Washington State Action Plan Table 2026 Application/2024 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Expand access to timely, high-quality maternal health care.	Increase to 92% the percent of mothers who attend postpartum visit within 12 weeks of delivery	Maternal Hypertension Care: Provide outreach, training, and technical assistance to health care providers and hospitals on maternal hypertension care, including implementation of the WA Blue Band Initiative. Perinatal Substance Use Care: Provide technical assistance to hospitals in implementing components of the Centers of Excellence for Perinatal Substance Use certification offered by WA DOH.	ESM PPV.1 - Number of hospitals who received grant funding to launch a hypertension identification and treatment program for pregnant and postpartum women	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Expand access to timely, high-quality maternal health care.	Increase to 79% the percent of mothers who receive prenatal care in their first trimester	Maternity Care Access Collaborative (s): Convene LHJs, WA State Perinatal Collaborative, State Medicaid Program, WA State Hospital Association, The Rural Collaborative and other partners to identify and implement at least one new strategy to improve access to prenatal and maternity care in provider shortage areas.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: Percent of pregnant women who receive prenatal care beginning in the first trimester	**Linked NOMs:** Severe Maternal Morbidity
Perinatal/Infant Health					
Increased support for new parents and caregivers	Increase to 94% the percent of infants who have ever breastfed Increase to 15% the percent of postpartum women receiving a home visit after delivery of a baby (PRAMS) Decrease to 35% the percent of parents reporting material hardship in at least one area of basic needs. (Rapid Survey)	Breastfeeding and Lactation Support: Maintain availability of breastfeeding and lactation supports in community and hospital settings. Home Visiting and Newborn Outreach: Work with LHJs, DCYF, and other partners to design, pilot, and evaluate innovative community-based newborn outreach and/or home visiting models. 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 family's infants. (See also Child Health) Statewide Resource and Referral System: Provide funding to support ongoing development and capacity of the statewide Help Me Grow WA	ESM BF.1 - Number of hospitals that utilize human donor milk (including shelf-stable milk products) for at-risk newborns ***Inactive -*** *ESM BF.2 - Percentage of births taking place in facilities certified as compliant with LIFE by Washington State Department of Health.*	NPM - Breastfeeding	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality

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		system to connect families to concrete supports and resources, including housing and other services.			
Child Health					
Access to comprehensive and family-centered pediatric care	Increase to 53% the percent of children (0-17 years) with a medical home (NSCH)	Rural Pediatric Access Collaborative: Convene LHJs, state health care provider organizations, dental organizations, State Medicaid Program, ACHs, and other partners to assess and identify pediatric primary care, oral health care and specialty care needs in provider shortage areas and implement at least one new strategy to address challenges. Pediatric Community Health Worker Training and TA: Promote the inclusion of community health workers in pediatric care teams by providing training and technical assistance to new CHWs, health care practices, and other organizations employing Pediatric CHWs. Health Care-Help Me Grow Collaboration: Provide funding and technical assistance to support increased connections between health care providers and HMG WA (or local resource and referral system, as appropriate). Title V-Medicaid Partnership: Participate in state technical assistance opportunities to strengthen interagency coordination between DOH and HCA and identify innovative policy or financing strategies that enhance screening, referral, and care coordination processes for children.	***Inactive -*** *ESM MH.1 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients* ESM MH.2 - Number of pediatric health care provider referrals to Help Me Grow ESM MH.3 - Percent of care coordinators receiving training who report increased understanding of best practices in care coordination for CYSHCN as a result of training or materials	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Access to child and family basic needs and community resources	Increase to 45% the percent of children in low-income families who are ready for kindergarten (WA Kids)	Family Housing Assessment and Plan: Work with MCH interns and partners to conduct a family housing assessment and identify recommendations to address priority needs for children and their families. (See also Perinatal/Infant Domain) Child Care Access Coalitions: Participate in state and local advisory committees and coalitions focused on increasing childcare access and quality, especially in areas with fewer options and for infants, toddlers and CYSHCN.	ESM HI-Child.1 - Number of new strategies identified and implemented from statewide assessment of child housing need	NPM - Housing Instability - Child	**Linked NOMs:** School Readiness Child Mortality Child Injury Hospitalization Children's Health Status Behavioral/Conduct Disorders Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent -

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		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 supports for fathers and other caregivers.			All Adverse Childhood Experiences
Adolescent Health					
Access to youth friendly health services and well-being supports.	Increase to 68% the percent of 10th grade students who report they have seen a provider in the past 12 months for a reason other than being sick. (WA HYS) Decrease to 10% the percent of 10th graders who report having no adults to turn to when feeling sad or depressed. (WA HYS)	Youth Friendly Care: Work with health care providers to promote adoption of youth-friendly care principles in primary care and behavioral health care settings serving adolescents and young adults. Medicaid Partnership for Well-Visit Promotion: Sustain partnership with Medicaid via an interagency agreement and EPSDT to produce provider-facing and patient-facing education and awareness initiatives about well visits and preventive care. Youth Wellness Promotion Programs: Work with youth advisory council, other DOH programs, community-based organizations, and other partners to promote positive youth relationships and wellness habits.	***Inactive -*** *ESM AWV.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year* ESM AWV.2 - Number of clinics/practices participating in Youth Friendly Care activities ESM AWV.3 - Number of clinics/practices adopting Youth Friendly Care policies and practices	NPM - Adolescent Well-Visit	**Linked NOMs:** Teen Births Adolescent Mortality Adolescent Motor Vehicle Death Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Children's Health Status Child Obesity Adolescent Depression/Anxiety CSHCN Systems of Care Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All
Children with Special Health Care Needs					
Access to comprehensive and coordinated health services and supports	Increase to 50% the percent of CYSHCN receiving needed care coordination. (NSCH) Increase to 71% the percent of CYSCHN who had no difficulty getting needed referrals (NSCH)	Care Coordination Workgroup: Continue to convene collaborative care coordination workgroup to identify and implement ways to improve access to comprehensive, family centered care coordination that includes use of shared plans of care and peer support, and leverages health information technology. Care Coordination Standards and Training: Work with key partners to develop materials and train providers and families about best practices,	***Inactive -*** *ESM MH.1 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical*	NPM - Medical Home; Medical Home_Care Coordination	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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	Increase to 82% the percent of CYSHCN who receive family centered care. (NSCH)	resources, guidelines, and standards of care coordination for CYSHCN. Integrated Networks: Provide coordination and support for expanding integrated services and resources through interdisciplinary networks and teams including local School Medical Autism Review Teams (SMART), the Nutrition Network, and the Type 1 Diabetes Workgroup. Genetics Clinics: Maintain access to statewide genetics services and resources through contracted clinics, Medicaid partnership, and informational resources. CYSHCN and Family Well-being Promotion: Promote supports for CYSHCN and their families by sharing data and best practices, including peer support, anti-bullying, concrete/financial supports, caregiving supports, and accessible community spaces. CYSHCN Family Partnership: Increase partnership with families to co-design models of family centered care and ensure that needs of families are represented in block grant activities through partnering with family led organizations, engaging with family and youth advisory councils, and training for families.	*home to their patients* ESM MH.2 - Number of pediatric health care provider referrals to Help Me Grow ESM MH.3 - Percent of care coordinators receiving training who report increased understanding of best practices in care coordination for CYSHCN as a result of training or materials		
Cross-Cutting/Systems Building					
System coordination and collaboration for Prenatal-to-5 and CYSHCN populations	Increase percent of governmental public health partners who report annually that collaboration has resulted in streamlining workflows, leveraging points of influence, and systems improvements (baseline to be established) Increase number of family leaders engaged in MCH Block Grant process	Public Health System Collaboration: Collaborate with governmental public health system partners to co-design new structures and processes for working together to improve systems of care and health outcomes for CYSHCN and Prenatal-to-5 populations. Family Involvement Program: Coordinate with the Oregon Center for Children & Youth with Special Health Needs to recruit and train established family leaders on the Federal MCH Block Grant process to create a cohort of knowledgeable family representatives who will partner with Title V staff year-round on key activities.	No ESMs were created by the State. ESMs are optional for this measure.	SPM 1: Number of LHJs participating in systems coordination for CYSHCN and/or P-5 populations	

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