system, as appropriate) by providing funding and technical assistance	Number of pediatric health care provider referrals to Help Me Grow		**Child Flourishing** Sub-population focus: Families with income 200% below the federal poverty line (percent of children, ages 6 months–5 years who are flourishing)

			3.4.1. MCH-Medicaid Partnership: Participate in Center for Maternal Child Health-Medicaid Partnerships (CMMP) State TA Cohort. Explore innovative financing or policy options to increase developmental screening and timely referral, including adoption of EPSDT guidelines in health care practices			
	4. Promote whole child, whole family well-being by improving access to basic needs and community resources	4.1. Increase to 45% the percentage of children in low-income families who are ready for kindergarten (WA Kids)	4.1.1. **Family Housing Assessment and plan *(Families with children)*:** Work with MCH interns and partners to conduct a family housing assessment and identify recommendations to address priority needs for children. (See also Perinatal/Infant Domain)	Conduct a statewide assessment of child housing needs. Identify at least 1 evidence-based strategy to mitigate the impacts of inadequate and unstable housing on child health and development	**NPM: Housing Instability** (percent of children, ages 0–11, who experienced housing instability in the past year)	**Child School Readiness** (percent of children, ages 3–5, who meet age-appropriate developmental expectation in 4 of 5 domains without needing support)

			4.2.1. Child Care Access Coalitions: Participate in state and local advisory committees and coalitions focused on increasing childcare access and quality, especially for infants, toddlers, and CYSHCN in areas with limited options **4.3.1. Community-based Family Resource Development:** Work with families, LHJs, DCYF, DSHS, Family Resource Centers, and other community partners to identify existing resources, gaps, and opportunities for improvement—including support for fathers and other caregivers			
Adolescent	**5. Promote positive youth development and well-being by making it easier for youth to access and use health care services and resources that promote healthy**	5.1. Increase to 68% the percentage of 10th grade students who report seeing a provider in the past 12 months for a reason other than being sick (WA	**5.1.1. Youth Friendly Care (YFC):** Work with primary care and behavioral health care providers to launch a community of practice focused on adopting youth-friendly care principles	Number of provider practices engaged in YFC activities. Number of practices adopting YFC principles.	**NPM: Adolescent Well Visit Rate**	**Adolescent Depression/ Anxiety** (percent adolescents ages 12–17, who are reported by a parent to have depression or anxiety problems by a health care provider and currently have the condition)

habits and relationships	Healthy Youth Survey; HYS)			
		5.1.2. Medicaid Partnership for Well-Visit Promotion: Sustain partnership with Medicaid via IAR and EPSDT to develop provider- and patient-facing education and awareness initiatives about well visits		**Children in Good Health** (percent of children 0–17 in excellent or very good health)
	5.2. Decrease to 10% the percentage of 10th graders who report having no adults to turn to when feeling sad or depressed (WA HYS)	**5.2.1. Youth Wellness Promotion Programs:** Work with Youth Advisory Committee, other DOH programs, community-based organizations, and partners to create activities that build youth relationship and communication skills and support overall well-being. Promote positive child/youth experiences in other areas, including		**Child/Adolescent Flourishing** (percent of children and adolescents, age 6–17 years, who meet all 3 flourishing indicators: interest and curiosity in learning new things, persistence to finish tasks, emotional regulation stay calm and in control when faced with a challenge)

			sleep, nutrition, physical activity, healthy screen time, social media habits, family and peer connections, and community activities		
CYSHCN	**6. Improve well-being of CYSHCN and their families by expanding access to comprehensive and coordinated health services and other supports**	6.1. Increase to 45% the percentage of CYSHCN receiving needed care coordination (data from the National Survey of Children's Health)	**6.1.1. Care Coordination Workgroup**: Continue convening the care coordination workgroup to identify and implement ways to improve access to comprehensive, family-centered care. Focus areas include shared plans of care and peer support, and use of health information technology.	**NPM: Medical Home (CSHCN: Care Coordination)**	**CSHCN Well-functioning system of care**: percent CSHCN ages 0–17, reported by a parent who receive all components of a well-functioning system of care (families partner in decision-making if needed, medical home, preventive medical and dental care, continuous and adequate insurance, easy access to services, and preparation for transition to adult health care among adolescents)

		6.1.2. Care Coordination Standards and Training: Work with partners (UW IHDD, WSLI, P2P, PAVE, and other state agencies) to develop materials and train providers and families about best practices, resources, guidelines, and standards of care coordination for CYSHCN.	ESM: percentage of care coordinators trained with an increased understanding of best practices in care coordination for CYSHCN as a result of training or materials		
	6.2. Increase to 65% the percentage of CYSCHN who had no difficulty getting needed referrals (NSCH)	**6.2.1. Rural Pediatric Access Collaborative:** (See also Child Health) Collaborate with partners to address pediatric health care access challenges, with a focus on CYSHCN			
		6.2.2. Integrated Networks: Expand integrated services and networks by supporting the local School Medical Autism Review Teams (SMART), Type 1 Diabetes Workgroup,			

		and other interdisciplinary teams		
		6.2.3. Genetics Clinics: Maintain access to prenatal and pediatric genetics evaluation and consultation services in rural areas through contracted clinics, telehealth and mobile services		
		6.2.4. CYSHCN Nutrition Network: Increase access to feeding, nutrition, and dietitian services for CYSCHN through ongoing support of CYSHCN Nutrition Network		
	6.3. Increase to 82% the percent of CYSHCN who receive family centered care. (NSCH)	**6.3.1. CYSHCN and Family Well-being Promotion:** Promote support for CYSHCN and their families by sharing data and best practices, and supporting peer support, anti-bullying, financial and caregiving support, and accessible community spaces		**CSHCN Flourishing:** Percent CSHCN (ages 6–17) who met all 3 flourishing indicators

			6.3.2. CYSHCN Family Partnership: Strengthen family partnerships by co-designing care models with family-led organizations and councils. Ensure that family needs are represented in Block Grant activities by partnering with family-led organizations, working with family and youth advisory councils, and provide training for families			
Systems-Building	**7. Improve maternal and child health systems of care by strengthening coordination and collaboration between state, local, and Tribal partners and families**	7.1. Increase the percent of governmental public health partners who report annually that collaboration has helped streamline work, increase shared influence, and systems improvements (baseline to be established)	**7.1.1. Public Health System Collaboration:** Collaborate with governmental public health system partners to co-design new structures and processes for improving systems of care and health outcomes for CYSHCN and prenatal-to-5 populations		**SPM:** Number of LHJs participating in systems coordination for CYSHCN, prenatal–5 populations, or both	

	7.2. Increase the number of family leaders engaged in MCH Block Grant process	**7.2.1. Family Involvement Program:** Partner with the Oregon Center for Children and Youth with Special Health Needs to recruit and train established family leaders on the Federal MCH Block Grant process. Create a cohort of knowledgeable family representatives to partner year-round with Title V staff on key activities.	