Maternal and Child Health Services Title V Block Grant

Washington

FY 2022 Application/ FY 2020 Annual Report

8/26/2021
Final Submission

DOH 140-139 August 2021

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I. General Requirements

I.A. Letter of Transmittal

STATE OF WASHINGTON

DEPARTMENT OF HEALTH
Prevention and Community Health
Office of Family and Community Health Improvement
Post Office Box 47855
Olympia, Washington 98504-7855

August 26, 2021

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 2022 Maternal and Child Health Block Grant Application and the Federal Fiscal Year 2020 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 our Maternal and Child Health Block Grant Coordinator, Kathleen Estes, at (360) 236-3495 or Kathleen.Estes@doh.wa.gov.

Sincerely,

Katie Eilers, MPH, MSN, RN
Director
Office of Family and Community Health Improvement
Title V Maternal and Child Health Director
(360) 236-3687
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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

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 collaborate with many partners daily to do this work.

The state's Title V Maternal and Child Health (MCH) program resides within 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 essential financial and technical support to the state to deliver programs that improve the well-being of mothers, infants, children, and youth, including children and youth with special health care needs (CYSHCN), and their families. This support 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, underserved populations, and where there is demonstrated need. This has led us to target our work to increase health equity through supporting community-driven solutions and tailoring systems improvements that have a direct link to disparities, with particular emphasis on improving birth outcomes of Black and African American and American Indian/Alaska Native people. We also work to identify gaps where demand for services is greater than the supply, such as perinatal and genetic services in rural areas, and we develop agreements with providers to better serve those regions.

All of the work we do through the MCHBG is related 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 to inform objectives and strategies for MCHBG work over a five-year period.

We identified **four core principles** to be at the foundation 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 are committed to being anti-racist in our programs and policies.
- We value both evidence-based and community-developed promising practices to ensure all people, especially those marginalized by mainstream society, are served by health systems 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 in light of the pandemic, 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 women who use illegal substances during their pregnancy
- Increase the percentage of pregnant women who are screened by their providers for depression during their pregnancy
- Increase the number of infants with at least one entry in the Washington state universal developmental screening system
- Increase the percentage of children who received mental health care when they needed it
- Increase the percentage of sixth grade students who report they have an adult to talk to when they feel sad or hopeless
- Increase the percentage of children who arrive in kindergarten demonstrating the appropriate social and emotional characteristics of children of their age
- 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
- Reduce the percentage of adults who did not get health care because of cost
- Initiate 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 majority of the MCHBG funding through to 34 local health jurisdictions (LHJs) and one local hospital district to improve public health systems and provide MCH services throughout the state. As 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, 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 a variety of ways, including two staff consultants whose primary focus is LHJ coordination, connection with DOH subject matter specialists, biweekly emails providing information and resources relevant to MCH work, conference calls and meetings focused on MCH topics, and reporting requirements. These community consultants have a strong sense of the landscape of 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 comprehensive program funding for public health nursing has not kept up with the increasing costs of doing business, and historically most LHJs have centered their CYSHCN work on nursing case management. Few can provide competitive salaries to hire or replace nursing professionals, and to maintain sustainable programs and services they increasingly 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. DOH will talk with LHJs over the next year to look at our MCHBG funding distribution model and requirements, including our current requirement that all LHJs do some work to serve CYSHCN, to identify if there are ways to leverage efficiencies and better meet statewide needs. This was an action we had planned for 2020, but was delayed due to urgent COVID-19 priorities.

- We use Maternal and Child Health Block Grant funding to support family partnership to continue building community support networks for families of CYSHCN. Of the many organizations we work with, the Washington State Leadership Initiative, a collaborative of family-led organizations and their community- and state-level partners, has been a particularly valuable and sustainable model for family and consumer partnership activities and cross-systems cooperation to share training and services.

- 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 to determine contributing factors and develop recommendations for preventing deaths. The findings highlight a number of racial and socioeconomic inequities that have contributed to these deaths, and we are using this information to influence our future work and priorities.

- Our perinatal health unit is working with a variety of partners to address issues related to opioid use, especially as it affects pregnant women 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 development of 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. Following receipt of funds through the Legislature, we are working to create a new universal developmental screening system, 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 populations with disparate health and social outcomes, may have a difficult time accessing the medical care system due to many factors, such as 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 go regularly 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; increase graduation rates; and improve management of diabetes, asthma, and mental illness.

  School-based health centers face numerous 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 in partnership with SBHCs, the Health Care Authority, and others to address billing and reimbursement issues. In addition, a number of Washington adolescents and young adults are eligible for Medicaid but are not yet enrolled. We are developing strategies to increase enrollment, which should help increase the number of youth who receive health care services.

  We are starting exciting new work thanks to the 2021 passage of Substitute House Bill 1225: Concerning School Based Health Centers. This 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. This is another example of how funding from multiple sources is used 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.

Our overall MCH program is supported by a variety of state and federal funding sources. 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; promote the importance of coordinated care within a medical home; and address issues of insurance coverage adequacy.

The Title V Maternal and Child Health Block Grant is an important contributor to our efforts to realize the vision of Washington’s Healthiest Next Generation initiative: *Make the next generation the healthiest ever by ensuring all*

children achieve their highest health potential.

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

Public health needs have been increasing, and so has the cost of doing business. State and local revenue have not kept pace. States across the country struggle with this reality, and Washington is no exception.

A 2016 report to the Legislature indicated a shortfall of $312-$344 million per biennium to support Washington's ability to deliver core services necessary to keep communities healthy and safe. In response, the Legislature made an initial 2017-2019 biennium investment of $12 million. The aim was to rebuild, transform, and fund a 21st century public health system, prioritizing a limited set of foundational public health services (FPHS) funded through predictable, sustainable state funds and fees. Eighty-three percent of this initial allocation went to local health jurisdictions, and 17 percent supported state public health.

A 2018 FPHS baseline assessment updated the estimated need to $450 per biennium. In 2019, $22 million was allocated to support FPHS for the 2019-2021 biennium, still only a fraction of the identified shortfall.

The COVID-19 pandemic clearly illustrated some of the detrimental effects of failing to adequately fund public health and FPHS. In response, the state budget was increased to better support FPHS, amounting to $147 million in the current 2021-2023 biennium and $296 million in future biennia ongoing. Over time, the resources will be used at the state and local levels to strengthen and develop work in specific programmatic areas like 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.

Title V and the Maternal and Child Health Block Grant enable state and local agencies to fill some of the gaps in providing maternal and child health services. Local health jurisdictions receive 57 percent of Washington's Title V funding to provide services based on a menu of options aligned with our state priority needs. Seven percent supports contracts with health care and community service organizations that are working with the Department of Health on state priorities. The remainder supports statewide maternal and child health services, surveillance and evaluation, statewide needs assessment and planning, and addressing underfunded priorities.

III.A.3. MCH Success Story

Over the course of 2020, the 35 local health jurisdictions in Washington diverted staff from regular MCHBG duties to respond to the COVID-19 pandemic. In their monthly reporting, many wrote about the ways their COVID-19 response affected their work. Some felt positive about meeting the needs of families by providing resources to enable isolation and quarantine. Many developed and shared resources in a variety of languages and found new ways to identify and connect with residents from typically underserved populations in their communities. Below are examples of how LHJs shifted their work to best meet the needs of their MCH population.

- **Adams County** developed two collaborative community assistance volunteer groups, one at each end of the county, that provided food, rent assistance, electrical or propane needs, water supply, medication delivery, and food for pets during isolation and quarantine of individuals and families.
- **Clark County** held faith-based coffee meetings focused topics such as: the child care crisis and ways to share information; a compassion and safety campaign created specifically for people of color; updates from schools and faith communities on COVID-19 and resilience responses; and child abuse and mandatory reporting. They reached out to multiple breastfeeding experts in the community regarding changes their organizations made and their plans to support breastfeeding families during COVID-19.
- **Grays Harbor County's** Children and Youth with Special Health Care Needs staff continued to find ways to check in with families and offer support and information about changes in procedures and services to programs and resources, such as CARES Act funding and local food distribution events. They supported the county COVID-19 call center and community-based testing site and developed testing referral protocol sheets, trained and oriented Medical Reserve Corps volunteers. They also provided surge support to the county's COVID-19 contact investigation and tracing team and provided bilingual staff support.
- **Seattle-King County's** Childcare Health Team engaged in communications with providers around the traumatic impacts of COVID-19 especially for low-income, marginalized, and underserved provider communities. Given the trauma-informed impacts of language, culture, immigrant/refugee status, and other factors, staff created and shared basic needs resources (food, helplines, etc.) for Spanish-speaking community members.
- **San Juan County** set up a vulnerable populations branch to serve individuals and families most at-risk for contracting COVID-19 and ensured they had home-delivery services in place for groceries, medications, and other household essentials. They partnered with school districts to ensure a summer feeding program was in place for children to continue to receive nutritious meals. They created an online video community conversation to address services being offered during COVID-19 and a reminder to families to resume well-child visits and immunizations.
- **Spokane County** created a care coordination system to triage the needs of individuals who tested positive for COVID-19 and were required to isolate. These were primarily families with extensive, complex needs, including rental assistance, unemployment, food, water, medications, and temporary housing for isolation. Priority populations were identified. Members of the community who were community health workers were hired to help reach priority groups including Slavic-speaking, Spanish-speaking, and Marshallese.

III.B. Overview of the 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 percent gain, compared to a 1.5 percent gain the previous year. For the fourth year in a row, the highest growth (over 70 percent) occurred in the five largest metropolitan counties (Clark, King, Pierce, Snohomish, and Spokane). (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 high of 90,489 in 2016, they have been trending down again. In 2019, there were 84,918 births in Washington, a slight decrease from 2018's 86,047 births. (Department of Health [DOH] Birth Certificate Data)

In 2019, an estimated 19.5 percent of the population, or 1.47 million, were female of reproductive age (15 to 44). There were approximately 1.68 million children under the age of 18 in the state, making up 22.3 percent 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 surrounding Seattle and Tacoma. The percentage of state residents classifying themselves as Hispanic or Latino grew from 8 percent in 2000 to 13.5 percent in 2020, while the percentage identifying as Asian grew from 5 to 9 percent. (OFM) Increasingly, mothers identify themselves on their infant's birth certificate as more than one race, with that category increasing 40 percent since 2010. (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 in central and eastern Washington, which include large agricultural areas. However, the largest number of Hispanic or Latino people are in the populous western Washington counties. Black or African American, Asian, and Native Hawaiian or other Pacific Islander populations are also generally concentrated in a few western counties, though a significant population of Marshallese people live in Spokane County in eastern Washington.

Washington is home to 29 federally recognized Indian tribes, each with varying populations and land areas. There are seven additional tribes, some of which are seeking federal recognition. DOH also works with two urban Indian health organizations and 12 recognized American Indian organizations in the Pacific Northwest.

Geographically, the state is divided by the Cascade Range. This results in a stark 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 located 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 makes up 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 low population density, 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, wheat, milk, potatoes, and forest products. High-growth industries also include aerospace, clean technology, information and communication technology, online sales, life science/global health, maritime, and military/defense sectors. It is the most foreign-trade-dependent state in the United States.

Washington's seasonally adjusted unemployment rate in April 2021 was 5.5 percent, compared to 16.3 percent in April 2020. Before the COVID-19 pandemic, the unemployment rate was at a low 3.8 percent in January 2020. Employment spiked in June 2020 after the lifting of some COVID-19 restrictions, and continued to make gains through the summer of 2020. In the fall and winter, employment growth slowed, turning negative in December, but returning to relatively strong growth in February, with 29,600 jobs added, and March, with 28,100 jobs added. It tapered off a bit in April, with 11,200 jobs added. From March to April 2021, employment increased in eight major industries, decreased in four, and remained steady in one. Among the industries gaining the most jobs were leisure and hospitality, 8,100 jobs, and education and health services, 1,300 jobs. Both of these sectors disproportionally employ women and lower-income workers, especially in leisure and hospitality. Professional and business services experienced the greatest decline, losing 3,400 jobs in that period (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 similar to or 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).

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.

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.

Washington experienced over 424,000 confirmed cases and over 6,000 COVID-19-related deaths as of July 20, 2021. By July 14, 2021, 70 percent of Washingtonians 16 years or older had initiated vaccination against COVID-19. Disparities in vaccination rates remain, with communities of color, low-income, and rural communities lacking full access to vaccines. 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 other 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.

COVID-19 transmission is highest among health care workers; retail trade workers; manufacturing and food production workers, including those who work in produce and meatpacking plants; and seasonal workers in congregate living spaces. With the cost of housing being an issue even prior to the COVID-19 pandemic, there is growing concern that individuals and families who have been out of work and have fallen behind on rent may face skyrocketing rent increases or eviction when current eviction moratoriums end. Lower-income people and communities of color are at a disproportionally higher risk for this form of homelessness. Schools and educational programs, home visiting programs, and many in-person support services for families are still impacted as well.

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. 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.

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.

Most of the 29 federally recognized Indian tribes in Washington provide public health and health care services 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.

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.

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

Strategic Plan

Vision: Equity and optimal health for all.

Mission: The Department of Health works with others to protect and improve the health of all people in Washington state.

The DOH Strategic Plan is available online. The strategic plan focuses on making four foundational transformations in the following areas:

- Outward mindset
- Funding
- Data information, technology innovations
- Equity, diversity, inclusion

DOH is working to incorporate Culturally and Linguistically Appropriate Services (CLAS) across all programs. This includes the adoption of internal policies to improve CLAS compliance, staff training, development of resources and tools, and the creation of 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.

Healthier Washington

Washington completed a State Health Care Innovation Plan in 2013 with participation from both the private and public sector. It focused on integrating mental health services with other health services, developing Accountable Communities of Health (ACHs), and looking at models of payment that would reduce costs. The Health Care Authority (HCA), which administers Medicaid and public employee benefits in the state, was awarded $65 million from the Centers for Medicare and Medicaid Innovation (CMMI) to be used from 2015 to early 2019 to help implement the health care innovation plan, known as the Healthier Washington initiative.

Healthier Washington was the blueprint to transform the statewide health care delivery system to achieve better health, better care, and lower costs. The overarching goals were to improve how services are paid for by rewarding quality over quantity, ensure health care meets physical and behavioral health needs by focusing on the whole person, and build healthier communities through a collaborative regional approach.

An element of this initiative was the state's effort to lead strategic changes within Medicaid, allowing for testing of new and innovative approaches to providing health coverage and care. The transformation sought to achieve bidirectional integration of behavioral health and primary care, convert 90 percent of Medicaid payments to reward quality of care, improve equity, and improve supports for the aging population. The state innovation models grant ended in 2019, and the Medicaid transformation work continues through 2021, continuing the vision of Healthier Washington.

Nine Accountable Communities of Health began formally organizing across the state in 2015, with their boundaries aligned with the state's Medicaid regional service areas (see map below). The ACHs serve as implementation leads for the Medicaid demonstration project.

Medicaid Transformation Project
Implementation by Accountable Communities of Health

*required project	Better Health Together	Cascade Pacific Action Alliance	Elevate Health	Greater Columbia ACH	Healthier Here	North Central ACH	North Sound ACH	Olympic Community of Health	Southwest ACH	Total Number of ACHs Per Project
2A: Bi-directional Integration*	X	X	X	X	X	X	X	X	X	**9**
2B: Community-Based Care Coordination	X	X	X			X	X		X	**6**
2C: Transitional Care		X		X	X	X	X			**5**
2D: Diversions Intervention						X	X	X		**3**
3A: Opioid Crisis*	X	X	X	X	X	X	X	X	X	**9**
3B: Reproductive and Maternal/Child Health		X					X	X		**3**
3C: Access to Oral Health Services							X	X		**2**
3D: Chronic Disease Prevention and Control	X	X	X	X	X	X	X	X	X	**9**
Total Number of Projects Per ACH	**4**	**6**	**4**	**4**	**4**	**6**	**8**	**6**	**4**	**46**

ACHs bring together leaders from multiple health sectors in their communities with a common interest in improving health and health equity. They evaluate health needs, take local action on those needs, and, where appropriate, advise state agencies. ACHs will join others in providing feedback on the design and operation of the Medicaid program and how it might be improved, particularly from a local perspective. As Medicaid moves to better integrate physical and behavioral health care, and to link clinical care with other community services, the collective, multisector insights of ACHs will be critical to designing a supportive payment structure. However, ultimate legal and financial responsibility for Medicaid contracting, including monitoring and oversight, will remain with the state.

The Healthier Washington initiative also sought to transform our health system through workforce innovation, including the use of community health workers (CHWs). Research demonstrates CHWs can improve health outcomes and the quality of care while achieving significant cost savings, particularly when working with underserved populations. In early 2016, the CHW Task Force released recommendations, providing a platform for partners to support a CHW workforce and integration of CHWs within Healthier Washington and other health reform efforts. In a 2018-19 budget proviso, the state Legislature set aside funds for a collaborative task force effort to recommend guidelines for CHW education and training, resulting in a report to the legislature in June 2019. DOH is continuing work to implement the recommendations included in this report.

Also related to the Healthier Washington initiative, the state Legislature passed Engrossed Second Substitute House Bill 2572 in 2014, directing a governor-appointed performance measures coordinating committee to

recommend standard statewide measures of health and health care performance. In a well-functioning health care system, everyone should receive a similarly high level of evidence-based care for the same condition. An important step in reducing variation is to measure and share results to develop an understanding of what needs to improve.

The Statewide Common Measure Set for Health Care Quality and Cost provides a foundation for health care accountability and allows for measurement of progress toward achieving healthier outcomes for all residents. The common measure set includes 63 measures relating to:

- Immunizations
- Primary Care and Prevention
- Behavioral Health
- Effective Management of Chronic Illness
- Ensuring Appropriate Care – Avoiding Overuse
- Effective Hospital-Based Care
- Opioid Prescribing
- Washington State Health Care Spending

These measures are tracked, reported and revised as appropriate over time.

Finally, the Population Health Guide, a key product of the Healthier Washington initiative, is a set of strategies, data, and resources to help promote population health initiatives. It provides a structured process for improving population health as a state, while allowing flexibility for the unique needs and resources of local communities. Resource pages are available for specific health focus areas and include current work, emerging issues, health equity data and recommended strategies.

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 in 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. Public hospital districts are guided by independently elected board members.

Three hospitals are dedicated children's hospitals, located in Seattle, Tacoma and Spokane; these are 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 one meeting needs specific to its community.

Legal Authority

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.

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.

National Accreditation

One element of DOH's commitment to excellence and continuous improvement is to maintain accreditation by the Public Health Accreditation Board (PHAB). DOH was one of the first PHAB accredited public health departments in the country, 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, and 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 2022 Application/FY 2020 Annual Report Update

Ongoing Needs Assessment Activities

Throughout the 2020-2021 grant year, we have continued to collect data and information to better understand Maternal and Child Health Block Grant (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, have initiated ongoing needs assessment activities to collect feedback from priority populations and community leaders over the next four years, and are continuing to plan and develop dashboards and materials to better communicate public health findings to the public.

Our Title V activities include analyzing Pregnancy Risk Assessment Monitoring System (PRAMS) and birth certificate data to assess trends in behavior, access to care, and birth outcomes among the maternal/women's and perinatal/infant health domains. The Perinatal Indicators Report for Washington state, including data through 2018, was published online in December 2020, and an updated summary of perinatal indicators through 2019 was prepared and presented to the Perinatal Advisory Committee in May 2021. Other improvements include continued development of data linkages between the Women, Infants and Children Nutrition Program (WIC) and birth certificate data; ongoing development of the birth defect surveillance and universal development screening data systems; and a successful grant proposal to link PRAMS data with the Washington Comprehensive Hospital Abstract Reporting System (CHARS). During the past year, additional topical fact sheets and materials were developed specific to maternal prenatal vitamin use, alcohol and tobacco use during pregnancy, access to prenatal care, preterm birth, low birth weight, and infant sleep position. Topical materials on well-child and adolescent medical visits, a common indicator of care among these youth populations, are currently in development for intended publication over the next year.

Beginning in January 2021, state Title V program leads and epidemiologists developed an ongoing qualitative collection model to help us better understand emergent needs, both in general and in relation to COVID-19. Specific questions include unmet needs, opportunities for improvement, community strengths, impacts of COVID-19, and trusted sources of health information. These questions have been incorporated into key stakeholder meetings, focus groups, and surveys in MCHBG-funded activities and related topical grant work within DOH. To date, these questions have been used in focus groups with the Birth Equity Project in Pierce County, children and youth with special health care needs (CYSHCN) stakeholder groups, and the Essentials for Childhood Steering Committee, which addresses childhood abuse, neglect, and protective factors throughout the state. This model of ongoing data collection will span multiple years and provide timely identification of emerging issues across racial/ethnic groups, ages, and geography.

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. For example, epidemiological staff are currently developing data dashboards on perinatal indicators, CYSHCN served by MCHBG funding, and state indicators on childhood risk and protective factors. We hope to create a dashboard soon for infant hearing screening data as well. A story sheet is currently in development, which will combine qualitative findings from the 2020 five-year maternal and child health needs assessment with data related to child access to care, including OFCHI's well-child visit pilot project with managed care organizations (MCOs). Over the next year, we anticipate continued development in data presentation and reporting.

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 other 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 other 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.

Changes in Health Status and Needs Among MCH Populations

Cross-cutting Overall Population Health

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.

An estimated 15 percent of all Washingtonians, and 19 percent of those under 18 years old, lived in poverty (<125 percent federal poverty level [FPL]) between 2014 and 2018. This was unevenly distributed around the state: County-specific estimates range from 11 to 33 percent, with rural counties having higher rates. There were significant racial and ethnic disparities, with an estimated 30 percent of Black or African American, 27 percent of American Indian/Alaska Native, 24 percent of Native Hawaiian or other Pacific Islander, 21 percent of Hispanic, 12 percent of Asian, and 8 percent of white residents living in poverty. (American Community Survey, 5-year rolling average 2014-2018)

In 2019, 16 percent of adults in Washington reported poor or fair physical health, compared with 18 percent in the U.S. This was highest among American Indian/Alaska Native (31 percent) and lowest among Asian (11 percent) populations. One-fourth of all adults (25 percent) reported diagnosed depression, higher than the national prevalence of 20 percent and slightly higher than in 2014 (22 percent). This was highest among American Indian/Alaska Native (35 percent), multiracial (34 percent), Black or African American (27 percent) and white (26 percent) populations. Seventy-one percent of adults had a medical check-up in the past year (compared with 78 percent nationally), with Hispanic respondents reporting significantly lower rate (65 percent) and white respondents reporting a higher rate (73 percent). Twelve percent delayed medical care due to cost, with Hispanic adults (21 percent) being the most impacted group. (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 of the MCH population domains.

Impacts of COVID-19 Pandemic

While DOH is working to better understand the impacts of COVID-19 among children, early indications suggest that access to care has decreased during 2020. Among 3- to 4-year-olds covered by Medicaid, preliminary reports indicate that only 54 percent received adequate well-child visits in 2020. This is compared with 67 percent in 2019 and 66 percent in 2018.

For adolescents, among 12- to 21-year-olds covered by Medicaid, only 28 percent received well visits in 2020. This is compared with 43 percent in 2019 and 40 percent in 2018 (MCO). In fall of 2020, Washington administered the COVID-19 Student Survey (CSS) in order to get a better understanding of how the lives of high school students were affected. Among the 30,000 students surveyed, 7 percent had received a positive COVID-19 diagnosis, and 16 percent had at least one diagnosis in their household. Around 30 percent of students reported not having received regularly scheduled medical care since the beginning of the 2020 school year. While 22 percent were worried about getting sick themselves, almost half (48 percent) were worried about friends and family members getting sick, and more than half (54 percent) were worried about falling behind in school. More than two-thirds (69 percent) reported that school felt more challenging during the pandemic, with 41 percent reporting lower grades compared with 27 percent reporting higher grades. Fifty-eight percent of responding students felt depressed or sad most days, 17 percent considered suicide, and 4 percent reported attempting suicide in the past 12 months. Unmet mental health needs and resources for adolescents were a known concern prior to the pandemic, and CSS results confirm this: only 23 percent of students sought mental health services in the past year, and of those, 69 percent were successful in receiving services.

The Community Recovery-Oriented Needs Assessment (CORONA) survey, which explored the behavioral, economic, social, and emotional impacts of COVID-19 on Washington residents, found that 43 percent of pregnant respondents and 42 percent of all women ages 18 to 44 were not able to see a doctor when they wanted to after February 2020 due to COVID-19. Respondents also indicated reduced access to medication, with 13 percent of pregnant respondents and 13 percent of women ages 18 to 44 reporting an inability to access medicine due to COVID-19. Among households with children, 57 percent reported that children experienced more difficulties with emotions, concentration, behavior, or getting along with others.

Parents participating in 2020 Birth Equity Project focus groups in Pierce County also cited teen mental health, depression, anxiety, and loneliness as top needs within the Native Hawaiian or other Pacific Islander and Black or African American community. According to one parent:

> *[It is] more difficult than ever to figure out what we can do. [My] child started at a new school and left [their] friends, how [are they] to meet new people in a new school? [They are] feeling left out*.

We will continue exploring the impacts of the COVID-19 pandemic on the mental and behavioral health of adolescents, as well as the impact on systems of care for adolescents.

Working Toward a Better Understanding of MCH Needs

We are continuing development of the CHIF data system so we are better able to capture and use data related to CYSHCN in the state, with the intention of using that data to influence and improve services. We are developing a UDS data system, improving our Birth Defects Surveillance System, and making progress toward increasing data linkage across previously siloed systems.

We plan to focus on development of data dashboards, story sheets, and other material that will help us better communicate public health findings to our stakeholders and the public. We are being proactive in our data collection, particularly among hard-to-reach populations, to inform ongoing decision-making and the next needs assessment. 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.a. Process Description

Introduction

Starting in fall 2018, the Department of Health (DOH) Office of Family and Community Health Improvement (OFCHI) formally began its work on the maternal and child health (MCH) five-year needs assessment to be completed in 2020. Under the guidance of the Title V MCH Director, an approach and timeline were developed and implemented.

Personnel from each of the OFCHI Title V sections were identified to work on a core team called the MCH Needs Assessment Workgroup. This team of eight individuals met twice monthly from fall 2018 through February 2020 to refine the approach, address emerging issues, and assure that work proceeded in a timely manner. The group formed teams and brought additional personnel into the work as needed.

The Title V MCH Director also convened a second group to inform the process from local perspectives, called the MCH Block Grant Needs Assessment Advisory Group. This group included nine representatives of local health jurisdictions (LHJs) and a staff person from the American Indian Health Commission's Maternal and Infant Health program. The group's makeup was diverse in the sizes and geographic locations of the organizations represented.

Washington Maternal and Child Health Needs Assessment Framework

Align with MCHBG guidance | Align with existing state health plans | Emphasize health equity, social determinants of health and life course perspective

Framework used to guide data collection, analysis, and dissemination plans

Together the Washington State Title V program leads and epidemiologists developed the needs assessment methods, collected data from four distinct qualitative data sources, completed qualitative and quantitative data analysis, and reviewed a number of community and DOH program documents as a part of this five-year needs assessment.

Qualitative data were a significant source of information for the needs assessment, and include the following: LHJ-specific needs assessment reports, notes from facilitated discussions with DOH staff and program partners, notes on key informant interviews from subject matter experts throughout Washington State, and a population-level Discovery Survey conducted online (more detail below).

Quantitative data used to inform the needs assessment included vital statistics data (birth, death, infant death), Pregnancy Risk Assessment Monitoring System (PRAMS), National Survey of Children's Health, Washington State Smile Survey, and the Behavioral Risk Factor Surveillance System (BRFSS). Existing reports that informed the needs assessment include the Perinatal Indicators Report, the Home Visiting Needs Assessment, Washington State Maternal Mortality Report to the Legislature, and Infant Mortality Reduction Report. Information regarding data collection and management methods for these sources can be found at their respective program sites.

Primary Data Collection and Analysis Methods

Local Health Jurisdiction Needs Assessments

In order to provide community-level perspective on challenges and opportunities facing Title V activities, each LHJ conducted a local needs assessment in 2018-2019. These needs assessments used a combination of quantitative and qualitative methods. DOH developed a data-book with specific MCH indicators at an LHJ and state level, as well as related Healthy People 2020 goals. Each LHJ was asked to complete a brief report outlining the status of their MCH populations, including information on strengths, opportunities, and needs. The report included a narrative section as well as a list of topics to be ranked (High, Medium, Low, or Not Applicable) according to perceived priority and capacity to address at both an LHJ and community level.

These reports, submitted by all 35 LHJs, were reviewed independently by three DOH staff to assess regional patterns and themes in content. Final summary documents were uploaded and qualitatively analyzed in nVivo 11.0 using a coding

schema that was developed using all primary data collection materials. Data was used to generate “word clouds” on various themes, and the coding schema was used to identify key quotes which most clearly represented identified patterns. In addition to integrating findings into an overall summary of needs assessment findings, an LHJ Needs Assessment Report was produced to be shared back with LHJs to help inform regional understanding and encourage continued participation in Title V partnerships and collaborative efforts. See *Appendix B – MCH Local Work* for additional information about the local needs assessments.

Facilitated Discussions

In the spring and summer of 2019, DOH conducted facilitated discussions with a range of stakeholder group to identify needs, gaps, and strengths related to the health and wellness of MCH Title V populations. Discussions were conducted separately with the following entities:

- American Indian Health Commission Maternal and Infant Health Workgroup
- Children and Youth with Special Health Care Needs Communication Network
- Essentials for Childhood Steering Committee
- Washington State Interagency Fatherhood Network
- Graduation, Reality, and Dual-Role Skills (GRADS) Instructors
- Home Visiting Advisory Committee
- Washington State Perinatal Collaborative
- DOH Office of Family and Community Health Improvement

Discussions included small group work to identify needs, strengths, and gaps on poster paper. Groups voted on top priority needs using stickers, and the results were discussed by the larger groups and collected by facilitators.

Notes were transcribed by DOH staff and all findings were divided into needs, strengths, and gaps. Final summary documents were uploaded and qualitatively analyzed in nVivo 11.0 using a coding schema that was developed using all primary data collection materials. Themes from these discussions were ranked based on the number of meeting groups they were mentioned in, the number of votes received, and the number of times each larger qualitative theme was coded into the summary notes.

Key Informant Interviews

Commonly referenced words in interviews

Key informant interviews were conducted with community leaders representing a diverse array of communities around the state. Key themes of the interviews included: emerging and ongoing health needs of women, children, and families; local and regional strengths related to the ability to respond to identified needs and gaps; and gaps or improvements needed at a state level to address identified needs. DOH developed a key informant interview guide, and all interviews were conducted and documented by one of two partner staff at the University of Washington (UW) Medical Home Partnerships Project. Invitations to participate were sent from the Office Director for OFCHI, and UW staff were sent a list to follow up with each individual selected. Notes were shared back with interviewees to check for completeness and accuracy before being sent to DOH for analysis. Forty potential interviewees were selected, and twenty two interviews were completed.

Final summary documents were uploaded and qualitatively analyzed in nVivo 11.0 using a coding schema that was developed using all primary data collection materials.

Discovery Survey

In order to develop a broader understanding of emerging health needs across the state from the perspective of Washington residents, an online “Discovery Survey” was developed, modeled with permission after a Discovery Survey implemented by the state of Minnesota. Questions were intentionally open-ended in order to allow for and encourage responses that inform

the needs assessment on ***all*** needs, and not limited only to those viewed as healthcare related or Title V funded. The survey included the following questions:

- What is the most important thing that women, children, and families need to live their fullest lives?
- What are the biggest unmet needs of women, children, and families in your community?

The survey also asked about geography, age, race/ethnicity, and public health role in order to determine which populations were best represented and where additional outreach might be needed. Informed by demographics of the first half of responses, and comparing that to statewide population demographics, we placed advertisements with the survey link on Facebook and Instagram, focused in zip code areas with high Hispanic and Latinx populations, in both English and Spanish language text. We received a total of 1,114 responses to the survey, which was open for a month.

Commonly referenced words in Discovery Survey

The survey was conducted in English and Spanish using SurveyMonkey, and was later analyzed qualitatively in nVivo 11.0 using a coding schema that was developed using all primary data collection materials. All identifiable information was redacted prior to analysis. All responses were coded by content theme and by question asked, and then summarized in a draft MCH Block Grant Needs Assessment Summary report. There is ongoing work to develop thematic "story sheets" which take a closer look at specific themes and patterns that emerged.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Summary of Five-Year Needs Assessment Findings

The qualitative findings described below are summarized from four sources: the LHJ needs assessment reports, facilitated discussions with stakeholders, key informant interviews, and the Discovery Survey responses. Each section below includes an overall summary of need, specific needs identified by one or more of the four qualitative data sources, quotes by participants, and strengths.

The first section is about cross-cutting topics. These were identified by participants in all four qualitative data collection methods. After cross-cutting topics are findings specific to the Title V population domains: women, infants, children, adolescents, and children with special health care needs. In addition to qualitative findings, the population domain sections include quantitative data used to describe the populations, key indicators, and disparities.

Appendix C includes a list of priorities and performance measures selected in the needs assessment process for the each of the population domains.

Cross-Cutting Topics

Cross-cutting topics include need and gaps across all MCH populations. Many of these are also considered social determinants of health.

Needs. Participants in the needs assessment identified six broad cross-cutting needs or gaps for women, children and families in Washington:

1. **Families across the state are struggling with cost of living**, and their health and wellness are negatively impacted. In the Discovery Survey, the impacts of the social determinants of health often came before healthcare needs. In all data sources people speak of need for economic security and the challenges of poverty.
    - Poverty and lack of economic security impact the MCH population and families' ability to meet basic needs. This is reported across the state and in many urban counties. While lower wage jobs are available in areas such as Seattle, Tacoma, and Spokane, the income does not cover the cost of living. *(LHJ summary)*
    - Participants reference several ways to work toward economic security and reduce poverty, including adding more jobs with living wages, job training, and better family leave policies. *(Facilitated discussion summary)*

My husband and I need fair wages and prices so we can raise our children and have time for self-care and exercise and enough money just to cover mortgage/car and basic bills. (Discovery Survey participant)

2. **Housing, childcare, transportation, and food security** top the list of essentials needed to ensure women, children and families could live their most healthy lives.

- Citing homelessness and economic concerns, participants emphasize the importance of affordable housing for low- and middle-income populations. For families in crisis, there is a need to have appropriate, accessible shelters. *(Facilitated discussion summary)*
- Many families have a difficult time finding and paying for childcare. When childcare is available, it is expensive. It often has restrictions on age, schedule for working families, and accommodation for children with disabilities, special needs, or behavioral challenges. *(Discovery Survey summary)*

Some families have transportation issues preventing them from completing health care not only for children but themselves. Public transportation has limitations. Also have issues with childcare, even just for an appointment and keeping appointments. (Discovery Survey participant)

3. **Access to care and services** is universally mentioned. Families need access to affordable care, and to be covered by an insurance network that has providers of needed services such as physical, behavioral, mental health, and specialty care. Participants also stress the importance of trauma informed service delivery.

[There is] no place to send people struggling with substance abuse or mental health; the system doesn't have capacity. (Facilitated discussion participant)

Mental health needs and access [is] often dependent on your insurance. [It is] much harder to get mental health services if you have private insurance in [county in eastern Washington]. In western Washington it's the opposite. It's hard to tell parent of suicidal kid there is no psychiatrist available to help. (Key informant)

In general there is a need for expanded service capacity for all populations related to MCH health and wellbeing, such as access to medical and behavioral health care. (LHJ report)

Related to access to care, challenges with systems coordination and referrals are often mentioned. Participants specifically want systems to share information, and to have current referral information accessible to providers and families. Participants identified the need for telehealth or technology-based remote services, and note that it presents a possible solution to regional service provider shortages.

4. **Cultural humility and serving marginalized populations** is a prominent theme in all data sources. Participants express a need for services that respect diversity, acknowledge and train for cultural awareness, have adequate language services, are non-discriminatory, and have a culturally representative workforce.

[We need] access to Culturally Relevant Health Services free from structural racism, with practitioners who are supportive partners with cultural humility who have an understanding of their own implicit biases and how that bias impacts the clients that they serve. (Discovery Survey participant)

Recognize different kinds of families and adapt services for [them]. Don't get locked into typical families. [Put] more focus on families that look different (same sex, generational, different cultures, blended families). (Facilitated discussion participant)

5. **Disparities** among tribal communities, women and children of color, LGBTQ community, people who are differently-abled, and rural versus urban communities are of concern for needs assessment participants.

[There is an] impact of racism on body, life course, and health and birth outcomes. (Facilitated discussion

participant)

The more rural you get, the more difficult [access] is, especially if a family is experiencing any kind of transportation barriers … [in particular] rural access [creates challenges] for both farm workers and refugees and non-refugees. (LHJ report)

6. **Community and social supports** are central to the health of all members. Families need safe and caring communities with a sense of social connection and embedded programs to help provide support when they struggle.

[We need] a village … especially [as] a single mom. Direct involvement and support of others with a vested interest in the welfare of our children and the physical and emotional health of the entire family unit. Families need to feel less isolated and secure in knowing that there is a community there to help when needed. (Discovery Survey participant)

Community based programs addressing substance use, gang activity and other forms of community violence, including sexual violence are among some of the top unmet needs.... (Discovery Survey participant)

Strengths. During the facilitated discussions and for the LHJ needs assessment, we asked about existing strengths in Washington.

Strengths identified by participants in the facilitated discussions include:

- The MCH population is a priority in Washington.
- Washington is a compassionate, innovative place with progressive policies.
- The governor and state legislature typically champion MCH initiatives.
- Strong partnerships exist within communities and between local organizations and state agencies.
- State-led or state-run initiatives and programs, such as the Maternal Mortality Review Panel and Breastfeeding Friendly Washington, are strong.
- Wide health care coverage exists in the state, particularly as a result of Medicaid expansion.
- Public health work is data-informed.

Strengths identified by LHJs include:

- LHJs ability to partner with other governmental, private, non-profit, and faith based groups; and to leverage resources to serve the MCH population in their communities.
- There is strong community involvement in local MCH initiatives, including parents as advocates and partners. Community commitment to supporting families is prevalent.
- Many LHJs reported developing their workforce with continuing education opportunities and specialized trainings to stay abreast of issues and concerns relating to the MCH population in their communities. Adverse Childhood Experiences training is mentioned as a useful tool that is shifting the care paradigm.
- Vaccination coverage is seen as a success for some LHJs. Adequate and appropriate immunization of the children and youth with special health care needs (CYSHCN) population is identified by LHJs as a priority issue that is being addressed.

Additional strengths were identified through assessing quantitative data. Washington ranks favorably in comparison to other states on many MCH indicators such as low birth weight, premature birth, teen/adolescent pregnancy, and infant mortality. It also has met many Healthy People 2020 goals including premature birth, low birth weight and very low birth weight deliveries, teen pregnancy, and high risk deliveries in appropriate care settings. It is close to achieving the goal on others, such as Nulliparous, Term, Singleton, Vertex C-sections.

Women

Population. In 2019, there were 1,472,279 women of reproductive age (ages 15-44) in Washington. In 2009 non-Hispanic White women made up 69 percent of this population, while in 2019 it had dropped to 61 percent, an 11 percent decline. Non-Hispanic Native American/Alaska Native women's population also declined by 9 percent from 2009 to 2019. The population of non-Hispanic Asian and non-Hispanic multi-racial women is increasing the fastest, 33 percent and 29 percent

respectively. Women under 30 years of age saw marked decreases in pregnancy rates over the past decade. Women 30-34 years of age did not see a statistically significant decrease, but over the last three years their rates began to drop as well. Pregnancy rates for women over 35 increased over this same time period.

Needs. Mothers and women of childbearing age need comprehensive care throughout their lifetime, including preconception, OB/GYN, family planning, early prenatal and post-partum care. For example:

- Access to health care for women is identified by most LHJs as a priority. Many of the least populous counties report having no or only one provider to meet these needs. Likewise, in more rural areas, access to both general practice services and obstetric care are scarce. *(LHJ summary)*
- Racial and ethnically diverse counties note that women of color have less access to services that meet their needs than non-Hispanic White women. In addition, women with more financial resources have less difficulty in obtaining services than those without. *(LHJ summary)*
- Postpartum care and support during the “fourth trimester” is lacking or absent. More postpartum care will allow providers to check in with mothers about their mental health and other medical issues. *(Facilitated discussion summary)*

> *With pregnant women carrying future generations, I think that it is really important we do more about taking care of women. They are setting the life course of future generations. (Facilitated discussion participant)*
>
> *In rural communities, we are seeing real challenges in rural hospitals opting out of delivering babies except in emergencies. Moms may now have to drive long distances for OB care. (Key informant)*
>
> *Cuidado de salud garantizado antes, durante y despues del embarazo. (Guaranteed health care before, during and after pregnancy.) (Discovery Survey participant)*

Key Indicators. In 2018, 11 percent of pregnant women had diabetes, which represents a 75 percent increase since 2008. Pre-existing diabetes was up 43 percent, and gestational diabetes was up 79 percent. Hypertension increased as well, up 53 percent overall since 2008. Gestational hypertension and pre-existing hypertension increased at approximately the same rate, 53 percent and 54 percent respectively.

Pre-pregnancy obesity and morbid obesity were up 12 percent and 16 percent respectively since 2008. Obese and overweight categories made up a little less than 50 percent of pregnancies in Washington.

Disparities. While the overall rates of obesity are up for pregnant women in Washington, the impact is greater in some racial/ethnic groups. Among Native Hawaiian or Pacific Islander women, 55 percent were obese and 16 percent were morbidly obese. Among American Indian/Alaska Native women, the rates were 41 percent and 7 percent respectively. Black/African American, Hispanic and multi-racial women all had higher rates of obesity than White and Asian women.

Native Hawaiian or Pacific Islander women were also the least likely to have received pre-natal care (PNC) in the first trimester, 45 percent, and more likely to have started PNC in the third trimester or to have received no PNC at all (20 percent). Black/African American and American Indian/Alaska Native women, while having higher rates of first trimester PNC than Native Hawaiian or Pacific Islanders, lagged behind women of other racial/ethnic groups.

Singleton low birth weight was higher for Black/African American infants (8.0 percent) than for any others. White infants had the lowest rate (4.3 percent), followed by Hispanic (5.5 percent) American Indian/Alaska Native (6.7 percent), Asian (6.8.percent) multi-racial (6.9 percent) and Pacific Islander (7.3 percent) infants.

White mothers had the lowest rate of preterm birth (7.6 percent), significantly lower than all other groups. American Indian/Alaska Native women had a preterm birth rate of 13.1 percent, significantly higher than all other groups. Native Hawaiian and Pacific Islander, Black/African American and multi-racial women had similar rates (9.7 percent, 10.1 percent, and 10.2 percent), followed by Hispanic (8.7 percent) and Asian (8.0 percent) women. These data are from all births.

While smoking has decreased among new mothers in Washington, there is a large disparity by Medicaid status. Rates of

smoking three months before pregnancy, during pregnancy, and postpartum for women with Medicaid were higher at all three points of time in comparison with women who do not have Medicaid.

Women who receive Medicaid had high rates of breastfeeding initiation, but by two months postpartum they lag behind non-Medicaid women by a significant amount, 73 percent to 91 percent respectively.

Strengths. Many LHJs report a good working relationship with their Women, Infants, and Children Supplemental Nutrition Program (WIC). In some of the smaller LHJs, WIC is the primary way they interact with the MCH population. Breastfeeding is strongly promoted in WIC. High breastfeeding initiation rates is mentioned by many LHJs as a strength.

Rates for cesarean section and vaginal birth after cesarean (VBAC) have improved over the past decade with overall C-section rates down by 3 percent and VBAC rates increasing from 12.0/1,000 live births in 2009 to 19.9 in 2018. Over the same time period vaginal deliveries increased by 4 percent. Smoking among women of childbearing age is down significantly since 2008.

Infants, Children and Adolescents

Population. In 2018 there were 86,407 **births** in Washington. The racial/ethnic makeup of the newborn cohort is becoming more diverse. The number of births had decreased over the past few years. The population of **children** age 1-11 was 1,023,000 in 2018 and is undergoing the same demographic changes seen in infants, with the state's percentage of non-Hispanic White children decreasing, making up 62 percent in 2008 but only 53 percent in 2018. In 2018 there were 553,000 **adolescents,** ages 12-17, accounting for 7.4 percent of Washington's population. The racial/ethnic percentages of this population were 58 percent White, 20 percent Hispanic, 8 percent multi-racial and Asian each, 4 percent Black/African American and 1 percent both American Indian/Alaska Native and Pacific Islander.

Needs. Infants, children, and adolescents need care by providers in their communities who specialize in their unique developmental opportunities and challenges. They need providers who can administer developmental screenings and make referrals to needed care. Mental and behavioral health services from infancy to adulthood should be integrated and easy to access.

- Children and adolescents need specialized care in addition to a stable medical home. *(Key informant summary)*
- Access to oral and mental health are concerns throughout the state. *(Key informant summary)*
- Bullying is identified as an issue among teens and older children, especially among the LGBTQ population. *(LHJ summary)*
- Many LHJs report increasing rates of vaping among adolescents. This is a major set-back given the recent success in reducing tobacco use in this age group. Marijuana use is also reported as a topic of concern in this age group. *(LHJ summary)*

> *[There is a] growing substance use disorder with big impact on children and infants, and moms using. [There is an] increasing rate of Neonatal Abstinence Syndrome … [we] need targeted education to moms who are substance using – in treatment or not – for healthy deliveries. (Key informant)*
>
> *There are challenges across many parts of the state to [access] medical homes for kids, especially those on Medicaid ... there are areas where because Medicaid reimbursement is so much lower than Medicare, practices won't take kids on Medicaid which reduces pediatric access to medical home. (Key informant)*
>
> *We have an epidemic of depression and anxiety in youth at the middle and high school level. We do not have enough psychiatric professionals that serve youth, need social workers in our K-12 public schools, and greater awareness of the impact of mental health on students' ability to be successful academically in school. (Discovery Survey participant)*

Key Indicators

Infants. In 2018 there were 400 deaths in Washington State resident infants, higher than the 373 per year average from the past five years. Low birth weight among singleton deliveries is up after many years of remaining constant, increasing 13

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percent in the past decade. About half of all deliveries were paid for by Medicaid, indicating a high rate of infant/child poverty.

Children. Compared with other populations, we have little quantitative data about health needs of pre-adolescent children in Washington, especially by sub-populations and geography. Some information is available in the National Survey of Children's Health (NSCH), with limitations; one particular disparity in 2017-2018 NSCH data shows that children, aged 4 months to 17 years, have disparate differences in sleeping the recommended age appropriate hours on weeknights. Hispanic children have a lower percentage of sleeping the recommended hours (49 percent), compared with non-Hispanic White children (74 percent). Another data source is the Washington Oral Health Basic Screening (Smile) Survey. Based on the Smile Survey, the 2015/16 rate of caries experienced among third graders was 53 percent, making it the most prevalent communicable and chronic condition in the state. Among low income preschool aged children, 45 percent of children had caries, which does not meet the Healthy People 2020 goal of 30 percent.

Adolescents. In 2018, 78 percent of tenth graders in Washington did not meet the recommended daily amount of physical activity. Vaping has increased from 18 percent to 21 percent between 2014 and 2018. Fifty-six percent of tenth graders reported vaping a product with nicotine, 21 percent with tetrahydrocannabinol (THC), and 33 percent vaping with only flavor. While the prevalence of marijuana use among tenth graders has not changed since 2008, remaining around 20 percent, perceptions of how problematic occasional or regular use of marijuana is have changed, with significantly more youth expressing there is no or a low risk from using marijuana. Seventy-three percent of tenth graders reported consuming sugar-sweetened beverages in the past week, and 61 percent reported eating chips or other snack foods at school. Eighty-three percent reported eating fewer than five servings of fruits/vegetables per day.

Disparities

Infants. Historically, infants born to Black/African American and American Indian/Alaska Native women have had the highest mortality rates in Washington. However, when compared to infants born to multi-racial women and Pacific Islander women, there is no statistically significant differences among them. From 2016-2018, the rate of infant mortality among Black/African American infants was 8.6 per 1,000 births, 7.9 for American Indian/Alaska Native infants, 7.0 for multi-racial infants , and 5.6 for Native Hawaiian or Pacific Islander infants. In comparison, the rate of infant mortality was 4.2 for Hispanic infants, 3.9 for White infants, and 3.2 for Asian infants. Although disparities in infant mortality are well documented, the rate can vary considerably between years for these groups.

Singleton low birth weight has increased among Native Hawaiian or Pacific Islander women by 74 percent over the past decade. Hispanic women and Asian women saw increases of 15 percent and 10 percent respectively. Black/African American and White low weight births saw slight increases of 1 percent to 2 percent, and American Indian/Alaska Native women saw a decrease of 6 percent over the same time period. Infants whose mothers had Medicaid-paid birth are less likely to be placed on their back to sleep compared with those who did not have a Medicaid-paid birth. This disparity has increased by 4 percent over the past 10 years.

Children. Third grade students of color, especially Hispanic (71 percent), Pacific Islander (75 percent) and American Indian/Alaska Native (67 percent) experienced a far higher burden of dental caries than did their White classmates (45 percent). However, when it came to dental sealant placement on molar teeth, Hispanic children had higher rates (61 percent) than did White children (48 percent) and the combined state average of 50 percent among all children.

Adolescents. Among tenth graders surveyed, students who identified as gay, lesbian or bisexual were more likely to have been bullied in the prior month than their straight peers. They were also more than twice as likely to have attempted suicide in the previous year. Smoking did not vary by race/ethnicity in tenth graders surveyed.

Strengths

Infants. The sudden unexpected infant death (SUID) rate significantly decreased from 2008 to 2018, from 1.0 deaths per 1,000 live births to 0.6 deaths. Compared to other states, Washington's infant mortality rate is among the lowest, including among non-White infants.

Children. According to the NSCH, over 90 percent of young children in Washington had their health status reported as excellent or very good, comparable with the national rate. Due to Washington State's Medicaid expansion program, Apple Health, insurance coverage among children is near universal in the state. Between 2005 and 2015/16, the rate of untreated decay in third graders decreased in Washington, meeting the Healthy People 2020 goal. The caries rate among low-income preschoolers also declined since 2005 from 26 percent to 17 percent.

Adolescents. Birth and pregnancy rates among adolescents continue to decline, reaching the lowest ever recorded. Among 15-17-year-olds the pregnancy rate went from 27 per 1,000 in 2008 to 9 per 1,000 in 2018. This meets the Healthy People 2020 goal of 36.2 per 1,000 population. Use of cigarette and smokeless tobacco products by tenth graders has decreased since 2008, from 14 percent and 7 percent, to 5 percent and 2 percent respectively.

Children and Youth with Special Health Care Needs

Population. According to the NSCH (2017-19), 19 percent of children in Washington ages 0-17 have a special health care need. This represents has an estimated 311,000 children and youth in Washington with a special health care need. Of these, an estimated 195,000 are non-Hispanic White children, 57,000 Hispanic children and 52,000 children classified as other non-Hispanic.

Needs. Children and youth with special health care needs and their families need adequate screenings and services that are accessible across the state. CYSHCN need all the services that children their age need, with providers that are competent in the care of CYSHCN. This includes access to childcare, recreation and other services.

- CYSHCN and their families experience significant barriers to accessing services. Screening, therapeutic treatments and support are significantly impacted by provider shortages, especially in remote areas. For some CYSHCN and their families, financial eligibility is a barrier to accessing health care and other support services. Additionally, there can be long waitlists to access care for this population. *(Facilitated discussion summary)*
- Transitioning of care from CYSHCN pediatric to adult specialty services can be disruptive to the person with special health care needs and their support system. *(Facilitated discussion summary)*
- Inadequate numbers of providers are trained on needs specific to the CYSHCN population. *(Facilitated discussion summary)*
- CYSHCN and their caregivers can usually receive needed screenings, but the distance to those and other services can be prohibitive. Specialized services, regular therapeutic treatments, access to respite care, and mental/behavioral health services for the population are harder to access for those living in remote areas. Those in more urban areas struggle with transportation and long waiting lists. *(Key informant summary)*

> *[There is a definite] growing need for mental and behavioral health services for children with behavioral disabilities including [autism spectrum disorder] … [as well as a] need for [applied behavior analysis] providers in rural areas. (Key informant)*
>
> *Childcare that's available, affordable, and high quality. This includes supporting children with special needs who need diapering far past age three and need supported care past age 12. (Discovery Survey participant)*
>
> *[We need] multiple supports for families of kids with disabilities, especially kids with challenging behaviors, including those who don't reach eligibility for special services. (Facilitated discussion participant)*

Key Indicators. Based on the NSCH only 45 percent of children with special needs had a medical home.

Disparities. Language and cultural barriers make it more difficult for non-English speakers and those from other cultures to access appropriate services, information, and resources for their CYSHCN. This is especially true among recent immigrant and refugee populations. More severely affected children were found to have more difficulty in obtaining necessary services as well. In some cases, families may have had to move to obtain the needed services, potentially disrupting the lives of all the members of the family.

Strengths. Since 2010, universal developmental screening (UDS) has been a DOH priority. DOH is currently in the process

of developing a UDS data system in order to facilitate increased screening and referral. In 2018, Washington's Early Hearing-loss Detection, Diagnosis and Intervention Program successfully screened 83,343 infants' hearing. In spring 2020, a new Child Health Intake Form data system was developed, which will make care coordination for CYSHCN easier across the state.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

The Department of Health is led by Secretary of Health John Wiesman, who reports directly to Governor Jay Inslee. Title V programs are located in the Prevention and Community Health (PCH) division. Acting Assistant Secretary of Prevention and Community Health Michele Roberts reports to DOH Chief of Staff Jessica Todorovich. Organizational charts in front of the appendix show these reporting relationships.

Approximately 68 percent of Maternal and Child Health Block Grant (MCHBG) funds are distributed to partners, including 59 percent to local health jurisdictions. The remaining funds support DOH activities, mostly within PCH's Office of Family and Community Health Improvement. OFCHI Director Katie Eilers is designated the Title V Maternal and Child Health Director and is the primary administrator of programs with allotments under Title V. The second page of the organizational chart shows programs supported by federal MCHBG funds highlighted in yellow.

OFCHI includes the following:

- **Thriving Children and Youth** includes the adolescent health, child health and development, children and youth with special health care needs, and Essentials for Childhood programs.
- **Community Healthcare Improvement Linkages** includes the breast, cervical and colon health; community health worker training; family planning; and perinatal health programs.
- **Surveillance and Evaluation** oversees data collection and assessment activities that inform OFCHI programs and policy decisions, including the Healthy Youth Survey, PRAMS, home visiting evaluation, maternal and child health epidemiology and evaluation, Birth Defects Surveillance System, and State Systems Development Initiative.
- **Healthy Systems and Operations** coordinates contracts and activities with the local health jurisdictions' maternal and child health programs, oversees the MCHBG, and works on health systems improvement and population health initiatives.
- **Screening and Genetics** includes the Early Hearing-loss Detection, Diagnosis and Intervention; cancer genomics; and genetic counseling programs.
- **Equity and Community Engagement** focuses on development of the community based workforce and advancing equity in our funding, program development, and processes.

MCHBG funds also support the Injury and Violence Prevention program and the Oral Health program in the Office of Healthy and Safe Communities.

III.C.2.b.ii.b. Agency Capacity

The Department of Health plays an important role in helping to build healthier communities, including supporting the health of the populations addressed in the MCHBG. We work to assure the quality of our health system and provide the data and information necessary for research and resource planning. We also provide funding and technical assistance to and collaborate with partner organizations working on key prevention issues. This includes providing preventive health information and educational messages to the public and to health care providers about early identification of health issues, referral and linkage to services, and coordination of services.

OFCHI generally does not fund direct services, but can support a "last-stop safety net" when there is a major gap in services for the maternal and child health population, especially for children and youth with special health care needs.

Preventive and primary care services for pregnant women, mothers and infants up to age one
The DOH Perinatal Health unit focuses on women's health, infant health and the mother/infant dyad. The program offers educational materials and links to resources on a wide range of topics that affect women. Following culturally and linguistically appropriate service (CLAS) recommendations, publications are available in multiple languages. The unit manages specific programs to improve birth equity in communities where disparities exist.

The Screening and Genetics program works to improve the health of people with, or at risk of, genetic disease. The program identifies babies who have hearing loss and works to assist in getting them enrolled in early intervention by six months of age. It provides information on genetic conditions for parents and health professionals, promotes educational opportunities for health and social service providers, and evaluates quality, trends, and access to services.

PRAMS is a survey of new mothers conducted by DOH and the Centers for Disease Control and Prevention (CDC). PRAMS gathers information from mothers about their experiences before, during, and after their most recent pregnancy. PRAMS survey answers give us information about access to health care, quality of health care, and other circumstances that may affect the health of the mother and her new baby. PRAMS informs program needs throughout the state.

DOH offers resources and technical assistance to parents, child care, foster care, group care, juvenile and correctional institutions, community action groups and others on how to prepare and keep children safe, healthy and in developmentally appropriate learning environments. Topics include developmental screening and milestones, infant safe sleep practices, and feeding infants.

Preventive and primary care services for children
The Thriving Children and Youth (TCY) section promotes integrated systems that improve access, linkages and coordination directed toward health and well-being, health equity, early and ongoing learning and development, and safe environments and relationships for children, youth, and their families.

The Essentials for Childhood unit within TCY is part of a comprehensive child abuse and neglect prevention effort across several states supported by the CDC and other funders. The focus is coordination and collaboration to align systems, strategies, and policies to improve how families experience supports, reduce stress, and increase resilience.

The Adolescent Health program in TCY works to ensure equitable opportunities for improved social, emotional, and physical health and wellbeing for adolescents and young adults. Program goals include providing access to quality health services that are age-appropriate, ensuring safe and supportive environments at home, school, and in the community, and increasing reproductive health services and information.

The Injury and Violence Prevention Program coordinates Safe Kids Coalitions throughout the state to prevent unintentional injuries to children. The statewide network involves hospitals, local agencies, advocacy organizations, and private sector partners. They educate adults and children, conduct research and collect data, and strengthen laws to help families and communities protect children. They also provide safety devices to families in need.

DOH's Oral Health program promotes prevention and access to oral health care. They coordinate the Smile Survey, a report on the oral health of Washington's children, in partnership with the Office of the Superintendent of Public Instruction (OSPI), the Department of Children, Youth, and Families (DCYF), school districts, early learning programs and dental professionals. They provide information on finding dental care and resources through a number of organizations in the state.

The Healthy Youth Survey is a collaborative effort of DOH, OSPI, the Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery, and the Liquor and Cannabis Board. The survey provides information about youth in Washington, including safety and violence; physical activity; diet, alcohol, tobacco and other drug use; and related risk and protective factors. County prevention coordinators, community mobilization coalitions, community public health and safety networks, and others use this information to guide policy and programs that serve youth.

The Child Profile Health Promotion System sends child health and safety information to all families with young children in

Washington State by mail and e-mail. Each mailing has age-specific reminders about well-child checkups and immunizations. They also give up-to-date information on growth and development, nutrition, safety, and many other health topics. This work is conducted in the Office of Immunization and Child Profile, also part of the PCH division.

The Office of Nutrition Services in PCH manages the WIC program. The Office of Healthy and Safe Communities (OHSC) manages the Injury and Violence Prevention and Oral Health programs mentioned above, as well as the Healthy Eating Active Living program, the Tobacco/Vapor Product Prevention and Control program, and the Marijuana Product Prevention program. Title V staff coordinate with each of these programs that has close ties to and influences our work and priorities to protect and improve children's health.

Services for children with special health care needs

The Children and Youth with Special Health Care Needs (CYSHCN) program within TCY promotes an integrated system of services for infants, children and youth who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related services of a type or amount beyond what is generally needed. At the state level, the program collaborates with families, policy makers, health care providers, agencies, and other public-private leaders to identify and improve health system issues that impact this population. At the local level, the program supports public health staffing and contractors to help families with resources and linkages to community services including family support, care coordination, and health information.

This work is carried out through partnerships with other state-level agencies and contractual relationships with LHJs, the University of Washington (UW), and family service organizations. These contracts and partnerships significantly extend CYSHCN program capacity in the areas of assessment, provider education and technical assistance, improvement of care coordination, and family leadership development. Our work is guided by and aligned with the national Standards for Systems of Care for CYSHCN.

Cross-Cutting and Systems Building

Supporting work in all domains, the Surveillance and Evaluation section oversees assessment activities (including HYS, PRAMS, and the five-year MCH needs assessment) required for effective planning, monitoring, and action to improve health outcomes in many program areas.

DOH promotes a patient-centered medical home approach to meeting consumers' physical and mental health care needs. To that end, DOH offers, promotes, and participates in collaborative learning opportunities, such as in-person trainings, webinars, primary care practice coaching, community asset mapping, and other technical assistance.

Community Health Workers (CHWs) provide services such as health education, informal counseling, social support, care coordination, and health services enrollment, navigation, and advocacy. To support the system of CHWs in Washington, DOH offers a free online training curriculum that strengthens common skills, knowledge and abilities. The core competency training is a free ten-week program. It was formerly held as a combination of online and in-person training held regionally throughout the state, and in response to the COVID-19 pandemic, the curriculum has transitioned to fully online. Free Continuing Education Health Specific Modules are available for additional learning for CHWs after the core curriculum has been completed.

The DOH agency capacity has been significantly affected by the COVID-19 public health emergency, as has that of LHJs. Staff have been reassigned to incident management teams and also to backfill positions to ensure continuity of operations of core functions. Agency and program priorities have been reassessed and revised. As has occurred world-wide, staff transitioned to primarily working from home for an unknown duration, and many must balance family care and education needs with work. Due to economic impacts of COVID-19, the Governor has imposed mandatory furlough days for most state employees, including Title V program staff.

Many elements of our regular program work have been set aside or slowed significantly as we address the public health emergency and current and emerging needs. We are also in the early stages of shifting how we manage our COVID-19 response. Initially it was organized as an agency-wide incident management team structure. Now we are integrating COVID-

19 planning and response into the agency's divisions for long-term response and recovery.

III.C.2.b.ii.c. MCH Workforce Capacity

For federal fiscal year 2021, the total number of full-time equivalent (FTE) positions in DOH to be funded by federal MCHBG dollars is 17.55 FTE (down 0.45 FTE from 2020). This represents 35 individuals; most positions are funded using multiple sources. Title V activities are the predominant focus of OFCHI, as highlighted in the attached organization charts.

In the Perinatal and Women's Health programs, MCHBG funds contribute toward 0.95 FTE (portions of two positions) of the total staffing of eight FTEs.

In the Child Health and Development and Adolescent Health programs, federal MCHBG funds contribute toward 4.0 FTEs (portions of five positions) of the total staffing of eight FTEs.

The CYSHCN unit includes 1.6 FTEs funded by federal MCHBG (one full position and portions of three others), of the total of four FTEs. One of these positions is a paid Family Engagement Coordinator. This position provides leadership for inclusion of family and community perspectives in policy and program development, oversees parent leadership development programs, and serves as a statewide resource for promoting quality, culturally appropriate, integrated systems of care for children and youth, including those with special health care needs and their families. This position is consulted for assistance in family engagement in the other population domains as well. The person currently in this position has a family member with special health care needs, providing lived experience in this area.

The Screening and Genetics program includes 1.2 FTEs (portions of three positions) funded by federal MCHBG. Their total staffing is six FTEs.

Surveillance and Evaluation includes 6.31 FTEs funded by federal MCHBG (portions of 12 positions), of the total 19 staff.

The Healthy Systems and Operations budget includes 3.1 FTEs funded by federal MCHBG (one full position and portions of six others). This includes the MCHBG coordinator, the two community consultants who provide liaison and contract management with the LHJs, and fiscal and policy support.

In the separate Office of Healthy and Safe Communities, we use MCHBG funding to supplement two positions (0.39 FTE) that focus on child injury prevention and oral health.

Each of the 35 LHJ contracts funds at least part of an FTE to focus on maternal and child health. In some of the larger LHJs, several MCH staff are funded in part or entirely by MCHBG. In very small LHJs, MCHBG funds a portion of time for one staff.

Katie Eilers, RN, MSN, MPH, is the state Title V MCH Director. Katie is the Director of the Office of Family and Community Health Improvement in the Prevention and Community Health division of DOH. Katie has been with DOH since February 2019. She has 20 years of experience working on family and community health in a variety of positions in Washington, California and in Africa. Her experience in family and community health includes direct care, coalition work, program management, program evaluation, planning and policy work and leadership.

Rose Quinby, MSW, is the state Title V CSHCN Director. As Section Manager of the Thriving Children and Youth section in OFCHI, Rose provides leadership and strategic direction for the child, adolescent, and CSHCN activities of the MCHBG. She manages the CYSHCN Unit Supervisor position and the Essentials for Childhood and Adolescent Health Program Manager. Rose has been with DOH since February 2020. Prior to her position at DOH, Rose held leadership positions with significant responsibility for management, public health systems change, and research focused on children with special health care needs and their families.

The MCHBG has provided a relatively stable amount of funding over the past several years. The costs of doing business, however, have continuously increased over time. We have committed to maintain a consistent level of pass-through funding

to distribute to the LHJs. But the increases in operating costs have resulted in decreases in the DOH MCH workforce (staffing level) over the years due to funding availability. Most often this takes place as not filling vacant positions, or combining and shifting positions to better align with current needs. This causes us to focus more precisely on core public health functions and our identified priority needs.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Maternal and child health work at the state-wide level requires strong partnerships with other organizations. We asked program leads of our MCH programs to provide suggestions about which organizations, work groups, and committees we should reach out to as we conduct the needs assessment and establish priorities.

The list included:

- 38 multi-agency work groups our program staff were involved with on specific issues of maternal and child health
- 8 key partner organizations that could reach out to their networks to share and receive information to inform the needs assessment
- 6 large email distribution groups focused on MCH information sharing

The list of partner groups included work teams with focus on specific projects or programs, committees, and coalitions. It included healthcare providers, community service providers, community and cultural groups, advocacy groups, individual consumers, interagency and local health partners, educational partners, and private and corporate partners.

As discussed in the *Process Description* section above, from this large list we selected groups to meet with for facilitated discussions, representing all the population domains. We used this list and suggestions from the program leads to identify potential key informants. We sent the Discovery Survey to members of these work groups as well.

The list represents the many organizations and partnerships we work with day-to-day. In the population domain narratives we describe specific examples of our work with various key partners. In a variety of ways, these partners have shaped our priority needs, our work programs, and MCH policy and funding decisions in Washington. These partnerships also allow us to reduce duplication of efforts and connect the work of related programs and initiatives.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Data from each of the four primary data collection methods described above (LHJ Needs Assessments, facilitated discussions, key informant interviews, and population-level Discovery Survey) were analyzed qualitatively in nVivo and compiled by topic into a summary report by a team of four epidemiologists and qualitative analysts. This summary report was shared with the MCH Needs Assessment Workgroup, the MCHBG Needs Assessment Advisory Group, and LHJ contacts for feedback on identified themes and content. The workgroup then developed a document organizing themes across data collection sources ranked by total number of coding references to guide further discussion.

DOH contracted with Cardea Services to facilitate a series of regional community dialogues with LHJ representatives (held October 22, 23, 29, and 30, 2019) and DOH staff (held November 6, 2019). The workgroup compiled notes from Cardea's facilitated discussions into a single cohesive list of 34 distinct topics, ranked by number of total references from small group discussion. In addition to number of unique references, key considerations when discussing potential state-level priorities included the role of public health in addressing the issue, the severity of or potential harm caused by each issue, known disparities among vulnerable populations, and consistency or agreement across LHJs. Topics were then classified by population domain, and related topics were combined where appropriate. Cardea encouraged participants to focus on available data and intended outcomes, and work back towards viable evidence-based strategies and best practices to prioritize. Equity and addressing known disparities emerged as a key theme throughout LHJ engagement.

The products from these discussions were presented and discussed at three online prioritization discussion webinars, which were promoted to individuals who had contributed to the needs assessment data collection and on the DOH website for

anyone interested in participating. These webinars were held November 15, 18, and 21, 2019.

The workgroup then used feedback from all these discussions to compile a list of eight priority need statements which incorporated as much feedback from all sources as possible. This was shared with LHJs with the notes from the Cardea-facilitated meetings.

The workgroup and MCHBG Needs Assessment Advisory Group held a joint performance measures work session on February 12, 2020. The intent of the meeting was to finalize the draft priority need statements, determine the performance measures to focus on, and identify potential strategies and activities.

At this meeting, two core principles were added to be incorporated across all priorities. Then, after continued discussion among the workgroup, these were expanded to four core principles to shape our work.

Core Principles Informing the State Action Plan:

- 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 in our programs and policies.
- We value both evidence-based and community-developed promising practices to ensure all populations, especially those who have been historically marginalized, are served by health systems that embrace cultural humility and appropriateness.
- We are working to ensure trauma informed approaches are incorporated in all our programs and services.
- We must continue to assess the effects of COVID-19 on all programs and make adjustments as needed in light of the pandemic, with particular focus on our values and goals associated with racial and ethnic equity.

Two priority needs were added by the workgroup and leadership after the February meeting, making a current total of ten. A priority related to strategic planning emerged as the need for a cohesive public health strategy across localities was identified. And as the COVID-19 pandemic occurred and evolved, it became clear there will be long-term impacts to our workload and capacity. State and public health agencies will need to take on new roles and new work to respond to and recover from the pandemic, and prepare for new and emerging public health threats.

The final ten priorities were then refined and developed in collaboration with population domain leads (i.e. adolescent health, perinatal health, and children and youth with special healthcare needs team leads) to refine definitions, integrate agency and partner strategic plans and goals, and finalize development of state performance measures. See *Appendix C* for a list of these priorities and performance measures.

As the list and language were being finalized, Washington State was identified as an early potential U.S. epicenter of the COVID-19 pandemic, impacting staff roles and public health infrastructure across the state at all levels. The workgroup has not yet created a final summary report on the full needs assessment and prioritization process, or developed thematic “story sheets” which take a closer look at specific themes and patterns which emerged.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$8,846,149	$8,661,649	$8,916,002	$8,450,065
State Funds	$7,573,626	$7,573,626	$7,573,626	$7,573,626
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$1,203,470	$1,203,470
Program Funds	$0	$0	$0	$0
SubTotal	$16,419,775	$16,235,275	$17,693,098	$17,227,161
Other Federal Funds	$16,197,952	$24,317,085	$23,699,780	$22,044,275
Total	$32,617,727	$40,552,360	$41,392,878	$39,271,436

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$8,930,530	$8,011,365	$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	$16,504,156	$15,584,991	$16,473,626	
Other Federal Funds	$21,852,047	$16,351,318	$12,716,080	
Total	$38,356,203	$31,936,309	$29,189,706	

	2022	
	Budgeted	**Expended**
Federal Allocation	$8,900,000	
State Funds	$7,573,626	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$16,473,626	
Other Federal Funds	$17,698,731	
Total	$34,172,357	

III.D.1. Expenditures

At the time of this writing, Washington has expended an estimated $8,011,365 of the $8,810,592 of Title V Maternal and Child Health Block Grant (MCHBG) funding awarded for federal fiscal year (FFY) 2020.

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

$1,250,237	16%	Pregnant women
$1,250,237	16%	Infants
$2,225,867	28%	Children 1 through 21 years
$2,753,947	34%	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 percent requirements of the program.

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

$37,472	<1%	Direct services
$489,379	6%	Enabling services
$7,484,514	93%	Public health services and systems

Washington is aware of and dedicated to compliance with legislative financial requirements (e.g., 30/30/10 percent 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

Sixty percent of the budget for FFY 2020, or $5,343,804, 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 2020 are also described here.

Local Health Jurisdictions: DOH contracted with 34 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 percent 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; 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

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

Cayzen Technologies: Operate and maintain Child Health Intake Form database.

Supports NPM 11
Priorities: Healthy Starts; 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 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.

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

Washington made an allocation assumption of an estimated $8,900,000 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:

$1,807,219	Salaries and benefits
$5,958,166	Contracts
$101,629	Goods and services
$68,903	Travel costs
$0	Capital equipment
$192,466	Intra-agency costs (e.g., employee workspace, computer, computer support)
$771,617	Administrative costs. The Department of Health Prevention and Community Health division provisional indirect rate is 30.5 percent.
$8,900,000	**Estimated total allocation**

The federal investment in services benefitting specific populations:

$1,002,463	11%	Pregnant women
$1,002,463	11%	Infants
$2,948,035	33%	Children 1 through 21 years
$3,041,002	34%	Children and youth with special health care needs

The federal investment from the perspective of service level:

$89,304	1%	Direct services
$468,400	5%	Enabling services
$8,342,296	94%	Public health services and systems

Washington is aware of and dedicated to compliance with legislative financial requirements (e.g., 30/30/10 percent 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 $5,958,166 budgeted for contracts, most of that, $5,054,430, 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 34 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

American Indian/Alaska Native Maternal and Infant Health: Address health disparities among American Indian and Alaska Native women, infants, and children in Washington and improve their health.

Supports NPMs 1, 4; SPMs 1, 3, 4, 5, 6, 7, 8, 9, 10
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.*
- *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.*

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 NPM 1, 4, 6; 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.*

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.*

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
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 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
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.*

Cayzen Technologies: Operate and maintain Child Health Intake Form database.

Supports NPM 11
Priorities:

- *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, and Virginia Mason 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 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

The Washington State Department of Health (DOH) is led by Secretary of Health Umair A. Shah, MD, MPH, who was 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), which is 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 at every stage of life through policies, systems, and environmental changes with emphasis on health equity, life course theory, 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 in turn 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 are committed to being anti-racist in our programs and policies.
- We value both evidence-based and community-developed promising practices to ensure all people, especially those marginalized by mainstream society, are served by health systems 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 in light of the pandemic, 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 percent) 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.

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. 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

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. 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, a number of 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 18.76 FTE. This represents 40 individuals, as most positions are funded from multiple sources. This is an increase from last year's level of 17.55 FTE (portions of 35 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 prioritize employee retention and succession planning. When we have a position vacancy, we consider whether to fill the position 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.

- 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. After a pause due to the COVID-19 response, training sessions have resumed and are now provided online.

- 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 managers will complete 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.

- 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 and facilitation training that is available in short segments; both for supervisors and for those who lead external, community efforts is a need within the Thriving Children and Youth section.

- Linkage of Essentials for Childhood child abuse and neglect prevention work funded by CDC with MCH theory of change, including state performance measures, evidence-based strategy measures, strategies, and objectives. In the *Technical Assistance* section, we mention our plan to request consultant assistance in this area.

- Continued training around telehealth and teleintervention. A recent needs assessment conducted by the Early Hearing-loss Detection, Diagnosis and Intervention (EHDDI) program to better understand barriers to EHDDI services during the COVID-19 pandemic revealed that parents were reluctant to receive early intervention services virtually. Training and education may assist providers and families to better utilize teleintervention when necessary or preferred.

- On examination of the MCH Navigator report on workforce needs in Washington, we will encourage our MCH staff to pursue several specific training resources through the navigator, including the Policy 101 portal, strategies for implementing health equity, and implementation briefs.

Innovations in Staffing Structures and Key Training Partnerships

We are widening our scope of partners to learn from and involve in program planning. We have added three community partners from diverse geographic regions and a key private foundation partner, and are in the process of adding parents and caregivers to our cross-sector Essentials for Childhood Steering Committee. We had an opportunity this year to include the LHJs directly in contributing to an “Inventory of What Works” for child abuse and neglect prevention and building family resilience. We also added multiple partners from specific communities through our Vroom parenting program grant dissemination. See *Child Health Annual Report* for more information.

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

The statewide Critical Congenital Heart Disease (CCHD) Workgroup is hosted by the Genetics program. This is a group of statewide stakeholders who meet periodically to work on challenges, gaps and barriers to effective CCHD screening and diagnoses in Washington.

The Genetics program compiles a biannual hospital report sent out to all birthing hospitals and midwifery clinics on the status of CCHD diagnoses in Washington. These infants are diagnosed through a variety of ways, including prenatal testing and newborn screening. The reports contain data on the diagnoses, as well as narratives provided by clinical experts on the best adherence practices to the screening algorithm, and other practices that reinforce the training needed to detect CCHD among newborns in Washington.

The Genetics program maintains a webpage of comprehensive resources to families and providers of persons with Down syndrome. This is updated annually.

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

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 this year 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 has decided to work toward a virtual summit hosted in late summer 2021 to promote work around health equity and family leadership and involvement, as well as to bring new agencies to the table.

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, word scanners, 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, even through shifts to virtual platforms in 2020. 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. Interest in this bulletin is growing, with a total of 3,100 subscribers as of June 2021, up from just about 2,000 the previous year.

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 passes 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 through its annual statewide training weekend and semiannual regional training weekends, providing regular support and development to new and continuing coordinators. In the year of COVID-19 shutdowns 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 been 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 is well received and partners 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 was 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 are able to make connections with the 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 the different 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. In 2020, WSFN pivoted to offering virtual meetings for its local chapters, opening up reach to fathers from across the state to join other groups, and continued to provide advocacy training in an online format. Social media engagement became more important than before throughout the continued shutdowns, 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, the network began regularly sharing information regarding systemic racism and available supports for Black and Indigenous families, and other families of color, particularly those with CYSHCN.

Washington State Parent to Parent is now statewide and they continue to be a partner with the CYSHCN program at DOH through WSLI. Local P2Ps host trainings and webinars on a variety of topics for families and individuals with special health care needs throughout the life course. Many P2P programs also feature Spanish-language trainings and bilingual parent groups supported by P2P staff.

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. This allowed DOH Title V staff to collect direct feedback and data from families across the state for the 2020 MCH Needs Assessment and throughout the COVID-19 pandemic, in real time.

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 dedicated resources to this work. Staff have engaged a contractor to develop and launch a family engagement process from May through September 2021. The contractor is recruiting six parents to participate in a series of meetings over the summer to develop an EfC parent involvement roadmap. All participants will receive stipends, and we hope to continue to engage this group after the roadmap is complete.

The Family Engagement Coordinator engaged partners around the state in a body of work to improve care coordination and navigation for families of CYSHCN beginning in fall of 2019. This builds on and expands work that had previously focused on autism-specific navigation. Many of the partners who began work on this project were

pulled away in early 2020 due to pressing needs and budget constraints brought on by the COVID-19 crisis. As such, this workgroup is on hold, but has continued to touch base throughout 2020 and early 2021 to maintain interest in the project. As the response efforts wind down, this workgroup is expected to resume. The ultimate goal of the workgroup is to create a toolkit for family navigation services that outlines best practices for care coordination, along with connecting families to economic and psychosocial supports.

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

Additionally, we engaged our partners through the creation of a community health worker (CHW) education module on autism diagnosis and supports for families. Community partners, clinical, and family-serving providers piloted the module in July 2020 and provided overwhelmingly positive feedback on its depth of content and local resource connections. This module joined the regular rotation of CHW modules offered for continuing learning in 2021.

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

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

Surveillance and Evaluation Section

The mission of the Surveillance and Evaluation (S&E) section 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.

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

Of the approximate 21 FTE in S&E, 15 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) (1.0 FTE); MIECHV
and state Home Visiting Funds (4.2 FTE); other federal grants (2.3 FTE); and by state and other funds (4.7 FTE). Non-analytic staff funded by MCHBG in S&E include PRAMS operations and administrative support staff.

The analytic staff classifications in S&E include Epidemiologist 1 (2.0 FTE), Epidemiologist 2 (7.0 FTE), Epidemiologist 3 (3.0 FTE), Sr. Epidemiologist (1.0 FTE), and Research Investigator 3 (2.0 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.

Of the 15 positions, 11 are currently filled and four are in the process of recruitment. Of those in the process of recruitment, two are vacant due to staff moving to positions outside of S&E (COVID-19 position and promotional opportunity); the other two vacant positions are new. The two new bodies of work, which will be filled by Epidemiologist 2, include universal developmental screening (UDS) evaluation and surveillance, and data support for quality improvement work with managed care organizations.

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 1.0 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, Healthy Youth Survey administration, 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.

COVID-19 response activities by S&E staff have greatly decreased since the local peak of the pandemic in 2020. However, the high number of open analytic positions related to COVID-19 has impacted the candidate pool in filling some of S&E’s positions. While the agency’s body of work and organizational structure has changed due to COVID-19, there has been no recent restructuring that directly impacts S&E.

Emerging Needs

Emerging needs within the Surveillance and Evaluation section include increasing our ability to develop complex data linkage, and developing skillsets to manage additional data systems, such as UDS.

In addition, we are currently envisioning new ways to 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)

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.

It is important to note that two SSDI-supported epidemiologists were tasked with roles in the COVID-19 state emergency response. Both were in epidemiological roles. The Epi 3 worked as the State Surveillance Lead and Surveillance Reporting Lead, managing the data dashboards and providing data quality assurance. The Epi 2 worked as the Local Health Jurisdiction Epidemiologist, performing data quality assurance, and acting as the point of contact for the LHJs. The two epidemiologists each spent over eight months working on the response during 2020. While their work helped increase data capacity for the COVID-19 response, it also significantly decreased epidemiologist time available to support MCH data capacity needs.

For the 2020 Five-Year MCH Needs Assessment, epidemiologists worked in partnership with program leads to design and implement data collection, complete analyses, and finalize the results for the development of the state priorities. Over the past year, we have developed an 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.

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 is in the process of being deidentified. 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.

In order to enhance data systems and linkages for our Title V program, S&E is in the process of developing a new and modernized Birth Defects Surveillance System. Once it is completed, we intend to link BDSS to birth certificates. S&E has already submitted a data-sharing agreement with the Washington Center for Health Statistics (CHS) to develop the BDSS-BC linkage.

S&E has recently been notified of a funding award from the Association of State and Territory Health Officials (ASTHO). In partnership with CHS, we will expand SSDI-supported surveillance system development. The goal of this ASTHO-supported work is to link up 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 mothers and infants. In addition, CHS will include hospitalization data for women approximately 10 years before the birth, and/or hospitalization data after the birth for both woman and infant,

based on available data. All activities will be completed by DOH staff dedicated to this project.

To link CHARS with PRAMS data, we will create an intermediate linkage between birth certificate and CHARS, using machine learning methodology. While this linked dataset, the Birth Event Records Database (BERD), is not new, the last linkage was performed in 2014 and used probabilistic matching, requiring significant manual review. For this project, BERD will be created using a hierarchically organized set of machine-learning algorithms. This pure machine-learning strategy has several advantages over traditional methods. We will create the final PRAMS-CHARS dataset(s) by linking PRAMS to BERD data, using deterministic matching of birth certificate numbers in both datasets.

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.

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 ASTHO funding to link PRAMS with hospitalization data, the PRAMS program 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 OFCHI's neonatal abstinence work. The PRAMS program also intends to apply for and implement the COVID-19 vaccine PRAMS supplement.

Birth Defects Surveillance System

S&E, along with OFCHI leadership and partners across the agency, continue planning for a 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. We anticipate the first phase of the new BDS data system will be developed in 2021 or 2022.

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. S&E plans to integrate the use of existing birth, death, fetal death, and hospitalization records to increase data quality and case ascertainment.

S&E has recently made improvements to allow easier access to data in the current BDS data system, which is outdated and has limited functionality. S&E is currently in the process of developing a data-sharing agreement with the Center for Health Statistics. As a first step toward our goal of integrating existing records into BDS, this agreement will allow S&E to link birth certificate data to historic BDS data in our current system.

Universal Developmental Screening Data System

S&E staff have been active participants in the development of the UDS data system and are currently in the process of recruiting for a UDS Epidemiologist. 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. Like the BDS data system, S&E anticipates eventual linkage of UDS data with birth certificate and other existing datasets.

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 includes continued information gathering and planning for new data system functionality. The current system is a patchwork of databases that is neither sustainable nor adequate for the growing needs of home visiting. The goal in the next 24 months is to complete an assessment of potential alternatives with stakeholders and secure funding for future improvements. This is timely, given the expanding resource commitment from local, state, and federal funders of home visiting services in Washington. In this new biennium, funding for the Home Visiting Services Account will increase the number of families served by 20 percent.

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. 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. 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, but there has been little Title V staff involvement in the development of statewide planning efforts in recent years prior to COVID-19. This is an opportunity for future growth.

Title V staff have been involved in emergency response activities in varying roles from leadership, to operations, planning, logistics, and administrative support. To date, during FFY2021, 20 Title V staff have been reassigned for short- or long-term activations for COVID-19, with eight of them supporting vaccination efforts. 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.
In the local health jurisdiction MCHBG contracts, we have included the following language:

> MCHBG funds may be expended on COVID-19 response activities that align with maternal and child health priorities. 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.

As the COVID-19 pandemic has evolved, it has become clear there will be long-term impacts to our workload and capacity. State and public health agencies will need to take on new roles and new work to respond to and recover from the pandemic, and prepare for new and emerging public health threats. To better understand the impacts, we have been and will continue participating in surveillance and data collection activities, such as the COVID-19 Student Survey described in the *Needs Assessment Update* section, and the pregnancy and COVID-19 case reviews described in the *Women/Maternal Health Annual Report*.

Our response and recovery are gradually transitioning from being incident management team-based to being integrated into divisions and programs as part of our ongoing program responsibilities. Participation in after-action reporting and improvement planning will be ongoing for some time.

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

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 April 2021, 2,050,619 people in Washington had access to Medicaid services, including 876,687 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, May 2021)

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 maternal and infant health activities associated with Perinatal Regional	Page 39 – agreement

	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

The state is pursuing strategic changes within Medicaid to allow us to move toward better health. In January 2017 Washington entered an agreement with the federal government, a Section 1115 waiver, which allows us to test new, innovative approaches to providing health coverage and care, and to manage costs.

This five-year contract with the Centers for Medicare & Medicaid Services (CMS) authorizes up to $1.5 billion in federal investments to promote innovative, sustainable and systemic changes that improve the overall health of Washingtonians.

The demonstration project goals are 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

These investments will help us spend Medicaid dollars more wisely and lead to a healthier Washington for all residents. As part of the waiver, each of Washington's nine Accountable Communities of Health are engaged in mandatory and optional projects. Some ACHs have focused their optional project on maternal and child health and care coordination, which can include services specifically for women and children with complex health and social needs.

In 2018 an amendment request was submitted to CMS and authorized to provide flexibility to improve access to high quality, clinically appropriate treatment for opioid use disorder and other substance use disorders, while incorporating quality improvement metrics to measure health outcomes.

In March 2020 a disaster waiver request was submitted to request financial flexibility, expanded eligibility, and provider and community supports related to the COVID-19 emergency response efforts. The request was approved in part.

In January 2021 a one-year extension of authorities was requested to extend the project to a sixth year. This additional time has been requested due to COVID-19 disruptions.

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

State 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 and 2021. As a result, significant resources, including existing staffing, were diverted to the response for a large portion of 2020 and early 2021. In addition, internal hiring prioritized filling new COVID-19 response positions and hiring for other positions was frozen for a period of time, resulting in significant delays to fill vacancies. As such, some of our planned work was not completed, as noted in the following sections. As we move from COVID-19 response to recovery, we expect to pick up where we left off and continue work on these important projects.

Despite these challenges, we have filled a number of key Title V positions over the course of the last year. In September 2020 we hired Caroline Sedano as Perinatal Health Unit Manager. In October 2020, we hired Monica Burke to lead our Children and Youth with Special Health Care Needs unit, and designated her as Washington's Title V Children with Special Health Care Needs Director in February 2021. More recently, in June 2021 we hired Angie Funaiole in a new position as Child Health Services Consultant. Also in June 2021, Alexis Bates, who had previously led our maternal mortality review program for five years, moved into a new position as Adolescent Health Consultant. We are still working to fill key positions in our Surveillance and Evaluation section.

During this application period, we were able to take some time to review the state action plan submitted last year, and we have made a few changes to reflect our current plans and capabilities. In addition to a number of minor changes, we made two significant revisions of note. First, in the Children with Special Health Care Needs domain, we added activities associated with National Performance Measure 15 – Adequate Insurance, which had previously been in our 2016-2020 state action plan. Second, in response to discussion and recommendations that took place during the 2020 block grant review, we added state performance measures in a number of areas. The block grant review discussion last year also indicated we could improve our use of data in our block grant submission. We have attempted to frame the state of health of our population domains with recent data, and are diligently investing in additional surveillance and data gathering opportunities to better understand the impact of COVID-19 and its accompanying societal disruption on the maternal and child health population.

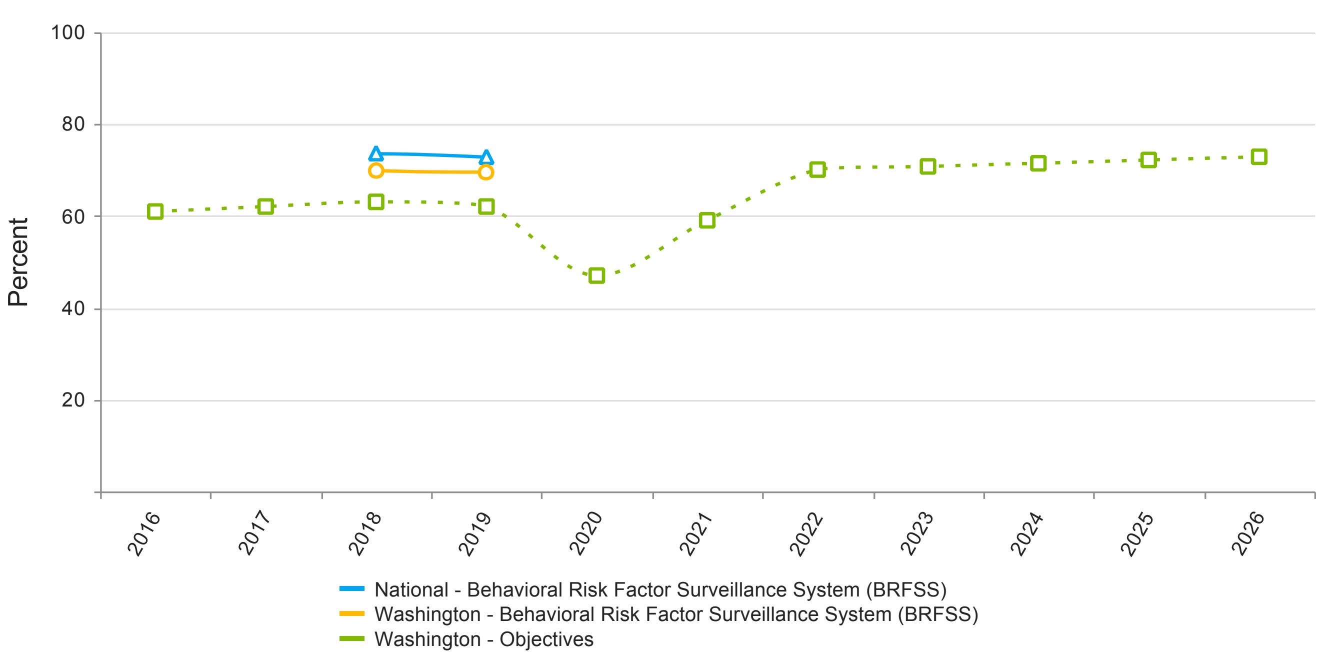
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	66.8	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	15.8	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	6.4 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	8.5 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	25.3 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	4.6	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	4.7	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	3.1	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.5	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	145.2	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2019	7.4 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	9.7	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	12.7	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	12.9 %	NPM 1

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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					47
Annual Indicator				69.7	69.3
Numerator				919,438	939,935
Denominator				1,318,605	1,355,481
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	59.0	70.0	70.7	71.4	72.1	72.8

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
Annual Objective		
Annual Indicator	67.3	66.4
Numerator		
Denominator		
Data Source	WA PRAMS	WA PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	43.0	51.0	51.5	52.0	52.5	52.6

State Performance Measures

SPM 1 - Substance use during pregnancy

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	6.2
Numerator	65
Denominator	1,048
Data Source	PRAMS
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	6.2	6.2	6.2	6.2	6.2

SPM 2 - Provider screening of pregnant women for depression

Measure Status:	Active

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

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	87.2	87.2	87.4	87.4	87.6

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 January 31, 2021, update Guidance for Pregnant Women and Parents during COVID-19 with up-to-date COVID-19 data (including racial disparity considerations) and understanding.

By August 2021, explore next steps to implement Senate Bill 6128 passed by the Washington State Legislature to expand Medicaid coverage to one year postpartum.

By September 2022, 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
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.
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 access to and communication clarity around emerging guidance for COVID-19 vaccination during pregnancy and lactation.
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.
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.
Address the need for more services, support, providers, and insurance coverage, particularly in rural communities and remote areas.
Promote and expand doula care.
Ensure all people, regardless of gender identity, have a full range of education, access, and ability to utilize reproductive health and family planning options that meet their individual needs.
Identify gaps and improve access to services for transgender and non-binary populations.
Identify and develop methods to monitor systems and data gaps and improvements needed in preventive care.

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 March 31, 2022, in partnership with Child Protective Services at the Department of Children, Youth, and Families and the Washington State Hospital Association, finalize a revised process for plans of safe care for newborns born with abstinence syndrome, including promotion of supports for the substance-affected mother/infant dyad.

Strategies

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.

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

In January 2023, submit a revised maternal mortality review panel report to the Washington State Legislature, covering the deaths that occurred to women 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 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 for the administration of maternal mental health screenings and referrals 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.

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.

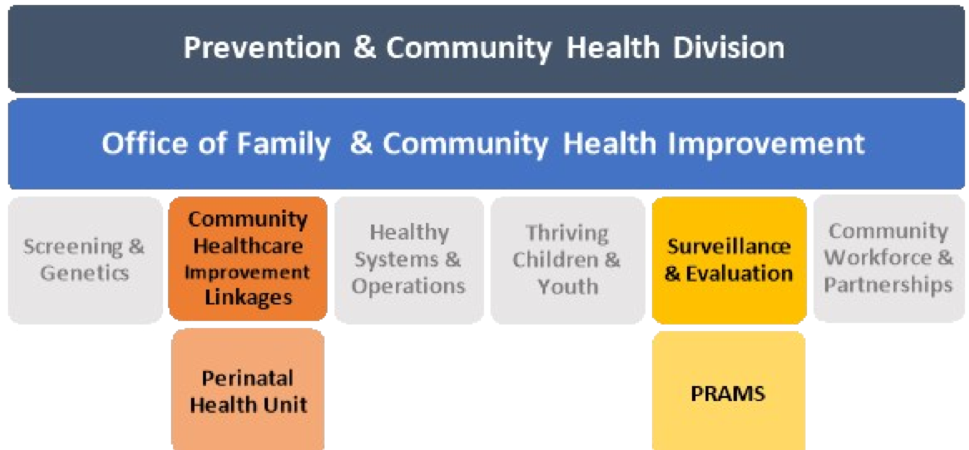
Implement trauma-informed services into community services, health care systems, and the public sector.

Explore implementation of Maternal Levels of Care in Washington state.

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 increased access to behavioral health services through innovative and proven strategies, including but not limited to telehealth, expansion of coverage by managed care organizations, use of peers/community health workers, promotion of diversity in the work force, and addressing shortages in rural communities and remote areas.

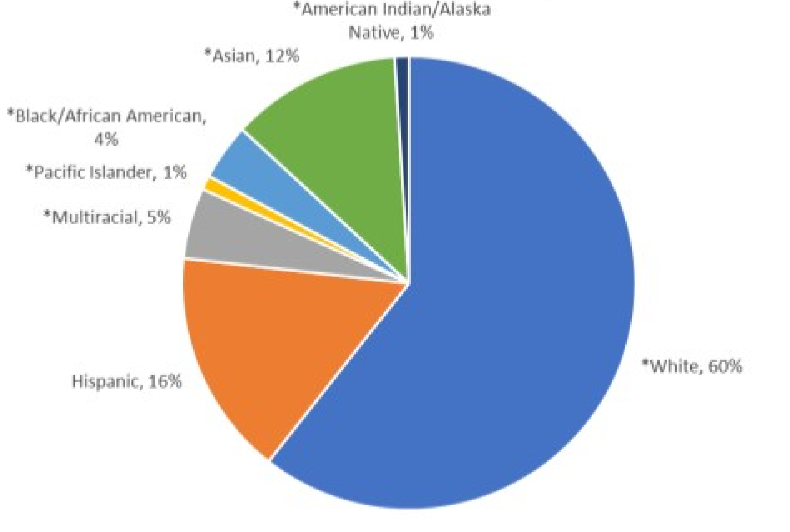


Overview

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.

Through our website, 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. Materials are available in a variety of languages.

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 68 percent of women of reproductive age in 2010; this decreased to 60 percent in 2020, an 11 percent decline. The population of American Indian/Alaska Native women also decreased over this period, decreasing to 1.3 percent. Groups whose populations of women of reproductive age increased include Hispanic (16 percent), Asian (12 percent), Black or African American (4 percent), Native Hawaiian or other Pacific Islander (1 percent), and multiracial (5 percent). The largest population increases from 2010 to 2020 were to Asian (increased 37 percent), Native Hawaiian or other Pacific Islander (increased 27 percent), and multiracial (increased 26 percent). See chart below.



*non-Hispanic

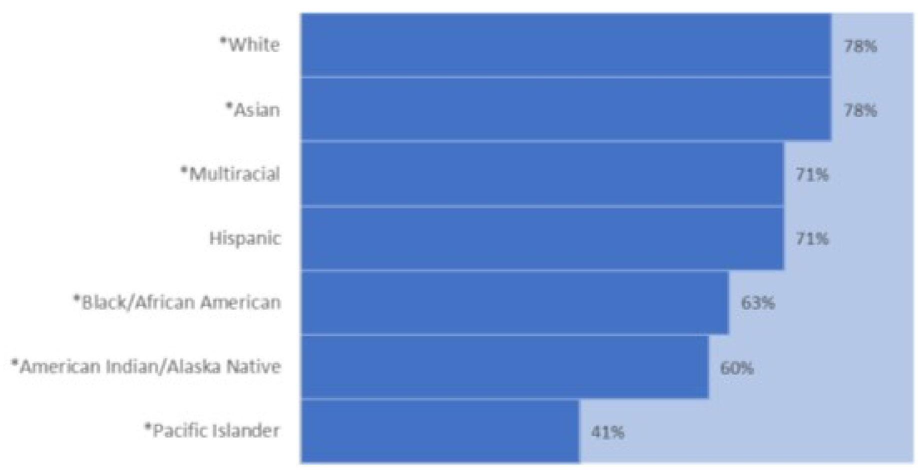
In 2019, just over three quarters (76 percent) of adult women received a medical check-up in the past year, an increase from the 2014 rate of 68 percent, and a higher rate than men (67 percent in 2019). Ten percent of women reported 14 or more days of poor physical or mental health in the past month. More than half (53 percent) of women reported receiving a flu shot, a record high and a rate significantly higher than men (44 percent) (Behavioral Risk Factor Surveillance System [BRFSS]). As of July 17, 2021, 69 percent of women had initiated COVID-19 vaccination and 63 percent were fully vaccinated, both higher rates than men (63 percent and 58 percent, respectively).

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 percent 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 percent female, 51 percent were a racial/ethnic minority, and 53 percent were at or below the poverty level.

Between 2010 and 2019, the overall birth rate in Washington decreased by 8 percent. This drop is most pronounced among women ages 15 to 17 (65 percent decrease), ages 18 to 19 (48 percent decrease), and ages 20 to 24 (31 percent decrease). During the same time period, birth rates increased among women ages 35 to 39 (17 percent increase) and ages 40 to 44 (32 percent 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 2015-2018, birth rates to teenagers were highest among Native Hawaiian or other Pacific Islander, American Indian/Alaska Native, and Hispanic populations. Pregnancy rate, which includes births, fetal deaths, and abortions, decreased from 80 to 70 pregnancies per thousand women from 2010 to 2019.

There are also changes in how women are choosing to give birth. From 2010 to 2019, deliveries by an MD or DO decreased by 5 percent, while deliveries by certified midwives increased by 47 percent. Births in birthing centers increased by 42 percent and home births increased by 11 percent.

There continue to be significant disparities of first trimester prenatal care by Medicaid status at time of birth, and by race and ethnicity. The disparity by Medicaid status at birth has decreased from a 20 percent difference in 2010 to a 14 percent difference in 2019 (81 percent among non-Medicaid and 67 percent among Medicaid covered). In 2019, 78 percent of white, 78 percent of Asian, 71 percent of Hispanic, 71 percent of multiracial, 63 percent of Black or African American, 60 percent of American Indian/Alaska Native, and 41 percent of Native Hawaiian or other Pacific Islander mothers accessed care during the first trimester (WA Birth Certificates). See chart below.



*non-Hispanic

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 percent first trimester prenatal care for all women giving birth.

Diabetes during pregnancy increased 70 percent from 2019, including a 74 percent increase in gestational diabetes. Among all pregnancies, 11 percent of expectant mothers experienced some form of diabetes. Hypertension during pregnancy increased 59 percent over this same period, and also impacted 11 percent of pregnancies.

Postpartum depressive symptoms were reported in an estimated 13 percent of women in 2019 (WA Pregnancy Risk Assessment Monitoring System [PRAMS]). Seventeen percent of women with Medicaid coverage reported depressive symptoms, compared with 9 percent of women who did not have Medicaid.

National Performance Measure 1 – Well-Woman Visit

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

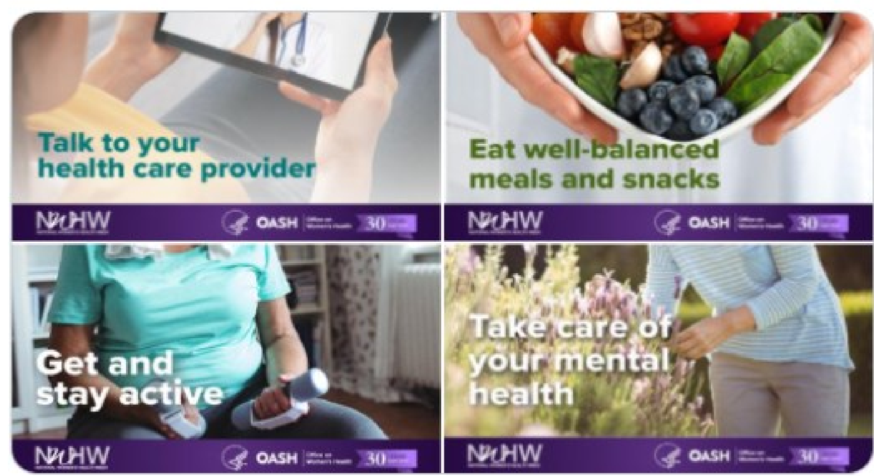
In 2019, 69.3 percent of women received a preventive medical visit within the past year. This exceeded our objective of 47 percent, but is slightly lower than the previous year. The percentage remained relatively steady between 2009 and 2017, but the survey data from those years are not comparable to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

Perinatal Health unit staff continued to monitor issues related to the mandated preventive services for women and worked 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.

Since 2016, Washington state has been working to fully integrate the financing and delivery of physical health services, mental health services, and chemical dependency services in the Medicaid program through managed health care by 2021. This Medicaid Transformation Project is a multiagency effort led by HCA and supported by federal funding to build healthier communities through a collaborative regional approach to integrate how we meet physical and behavioral health needs so that the health system focuses on the whole person and improve how we pay for services by rewarding quality over quantity.

WA Dept. of Health @WADeptHealth · May 12

When it comes to taking steps for better health, we know it's not always easy, especially during a pandemic. Women's Health Week is a reminder for women and girls, especially during the outbreak of COVID-19, to make their health a priority. #NWHW #OWH30



In 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.

Additional Work Supporting Women's/Maternal Health

We continue to partner with HCA/Medicaid, the Washington State Hospital Association (WSHA), the March of Dimes (MOD), and Swedish Addiction Services in Seattle to encourage an increase in the number of providers offering group prenatal care, especially to women struggling with substance use disorder and mental health issues. MOD is working to support five clinics in Washington to begin offering this model of care of integrating substance use needs with group prenatal care. This was delayed due to the COVID-19 pandemic, but they are now resuming this work and plan to begin training for clinics to prepare for offering services later this year.

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 a single point of entry 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 24,194 page views with 19,039 total unique page views in calendar year 2020.

WithinReach's Help Me Grow Washington (HMG-WA) Hotline is the state's maternal and child health hotline. During federal fiscal year (FFY) 2020, the hotline received and responded to 14,468 calls. Questions relating to food and nutrition resources generated the greatest number of inbound calls, and resulted in 8,462 food assistance referrals and 5,478 referrals to WIC. Numerous additional referrals were made for pregnancy-related services and determinants of health, including 362 referrals for housing assistance.

WithinReach provides health information in a variety of languages for people who are not proficient in English. During FFY 2020, the total number of HMG-WA hotline Spanish phone calls was 1,184. The hotline averaged 347 non-English calls per quarter. Nearly all of the call center staff are bilingual, and nearly 99 percent of Spanish-language calls are completed without a third-person interpreter.

Policy and Practice Improvement

We have developed an evidence-based strategy measure (ESM) to track the number of policies and practices influenced and promoted by staff that positively impact the rate and quality of well-women medical visits for women of childbearing age in Washington. We worked on 10 policy and practice areas:

- 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 hospitalwide 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 to prepare for rollout of the substance use bundle, and continues to work on integrating equity and elimination of inequities into all of their quality improvement efforts. An in-person SPEAK UP Against Racism training was planned and delayed twice due to COVID-19, so we began a planned transition to an online training (1).

- 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 (2).

      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 removal practices
- Supporting evidence-informed breastfeeding guidelines
- Decreasing addiction to opiates, and increasing recovery for women and their families

The workgroup has worked with local public health in Skagit and Snohomish counties, MOD, and Swedish Addiction Services to provide an all-day training conference on perinatal substance use.

- DOH continues to be involved in two initiatives launched by an Association of State and Territorial Health Officials (ASTHO) interagency team led by Title V staff: (a) to clarify and write policy around the federal 2016 Child Abuse Prevention and Treatment Act (CAPTA) regulations to notify Child Protective Services of all drug-affected infants, and (b) to 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. This is to be accomplished by creating billing structures for birthing hospitals to treat the mother and baby together (start on medication-assisted treatment and monitor baby for withdrawal), and then transition birth parent and baby to residential treatment for pregnant and postpartum people. This assures the safety of the infant and supports the maternal recovery and parenting transition of the birth parent (3).

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.

Through our partnership with DCYF, we coordinated three online trainings for child welfare workers across the state:

- Medication Assisted Treatment during Pregnancy and Parenting – 158 people attended, and 83 percent reported that they planned on making changes to their practice as a result of the training.
- Compassionate Care and the Lived Experience – 195 people attended, and 92 percent reported that they planned on making changes to their practice as a result of the training.
- Destigmatizing Care – 210 people attended, and 95 percent reported that they planned on making changes to their practice as a result of the training.

To address the second initiative, in the 2019 legislative session the HCA was required to write a report and fiscal analysis with recommendations for the care and treatment of neonatal abstinence syndrome

(NAS) and maternal stabilization. They are also currently working to create an administrative day rate billing code for birthing hospitals to support birth parents to room in with their infant and receive MAT after they've been medically discharged and their infant is being monitored or treated for NAS.

    - In March 2019, an Association of Maternal and Child Health Programs (AMCHP)/ASTHO interagency team led by Title V staff was launched to address the housing needs of families impacted by the opioid epidemic through policy changes. This was a cohort of the national Promoting Innovation in State Maternal and Child Health Policymaking (PRISM) learning community. During the 2019 fiscal biennium, Washington allocated $35 million for housing services that prioritize people with behavioral health needs. DBHR is creating a registry for resident housing with a revolving loan fund for recovery housing and is increasing their contracts for recovery residences (housing) for people in recovery from substance use (4).

- Led by perinatal contractors, the **obesity workgroup** met regularly with guidance from the Title V-supported Perinatal Nurse Consultant. The obesity workgroup is developing guidelines and protocols for the care of pregnant women with a high body mass index (BMI) (5).

- DOH is working on a number of interagency initiatives associated with **maternal mortality review and prevention**:

    - Washington's second Maternal Mortality Review Panel (MMRP) Report was released in October 2019 and covered deaths from 2014-2016. This report included data and findings related to deaths from suicide and behavioral health conditions. Staff continue to disseminate findings from that report through presentations and communications materials to providers, hospitals, and other partners and interested groups. Staff continue to coordinate and support the maternal mortality review process and panel to review deaths of Washington residents that occur within a year of pregnancy (6).

    - As part of quality improvement resulting from the maternal mortality review recommendations, perinatal staff worked to have the state's maternal mortality law amended to require 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 (7).

- In 2020, Washington state policymakers cited the MMRP report in Senate Bill 6128 to **extend Medicaid coverage to 12 months postpartum**. This bill passed in the House and the Senate; however, it was vetoed by the governor due to budget cuts related to the COVID-19 response. In 2021, the bill was active again as Substitute Senate Bill 5068 and was passed and signed by the governor (8).

- 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 (9).

- 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 2021, will include an appendix with information on suicide among this population (10).

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 perspectives, 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

After publishing the report, we spent much of late 2019 and early 2020 on a "road show" presenting the report in person and virtually to a variety of audiences, including perinatal providers and partners. Some well-known audiences included the Washington State Hospital Association, the Washington State Obstetrics Association annual conference, and the UW obstetric grand rounds.

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.

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 2018, and deaths that occurred out of state from 2014-2018. We are preparing to review maternal deaths from 2019, and will review 2020 deaths by mid-2022. 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 more timely 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.

COVID-19

The Women's and Perinatal Nurse Practitioner has convened a perinatal COVID-19 workgroup that includes representation from DOH, WSHA, HCA, birthing hospitals, and many different types of inpatient and outpatient perinatal providers. We met regularly to hear from community members and partners, and discussed what supports were needed to address the maternal/infant impacts and needs associated with the COVID-19 pandemic. Patient education materials were developed and released in many languages. A website was created with content for people who are pregnant and parenting, and for health care providers offering perinatal care. 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.

During the first months of the pandemic, the University of Washington partnered with several birthing hospitals and clinicians to track birth outcomes, and they reached out and connected with the DOH Perinatal Health Program Manager and Epidemiologists to discuss this work. Later during the pandemic, DOH received a CDC grant to track and measure perinatal outcomes through case review of everyone in Washington who tested positive for COVID-19 during pregnancy. Both UW and DOH have shared information about their work and perinatal/COVID-19 measures to a variety of audiences.

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 March 31, 2022, in partnership with Child Protective Services at the Department of Children, Youth, and Families and the Washington State Hospital Association, finalize a revised process for plans for safe care for newborns born with abstinence syndrome, including promotion of supports for the substance-affected mother/infant dyad.

Strategies:

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.

In response to Washington state's ongoing opioid crisis, an interagency Washington State Opioid Response Plan was finalized in 2018. This plan prioritizes supports for pregnant and postpartum women who use substances, including a goal to "partner with the Department of Children, Youth, and Families' Child Welfare division to increase consistency in child removal practices, including working to strengthen connections between child welfare social workers and community resources at the local level."

Currently, Washington systems of care do not uniformly and equitably identify care and support for mother/infant dyads affected by substance use. This includes a lack of streamlined child protective policies, resulting in both under- and overreporting to Child Protective Services (CPS) for intervention. Plans of safe care for infants are a requirement of child welfare legislation and have been expanded to include infants affected by substance abuse withdrawal symptoms. This has led to urgency around the need to establish shared definitions related to infants exposed to substances, to create separate databases for reporting and notification data, and to pilot voluntary referrals to wraparound services for mothers/infants with an organization that works in partnership with DCYF.

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.

Currently, Washington state does not have a pathway for infants who are deemed substance-affected to receive a plan of safe care without becoming a traditional child welfare case. DCYF has developed and is piloting an alternate path that would allow for CPS to be *notified* (rather than receiving a "report") of a substance-affected infant to stimulate the development of a plan of safe care, without creating a report that would result in an open child welfare case for the family. This is appropriate in particular for infants exposed to or experiencing withdrawal symptoms from legally prescribed medications and marijuana.

Further, for infants who have no substantial risk of safety concerns, the workgroup proposes that the plan of safe care be shepherded by a community provider rather than CPS, with a focus on connecting the mother/infant dyad to supportive services, such as "Eat, Sleep, Console*"* and perinatal home visiting programs. They have begun the work

of piloting the new policy and process in Yakima and Pierce counties, and DCYF is building a new reporting database that will be used by mandatory reporters when an infant born exposed to substances meets the new policy's criteria for a report to child welfare. We are also creating a system to collect aggregate data for the notification of infants exposed to substances without substantial safety concerns. We are connecting with communities to see if creating a statewide database for notification would support this work.

Objective:
In January 2023, submit a revised maternal mortality review panel report to the Washington State Legislature, covering the deaths that occurred to women 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 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.

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 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, the Washington State Hospital Association, and the

Washington State Perinatal Collaborative – to implement prioritized recommendations.

To date, the panel has reviewed maternal deaths from 2014-2016 – this includes deaths from substance overdose and suicide. The findings, 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 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 percent 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 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:

- Provide access to health equity learning and education opportunities for the MMRP, including free trainings like the SPEAK UP Against Racism training coordinated by WSHA.

- 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 session with the American Indian Health Commission, and hope to learn more about how to better collaborate with these partners. Plan to publish the results in our next report (scheduled for release in early 2023).

- 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 percent of birthing hospitals in Washington state have established processes for the administration of maternal mental health screenings and referrals 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 percent of pregnancy-related deaths were preventable, and that the leading causes of pregnancy-related deaths were associated with behavioral health conditions. 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 WSHA to join the AIM, which is a national organization run in partnership with the American College of Obstetricians and Gynecologists 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 will launch a 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. DOH will partner closely with WSHA and HCA to recruit and inform birthing hospitals of this certification program.

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 January 31, 2021, update Guidance for Pregnant Women and Parents during COVID-19 with up-to-date COVID-19 data (including racial disparity considerations) and understanding.

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.

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

In April 2020, DOH convened a multisector advisory group of lay and clinical perinatal providers from across Washington state to inform guidance for pregnant and postpartum women amidst the COVID-19 pandemic. The group prioritized development of three areas of guidance: (1) staying safe during pregnancy and COVID-19; (2) pregnancy, birth, and caring for an infant with suspected or confirmed COVID-19; and (3) going home after birth during the pandemic. Key messages included equipping pregnant people with an understanding of increased risk of COVID-19 during pregnancy; anticipatory guidance on the birthing experience based on a COVID-19 positive test for the mother or newborn; recommendations on caring for an infant with COVID-19; and special mental health considerations for the caregiver unique to the context of COVID-19.

DOH developed three guiding documents, available in 17 languages on the DOH website. We also distributed the resources broadly to providers to share with their pregnant and postpartum patients. These guidance documents were revised with special consideration of new learnings about the intersection of racial disparities and COVID-19 in the context of pregnancy and the postpartum period. As new information becomes available, the guidance will be updated.

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.

Objective:

By August 2021, explore next steps to implement 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.

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

In the published report on maternal deaths from 2014-2016, the Maternal Mortality Review Panel found that a large number of pregnancy-related deaths occurred between 43 and 365 days postpartum. The panel identified several contributing factors to deaths, including gaps in postpartum follow-up care and services, breaks in continuity of care and transfer of care to other providers, and lack of social support and support structures during the first year after pregnancy. These factors affected women who died from suicide and substance overdose, hypertension in pregnancy, and sepsis, as well as women who experienced fetal loss, and loss due to legal removal of an infant from the mother's care.

The MMRP recommended that the state ensure funding and access to postpartum care and support through the first year after the end of pregnancy. In the 2020 legislative session, Senate Bill 6128 to extend Medicaid through the first year postpartum passed both the House and the Senate and was expected to be signed by the governor, but COVID-19 budget cuts impacted its adoption. In 2021, the bill was active again as Substitute Senate Bill (SSB) 5068 and was passed and signed by the governor. We will meet with our partners at applicable agencies and organizations to discuss and plan for implementation and how we can best support this important policy change.

Objective:

By September 2022, 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.

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 birthworkers 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 the Tacoma-Pierce County Health Department to identify an external facilitator, develop a recruitment process, and develop a broad distribution list of organizations, groups, and individuals serving Black and African American birthing families in Washington. From there, committee recommendations will inform how DOH MCH leadership identifies birth equity priorities, improves funds distribution, and refines program development in alliance with anti-racist values.

Once a fourth project partner has been selected, they will work with DOH contract staff to develop a scope of work, implement their project, 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 percent 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." Successful applications will be funded for up to a year.

- 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 2021, 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'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 early 2022. We hope to include the findings of the listening session or translated recommendations and implementation activities relevant to tribal communities in the next MMRP report, scheduled for release in early 2023.

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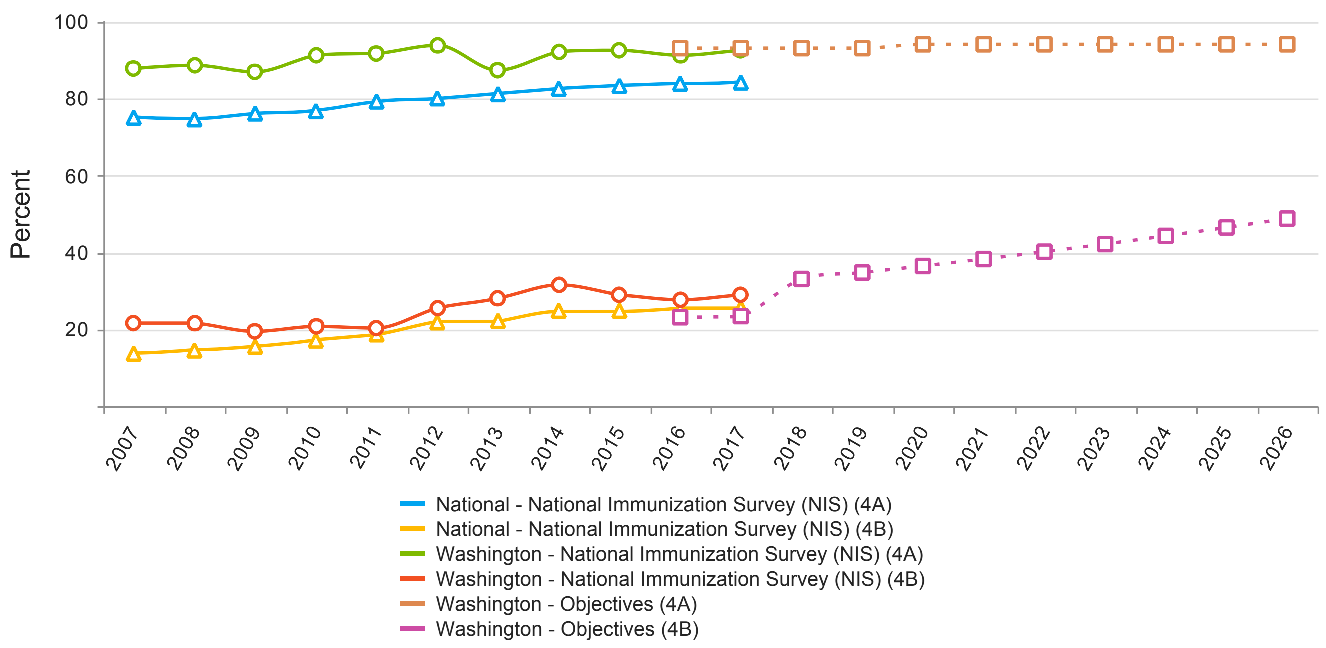
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	4.7	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.5	NPM 4
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	67.4	NPM 4

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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	93	93	93	93	94
Annual Indicator	87.5	92.1	92.4	91.0	92.5
Numerator	71,098	81,019	80,672	71,525	75,591
Denominator	81,303	87,977	87,274	78,591	81,714
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	93	93	93	93	94
Annual Indicator	93.4	94.5	94.2	94.1	94.1
Numerator	84,539	81,550	80,140	79,016	79,016
Denominator	90,489	86,284	85,113	83,941	83,941
Data Source	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	94.0	94.0	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)					
	2016	2017	2018	2019	2020
Annual Objective	23.2	23.5	33.1	34.8	36.5
Annual Indicator	28.0	31.6	29.1	27.6	28.9
Numerator	22,182	27,184	24,761	20,413	23,021
Denominator	79,360	86,004	84,974	74,010	79,683
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	38.3	40.2	42.2	44.3	46.5	48.8

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data

	2016	2017	2018	2019	2020
Annual Objective		26	46.1	57	58
Annual Indicator	43.3	43.4	55.3	57.9	59.2
Numerator	26	33	42	44	45
Denominator	60	76	76	76	76
Data Source	DOH	DOH	DOH	DOH	DOH
Data Source Year	2016-17	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	60.0	61.0	63.0	64.0	65.0	66.0

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

Measure Status:	Active

State Provided Data	
	2020
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

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	59.8	60.4	61.0	61.6	62.2

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	2026
Annual Objective	0.0	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.
Promote awareness and training opportunities to health care providers on provider bias and disparities on an ongoing basis.
By March 31, 2022, in partnership with Child Protective Services at the Department of Children, Youth, and Families and the Washington State Hospital Association, finalize diagnostic definition for neonatal abstinence syndrome as a central component to improve care of substance-affected newborns.
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.

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.
Promote education for health care professionals and pregnant women regarding medications and substance use (legal and other) during pregnancy and impact to the developing fetus.
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.
Address the need for more services, support, providers, and insurance coverage, particularly in rural communities and remote areas. Work toward ensuring services are accessible to people in the communities in which they live.
Facilitate access to free or affordable and accessible prenatal care across the state; ensuring culturally competent care such as doula care.

ESMs	Status
ESM 4.1 - Percentage of eligible facilities certified “Breastfeeding Friendly Washington” by Department of Health	Active
ESM 4.2 - Percentage of births taking place in facilities certified as Breastfeeding Friendly by 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 October 31, 2021, develop outreach plan to 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, 2022, complete stakeholder engagement regarding feasibility of establishing by statute a newborn hearing screening fee.

By December 31, 2022, complete a statewide gap analysis for perinatal behavioral health services, and align this analysis with county-level maternal mortality data.

By January 31, 2022, begin implementation of new statewide developmental screening data system scheduled to go live in fall 2021, working with early childhood partners as part of a statewide effort to increase developmental screening rates and connection to responsive services.

Strategies

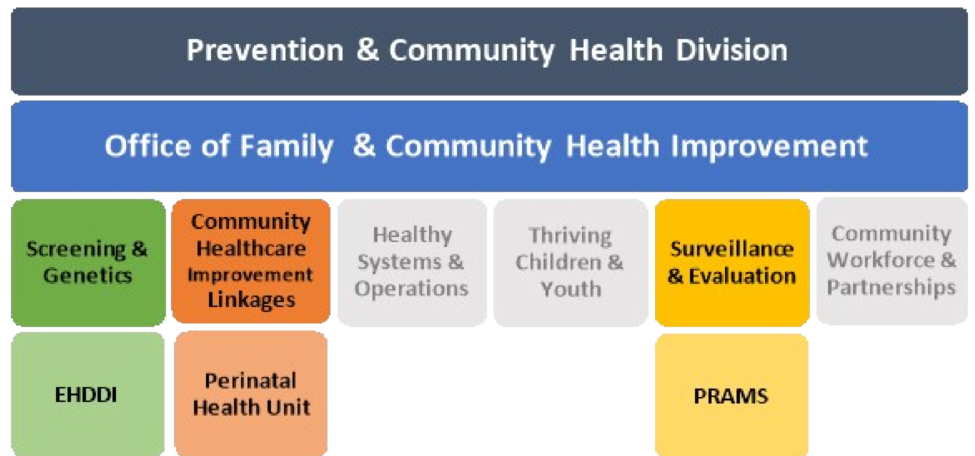
Support and promote bi-directional referral and linkage systems at the local, regional, and statewide levels.

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.

Foster measurable quality improvements across the health system throughout the life course.



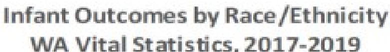
Overview

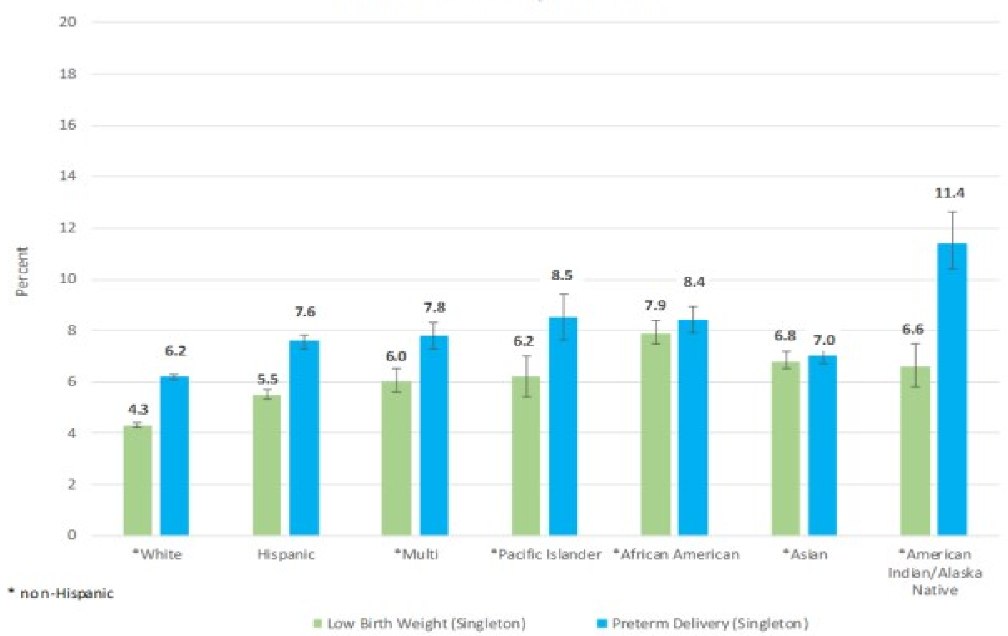
The Perinatal Health unit at the Department of Health (DOH) resides in the Community Health Improvement Linkages section of the Office of Family and Community Health Improvement in the Division of Prevention and Community Health.

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 percent of births were to white, 19 percent to Hispanic, 11 percent to Asian, 5 percent to Black or African American, 1 percent to American Indian/Alaska Native, 1 percent to Native Hawaiian or other Pacific Islander, and 5 percent 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 percent), Asian (6.8 percent), and American Indian/Alaska Native (6.8 percent) births, and lower among Native Hawaiian or other Pacific Islander (6.2 percent), multiracial (6.0 percent), Hispanic (5.5 percent) and white (4.3 percent) births. Pre-term births were more common among American Indian/Alaska Native (11.4 percent), Pacific Islander (8.5 percent), and Black or African American (8.4 percent) births, and less common among multiracial (7.8 percent), Hispanic (7.6 percent), Asian (7.0 percent), and white (6.2 percent) 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 or other 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.

Breastfeeding initiation and continuation show disparities by Medicaid coverage status, often used as a proxy for family income. Most infants were breastfed, with 98 percent of non-Medicaid and 93 percent of Medicaid-covered mothers reporting having initiated breastfeeding in 2019. At the time of the PRAMS survey (2-4 months postpartum), this disparity had increased to 89 percent among non-Medicaid and 68 percent among Medicaid-covered mothers. Breastfeeding initiation rates were lower among Native Hawaiian or other Pacific Islander and Hispanic infants at 92 percent, and by 2-4 months Native Hawaiian or other Pacific Islander breastfeeding fell to 59 percent, a full 14 percent lower than any other group. While lower, neither of these were statistically significant when compared with other racial/ethnic groups. Both initiation and breastfeeding at 2-4 months have remained steady since 2010 (Pregnancy Risk Assessment Monitoring System [PRAMS]).

In 2019, 89 percent 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 percent of Medicaid-covered mothers. Infant sleeping on stomach, a known risk factor, was only reported by 3 percent 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 other 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, child care, 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 program identifies babies who have hearing loss through the Early Hearing-loss Detection, Diagnosis and Intervention (EHDDI) program. We also promote 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.

In 2020, 99 percent of Washington-born infants were screened for hearing loss. 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 percent in 2011 to 70 percent in 2019 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 percent in 2011 to 3 percent in 2019. However, challenges still exist in the Washington state EHDDI system. In 2019, only 68 percent 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.

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 percent, an increase from 87 percent in 2013 before the Breastfeeding Friendly Washington program launched. The percentage of infants who were exclusively breastfed through 6 months was 28.9 percent, compared to 28 percent 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.

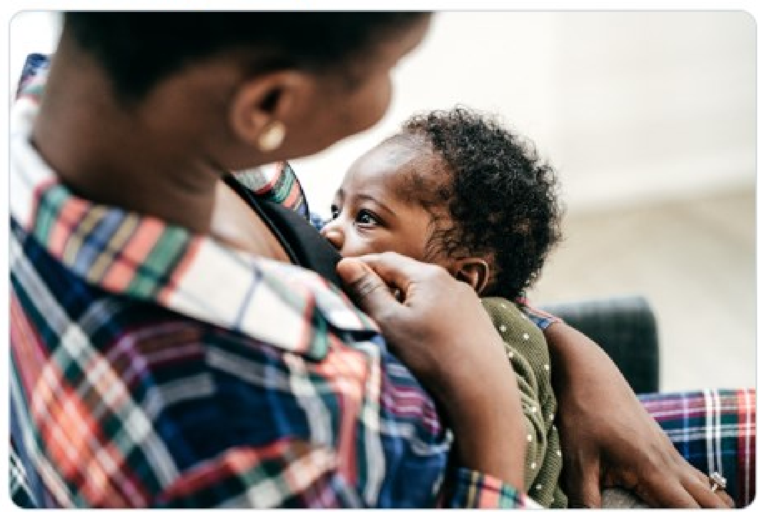
Hospitals play an important role in supporting breastfeeding. The Baby-Friendly® Hospital Initiative is an international designation program developed by the World Health Organization and the United Nations Children Fund and implemented by Baby-Friendly USA. DOH recognized that becoming a Baby-Friendly 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 percent, 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.

Congrats @MCCovingtonMC on becoming a Breastfeeding Friendly hospital! Thank you for all you do to support babies and parents 🙌 especially during the COVID-19 outbreak! #BFWA #BreastfeedingFriendly"



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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.

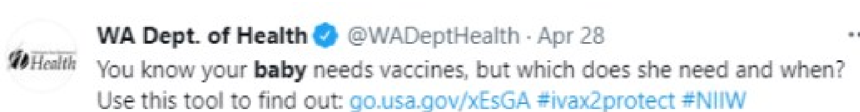
The Breastfeeding Coordinator:

- Coordinates breastfeeding messages and educational resources across programs within DOH.
- Reviews applications and modifies the Breastfeeding Friendly Washington program together with the DOH Breastfeeding 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 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.



State Performance Measures 3 and 5 – Native American and Black Infant Mortality

Through our state performance measures (SPMs) on the rates of Native American and Black infant mortality, we continued to track disparities in these populations, and our goal is to ultimately eliminate inequities. We released our report on infant mortality in December 2017, which contained culturally appropriate recommendations using community wisdom.

In 2018, infant mortality among the American Indian/Alaska Native population was 6.7 (2.9-13.2) deaths per 1,000 live births (2018, Vital Stats). Among Black or African American infants, the infant mortality rate was 9.7 (6.9-13.2) deaths per 1,000 live births (2018, Vital Stats), compared with 3.8 (3.3-4.4) deaths per 1,000 live births for white infants. Our 2020 objective for both populations was no more than 3.3 deaths per 1,000 live births (or all groups being equally affected by the infant mortality rate).

Title V funded part of the salary for a Maternal, Infant and Child Health Consultant who managed several maternal and child health contracts, including two focused on increasing health equity and improved birth outcomes for pregnant mothers who are from Black and African American and Native American communities.

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 and African American pregnant people in Pierce County, and provides them with culturally appropriate health messages. Title V staff worked with the Health Care Authority (HCA), the state's Medicaid administrative agency, and Tacoma-Pierce County Health Department (TPCHD), which oversaw the project, and supported health ministers in their efforts to improve referrals to the First Steps program. TPCHD also networked with and provided 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.

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:

Universal developmental screening system participation.

Objective:

By October 31, 2021, develop outreach plan to 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.

The Department of Health will continue to ensure readiness of each local jurisdiction's vaccine providers and partners to vaccinate at least 80 percent of their adult and teen population with COVID-19 vaccine, as indicated by the manufacturer.

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, 2022, complete stakeholder engagement regarding feasibility of establishing by statute a newborn hearing screening fee.

Strategy:

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

The Early Hearing-loss Detection, Diagnosis, and Intervention program works to ensure that all infants born in Washington state are screened for hearing loss 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 the EHDDI Advisory Group and DOH leadership to create and implement a stakeholder engagement plan to explore DOH using its authority to create a fee to provide funding for newborn hearing screening, surveillance, and follow-up services provided by the EHDDI program. The proposed fee would put Washington state in line with at least 10 other states that have implemented newborn hearing screening fees.

Between June 1, 2020, and June 30, 2021, we worked with our policy staff to develop a stakeholder plan to identify who we will engage to ensure the success of this proposal, and their potential support or concerns. On November 3, 2020, our policy team presented information about the proposed fee to the EHDDI Advisory Group and received initial feedback on the proposed fee and implications it may have on the EHDDI system. In the coming year, we will continue our work to implement our stakeholder engagement plan, including engaging with the Midwives Association of Washington State (MAWS), Washington State Hospital Association (WSHA), and families of children who are deaf or hard of hearing.

Objective:

By December 31, 2022, complete a statewide gap analysis for perinatal behavioral health services, and align this analysis with county-level maternal mortality 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 are exploring opportunities for expanding the analysis with state partners to see if it is possible 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.

Objective:

By January 31, 2022, begin implementation of a new statewide developmental screening data system scheduled to go live in fall 2021, 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.

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 Centers for Medicare and Medicaid Services. The 2021 Legislature has approved general state funding for ongoing maintenance and support.

The universal developmental screening (UDS) data system is on track to go live in September 2021. To meet the tight timeline, the initial version will limit user access to parents/guardians and health care providers, with the intent to add child care and early learning providers in future iterations. Coinciding with the go-live, DOH will stand up a UDS program to provide user support, engage with stakeholders, and conduct data analytics. Identified stakeholders include parents/families, health care providers, local health jurisdictions, tribal health departments, childcare providers, and government and nonprofit early childhood organizations. The Department of Children, Youth, and Families (DCYF) is a key collaborator, along with WithinReach/Help Me Grow Washington. The data system will serve as a tool as these partners move forward with developing a statewide early childhood system for coordinated care.

Priority:

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

National Performance Measure:

1. *Percent of infants who are ever breastfed.*
2. *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 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:

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 continue 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. Additionally, we have three trainings scheduled in summer 2021 with WSHA and DCYF to educate birthing hospital staff about existing disproportionality regarding who is reported to Child Protective Services (CPS) by mandated reporters. This content will be integrated into our upcoming Alliance for Innovation on Maternal Health (AIM) opioid bundle trainings in October 2021 and throughout 2022. 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 March 31, 2022, 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.

Support the Department of Children, Youth, and Families' creation of an online reporting system for infants exposed to substances that have safety risk, and support efforts to expand the rollout of the piloted programs and policy into more counties/communities.

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

Promote education for health care professionals and pregnant women regarding medications and substance use (legal and other) during pregnancy and impact to the developing fetus.

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, an interagency State Opioid Response Plan was finalized in 2018. This plan prioritizes supports for pregnant and postpartum women who use substances, including a goal to "Partner with the Department of Children, Youth, and Families (DCYF) child welfare division to increase consistency in child removal practices, including working to strengthen connections between child welfare social workers and community resources at local levels." Currently, Washington systems of care do not uniformly and equitably identify care and support for mother/infant dyads affected by substance use. This includes a lack of streamlined child protective policies, resulting in both under and over reporting to CPS for intervention. Plans of Safe Care for infants are a requirement of federal child welfare legislation, and have recently expanded to include infants exposed to legal substances during gestation. This has led to urgency around the need to establish shared definitions related to drug-affected infants, and determine interventions, support, and referral pathways for the mother/infant dyad affected by substance use.

DOH has been partnering with DCYF and WSHA to streamline these definitions and processes, and, in December 2019, facilitated a one-day training for partners from cross-sectors, including substance use disorder treatment, child welfare, health care, medication-assisted treatment providers, home visiting and early intervention providers. During the training, partners provided input on streamlining CPS involvement in a mother/infant dyad and oversight of Plans of Safe Care based on different levels of risk of harm to the infant. This included a robust consideration of pertinent definitions connected to the initiation of Plans of Safe Care – specifically, establishing shared definitions for the following terms:

- Prenatal substance exposure
- Affected by withdrawal
- Fetal alcohol spectrum disorder
- Report to CPS
- Notification to CPS

Finalizing these definitions was necessary to establish alternate pathways for infants who are deemed substance-exposed to receive a Plan of Safe Care without becoming a traditional child welfare case. The workgroup finalized definitions and they have been approved by DCYF. The state is piloting the new policy and program in Pierce and Yakima counties.

The definitions being piloted are:

Changes to the federal CAPTA [Child Abuse Prevention and Treatment Act] law mandate that healthcare providers involved in the delivery or care of infants born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder notify the child protective services system. The notification is not a report of child abuse or neglect. The CAPTA law further states that these identified infants receive a plan of safe care.

In Washington, prenatal substance exposure to controlled substances will lead to a plan of safe care for the infant and family and a notification to the Department of Children Youth and Families (DCYF). If the prenatal exposure is accompanied by child abuse or neglect concerns or there is imminent risk of serious harm to the child due to the parent's substance use or other risk factors, the infant will require a report to DCYF in addition to the plan of safe care.

- *A report to the DCYF child protective intake line occurs when there are child protection concerns.*
- *A notification to DCYF occurs when a newborn is prenatally exposed to controlled substances and there are NO child protection concerns. Health care providers should complete the notification form and fax this to their local DCYF office.*

To reach all of the state, DCYF has partnered with Help Me Grow to create an online portal for notification and referral to wraparound services for the Plan of Safe Care. The portal is scheduled to be piloted with 13 birthing hospitals in October 2021, and will then go live across the state at the beginning of 2022.

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.

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 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.

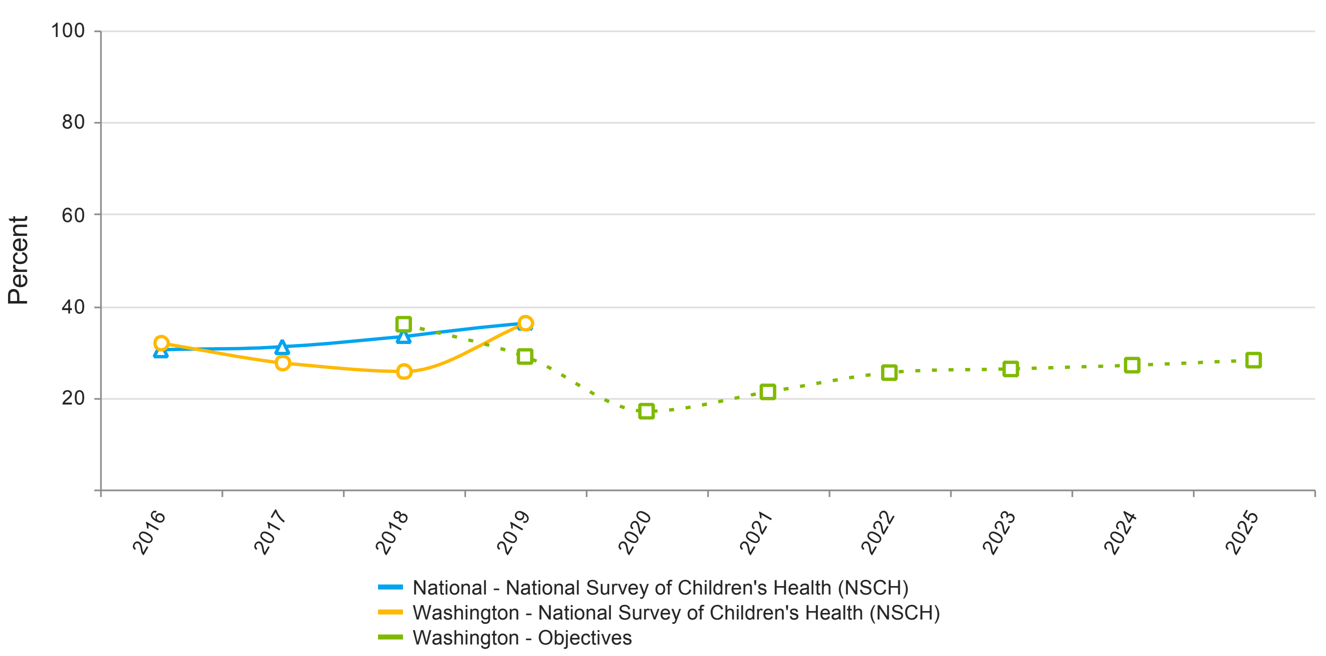
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.5 %	NPM 6

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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			36	29	17.1
Annual Indicator		31.9	27.7	25.6	36.2
Numerator		60,624	55,326	53,459	65,908
Denominator		190,110	199,961	209,028	182,179
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	21.3	25.5	26.3	27.1	28.2	29.3

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Number of ASQs provided by WithinReach to callers

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			381	1,135	904
Annual Indicator	686	529	1,113	834	785
Numerator					
Denominator					
Data Source	WithnREACH	WithinREACH	WithinREACH	WithinREACH	WithinREACH
Data Source Year	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1,113.0	1,135.0	1,158.0	1,181.0	1,205.0	1,230.0

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

Measure Status:	Active

State Provided Data

	2017	2018	2019	2020
Annual Objective			700	43,478
Annual Indicator			42,625	39,071
Numerator				
Denominator				
Data Source			Washington State Health Care Authority	Washington State Health Care Authority
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	44,782.0	46,126.0	47,510.0	48,935.0	50,403.0	51,915.0

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

Measure Status:	Active

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

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	61.0	62.2	62.8	64.1	65.4

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:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	78.3
Numerator	
Denominator	
Data Source	Healthy Youth Survey
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	78.3	78.4	78.5	78.6	78.7

SPM 5 - Ease of receiving mental health treatment or counseling

Measure Status:	Active

State Provided Data	
	2020
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	2026
Annual Objective	55.0	56.0	57.0	58.0	59.0

SPM 6 - Social and emotional readiness among kindergarteners

Measure Status:	Active

State Provided Data

	2016	2017	2018	2019	2020
Annual Objective		74	74.4	77	77
Annual Indicator	73.2	70.2	76.7	76.7	79
Numerator					
Denominator					
Data Source	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids
Data Source Year	2015-2016	2016-2017	2017-2018	2017-2018	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	78.0	78.0	79.0	79.0	79.0	79.0

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

Through September 2025, in the context of the COVID-19 pandemic, promote well-child visits and up-to-date vaccination completion.

By December 31, 2021, complete statewide universal developmental screening and referral data system, to be promoted with clinical, local health jurisdiction, and social services providers as component of plan to increase developmental screening completion for all Washington children.

Through September 2025, increase alignment and, where possible, correct misalignment between universal developmental screening data system development, the Help Me Grow Washington system, and other state child health screening/ assessment infrastructure through tracking of documented alignment milestones.

By September 2025, increase parent, public, and health professional awareness of developmental milestones and evidence-based well child care through communication strategies. Trends in developmental screenings will be tracked and measured against deployment of communication strategies.

Strategies

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.

Promote general universal developmental screening and other preventive care screening and wellness visits throughout the life course.

Encourage the coordination of pediatric screening efforts, results, and referrals among clinical care settings, medical homes, child-care settings, schools, and other organizations.

Foster measurable quality improvements in preventive care across the health system with emphasis on early childhood from birth through age 5.

Use Medicaid data provided through HCA-DOH mutual data share agreement to track number of children annually receiving developmental screening.

Communicate developmental screening information through a variety of social media and virtual/live modalities such as site visits with local health jurisdictions, Child Profile, DOH Facebook and other social media, and referrals. Document promotion efforts and the supports and barriers identified in the communication process.

Continue funding the statewide Help Me Grow Washington Hotline at WithinReach to enable trained hotline specialists to work with parents to conduct and interpret ASQs and connect parents to responsive, supportive services.

ESMs	Status
ESM 6.1 - Number of ASQs provided by WithinReach to callers	Active
ESM 6.2 - Number of children reported by HCA as receiving developmental screening	Active
ESM 6.3 - Percentage of children screened by Home Visiting/MIECHV programs	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 4 - Percentage of sixth grade students who have an adult to talk to when they feel sad or hopeless

Objectives

By April 2022, complete dynamic, community-driven inventory of statewide evidence-based and evidence-informed practices and policies that promote child and family mental, emotional, and behavioral health and resilience, to increase access and ethnicity/race specificity of models.

From January 2021 to September 2025, advocate, seek funding, and widen access for evidence-based and promising policy and practice strategies that promote mental wellness and resilience.

By June 2021, finalize an enhanced EfC data dashboard to measure outcomes and effective practices related to child maltreatment prevention. Include adverse childhood experiences measures.

Strategies

Working with ASTHO, AMCHP, Essentials for Childhood, CDC and other partners, develop recommendations for policy, procedure, and practice changes that strengthen family economic and community resources supports, strengthen positive parenting social norms, and provide direct skills to parents. Disaggregate approaches by community choice and effectiveness per racial/ethnic group.

Work with partners to expand scope of effective approaches to child and parent mental wellness and resilience in communities. Given limited workforce capacity, focus first on communities that have been underserved.

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

Support efforts to address and mitigate individual and community effects of substance use on children up to age 18, including inequities. Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges.

Implement trauma-informed services with racial/ethnic intersectionality considerations into community services, health care systems, and the public sector to address ACEs and promote resilience.

Work with Surveillance and Evaluation section partners and HCA to identify valid and reliable measures for ACEs incidence and promising prevention strategies at the state and community levels by June 2021.

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 5 - Ease of receiving mental health treatment or counseling

Objectives

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

Promote standardized depression, anxiety, and substance use screening for children and adolescents per the AAP Bright Futures, school-based health center models, and specific needs of communities. Support interventions to address suicide ideation among children and youth, especially among priority populations.

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 6 - Social and emotional readiness among kindergarteners

Objectives

By December 2021, work with two home visiting technical assistance providers to train home visitors (DCYF/NFP) in using Vroom to promote resilience.

By December 2021, share Vroom Brain Building messages and tools with at least 50 community partner organizations (such as local health departments, community services offices, early learning coalitions, tribal organizations, etc.) that connect with families of infants and children up to age 5.

By October 2021, determine need for and feasibility of a social norms campaign to promote positive parenting focused on early relational health and brain development per current research.

By September 2025, increase family and community-focused primary prevention practices, policies, and systems, based on the brain development of children and adolescents and community need.

Strategies

Increase protective factors and resilience through promotion of family supports, accessible to all families. Identify and develop methods to monitor systems, data gaps, and improvements needed to build capacity for a unified, comprehensive child and adolescent health screening, assessment, intervention, and treatment continuum. Selected protective factors: (1) Preschool based on neurodevelopmental science and enrichment, (2) Child care and after school programs of high quality, (3) Trauma-informed learning - adaptive, (4) Family supports (housing, public, work, social supports), (5) Mentoring/safe adults, (6) Parenting skills such as early relational health, (7) Well-child and adolescent visits, and (8) Screening and referral.

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.

Define future data needs to measure child and parent/caregiver health and well-being, to inform and support consumer-driven accessibility and quality. Support current data collection activities in this population, such as the oral health basic screening survey.

Overview

The child health program 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. This section also includes the Adolescent Health unit and the Children and Youth with Special Health Care Needs unit.

Child health is viewed holistically and through a life course development perspective by DOH. Our guiding vision encompasses the physical, mental, emotional, behavioral, and spiritual aspects of the child through the phases of growth. Building capacity for the disaggregation of strategies based on race, ethnicity, and geography is prioritized. We continue to promote the importance and availability of well-child visits, increasing and tracking the rate of developmental screenings, and eventually COVID-19 vaccinations. We work to reduce barriers to well-child health visits, increase connection to services, and improve provider billing practices. We promote parent and child mental wellness and resilience, and the prevention of adverse childhood experiences (ACEs).

This year, we started building a foundational inventory of the current landscape of policies and practices believed by researchers, evaluators, and communities to be effective. This will allow us to grow community and system-level prevention strategies, building on community assets. We will review policies and practices believed to build family resilience and wellness, based on a combination of research and community experiences. Ultimately, this will allow us to work with our state partners to increase access to racially and ethnically appropriate systems change, including access to racially and ethnically effective parental behavioral health care and other strategies. We work at the family, community, and system levels to increase positive parenting and reduce child abuse and neglect. Our work is based on the latest brain development research, and we keep considerations related to race and ethnicity at the forefront.

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), 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. 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 for a healthy start. The Immunizations and Child Profile 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. All of these programs collaborate toward our shared vision of healthy, safe, and active children.

In 2020, the Washington population of children and youth ages 0 to 17 was estimated to be 1,697,416, or about 22.2 percent of the total state population. The population of children ages 0 to 4 was estimated at about 5.9 percent of the total; ages 5 to 11 were about 8.9 percent; and youth ages 12 to 17 were about 7.5 percent. 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.

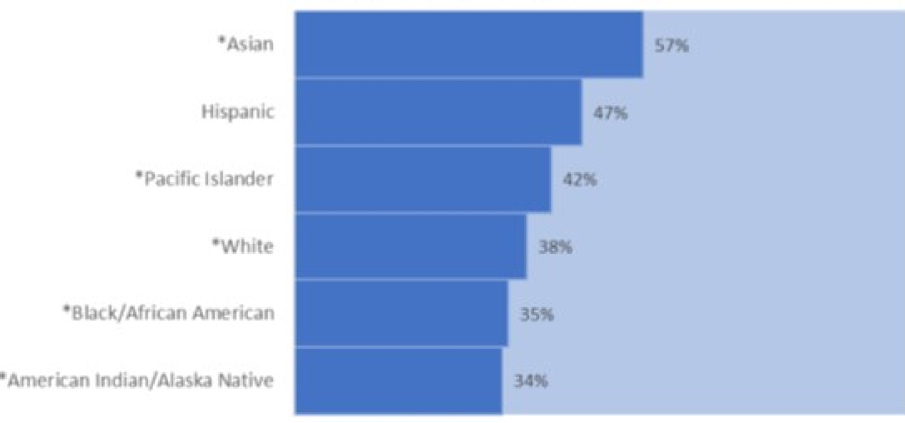
Washington 2020 Population Estimates by Race/Ethnicity, Youth Age Groups and Overall								
Race/ Ethnicity	**Total Pop, N**	**Total, %**	**Age 0-4, N**	**0-4, %**	**Age 5-11, N**	**5-11, %**	**Age 12-17, N**	**12-17, %**
White	5,124,654	*66.9%*	222,163	*49.5%*	356,744	*52.6%*	322,392	*56.5%*
Black	302,225	*4.0%*	19,831	*4.4%*	29,793	*4.4%*	25,847	*4.5%*
Am. Indian	95,040	*1.2%*	5,816	*1.3%*	9,511	*1.4%*	8,460	*1.5%*
Asian	718,728	*9.4%*	36,331	*8.1%*	56,302	*8.3%*	46,826	*8.2%*
Pac. Island	55,773	*0.7%*	4,320	*1.0%*	6,434	*0.9%*	5,723	*1.0%*
Multiracial	337,103	*4.4%*	47,369	*10.6%*	62,353	*9.2%*	45,649	*8.0%*
Hispanic	1,022,677	*13.4%*	113,298	*25.2%*	156,578	*23.1%*	115,646	*20.3%*
Overall	7,656,200	-	449,128	-	677,745	-	570,543	-

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 a third 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 2018-2019, an estimated 36 percent of children in Washington ages 9 to 35 months received a developmental screening, nearly identical to the national rate and higher than 2016-2017 (28 percent). In Washington, approximately 65 percent of families needing care coordination received it, compared with the national rate of 70 percent (National Survey of Children's Health [NSCH]).

Through 2019, vaccination rates among young children, measured as having received 10 recommended vaccines before 2 years of age, appeared to be increasing: 41 percent in 2019, 39 percent in 2018, and 37 percent in 2017. Vaccination coverage was uneven across racial and ethnic groups; 57 percent of Asian, 47 percent of Hispanic, 42 percent of Native Hawaiian or other Pacific Islander, 38 percent of white, 35 percent of Black or African American,

and 34 percent of American Indian/Alaska Native children received all 10 vaccines in 2019. See chart below.



*non-Hispanic

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

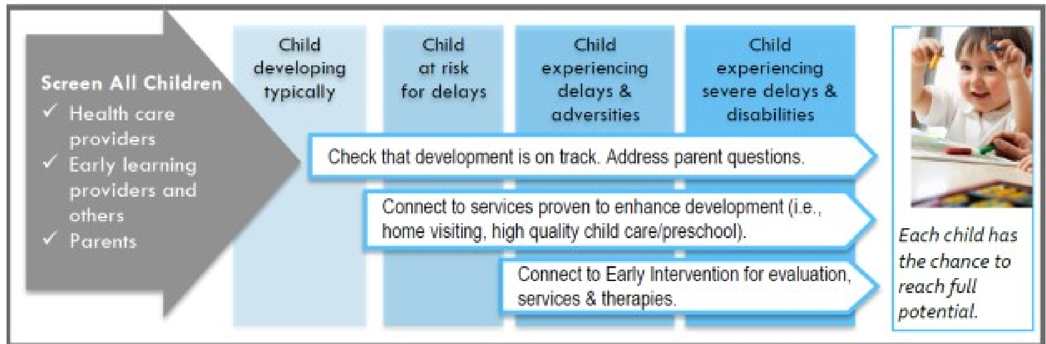
Percent of children, ages 9 to 35 months, receiving a developmental screening using a parent-completed screening tool in the last year.

The NSCH combined survey of 2018-2019 indicates that 36.2 percent of children ages 9 to 35 months received a developmental screening using a parent-completed screening tool. This is up from 25.6 percent reported in 2017-2018, and exceeds the objective we set.

Universal Developmental Screening in Washington

UDS and Connection to Responsive Services: A DOH Priority

A focus on universal developmental screening (UDS) is core with our strategic priorities. The DOH Strategic Plan includes two key objectives that are related to this. One is to foster the data integration, data sharing, and data analysis necessary to support better health outcomes; the other is to ensure equitable access to services, programs, opportunities, and information.



We developed and finished contracts that facilitated implementation of UDS, including Community Asset Mapping (CAM) within the University of Washington Medical Home Partnerships Project (MHPP) contract; Great MINDS (Great Medical Homes Include Developmental Screening); UDS toolkit development within the Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) expansion grant; integration of infant and child mental health as an important part of the developmental screening process within Project LAUNCH expansion; the Essentials for Childhood (EfC) grant, which has identified policy priorities related to UDS, Help Me Grow (HMG) 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 has been 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 organizations; university researchers; MCOs; local health jurisdictions; and WithinReach.

Community Asset Mapping and School Medical Autism Review Teams

About half of the state's counties participate in the Community Asset Mapping (CAM) 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 CAM and 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 CAM counties are doing UDS systems work to varying extents. Additional details about the CAM and SMART activities are included in the *CSHCN 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 14,468 calls in FFY 2020. WithinReach's ParentHelp123.org website data showed that in calendar year 2020, they had 24,194 page views with 19,039 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 state affiliate for Washington. DOH continued to work with WithinReach on Help Me Grow Washington expansion through partnerships on two 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, and (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.

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

Our first ESM is to track the number of Ages and Stages Questionnaires provided by WithinReach to callers. A total of 776 ASQs were completed by parents from October 2019 to September 2020 through WithinReach, which was a decrease from the previous year and far short of our objective of 1,135. 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), on track to launch this fall, has been 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 do 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 2020, 39,071 developmental screenings were completed for children, adolescents, and young adults ages 0 to 21. This was well below our objective of 43,478. We believe decreased provider visits due to the impacts of COVID-19 was the primary reason for this decline. In calendar year 2019, 42,625 screenings were completed; in 2018, 55,000 screenings; and in 2017, 48,933 screenings.

In early 2019, the Washington State Legislature approved 10 percent state matching funds to support a 90 percent 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. An internal project team began meeting weekly to develop detailed plans for the new system, and the UDS Steering Committee met monthly to hear progress reports and approve decisions. A full-time UDS Program Coordinator was assigned to the project in February 2020 and a Technology Project Director was hired in May 2020. External stakeholders were engaged, including leaders from DCYF, HMG, and the Washington Chapter of the American Academy of Pediatrics (WCAAP), and met monthly to receive updates and provide input. Local health jurisdictions (LHJs) and tribal health partners were also actively engaged.

The 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 will allow 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 Help Me Grow affiliates. The team began building out a roadmap and researching the best approach to procuring a vendor. They also developed a legislative ask for state General Funds for ongoing maintenance and operation beyond the September 2021 funding period. Despite the delays mentioned above, the system is on track to go live in fall 2021, and both internal and external partners and stakeholders continue to be engaged and supportive. In its 2021 session, the Legislature approved 75 percent of the additional funding requested for UDS maintenance and operation, which will enable us to move forward successfully.

In addition to the statewide work described above, eight of 35 LHJs had planned to use Title V funds in FFY 2020 to expand UDS in their communities. Primary areas of focus included provision of training and technical assistance to cross-sector partners, and engaging in policy and systems change efforts. However, much of the LHJs' planned regular work was put on hold in the past year as they turned their attention to the immediate needs of pandemic response. All LHJ efforts to affect policy or implement training were tabled for the time being. On the bright side, many LHJs have talked about improved relationships with community partners and greater ability to make connections. These relationships will be valuable when the time comes for LHJs to support the rollout of the new UDS data system.

Additional Work Supporting Children's Health

Enhancing Health Systems

DOH created flyers to remind parents of the value and importance of well-child visits even in the time of COVID-19. The flyers included information about behavior support for children and were adapted to be COVID-19 compliant, e.g., people on the flyers were masked. The flyers were distributed in late 2020 to families of children ages 0 months to 14 years, 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 partnered with Child Care Aware, a community organization with contacts in early learning and childcare centers, to test the success of providing flyers to parents of preschoolers. They distributed more than 4,000 flyers to parents by including them in deliveries of personal protective equipment (PPE) and food boxes to the childcare centers. The 2020 well-child visit rates in Spokane County, the test area, declined by only 5.24 percent, while statewide rates declined by 12.62 percent. Plans are underway to spread the impact statewide.

In February 2021, DOH hosted an online seminar, "Well Visits 2020 – Changes and Opportunities," about the Healthcare Effectiveness Data and Information Set (HEDIS) well-care visit measure changes announced by the 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 Alignment between Help Me Grow and UDS Data Systems Development

Two data systems are currently being developed in coordination with one another. Key leaders working on the Help

Me Grow Washington data system, which supports an information and referral network, presented on progress to the UDS Stakeholders Group in May 2021, and the WithinReach/Help Me Grow director provided an additional update in June. The DCYF Help Me Grow lead serves on the UDS Steering Committee and is actively engaged in collaborative planning for DOH's UDS program. We are working together to establish unique milestones for the UDS and HMG systems to determine how the systems will work together, and not duplicate input work for providers or parents. Additionally, we are identifying partners within the five counties that are Help Me Grow subaffiliates to conduct user acceptance testing of the UDS data system during a focused soft launch period once the system is built.

Increasing Family Resilience, Adverse Childhood Experiences Prevention

Essentials for Childhood convenes a statewide ACEs and Resilience Community of Practice, 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. Since 2018, we have held four in-person gatherings and two series of webinars. Participants learn together and from each other about how to create community capacity, foster resilience, and address ACEs in our communities. In FFY 2020, we pivoted in response to the new reality and partner interest in digging into the intersecting pandemics of COVID-19, systemic racism, and ACEs. A Community of Practice in-person event planned for southwest Washington in May 2020 had to be canceled due to COVID-19. Building on the original plans for the May event, we held a virtual event highlighting community-driven successes in southwest Washington. Those experiences provided a platform for meaningful discussion. Over 200 people participated in the day, which included presentations, small group discussions, and a panel.

Examining and addressing these intersecting pandemics have been the objective of all 2020-2021 events. We also continued our webinar series with seven sessions in 2020. Topics included what data tell us about what works to build resilience in Washington, youth mental well-being, and parenting for resilience.

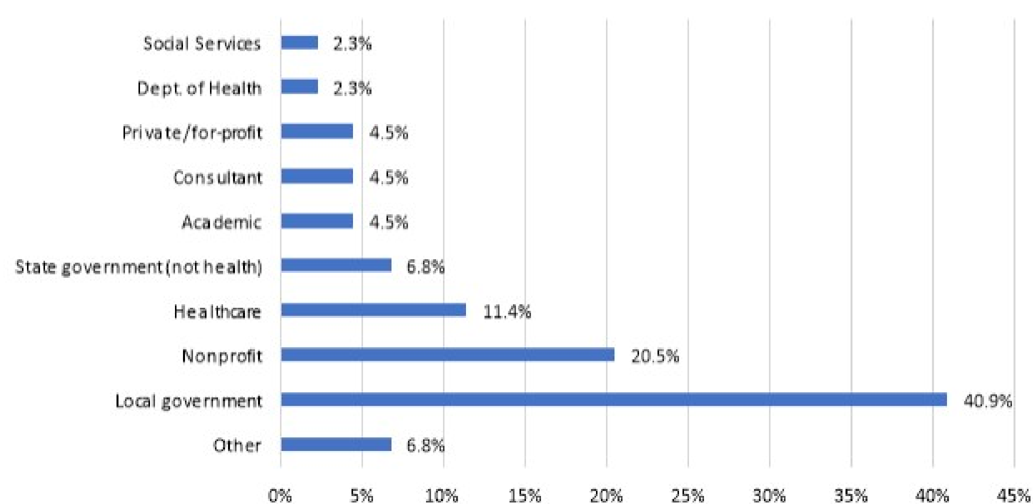
Through their MCHBG contracts, 26 of the 35 LHJs had planned to focus on work related to ACEs, including the following activities in their work plans:

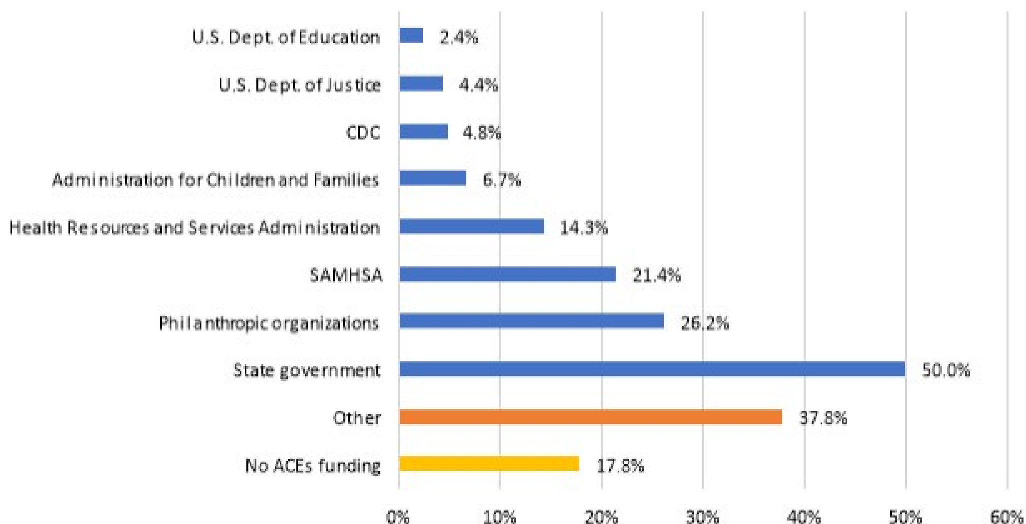
- Organizational implementation, including staff training and trauma-informed agency policies, was chosen by seven LHJs.
- Community planning and organization, including community coalition work, training events, local assessments, and work with partner organizations to develop trauma-informed approaches within their own agencies. This activity was selected by 18 LHJs.
- Home visiting, including providing education and resources to parents during home visits, and the Nurse Family Partnership program as an evidence-based prevention strategy. Nine LHJs selected this activity.
- Use of ACEs questions – selected by four LHJs
- Participation in state-level initiatives – selected by four LHJs

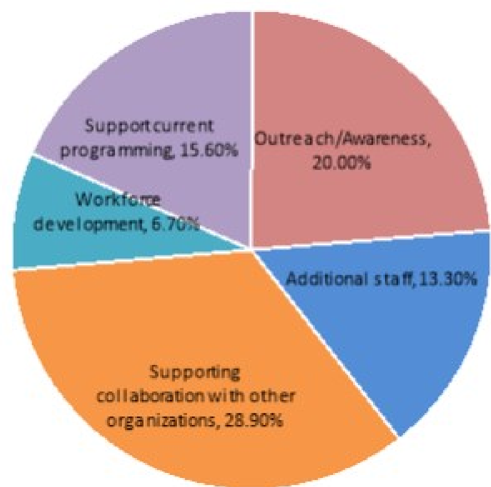
However, as described in *Appendix B - Maternal and Child Health Block Grant Local Work*, LHJs were forced to refocus their efforts on COVID-19 response in 2020, and generally were not able to spend the planned time on this work.

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. Selected tables below show information on partner sector, funding sources for ACEs prevention work, and likely uses of flexible funding that came from the survey. These data will be used to assess statewide capacity and plan for future funding opportunities.







Essentials for Childhood

The Essentials for Childhood collective impact 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 been awarded an MCH Early Childhood Comprehensive Systems 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 beginning of 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. At this time, 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, she will recruit and facilitate focus groups of diverse parents, and design an integration process to ensure parent leaders drive decision-making at the same table with other EfC community and state leaders.

The EfC Steering Committee met three times during FFY 2020, and twice in 2021, transitioning from in-person to virtual meetings because of the pandemic. An EfC Leadership Group was formed in 2020, and has met four times to shape our Policy and Steering Committee agenda. They have updated the EfC Framework for Action. This framework is 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 include 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 launched a statewide Policy Agenda of policies based on evidence, to promote child and family mental, emotional, behavioral health and family/community resilience. Selected criteria and questions used for our policy analysis are as follows:

1. Linked to Theory of Change: Protective factors, policies, outcomes of Essentials for Childhood framework. Will likely contribute to prevention of child abuse and neglect
2. Compared with the University of Texas Prenatal to 3 state strategies and policy roadmap
3. Looked at policy gaps in scorecard for our state
4. Looked for the centering of change in systemic racial inequities
5. Scanned for clear relationship to helping families and communities with impacts of current pandemic
6. Interviewed EfC Thought Leaders using key informant interview format to determine missing policies and for policy prioritization
7. Key questions: Is there organic movement already around this issue? Is there political will? Is there multiagency and local/state support for this? Is it community-informed?

Related to the policy work, EfC launched an *Inventory of What Works* in June 2021. It consists of promising, evidence-based, and community-driven practices and policies 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 mental 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. We are coordinating this inventory with the state's *Early Learning Coordination Plan* and *Preschool Development Grant Needs Assessment.*

The Help Me Grow movement continues to gain momentum and support. The vision is for HMG 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 launched a governance structure made up of a leadership team, six statewide Action Teams, and regional structures that mirror the statewide structure. HMG coordinates closely with EfC, presenting updates and getting input at each EfC Steering Committee meeting.

Since 2019, DOH has partnered with the Bezos Family Foundation to share Vroom Brain Building messages and tools in Washington state. Continued funding is likely, due to the high demand and positive response received statewide. Vroom is a set of asset-based, tested messages and tips for parents and caregivers of kids from birth to age 5. Content is deployed in a variety of ways, including an application, 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 reaching families furthest from opportunity and impacted by historic inequities.

Key activities during this period include:

- From October 2019 through June 2021, we have contracted with three organizations to embed Vroom brain-building messages and activities in community-based programs, and put brain science into the hands of families. We established a learning community among these partners, where they learn from each other.

- Request for proposal responses for additional community organizations to start Vroom were received in June 2021. We anticipate reaching our goal of 50 community partner organizations by December 2021.

- DOH provided customized starter sets of Vroom materials, along with technical assistance, to over 20 organizations around the state.

- We conducted outreach to engage Vroom partners, providing technical assistance through presentations, exhibits, webinars, one-on-one conversations, and emails. Our Brain Building with Vroom listserv is growing rapidly and now has over 2,200 subscribers. When the pandemic disrupted plans, DOH and our partners pivoted, adapting our outreach to new needs, and overcoming barriers to reaching families and partners.

- Our partners found that Vroom was a great tool for families who found themselves at home and spending more time with their children during the pandemic. They adapted their outreach to reach people where they were, including online and at food and diaper banks.

- Starting in July 2020, Washington families began getting Vroom information as part of the state's Child Profile Health Promotion mailings. Child Profile is a trusted source of information that sends health and development information to all families in Washington periodically over their children's first six years. Over 100,000 families per year receive this Vroom card as their children reach age 2½. The rack card is English on one side and Spanish on the other.

State Performance Measure 1 – Social/Emotional Readiness for Kindergarten

One of our state performance measures (SPMs) enabled us to better understand the impact of adverse childhood experiences in child development. We assessed the percent of incoming kindergarteners who demonstrated having the social and emotional characteristics appropriate to their age.

Data are from the Office of Superintendent of Public Instruction's Washington Kindergarten Inventory of Developing Skills (WaKIDS). For the 2019-20 school year, they indicate 79 percent of incoming kindergarteners demonstrated social-emotional school readiness. Our objective for 2020 was 77 percent, so we exceeded our objective. This was a slight increase from the previous reports of 76.7 percent in the 2017-18 school year, and 70.2 percent in 2016-17.

We had not initially continued this SPM in the 2021-26 state action plan, but we have decided to add it back in this year, as it will be a reasonable measure of effectiveness of our Vroom and ACEs and Resilience Community of Practice activities described above.

In Summary
Title V staff in the child health domain continued to promote statewide universal developmental screening, well-child exams, and appropriate follow-up and referral for intervention services. Our Title V vision is safe, stable, and nurturing relationships in families and environments for all children. We addressed system-level reform with the development and communication of a Policy Agenda, and the start of an *Inventory of What Works for Family Resilience*. 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 are aimed at family and community resiliency for all populations, especially for those who continue to face health inequities. In addition, Title V efforts in this domain are aimed at reducing child abuse and neglect through state and local level work.

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.

Objective:

Through September 2025, in the context of the COVID-19 pandemic, promote well-child visits and up-to-date vaccination completion.

General Status on this Objective to Date:

At this time, this work is taking place primarily through purchasers of care (Apple Health managed care organizations), their associated care provider networks, and local health jurisdictions. A dedicated DOH team provides training, data collection, and reporting of state outcomes to increase preventive care screening and wellness visits. Two-way communication with care providers is woven throughout the planning process for our universal developmental screening data system, which is funded by the state Legislature. The statewide Help Me Grow network will inform our care provider network through a grant-funded position dedicated to health care provider outreach. The communications work of the position includes informing providers about UDS. Lastly, we are requesting direct parent input on the new UDS system in the coming year, so system development is responsive to their needs and consumer experience.

Strategy:

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.

We track well-child visit rates with the Health Care Authority and other partners. We will work together with our DOH Office of Immunizations team to track trends of child COVID-19 vaccination from their data as the vaccination becomes available for different age groups. We will propose data collection to determine how many COVID-19 vaccinations were completed at well-child visits. Data will be disaggregated by community and racial/ethnic group where possible, to track and build equity of access. We will seek funding to build data collection capacity for these strategies as needed.

Strategy:

Promote general universal developmental screening and other preventive care screening and wellness visits throughout the life course.

We began work this year with the DOH Center for Public Affairs on a communications plan for UDS and the new UDS program being built. We promoted UDS through our multisector UDS Stakeholders Group, and worked with key pediatric providers to raise awareness and solicit testing participation in the new UDS system. Broader awareness raising for the new UDS program specifically is planned to begin by the spring of 2022, when the full UDS team is hired and trained. The team includes an Outreach Specialist position which will focus in the launch period on the most underserved racial and ethnic groups, and geographic areas. Our plan is to further enhance parent, public, and health professional awareness of developmental milestones and the importance of screenings and evidence-based well-child care through communication strategies such as Child Profile mailings, DOH Facebook and other

social media, and continued referrals to the Help Me Grow Washington network. This year, some of our local health jurisdictions planned to launch these, and other locally informed UDS communication strategies. This was delayed for many LHJs, given robust staff deployment for the public health COVID-19 response.

The informing of additional health providers, parents, and other family support providers about UDS is more important than ever during this time of pandemic, when some families have foregone well-child visits due to concerns about infection and/or lack of access to telehealth. We have learned some families prefer telehealth well-child visits, and they are concerned payers will not cover sole telehealth or hybrid service delivery in the post-pandemic environment. We will track and triage these systems concerns with our managed care organizations and Medicaid partners. We are exploring the use of HEDIS measures and other data sources outside UDS as complementary measurement systems. We will advocate for the disaggregation of data by race/ethnicity and geographic area.

Objectives:

By December 31, 2021, complete statewide universal developmental screening and referral data system, to be promoted with clinical, local health jurisdiction, and social services providers as component of plan to increase developmental screening completion for all Washington children.

Through September 2025, increase alignment and, where possible, correct misalignment between universal developmental screening data system development, the Help Me Grow Washington system, and other state child health screening/assessment infrastructure through tracking of documented alignment milestones.

General Status on these Objectives to Date:

Development is underway for the initial version of the UDS data system, anticipated to go live September 2021. The system will initially track developmental screening in children birth through age 5, with health care providers and parents able to access and enter data. Future versions will expand access to include child care providers and staff at early childhood organizations, including Help Me Grow affiliates. The DOH team is working closely with Help Me Grow Washington partners and the Department of Children, Youth, and Families in a collaborative effort to increase screening rates, connect families to supportive services, and improve equity in screening and referrals.

UDS will use the same platform and software as used by our HMG and DOH COVID-19 community resource tracking and linkage system, to better connect families impacted by COVID-19 in the future.

The project received a major boost when the 2021 Washington State Legislature approved 75 percent of the requested funding for ongoing UDS system maintenance and operations. This will enable the department to provide user support, conduct data analysis, and engage partners and stakeholders as we implement the new system. In addition to HMG and DCYF, engagement will expand on existing partnerships with local health jurisdictions, health care providers, community-based services, and tribal partners.

Key leaders planning the Help Me Grow Washington data system presented on their progress to the UDS Stakeholders Group in June 2021. They have implemented a pilot project in eastern Washington. We are working together with them to establish unique milestones for the UDS and HMG data systems to determine how the systems will be streamlined, avoiding duplication of input work for providers or parents.

Strategy:

Encourage the coordination of pediatric screening efforts, results, and referrals among clinical care settings, medical homes, child-care settings, schools, and other organizations.

The initial version of the UDS data system will limit access to individual records to parents and health care providers, who will be able to view the record and to manually input data if a record is missing or incomplete. Many developmental screenings take place outside the health care setting, and we will be working with early childhood programs, for example home visiting and early learning, to encourage parents to enter information into the data system and to share screening results with their health care providers. The system will also have the ability to run data reports, providing valuable information to early childhood partners and stakeholders who are working on coordinated care efforts.

Strategy:

Foster measurable quality improvements in preventive care across the health system with emphasis on early childhood from birth through age 5.

We will identify and develop methods to monitor systems and data gaps and improvements needed in preventive child care, early screening, and referral through creation and tracking of quality alignment milestones.

Quality measures are planned for future iterations of UDS, in collaboration with the Help Me Grow network, and informed by effective practices such as those in the American Academy of Pediatrics' (AAP) Bright Futures research. Input from partners about quality improvement is encouraged through stakeholder engagement, presentations, question/answer sessions, and key informant interviews. In addition, formal and direct parent stakeholder input will be incorporated into the UDS system development as we move forward.

DOH will conduct analysis of the data captured by the UDS data system, providing reports to health care providers, clinics, and larger health systems that will inform quality improvement efforts. This quality alignment work can be tracked through a combination of systems, which may also include the Help Me Grow network and HCA/MCO quality improvement metrics.

In addition to partnering with Help Me Grow on their statewide infrastructure improvements for preventive care, program staff will work with partners, including multisector UDS Stakeholder Group members and LHJs, to conduct education and outreach on the importance of UDS and provide training on the UDS data system, including data input and ability to view data. This will allow assessment of data gaps and improvements. Additionally, DOH is developing system requirements to ensure the data system includes information about relevant resources such as Help Me Grow. Gaps in communication to parents and caregivers via Help Me Grow partners and LHJs will be assessed using WithinReach to enhance screenings and visits.

Objective:

By September 2025, increase parent, public, and health professional awareness of developmental milestones and evidence-based well-child care through communication strategies. Trends in developmental screenings will be tracked and measured against deployment of communication strategies.

General Status on this Objective to Date:

The communications work to date has involved, and will continue to engage LHJs, the University of Washington Medical Home Partnership Project, Centers of Excellence across the state, the Washington Chapter of AAP, the CYSHCN Communication Network, the Help Me Grow Leadership Council, MCOs, and others to promote and increase the rate of developmental screenings and well-child visits at the local and state levels. The multisector UDS Stakeholders Group will continue to act as key ambassadors and communicators to raise awareness of UDS within their networks.

DOH Essentials for Childhood is partnering with WithinReach, the state Learn the Signs, Act Early Ambassador at Public Health Seattle and King County, and First5Fundamentals (Pierce County Help Me Grow) on a webinar that will highlight the fit between Help Me Grow, developmental milestones, and Vroom brain building messages and activities. The webinar will provide basic information and highlight how these programs and concepts fit together and can reinforce each other. The webinar is planned for the second half of 2021. We are targeting partners and providers who reach or work with families of children birth through age 5. Our prospective audience includes people who are already working with any of Help Me Grow, developmental milestones, or Vroom, and those who are new to all three.

A system to track the effectiveness of communication strategies by tracking how parents and providers learned about UDS, and/or trends in developmental screening after deployment of strategies, will be created by the UDS Epidemiologist and Outreach Specialist after they are hired by November 2021. The UDS communications plan will include this measure. Our partners in the DOH Center for Public Affairs will advise us as to communications methods with high impact.

Strategy:
Use Medicaid data provided through HCA-DOH mutual data share agreement to track number of children annually receiving developmental screening.

Our Surveillance and Evaluation team will track the number and rate changes of developmental screenings via a mutual data share agreement, in collaboration with our HCA partners. HCA is the Medicaid and Medicare payer agency at the state level.

Strategy:
Communicate developmental screening information through a variety of social media and virtual/live modalities such as site visits with local health jurisdictions, Child Profile, DOH Facebook and other social media, and referrals. Document promotion efforts and the supports and barriers identified in the communication process.

Methods of communication are often locally driven by each LHJ to fit with community culture and need. When possible, disaggregated racial and ethnic data drive culturally specific communications process, modality, and content, including language translation specific to the family values and practices specific to each audience. At the state level, there is collaboration with the Office of Immunization, MCOs, and our HCA partners to craft and deliver statewide messaging about the value of developmental screenings. Communication methods and content will be documented in LHJ reports and site visits, in order to determine the most effective strategies per community.

Strategy:
Continue funding the statewide Help Me Grow Washington Hotline at WithinReach to enable trained hotline specialists to work with parents to conduct and interpret ASQs and connect parents to responsive, supportive services.

The contract with WithinReach was recently renewed in order to continue to support Ages and Stages Questionnaire delivery in Spanish and English and connect parents with other services in as streamlined a way as possible. Parents and caregivers can access a no-cost ASQ through the ParentHelp123.org website or by calling the Help Me Grow Washington Hotline directly and working with a hotline specialist.

Over the years, the amount of funding provided to WithinReach has fluctuated. In previous years, the funding was adequate to support a dedicated ASQ Coordinator position for about three years. This position provided strong

linkages to the CYSHCN community and programs. WithinReach's ASQ numbers increased during the time this position was staffed, but they have not reached that rate again. ASQ delivery remains a service provided to Washington families through the hotline specialists, but they no longer have funding to support this coordinated outreach effort with a CYSHCN specialist.

Priority:

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

State Performance Measures:

Percentage of sixth grade students who have an adult to talk to when they feel sad or hopeless.
Ease of receiving mental health treatment or counseling.

Our three-step approach to the work under this priority can be summarized as an introduction to the objectives under this priority need:

1. **Assess existing policies, practices and programs** against evidence of science or community-based effectiveness in the promotion of child and family mental wellness and resilience. Build capacity to disaggregate by race. ***Product:*** *Inventory of What Works*

2. **Develop policy, program and practice recommendations** based on the inventory. ***Product:*** List of recommendations

3. **Vet and implement recommended system reform strategies with stakeholders, including parents** through system reform and influencing investments. ***Planned Outcome:*** Increased access, with attention to ethnicity/race specificity. Develop capacity to measure this.

Objective:

By April 2022, complete dynamic, community-driven inventory of statewide evidence-based and evidence-informed practices and policies that promote child and family mental, emotional, and behavioral health and resilience, to increase access and ethnicity/race specificity of models.

General Status on this Objective to Date:

Our Essentials for Childhood initiative promotes child health and prevention of maltreatment of children during early childhood. The broad EfC sectoral representatives have committed to a modified collective impact approach. To accomplish this, an inventory of effective, promising and community-driven practices and policies across family, community, and system levels has been launched. The *Inventory of What Works* will help state and community planners understand pathways for access statewide per geographic region and to spark spread of evidence-based, research-informed, and promising innovations. We are working with a consultant and local health jurisdictions to create the *Inventory of What Works*. By September 2021, the consultant will create a point-in-time assessment showing strategies (policies and practices) in place in Washington that are believed to build family resiliency and prevent child abuse and neglect. They will focus on children ages birth to 5 years old. The consultant will review trusted sources in the field to identify strategies that focus on shared risk and protective factors, or on decreasing risk and increasing protective factors for prevention of child abuse and neglect.

Five local health jurisdictions are adding to the inventory with their own assessments that will provide a detailed picture of strategies in place in those communities.

In summary, this inventory will:

1. Help community and state partners plan for the building of family resiliency with a focus on early childhood, on families with the least access to resources, and families that are over-represented in the child welfare system.
2. Create baseline data for the identification of assets and gaps, and to allow tracking of strategies thought to lead to family resiliency and prevent child abuse and neglect over time.

Strategy:
Working with ASTHO, AMCHP, Essentials for Childhood, CDC and other partners, develop recommendations for policy, procedure, and practice changes that strengthen family economic and community resources supports, strengthen positive parenting social norms, and provide direct skills to parents. Disaggregate approaches by community choice and effectiveness per racial/ethnic group.

Once the inventory is completed, recommendations will be developed based on assets and gaps in effective policies, programs, and practices statewide. The idea for an *Inventory of What Works* fits with the logic model approach to first assess effective resources available, before systems change and enhancement recommendations are developed. Our foundational understanding of system reform for family resilience is informed by seminal science-based work such as Bright Futures (AAP), the Association of Maternal and Child Health Programs (AMCHP), CDC Technical Packages, the National Academies Report, the Harvard Center for the Developing Child; and locally, University of Washington, Washington State University, and the Health Care Authority's Substance Abuse and Mental Health Services Administration (SAMHSA)-funded work based on the strategic prevention science framework.

This year, resources were identified for the review of secondary source data, to determine review process and the data collection requirements to produce the inventory, and a contract has been awarded. The *Inventory of What Works* will include an alignment of policies and practices with previous research capturing this information. Recommendations will be based on gaps identified statewide in effective strategies.

National sources for the *Inventory of What Works* will include:

1. The *Racism as a Root Cause: A New Framework* (Malawa et al., 2020) public health strategy
2. California Clearinghouse for Child Welfare Practice
3. Prenatal to 3 Policy Impact Center at The University of Texas at Austin
4. Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Home Visiting National Clearinghouse
5. Blueprints clearinghouse for effective practice
6. Harvard Center on the Developing Child
7. The Center for Disease Controls Essentials for Childhood Child Abuse and Neglect Prevention Toolkit and Prevention of ACEs Toolkit
8. Zero to Three organization
9. US Health and Human Services (HHS) Health Resources and Services Administration (HRSA) Maternal Child Health Bureau – early childhood strategies including systems recommendations
10. The Pew Charitable Trust
11. Title IV evidence-based and promising prevention strategies for the child welfare system
12. Other sources to be decided

Objective:

From January 2021 to September 2025, advocate, seek funding, and widen access for evidence-based and promising policy and practice strategies that promote mental wellness and resilience.

General Status on this Objective to Date:
As a prelude to the *Inventory of What Works* (inventory), in July 2020, DOH completed a partial review of effective state approaches and strategies at the family, community, and systems levels believed to increase family resiliency for healthy early childhood. This CDC-funded EfC inventory will address the MCHBG priority to *promote mental wellness and resilience through increased access to behavioral health and other support services.* The inventory population focus will be broadened under block grant funding in the future to include children ages 5 to 11, and the resource query broadened to include strategies to promote mental wellness. One example of a resource included in the current inventory is the Help Me Grow system as one community strategy that drives system-level improvement.

Equipped with the learnings from our early inventory and other data, in 2020-2021, we submitted two grant proposals and a concept paper for a potential funding decision package to widen access for evidence-based and promising policy and practice strategies that promote family and childhood mental wellness and resilience. We did not receive funding for the first grant proposal, but we understand we were highly rated in a very competitive process. We recently received news that we will be awarded a HRSA MCH Early Childhood Comprehensive Systems grant, which will strengthen maternal mental health care and build early childhood resilience. The concept paper for the decision package has just been submitted to our DOH Prevention and Community Health Division Leadership Team for review.

Once recommendations are made and vetted for system development, based on the inventory findings, we can sharpen and refine our approach to influencing funding and investment strategies that address the gaps identified. We will do this by communicating through and to philanthropic and government entities, with our Health Care Authority and other partners. We will lead with partners by messaging our overall goal of system reform to widen access for effective work to promote family and child mental wellness and resilience.

The Essentials for Childhood initiative has prioritized identifying and building family, community, and system capacity to widen access to common strategies that are effective at the population level, through local health jurisdictions and communities. EfC began in 2020 to bring together the influence of our partnership to promote investment in these strategies. We are bringing a racial equity lens to this work, and are intentionally focusing on strategies to repair historical injustices, using Dr. Zea Malawa's *Racism as a Root Cause* public health strategy.

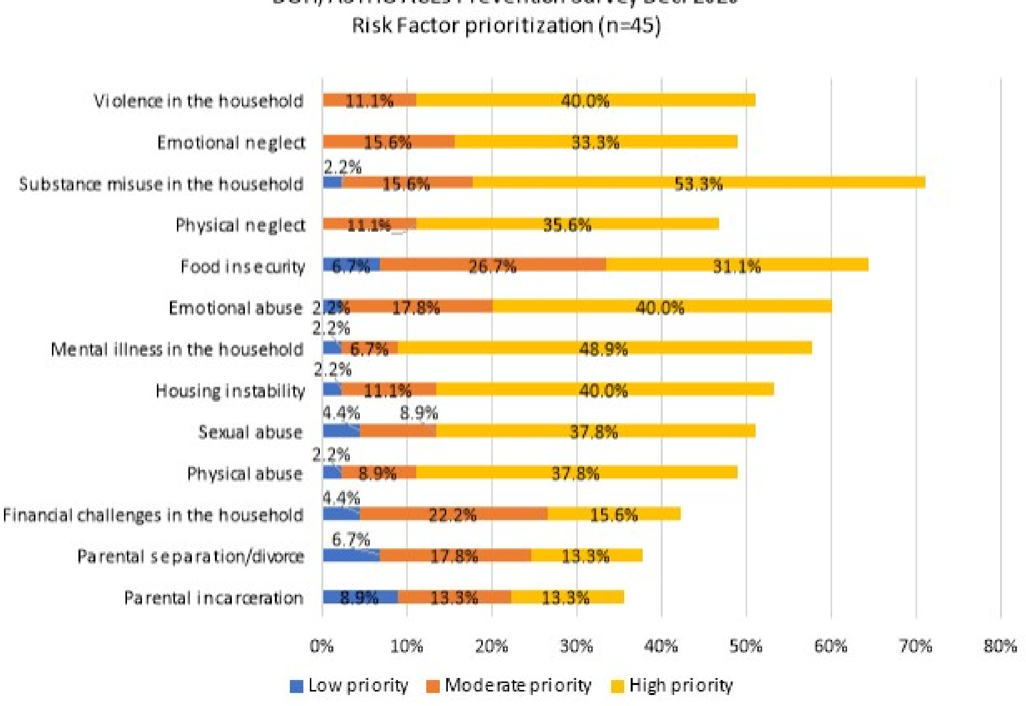
Starting in late 2022, we intend to build capacity to fill the gap in locally driven systems to address the needs of children in middle childhood and adolescents. We need to widen access to mental wellness and resilience resources for children, adolescents, and young adults across their lifespans. We will seek funding to build capacity to create a Phase 2 inventory. This will identify resource gaps, geographic implementation, scale up, and anticipated outcomes. This work to inventory and enhance effective resources statewide is aimed at improving the desired population level outcomes – defined as increases in indicators related to advantageous child and youth experiences and development; and decreases in those related to adverse child and youth experiences and development.

In 2021, EfC partners informed and promoted an agenda of policies to promote family resilience and reduce child abuse, neglect and other childhood trauma. Bills enacted by the state Legislature this year expand access to quality early learning, modernize and increase cash and food assistance, preserve family connections and reduce removal of children from their families, and fund more evidence-based prevention programs for families furthest from opportunity.

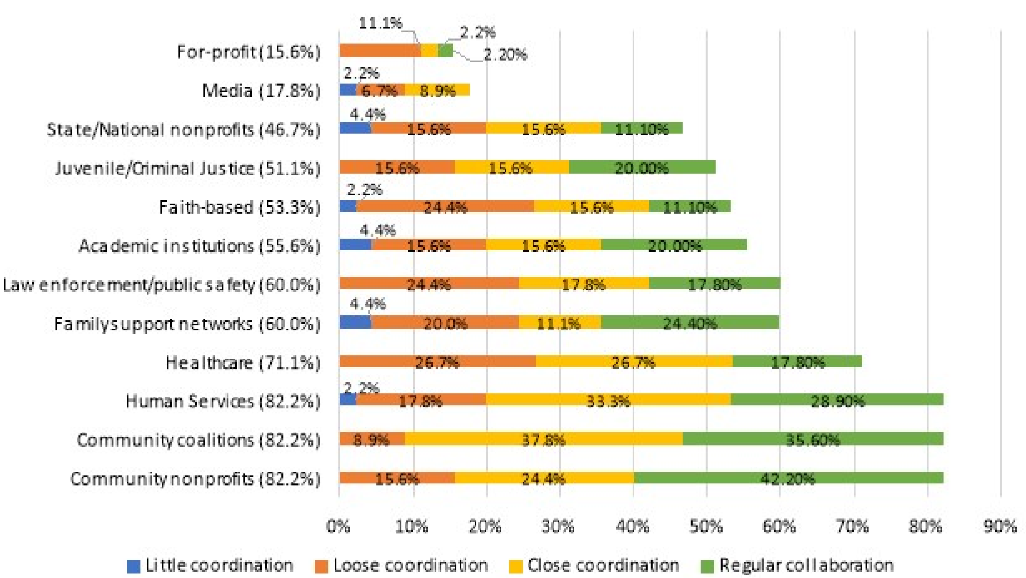
Strategies:
Work with partners to expand scope of effective approaches to child and parent mental wellness and resilience in communities. Given limited workforce capacity, focus first on communities that have been underserved.

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

From October to December 2020, DOH worked with the Association of State and Territorial Health Officials 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. More information about attendance, participating sectors, funding, and likely use of new resources for ACEs prevention are included in the *Child Health Annual Report*. We will base our state efforts, in part, on the outcomes of this survey. One science-informed objective is to build a prevention approach that focuses on the risk and protective factors associated with ACEs, and to improve community partnerships and state collaboration for a renewed focus on family resiliency. This assessment work was completed through the lens of the pandemic and renewed efforts to address systemic racism. As the following graph shows, the most commonly addressed risk factors are household substance misuse (71.3 percent), food insecurity (64.5 percent), emotional abuse (60.0 percent), and mental illness (57.8 percent).



Partnerships between multiple sectors at the community and state levels were measured by the survey because they are critical to reducing ACEs and building family resilience. Partnerships to coordinate ACEs activities are common among the surveyed organizations, with over 80 percent of participating organizations engaging in partnerships with human services organizations, community coalitions, and community nonprofits. The graph below shows the types of partners and levels of collaboration respondents reported with each.



With our partners, including those attending learning and community development events through the EfC ACEs and Resilience Community of Practice, we co-create processes that allow community-driven needs and strategies to emerge, in order to expand access to primary prevention, screening, assessment, early intervention, and treatment services. We have enhanced community-driven processes to support virtual events with parent and partner participation in the pandemic response environment. We have also supported telehealth approaches. Partnering with DCYF, we prioritize response to the needs of racial and ethnic groups in high-need geographic areas of our state. For example, the DCYF *Strengthening Families* pilot, a multilevel intervention to increase family resilience, will be implemented in areas of the state with the highest reports of child maltreatment. Essentials for Childhood supports this pilot as a key state strategy to reduce child maltreatment. DOH also supports the evaluation of DCYF evidence-informed and evidence-based home visiting approaches, and effective child and adolescent early intervention and treatment, through our partner, the Health Care Authority's Division of Behavioral Health and Recovery (DBHR). Home visiting and interventions designed to promote effective parenting and family bonding have been shown to improve mental, emotional and behavioral health, and reduce risk for maltreatment.

Strategy:
Support efforts to address and mitigate individual and community effects of substance use on children up to age 18, including inequities. Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges.

In June 2020, we developed a partial inventory of effective ACEs prevention strategies sponsored locally by state departments. DOH and DBHR both sponsor social norms campaigns to encourage parents and youth to seek help with substance use issues. For example, DOH supports the Opioid Task Force-sponsored *Start Talking Now* substance use intervention/social norms campaign with communication strategies that can be locally adapted for racial and ethnic considerations. We support the campaigns our HCA Recovery Support partners launched to reduce stigma around behavioral health. We also support school-based access for children and youth of all ages who seek help for issues related to substance use.

Strategy:
Implement trauma-informed services with racial/ethnic intersectionality considerations into community services,

health care systems, and the public sector to address ACEs and promote resilience.

The EfC ACEs and Resilience Community of Practice (Community of Practice) is a network of leaders from across the state who are successfully putting innovative practices to work on the ground in communities and learning from research. It is a forum where we learn together and from each other about how to create community capacity, foster resilience, and address ACEs in our communities. A growing body of research supports the notion that contextual factors in a community make a difference in fostering resilience in individuals, reducing adverse experiences and mitigating their impact. Contextual protective factors like social connections, community supports, social capital, and cohesion seem to have a positive impact. Community of Practice participants are engaged in efforts to address the context in their communities.

We are currently working with a consultant, who has lived experience of ACEs and professional background in public health assessment, to develop a two-year roadmap for the Community of Practice. This roadmap will reflect the needs and desires of diverse participants and potential new participants, and support the EfC framework and our MCHBG state action plan. The roadmap will be informed by the data from the DOH/ASTHO ACEs Partner Prevention Survey described here.

DOH will continue to provide technical assistance to the LHJs on child health and development. We will work with LHJs to continue to participate in community-level planning and initiatives around preventing ACEs and promoting resiliency. Twenty-seven of our state's 35 LHJs chose ACEs prevention as a strategy for their FFY 2020 contracts. Some have been involved in health system interventions to enhance screenings for ACEs in pediatric settings; others engage in general community awareness strategies.

Objective:

By June 2021, finalize an enhanced EfC data dashboard to measure outcomes and effective practices related to child maltreatment prevention. Include adverse childhood experiences measures.

Strategy:

Work with Surveillance and Evaluation section partners and HCA to identify valid and reliable measures for ACEs incidence and promising prevention strategies at the state and community levels by June 2021.

Finalization of the ACEs risk and protective factor measures as a part of our EfC data dashboard projected for June 2021 will be delayed, due to the assigned Epidemiologist's continual COVID-19 deployment in 2020-2021, and departure to a different job in April 2021. The position has remained vacant since then, due to unexpected pandemic-related and other delays in the human resources hiring process. Recruitment may begin again in summer 2021.

Our Surveillance and Evaluation section has a plan in the coming year with our EfC initiative to enhance measurement of factors related to ACEs for children, youth, and adults in our state, with qualitative data such as storytelling. In addition, a quantitative index for the prevention of child abuse and neglect for early childhood is partially completed, focused on data collected through our state's biannual Healthy Youth Survey, and national survey data. Together with our community LHJ partners, we supported additional Behavioral Risk Factor Surveillance System (BRFSS) questions about ACEs that are asked with every other administration of the survey.

A partial inventory that included state-sponsored, evidence-based and -informed ACEs prevention strategies was completed in June 2020, and the *Inventory of What Works* described above will be completed October 1, 2021. We will use information from the ASTHO survey for ACEs prevention planning to determine gaps and barriers to

replication and implementation. This information will also be included in the broader inventory of effective policies and practices for the promotion of child mental, emotional, and behavioral health.

Objective:

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

Strategy:

Promote standardized depression, anxiety, and substance use screening for children and adolescents per the AAP Bright Futures, school-based health center models, and specific needs of communities. Support interventions to address suicide ideation among children and youth, especially among priority populations.

The lead on this work at DOH is the Suicide Prevention unit in the Injury and Violence Prevention section. Recent legislation brings new resources to multiple state agencies and communities to strengthen protective factors, starting with populations furthest from opportunity. In the coming year, we will plan with them to determine the best way to support this collaborative work.

To address suicide ideation among youth, we support the science-based strategies the legislation was built on, such as those recommended by our state's Suicide Action Alliance, the University of Washington's Forefront Model, SAMHSA, and subject matter experts from DBHR's child mental health promotion and treatment teams. Together, we work to meet the prevention and intervention needs of children and youth who express suicide ideation, and their families, by supporting changes in Medicaid reimbursement rates for early intervention and treatment, and other integrated health care system reform such as population-level screening and information campaigns.

In 2022-2023, through our partnerships, such as those with MCOs and Health Homes delivering Medicaid services, we will support recommendations for the integration of standardized depression, anxiety, and substance use screening for children, adolescents, and their parents/caregivers. The AAP's Bright Futures recommendations are one example of widely accepted best practice approaches for health care providers. We will seek to understand the system barriers to implementing standardized as well as tailored approaches and tools for specific racial and ethnic groups.

Priority:

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

State Performance Measure:

Social and emotional readiness among kindergartners.

Objective:

By December 2021, work with two home visiting technical assistance providers to train home visitors (DCYF/NFP) in using Vroom to promote resilience.

By December 2021, share Vroom Brain Building messages and tools with at least 50 community partner organizations (such as local health departments, community services offices, early learning coalitions, tribal organizations, etc.) that connect with families of infants and children up to age 5.

By October 2021, determine need for and feasibility of a social norms campaign to promote positive parenting focused on early relational health and brain development per current research.

General Status on this Objective to Date:
Essentials for Childhood is in the final year (2020-2021) of a three-year grant from the Bezos Family Foundation to activate Vroom across Washington state. Vroom is a set of asset-based, tested tips for parents. Vroom is grounded in child development research for children from birth through age 5. This approach is described in more detail in the *Child Health Annual Report*.

Essentials for Childhood continues to work with partners to use Vroom as part of a strategy promoting parent and caregiver knowledge of parenting skills and child development, with geographic reach expanded this year. It includes promotion of community social environments that support and empower families. These strategies promote bonding and brain development, contributing to mental wellness and risk reduction. We have implemented a layered activation strategy that will include light touch, broad reach through statewide partners and networks, and more intensive, funded activation in a few communities.

Our two-pronged approach to engage partners to share Vroom and provide technical assistance and learning opportunities includes more intensive Vroom promotion by funded partners and lighter touch outreach and support cascading through our networks. We contract with nine community-based organizations who are bringing intensive Vroom promotion to underserved, priority-population families in at least seven counties. These organizations are leveraging their systems and networks to put Vroom into the hands of families. They leveraged their understanding of their communities and creatively adapted to the changes wrought by COVID-19.

Our lighter touch sharing of Vroom includes providing starter sets of Vroom materials and technical assistance to organizations around the state, including home visiting programs. In summer 2020 we provided Vroom starter sets to over 20 organizations around the state, reaching at least 1,235 families. A survey found that at least 12 of those organizations were still sharing Vroom six months later. We are providing Vroom starter sets and technical assistance to about 20 new organizations this summer. Other promotion activities include adding Vroom rack cards to the state's Child Profile Health Promotion mailings, annually reaching about 100,000 Washington families as their children reach 2 ½ years of age. We also shared Vroom information and resources in emails to our growing "Brain Building with Vroom" distribution list.

Social Norms
Shifting community social norms toward positive parenting approaches is increasingly associated in research with optimization of protective factors and resilience for parents, children, and youth of all ages. At this time, social norms campaigns exist in selected communities across the state; however, a web-based scan revealed that few of these campaigns are based on positive parenting approaches for early childhood, using science-based methods calibrated to racial, ethnic, and economic-specific community needs, to enhance population-level positive parenting norms. Our plan is to work with our state DOH, EfC, LHJ, DCYF, and HCA partners to assess social norms campaigns statewide. Based on our assessment, we'll determine need for and feasibility of additional social norms campaign(s). Key Child Health staff attended a recent review of effective and breakthrough social norms practice in a presentation by prevention scholar Dr. Jeff Linkenbach, Director and Chief Research Scientist at the Montana Institute. His early pioneering work was focused on positive parenting and early childhood, and we plan to consult with him on strategies for our state needs assessment of social norms, and future campaigns – if we discover there is a gap in our state.

Social norms campaign content should include science-based, community-driven parent messaging. This messaging will promote positive parenting, enhance trauma-informed services, and reduce ACEs. This work will require the development of workforce capacity to conduct the assessment. Workforce identification is already underway in our infrastructure planning for a continuum, life course development approach. In mid-June 2021, a new

Child Health Services Consultant with significant background in social norms research and community and state campaign implementation methodology joined our team. One job task in her position is to carry out the objective to determine the need for, and feasibility of, a social norms campaign.

Objective:
By September 2025, increase family and community-focused primary prevention practices, policies, and systems, based on the brain development of children and adolescents and community need.

General Status on this Objective to Date:
A contract was executed in early May 2021 to develop the first draft, and first phase of a Washington state *Inventory of What Works for Building Family Resilience* by October 1, 2021. The first phase will include the identification of policies and programs that focus on early childhood and the prevention of child abuse and neglect.

Strategy:
Increase protective factors and resilience through promotion of family supports, accessible to all families. Identify and develop methods to monitor systems, data gaps, and improvements needed to build capacity for a unified, comprehensive child and adolescent health screening, assessment, intervention, and treatment continuum. Selected protective factors:

- *Preschool based on neurodevelopmental science and enrichment*
- *Child care and after school programs of high quality*
- *Trauma-informed learning - adaptive*
- *Family supports (housing, public, work, social supports)*
- *Mentoring/safe adults*
- *Parenting skills such as early relational health*
- *Well-child and adolescent visits*
- *Screening and referral*

The EfC Steering Committee analyzed and endorsed a comprehensive child care bill that passed this year. This bill is projected to produce systems change including family supports, mentoring provided by safe adults, parenting skills, and preschool based on neurodevelopmental enrichment. In the coming year, we will develop the workplan for this strategy, now that we have hired an additional Child Health Services Consultant. We are encouraged that, as part of the pandemic response, there is anecdotal evidence of renewed policy and funder focus on protective factors for families and children.

Strategy:
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.

As the importance of the first five years of life has gained prominence in child development research, less attention has been focused on middle childhood. Nonetheless, middle childhood has been proven to be a critical developmental stage for increasing community and family protective factors for well-being, and to buffer the impact of trauma and other risk factors. We intend to identify workforce capacity to convene middle childhood experts, including parents, to recommend strategies for middle childhood. They will consider AAP's Bright Futures recommendations; evidence-based, universal and selected parenting and community practices; and other science, filtered by racial, ethnic, and income inclusivity.

Our planning to convene middle childhood experts has shifted to 2022-2023. In the coming year, we plan to identify capacity for this work across DOH.

DOH participated in the 2020 legislatively mandated School-Based Health Center Workgroup to recommend best practice models statewide, to promote optimal health for all children and youth. Legislation sponsored by the workgroup passed in the 2021 session. As a result, OFCHI will make nine grants available for the development or enhancement of school-based health centers serving students who are furthest from access or historically oppressed. The request for proposals for this work is projected for fall 2022. We plan to hire staff and develop plans for this work in 2021-2022. Middle school-based centers are a possibility, depending on community needs.

Adolescent Health

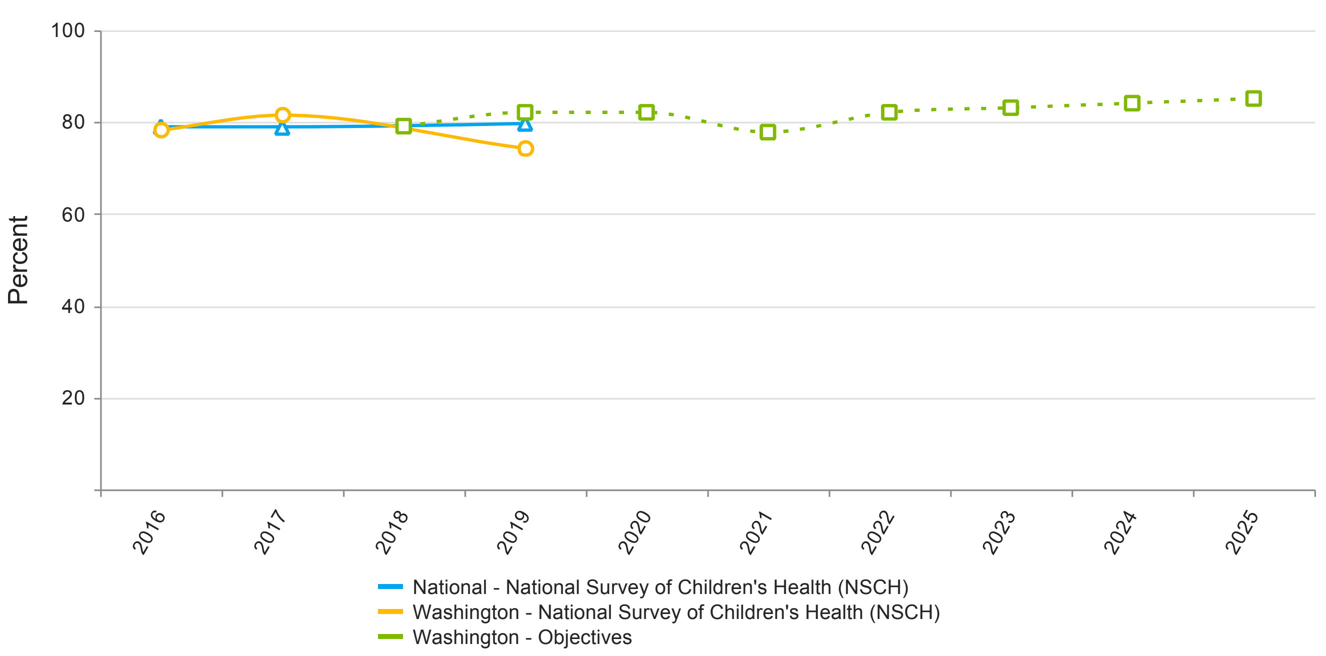
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2019	12.2	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	28.6	NPM 7.2 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	8.4	NPM 7.2 NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	15.7	NPM 7.2 NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	14.1 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	59.1 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.5 %	NPM 10
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)	NSCH-2018_2019	11.9 %	NPM 10
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)	WIC-2018	13.8 %	NPM 10
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)	YRBSS	Data Not Available or Not Reportable	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	66.9 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	72.0 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	89.8 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	83.3 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	12.7	NPM 10

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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			79	82	82
Annual Indicator		78.1	81.3	81.3	74.0
Numerator		424,264	432,006	432,006	405,716
Denominator		543,052	531,119	531,119	548,292
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	77.7	82.0	83.0	84.0	85.0	86.0

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
Annual Objective		
Annual Indicator	67.8	67.8
Numerator		
Denominator		
Data Source	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	60.0	68.0	69.4	70.8	72.2

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
Annual Objective	
Annual Indicator	59.9
Numerator	
Denominator	
Data Source	Healthy Youth Survey
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	60.0	60.1	60.2	60.3	60.4

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
Annual Objective		
Annual Indicator		18.8
Numerator		
Denominator		
Data Source		Healthy Youth Survey
Data Source Year		2018
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.8	14.8	13.8	12.8	11.8	10.8

SPM 9 - Adolescents reporting at least one adult mentor

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		69.8
Numerator		
Denominator		
Data Source		Healty Youth Survey
Data Source Year		2018
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	74.4	75.4	76.4	77.4	78.4	79.4

State Action Plan Table

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

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.

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.

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.

Promote school-based health strategies to serve adolescent populations where they are.

Identify and develop methods to monitor systems and data gaps and improvements needed in adolescent health.

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.

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

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, 2025, increase the number of school-based health centers with licensed mental health services by 5 percent.

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.

Take action to reduce stigma surrounding adolescents' and young adults' behavioral health conditions, treatment, and related challenges.

Implement trauma-informed services specific to adolescents and young adults into community services, health care systems, and the public sector.

Support interventions to address suicide ideation among youth, especially among those marginalized by mainstream society.

Promote standardized depression, anxiety, and substance use screening for adolescents and young adults.

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 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.

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 4

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).

Strategies

Support violence prevention efforts and promote healthy relationships among adolescents and young adults.

Implement and promote young fatherhood inclusion opportunities and support resources.

State Action Plan Table (Washington) - Adolescent Health - Entry 5

Priority Need

Identify and reduce barriers to quality health care.

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.

Strategies

Conduct needs assessment to identify top barriers for adolescents and young adults in seeking health care services.

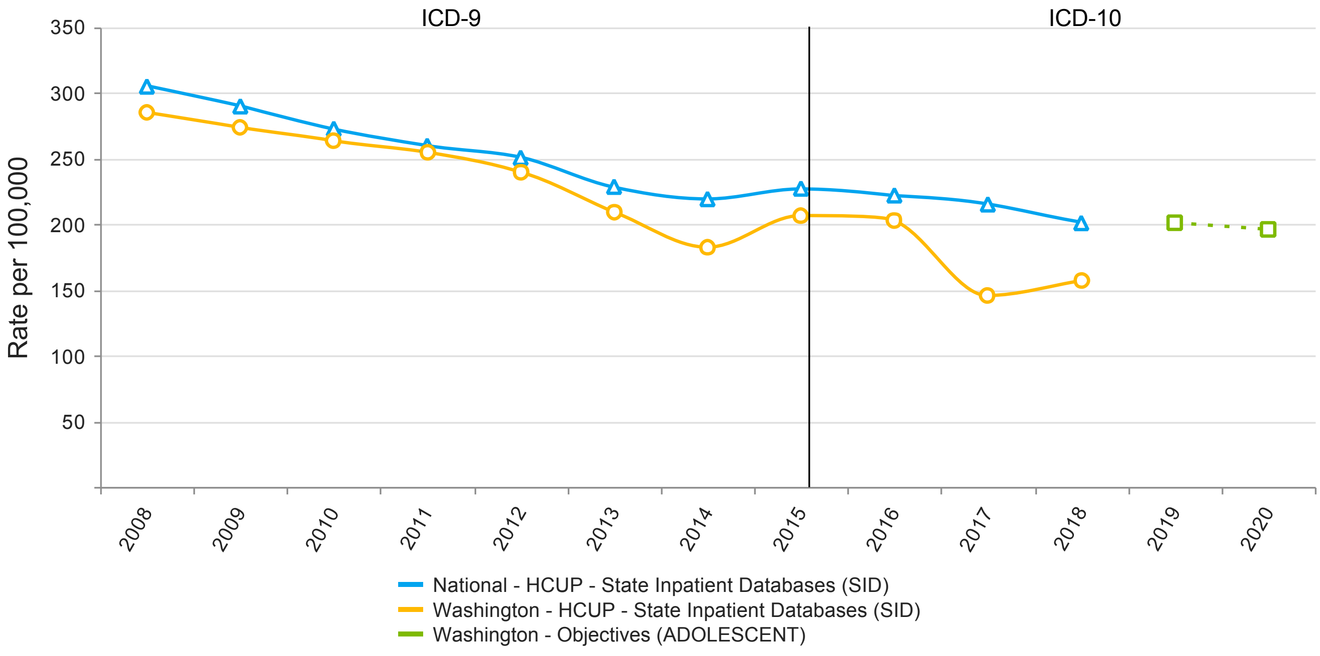
Through partnerships, understand and mitigate issues related to financial eligibility for health care and other support services for adolescents and young adults.

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.

2016-2020: National Performance Measures

2016-2020: NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 Indicators and Annual Objectives



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data				
Data Source: HCUP - State Inpatient Databases (SID)				
	2017	**2018**	**2019**	**2020**
Annual Objective			201	196
Annual Indicator	206.2	203.2	146.0	157.1
Numerator	1,360	1,803	1,311	1,429
Denominator	659,726	887,344	897,967	909,851
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2015	2016	2017	2018

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 7.2.1 - Number of Teens in Cars campaigns

Measure Status:				Active
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			1	1
Annual Indicator			1	0
Numerator				
Denominator				
Data Source			WA Dept of Health	WA Dept of Health
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

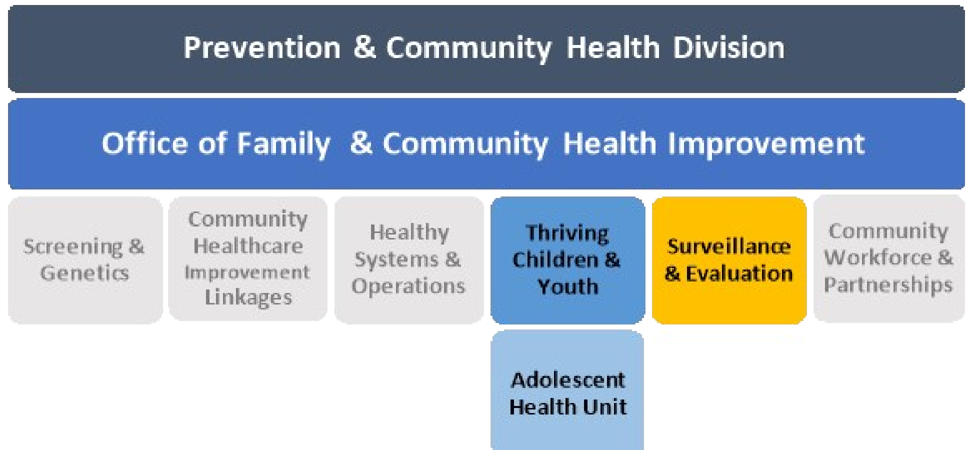
2016-2020: State Performance Measures

2016-2020: SPM 2 - Percent of 10th Graders who have a BMI between the 5th and 85th Percentile

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		74	74.5	70.5	71
Annual Indicator	70.8	70.8	68.9	68.9	68.9
Numerator					
Denominator					
Data Source	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2016	2016	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: SPM 4 - Percent of 10th Graders Who Report Adverse Childhood Experiences

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			40.1	40.1
Annual Indicator			15.3	15.3
Numerator			622	622
Denominator			4,064	4,064
Data Source			Healty Youth Survey	Healty Youth Survey
Data Source Year			2018	2018
Provisional or Final ?			Final	Final



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.

In 2018, 77 percent of 10th grade students reported seeing a doctor for a check-up or physical exam in the last year. This percentage did not vary by gender or disability. American Indian/Alaska Native students were less likely than white students to have accessed care, but there were no other statistically significant differences between racial and ethnic groups. Students identifying as gay, bisexual, or any sexual orientation other than straight were less likely to report a check-up in the last year than their straight peers, suggesting that lesbian, gay, bisexual, transgender, queer or questioning, and other sexual identities (LGBTQ+) students may be at higher risk for not getting regular check-ups (Healthy Youth Survey [HYS]). By 2018, 50 percent of all adolescents in Washington had completed the full 1:1:1 immunization series. The state goal is 80 percent. That same year, 28 percent of 13-year-olds had completed the 1:1:1 series, and 23 percent of all youth under 18 received a flu shot (Washington Immunization Information System [IIS]). As of July 17, 2021, 40 percent of 12 to 15-year-olds and 19 percent of 16 to 17-year-olds had initiated COVID-19 vaccination.

In 2018, reported bullying was the highest it had been since 2008, with 31 percent of 6th graders, 27 percent of 8th graders, 19 percent of 10th graders, and 17 percent of 12th graders reporting being bullied in the past month. 10th graders reporting being bullied were almost 50 percent more likely to report low grades compared with those who hadn't. Among 10th and 12th graders, 62 percent participated in after-school activities, a known protective factor.

Drinking within the past 30 days was higher among 12th graders (28 percent) than 10th (18 percent), with friends being the most likely source of alcohol for both groups. 10th graders were much less likely to drink if they reported that their parents think it's wrong (14 percent), compared with those who don't (50 percent). The same is true if the community thinks it's wrong (14 percent compared with 34 percent), suggesting that parental and community attitudes may have an influence on youth drinking. Looking at other commonly-reported substance use, 43 percent of 12th graders and 29 percent of 10th graders reported having tried marijuana at least once, with 61 percent and 49 percent respectively claiming that it was easy to get. Parent and community attitudes also appear to be strongly protective against marijuana use in 10th graders.

About 40 percent of high school respondents reported depressive feelings, and only half reported having an adult to turn to when sad or hopeless. Among 10th graders, 48 percent of female students reported depressive feelings, and 28 percent had considered suicide, compared with 31 percent and 18 percent respectively in their male counterparts (HYS). This was the highest level of reported suicide ideation for either gender since 2008, supporting the 2020 MCH needs assessment's emphasis on adolescent mental and behavioral 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 percent 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.

National Performance Measure 10 – Adolescent Well-Visit

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

The latest data from the National Survey of Children's Health (2019) indicate that 74 percent of adolescents, ages 12 to 17, received a preventive medical visit within the last year. This is a decrease from previous survey years, and short of our 2020 objective of 82 percent.

Much of the work for this measure in the reporting year has focused on three areas:

1. **Delivery of age-appropriate, evidence-based clinical services ("teen-friendly services").**
   We continued to encourage adoption of the Bright Futures Guidelines for clinical services and will include evidence-based practices for providing a culturally appropriate environment of care. Issues specific to adolescents addressed in Bright Futures include physical growth and development; social and academic competence; emotional well-being (coping, mood regulation and mental health, sexuality); risk reduction (tobacco, alcohol, or other drugs; pregnancy; STIs); and violence and injury prevention (safety belt and helmet use, substance use and riding in a vehicle, guns, interpersonal violence [fights], bullying).

   Over the last reporting period, the Adolescent Health unit planned to provide a 60- to 90-minute presentation on sexually transmitted infections to nursing students at three community colleges across the state, in Yakima, Bellingham and Bellevue. However, due to travel limitations and staffing challenges related to COVID-19 and our agency's response, we were unable to provide these presentations. We plan to reevaluate

implementation of this strategy for the next reporting period.

We implemented the Washington State Personal Responsibility Education Program (PREP) which 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.

2. **Support and promote School-Based Health Centers (SBHC).** Our evidence-based strategy measure (ESM) for 2020 was to continue to measure the increase in the number of SBHCs able to bill for services rendered. We met our goal of 85 percent of SBHCs able to bill for services rendered. We had the opportunity to address billing problems as a statewide issue rather than approaching it clinic by clinic.

   The Adolescent Health unit worked to promote school-based health centers across the state over the last year. During the previous reporting period, we reported that members of the Adolescent Health team, along with partners from the Health Care Authority (HCA); Office of Superintendent of Public Instruction (OSPI); and Department of Children, Youth, and Families (DCYF), met with the Governor's Office to discuss potential models to expand SBHCs. The Adolescent Health Program Manager participated on a state Senate workgroup around SBHC legislation. The 2020 legislative session had six SBHC-related bills introduced, all with the hope of expanding SBHC services for students.

   In 2021, Substitute House Bill 1225: Concerning School-Based Health Centers was passed by the Washington State Legislature. The bill 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. This new program office must:

   - Develop, in partnership with a statewide nonprofit organization, grant funding criteria.
   - Monitor and evaluate SBHCs that receive grant funding.
   - Partner with the statewide nonprofit organization to provide training and technical assistance to SBHCs.
   - Coordinate with the statewide nonprofit organization, educational service districts, the Health Care Authority, hosting school districts, and the Office of the Insurance Commissioner to provide support to SBHCs.

   The Adolescent Health team began work with partners to implement this bill in July 2021.

3. **Reimbursement for eligible services.** We continue to collaborate with HCA to address Medicaid billing issues and cost sharing. We plan to work with the HCA and other state agencies to increase knowledge of and offer training opportunities on billing and reimbursement for providers, specifically school-based health centers.

   The Adolescent Health Program Manager has continued 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 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.

   Washington is one of 15 states participating in this project, and has cross-agency representation, including

HCA, OSPI and DCYF, along with DOH. DOH's role on this workgroup is to bring the experiences of SBHCs to the table as Washington works with other states to create strategies to expand school-based health services. Over the last year, the Washington state team has received technical assistance around telehealth and trauma-informed care through this learning collaborative. The collaborative, cross-agency relationships created through this collaborative have helped leverage our work around SBHCs as well.

National Performance Measure 7 – Injury Hospitalization

Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19.

Unintentional injury is the leading cause of death among children in Washington. For non-fatal injuries, in 2018, the overall rate of hospitalization was 157.1 per 100,000 for adolescents ages 10 to 19, as reported in the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID). This was below our annual objective for 2020, but it was higher than the previous year's rate.

From the Comprehensive Hospital Abstract Reporting System (CHARS), we have different data. For 2020, the overall rate of hospitalization for adolescents ages 10 to 19 was 197.43 per 100,000 (compared to 193.22 in 2019 and 213.28 in 2018). The unintentional specific injury hospitalization rate for adolescents ages 10 to 19 for 2020 was 104.95 per 100,000 Washington residents (compared to 106.89 in 2019). Per CHARS, the top five leading causes of unintentional injury-related hospitalization for Washington adolescents ages 10 to 19 in 2020, and compared to 2019, were:

Unintentional Injury Hospitalizations of Adolescents in Washington

Top Five Leading Causes, 2019-2020

Type of Injury	2020	2019
Motor vehicle traffic	201	212
Fall	201	193
Drug poisoning	118	111
Struck by or against	43	83
Firearm	33	
Other specified foreign body		31
Non-drug poisoning		31

The 2019 Washington State Strategic Highway Safety Plan identified impairment, distraction, speeding and unrestrained occupants as the leading risk factors for road users in Washington. Young drivers in Washington, ages 16 to 25, were involved in 31 percent of all motor vehicle fatal injuries and 34 percent of all serious injuries, but represented just 13.5 percent of all drivers in 2015-2017. Among fatal injuries of young drivers, impairment was a factor in 61 percent of fatalities, speeding was a factor in 38 percent, distraction was a factor in 30 percent, and unrestrained passengers was a factor in 35 percent. Recommendations to address these issues for young drivers included: improve the Graduated Driver's License (GDL) law, publicize and enforce the seat belt law, and improve driver training.

A small workgroup committee including the Department of Licensing (DOL), Washington Traffic Safety Commission (WTSC), and DOH was planned for both GDL and review of the driving training curriculum starting in March 2020. Due to impacts from COVID-19 response by state agencies and transition to mobile working, these committees

being led by DOL were put on hold. As of July 2021, this workgroup has still not been reconvened.

The Motor Vehicle Safety Child Safety Learning Collaborative (CSLC) for Washington state worked on developing a plan to initiate the Impact Teen Drivers program in communities across the state. Impact Teen Drivers (ITD) is a non-profit intervention program designed to develop, promote, and facilitate evidence-based education and strategies to save lives and reduce injuries and fatalities caused by reckless and distracted driving.

The CSLC team has reached out to the ITD organization and is working with them to identify certified trainers to connect with communities and provide technical assistance. From March through September 2020, COVID-19 impacted this work as well and placed a temporary hold on these efforts. From June through September 2020 the CSLC team, ITD, and community partners began meeting virtually, and developed and promoted virtual train-the-trainer sessions on ITD curriculum so community members would be prepared to provide the sessions when schools opened back up for in-person training. The workgroup also began developing a hybrid model that could be presented to students virtually. Pilots of the virtual trainings are being planned for next year. The team will evaluate how to move forward, and will consult with OSPI on how future school and classroom structures and routines might require modification of how these curricula will be presented in schools as they open back up.

The CSLC also started reviewing a pilot of the Alive at 25 curricula in traffic court for teens. Alive at 25 is a National Safety Council four-hour course meant to complement standard driver education programs. A pilot for Alive at 25 was conducted in Snohomish County with the traffic court there, and preliminary outcomes look promising. Thurston County is the next county planned to spread the Alive at 25 programs for teen traffic offenses as a diversion strategy. The Alive at 25 program was expected to go live there in March or April 2020; however, due to COVID-19 shutdowns at the county, and staffing capacity at WTSC related to COVID-19 impacts, the rollout of the program was canceled by the county. As of July 2021, there are no current discussions of expanding this program.

Local Safe Kids Coalitions provide public health education and awareness at the community level, and are the main vehicle for information dissemination at the local level for child safety information and resources. From the last report we had planned to provide training on Positive Community Norms to all Safe Kids Coalitions to address motor vehicle injury prevention as well as other child injury mechanisms. Our partner, WTSC, held one training in early March 2020 just before the shutdown for COVID-19 issued by the governor. This training was to be followed with a workgroup session at our annual Safe Kids Coalition leadership conference held at the end of March. Unfortunately, the leadership conference had to be canceled. To date, we have only trained three of our 13 coordinators.

We will work with WTSC and their training contractors to find solutions and get the training to all our coalitions. We hope to reconvene our leadership conference for coordinators in 2021 if funds are available after any required redirection for COVID-19 response and recovery. As of July 2021, there is not a scheduled training for Positive Community Norms for Safe Kids Coalitions yet. Most coalitions are just starting to regain capacity to continue their community efforts after many were shut down for extended periods, lost considerable local funding, and in some cases had coalition leaders reassigned to COVID-19 response teams. Discussions have started with the Washington State Traumatic Brain Injury Statewide Advisory Council on partnering to provide Positive Community Norms training in the future as part of DOH Injury and Violence Prevention unit's Shared Risk and Protective Factor (SRPF) collaborations. These trainings are expected to begin late in 2021 through 2022.

The Western Pacific Injury Prevention Network (WPIPN), based out of DOH, provides technical assistance to state and local public health agencies on a variety of injury and violence prevention strategies and capacity building. WPIPN has focused on shared risk and protective factors, working with members on addressing upstream factors to injury. There were four meetings in FFY 2020 addressing topics of SRPFs and communications planning. Funding supporting WPIPN will end July 2021. Continued work to address SRPF will continue under the CDC Core State

Injury Prevention Program (Core SIPP) funding after that time.

Our ESM for 2020 was the number of Teens in Cars safety campaigns held. We continue to work to promote teen driver education curricula in local communities. We transitioned from the Safe Kids Teens in Cars curriculum to Impact Teen Drivers as there was greater statewide support through our partner, WTSC, to increase resources and reach through partnerships with Target Zero Task Force coalitions that cover areas where active Safe Kids Coalitions do not exist.

With position changes at WTSC, a new focus, and additional curriculum, Alive at 25, targeted toward a special population of adolescent drivers with traffic violations, is being planned for implementation and spread along with Impact Teen Drivers. Impact Teen Drivers programs were presented in schools in Pierce, King, and Snohomish counties from October 2019 until school shutdowns due to COVID-19 in March 2020, with five courses held during this time. ITD organization's reporting system currently only tracks trainers trained and not courses held or number of participants. Our numbers reported are based on reported numbers from the ITD workgroup only. DOH has discussed with ITD additional data needs to track reporting measures. Funding is required to upgrade the data collection and reporting service. DOH does not currently fund this implementation effort beyond minimal staff time to provide technical assistance and facilitation of collaborative efforts between partners.

State Performance Measure 2 – Healthy Weight

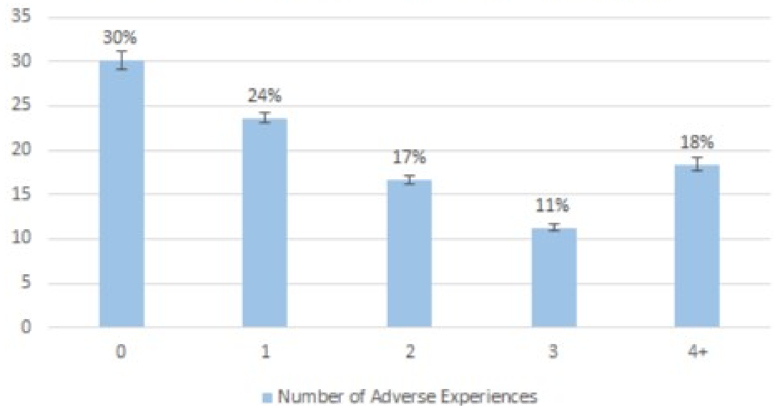
Our state performance measure (SPM) is the percent of 10th graders who have a body mass index (BMI) between the 5th and 85th percentile. The most recent data available are from the 2018 DOH Healthy Youth Survey, as the 2020 HYS was not conducted due to COVID-19 related suspension of most in-classroom education during 2020. The 2018 survey indicated 68.9 percent, which did not meet our 2020 objective of 71 percent.

Healthy eating is consuming a balanced diet that meets individual nutritional needs. A healthy diet includes a variety of vegetables, fruits, protein, and low-fat dairy while limiting excess salt, fat, and sugar. Healthy eating promotes growth and development, including brain development, oral health, and healthy body weight, and it reduces chronic disease over the life course. The Healthy Eating Active Living (HEAL) program at DOH aims to build a healthier Washington through policy, systems, and environmental changes that make it easier for people to eat healthy and be active—wherever they are. Evidence shows that people are more likely to make healthy choices when organizations, communities, and social structures support them. We target resources to underserved communities and populations with higher rates of obesity, food insecurity, poor nutrition, and low physical activity.

In 2020, the HEAL and Supplemental Nutrition Assistance Program Education (SNAP-Ed) activities to support healthy weight education and programs for youth were limited due to COVID-19 restrictions and temporary reassignment of staffing.

State Performance Measure 4 – Adverse Childhood Experiences in Adolescents

The 2016-2020 state action plan includes an SPM on adverse childhood experiences (ACEs) among adolescents. ACEs are indicators of severe stressors that occur during a person's first 18 years of life. Research has shown that these adverse experiences can influence physical, mental, social, and behavioral health across the lifespan. The Healthy Youth Survey adverse experience index includes 11 adverse experiences that youth may report on the survey. Questions for this measure were selected from the HYS that addressed topics identified through a literature review, including intimate partner violence, physical or sexual abuse by an adult, safety in school, bullying, and financial hardship, among other topics. This measure helps us to better assess the burden of these experiences among our state's youth.



Based on preliminary data from the 2018 Healthy Youth Survey, an estimated 18 percent of 10th grade students in Washington experienced four or more adverse experiences. Around 30 percent reported no adverse experiences, 24 percent reported one, 17 percent reported two, and 11 percent reported three adverse experiences (see figure above).

While we have access to preliminary data for 2018, the measure is in the process of being finalized. The current results do not account for non-random missing responses in HYS survey questions. We plan to address this in the 2021 Healthy Youth Survey.

After the 2020 MCH needs assessment, we established different SPMs for the next five-year period related to behavioral health and wellness for the adolescent health domain (reduce feelings of sadness or depression, reduce teen alcohol use, increase connections with adult mentors).

A second ACEs-related SPM, social and emotional readiness among kindergarteners, is located in the *Child Health Annual Report*.

Additional Work Supporting Adolescent Health

Washington has made considerable progress in decreasing statewide teen birth rates, but there are 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 Washington State Personal Responsibility Education Program (WAPREP) 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

Other partners include OSPI, Department of Social and Health Services, and Cardea Services.

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.

Over the last reporting period, we successfully completed the Expectant and Parenting Teens, Women, Fathers and Family (EPTWFF) project. This project worked with OSPI's Graduation, Reality and Dual-role Skills (GRADS) program, which focuses on work and family foundation skills of significance to these students. The implementation partners span several sectors, including faith-based organizations, social services, housing agencies, and tribes. They were able to effectively reach priority populations, including survivors of domestic violence experiencing homelessness; justice-involved fathers; Latinx families, including immigrant families who are Mixteco-speaking; American Indian teens; Black and African American and multiracial mothers; and pregnant or parenting high school students. The EPTWFF work is largely community-based, and focused on outreach and delivering interventions that are relevant for and driven by the community.

GRADS sites are in specific communities to improve education and health outcomes of pregnant and parenting teens. Through this work, the EPTWFF allowed implementation of evidence-based programming intended to reduce rapid repeat pregnancies, and support programming for teen fathers. Some highlights from this work include:

- The GRADS program had 424 students enrolled during the grant cycle.
- Over the reporting period, enrollment in the program increased during COVID-19 restrictions in school districts as the online course allowed students to easily access it at convenient times and avoid stigma related to teen pregnancy.

- A survey of GRADS participants indicated increases in key areas, including the number of participants using GRADS child care sites, the number of students reporting they have an adult to turn to when needed, and the number of students able to access education support services.
- In addition, VROOM, a child development application, was promoted during the grant cycle to support increasing child development knowledge.

The Adolescent Health program had received continued funding from the Health and Human Services, Office of Population Affairs, Pregnancy Assistance Fund (PAF) program since 2013. Since its inception, PAF programming served more than 4,000 expectant and parenting participants and over 3,000 dependent children across Washington. Our project implemented evidence-based and evidence-informed programs and services that are medically accurate to improve personal health, child health, and educational and social outcomes among pregnant and parenting teens and young adults. During the 2019-2020 federal grant cycle, PAF served 603 expectant and parenting young adults, an increase of almost 200 participants from the previous year. Additionally, PAF grant funding contributed to the cultivation and development of partnerships that will lead to the sustainability and continuity of programs and services now that PAF funding has ended. The PAF program increased partnership organizations from 14 to 86.

Subawardees at the state level included OSPI, the Office of the Attorney General, and the Northwest Portland Area Indian Health Board, a tribal non-profit organization that serves the 29 federally recognized tribes in Washington state. At the local level, our subawardees are Benton-Franklin Health District (Benton and Franklin counties), Columbia Basin Health Association (Adams and Grant counties) and Tacoma-Pierce County Health District. Implementation partners included Black Infant Health Ministers, Washington State Coalition Against Domestic Violence, and 12 school districts with GRADS sites.

The Adolescent Health program finished work on the first Teen Pregnancy Prevention (TPP) grant. This two-year grant began October 1, 2018, and was an innovative and collaborative effort to test a program aimed at preventing teen pregnancy. Our goal was to create a culturally relevant curriculum for underserved youth in rural areas of our state through input from youth served by the project and instructors implementing the curriculum. An independent evaluator, Cardea Services, created a mixed-methods implementation evaluation plan that captured the impressions and experiences of the program, as well as local and contextual factors. The evaluation highlights the importance and necessity of considering organizational context and external factors when implementing school-based programs, and has potential implications for schools and other organizations implementing prevention programs in a school-based setting.

Following the conclusion of the TPP grant, the Adolescent Health team, in collaboration with the Surveillance and Evaluation unit, applied for and was awarded one new grant for the next round of TPP funding. We are the only state agency awarded this funding, and one of only 13 grantees total.

The focus of this TPP 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. We partnered with OSPI and the Northwest Portland Area Indian Health Board; and at the local level, we will partner with four to six tribal sites and six to 10 nontribal sites. We are working with partnering sites to encourage preventive health screenings for youth, including sexual health, and improve linkages between prevention programs and health service settings. Youth voices will be included across the project, including in the development of interventions and evaluation. The experience we bring with our team, and our commitment to equity, will drive efforts toward improving optimal health, preventing teen pregnancy, and reducing STIs. A diverse review panel selected four sites to begin work right away. We hope to

select 10 more in the next year:

- Greater Destiny Church will partner with Korean Women's Association, MultiCare's Pediatric Primary Care, and Multicultural Child and Family Hope Center to launch Teens for Destiny - for Black, Indigenous, and people of color (BIPOC) teenagers in Pierce County who are at risk of unplanned pregnancy or STI and are experiencing serious social determinants of health barriers.

- Planned Parenthood of the Greater Northwest and Hawaii will build on what they have learned through IN•clued and Teen Council to promote user-centered interventions that address sexual and reproductive health disparities among lesbian, gay, bisexual, transgender, queer or questioning, and other sexual identities (LGBTQ+) youth in western Washington. They will work primarily with LGBTQ+ youth in King, Pierce, Mason, and Thurston counties.

- Nothing About Us Without Us: South King County Teen Clinic Innovation Project is a youth-driven approach to improving access to and experiences with sexual health services for marginalized young people in South King County.

- Sea Mar Community Health Educators will provide support and health-related education working one-on-one with adolescent patients to cover topics including sexual health, contraception options, family planning, cooking, exercise, and more. In addition, Sea Mar's adolescent clinic will look to employ two young adults ages 18-20 from the BIPOC community to serve as Health Education Peer Advocates (HEPA). In this role, the HEPAs will work with the clinic's health educator to bring in new community partners (high schools, community centers, etc.), develop patient messaging on reproductive and sexual health education, and conduct outreach to direct the adolescent population to resources.

Another of our priorities and objectives in the adolescent health population domain is to promote tobacco cessation and reduce adolescent tobacco use. DOH has continued to: (1) support successful efforts that increase the minimum legal age of tobacco and vapor product purchase from 18 to 21 years, (2) promote and support tobacco cessation, and (3) work to reduce tobacco-related disparities among priority populations. Over the last year, the Adolescent Program Manager collaborated with the tobacco unit within DOH to provide a letter of support for the five-year cessation grant as a way to best leverage resources to further our shared goals for youth prevention and cessation of tobacco use.

These projects demonstrate our commitment to developing programs that best address unmet needs for youth in our state, address gaps in services, improve the overall health and well-being of adolescents and young adults, and address inequities and disparities in order to increase equity in service delivery.

Adolescent Health - Application Year

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.

General Status on this Objective to Date:

Respondents to last year's 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 – 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 individuals can access care, not just to family planning and sexual health services, but also behavioral and more general physical health, benefits all. In fact, there is strong evidence that access to a school-based health center and regular well-adolescent visits reduces absenteeism, dropout rates, chronic illness, substance use, sexually transmitted infection, and pregnancy rates; increases graduation rates; and improves management of diabetes, asthma, and mental illness. An increase in the number of clinics trained in providing mental health care will make such a system of care more available.

The Adolescent Health team will begin work in July 2021 with partners, including the Office of Superintendent of Public Instruction and Health Care Authority, to implement Substitute House Bill (SHB) 1225: Concerning School Based Health Centers. Accessing behavioral health services can be challenging for adolescents for many reasons, such as lack of transportation, social isolation, or complex life situations. Some students might find accessing health care more convenient at school or other settings in which they are more comfortable. SHB 1225 provides expanded options for students.

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.

In addition to our ongoing and upcoming work with SBHCs mentioned above, we have identified additional strategies to strengthen our SBHC providers' ability to care for students with behavioral health needs and integrate behavioral health services into SBHCs throughout the state. Some of this work will include:

- Continue our partnership with the Health Care Authority to help SBHCs bill effectively for behavioral services rendered. School-based health centers face numerous barriers to receiving adequate reimbursement for services provided. Because no student is denied services because of inability to pay, this has a detrimental

effect on the funding and sustainability of these centers.

- Deliver technical assistance to health care providers around behavioral health services to ensure they are adolescent and young adult (AYA) friendly.

- Seek additional funds to complement SHB 1225 funds to ensure behavioral health services are also accessible through current and new school-based health centers, and that there is capacity at DOH to monitor and manage that access. Schools and SBHCs are well-positioned to identify behavioral health needs of students and connect them with needed resources, however, they lack adequate resources to do this. We are seeking additional funding so DOH can provide key resources and tools for schools and community providers/SBHCs to identify and address gaps in school and SBHC staff knowledge about addressing the behavioral health needs of adolescent students.

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 AYA rises – especially over the course of the COVID-19 pandemic – mental illness stigma can impede 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 percent of 13- to 18-year-olds experience anxiety disorders. Depression occurs in approximately 13 percent of 12- to 17-year-olds; attention deficit-hyperactivity disorder (ADHD) occurs in approximately 9 percent 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 includes internalized stigma, or "self-stigma," among individual youth; and external stigma and misperceptions of diagnoses among family, friends, and providers. Research has shown that youth often experience feelings of shame and secrecy related to a mental health diagnosis and treatment, and that they fear being "ostracized" from peer groups and not fitting in because of mental health diagnosis. This comes at a time when "fitting in" is an essential developmental need among adolescents and can have a strong influence on youth willingness to participate in any kind of activity, including mental health care and treatment. 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.

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. We plan to apply this strategy and implement social medial campaigns – like the Substance Abuse and Mental Health Services Administration's (SAMHSA) "What a Difference a Friend Makes" – to reduce stigma related to behavioral health conditions among youth to increase access to behavioral health care. Over the next project period, we will work with partners to plan a communication/social media campaign geared toward youth, their family, and youth-serving providers, which addresses key concepts related to "self-stigma" among youth, and public and institutionalized stigma. The communications campaign will focus on disseminating evidence-based information related to stigma reduction among 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.

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 approaches. According to a study by Darnell, Flaster, Hendricks, Kerbrat, & Comtois (2019), among adolescents between the ages of 13 and 17, 62 percent have been exposed to one or more traumatic events throughout their lifetimes. These numbers make it critical for those serving AYA 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, is an essential part of care for adolescents and young adults.

To continue toward this goal, 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 AYA. 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.
- Work with internal experts and partners to facilitate access to provider and school staff trainings on trauma-informed approaches to adolescent health care, including among SBHC providers. Some examples include SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach and Cardea Services' Promoting Adolescent Sexual Health.
- Given severe provider shortages, support 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.
- 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.

The "roadmap" work being done by the Essentials for Childhood ACEs and Resilience Community of Practice, described in the *Child Health Application Year Plan* section, will inform our AYA work as well.

Strategy:
Support interventions to address suicide ideation among youth, especially among those marginalized by mainstream society.

Suicide is the second leading cause of death for Washington youth between the ages of 15 and 19. On average, in 2017, each week in Washington, nearly four youths killed themselves, and two youths 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 percent 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.

Responses by eighth grade students on the 2018 Washington Healthy Youth Survey showed that 20 percent had considered killing themselves, and that 10 percent had attempted suicide in the past year.

To strengthen our work to address suicide risk among youth, we will partner with our Injury and Violence Prevention program to expand existing interventions that are proven effective and collaborate on new goals and strategies. This will include implementing strategies identified by the Washington State Children's Behavioral Health Workgroup.

Over the last year, the workgroup identified six strategies that agencies and partners can implement now to address the youth behavioral health crisis exacerbated by COVID-19. Recommendations include expanding the behavioral health workforce (strategy described above in the third bullet point), conducting population-level screening for students, training providers in trauma-focused interventions, and strengthening regional response teams.

One example of implementation of these recommendations is our work with partnering agencies to request additional legislative funding to support schools and community health providers/SBHCs to conduct population-level behavioral health screening for all students, and refer students to additional community supports when screenings indicate a need. Provided the legislation is put forward and passed, funding will cover access to screening and referral tools, technical assistance, and support at the state level; and cover additional training costs to enhance the workforce of school and community health provider/SBHC staff and increase their capacity to conduct screenings and referrals appropriately.

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 percent.

To work toward ensuring youth can participate in youth friendly and confidential screening for risk behaviors, we will promote the use of a youth-friendly standardized risk behavior screening tool among providers who serve youth and young adults. The Adolescent Health Initiative (AHI) at the University of Michigan has created toolkits and resources for providers and clinics that can be adapted to the local setting to encourage risk screening of adolescents. We will utilize internal communications resources – like social media, listservs, and adolescent-focused webpages – to disseminate information on this toolkit, 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.

This strategy also appears in our *Child Health Application Year Plan* – see that section for additional information about our activities.

Strategy:
Support efforts to address and mitigate individual and community effects of substance use among adolescents and young adults.

While the rates of tobacco use and exposure have significantly declined in our state, we are particularly concerned with the youth vaping epidemic because tobacco use is a risk factor for teen pregnancy. Additionally, the high smoking prevalence among pregnant women in our state presents serious health risks for both expectant mothers and their babies.

Over the next five years, the DOH Adolescent Health program will continue to collaborate with the Tobacco and

Vapor Product Prevention and Control Program (TVPPCP) on the following efforts to help address these issues:

- Connecting with adolescent health providers, understanding that school-based health centers may better serve youth than the traditional framework of primary care providers or behavioral health providers.
- Partnering on prevention and cessation outreach to American Indian/Alaska Native tribes and communities.
- Promoting the Washington State Tobacco Quitline and tobacco cessation smartphone app, with emphasis on each program's tailored pregnancy programs.
- Disseminating TVPPCP training and education opportunities to youth and young adult providers throughout the state.
- Providing letters of support to TVPPCP for activities that promote and support youth smoking cessation.

As mentioned above, we will also encourage the use of AYA-friendly screenings for risk behaviors, including substance use, during primary care visits.

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 will assess existing data to identify gaps in services and underlying socioeconomic factors playing into substance use. We also will examine structural issues through a lens that acknowledges systemic racism, sexism, and homophobia, and their effects on health inequities.

In addition, we will form a cross-agency workgroup to align substance use reduction and prevention strategies and efforts among internal programs. This will help inform current and future substance use reduction and prevention programming, and policy recommendations. 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.

General Status on this Objective to Date:
As mentioned in the *Adolescent Health Annual Report*, we will continue to collaborate with the HCA to identify and address billing issues and cost sharing. Many SBHCs have an "in-person assister" to help with Medicaid enrollment for youth who are eligible but not yet enrolled. Additional training will expand this service, and training development is currently underway. This work will be prioritized with the hiring of the new school-based health center position created as a result of SHB 1225.

Strategy:
Conduct needs assessment to identify top barriers for adolescents and young adults in seeking health care services.

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't work with their schedule (37 percent), not understanding how insurance works (38 percent), feeling judged (39 percent), and being afraid that their parent or caregiver will find out (48 percent).

Over the next reporting period, we will work to update and redistribute the survey. We will continue our partnership with the Office of Superintendent of Public Instruction and the Northwest Portland Area Indian Health Board to coordinate a new Washington Youth Sexual Health (WYSH) innovation network 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. Most of the efforts will be focused on interventions within the clinic setting, but the network will also include partners from all sectors who have bidirectional impact on youth sexual health care. We are currently in the process of developing the survey and hope to release it soon.

Our MCHBG epidemiologist completed a project, in collaboration with the Adolescent Health Program Manager, on well-adolescent visits. One of our goals was to identify major barriers to seeking care for AYA. We utilized the results of this project, along with earlier survey data on AYA well visits, to identify and address gaps in health care services. These results were used to inform many other projects in the Adolescent Health unit. Moving forward, we plan to conduct complementary qualitative data collection and analyses to learn more about individual experiences on AYA, and recommendations for improvement.

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 will continue to work with Health Care Authority / Washington Apple Health (Medicaid), to discuss strategies to ensure that adolescents have appropriate health insurance and better understand issues around billing for care. We will also work with the Family Planning program to ensure that clinics provide appropriate preventive services with no cost sharing.

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.

Support and enhance efforts to increase health literacy among adolescents and young adults.

We will continue to partner with tribal organizations to identify and help address specific needs of American Indian/Alaska Native youth. We will also work with community partners to evaluate the unique needs of other priority populations, including LGBTQ+ youth, Latinx youth, Asian American, Black or African American, and homeless youth. Youth can also inform this information gathering so we can be best informed of their individual needs in health services.

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.

We will continue to promote health literacy among AYA by partnering with OSPI to promote the inclusion of health literacy education in school curriculum 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, 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 percent (from 9.5 to 8.5 percent).

General Status on this Objective to Date:

Through four successful cycles of the Pregnancy Assistance Fund project through the federal Office of Population Affairs, we expanded and coordinated a diverse network of partners. The group of intervention partners through the PAF grant included: state agencies (OSPI and Office of the Attorney General), the Northwest Portland Area Indian Health Board and tribal health centers, local health jurisdictions, a nonprofit domestic violence coalition, a federally qualified health center, and other community-based organizations. We plan to continue relationships with these partners to increase access to community resources for AYA throughout the state. We finished this project over the last reporting period and will be working on strategies to maintain key partnerships we created through this work.

Strategy:

Support violence prevention efforts and promote healthy relationships among adolescents and young adults.

We will continue working with key partners to support efforts to promote healthy relationships among youth in our state, including:

- Continue to collaborate with tribal partners and other community entities, such as the Washington State Coalition Against Domestic Violence (WSCADV), working with priority populations to address community-specific issues around intimate partner violence and other related concerns.

- Collaborate with internal and external partners 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.

- 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 emergency medical technicians) to recognize signs of dating abuse, partner violence, and trafficking through screenings.

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.

Strategy:
Implement and promote fatherhood inclusion opportunities and support resources.

Over the last reporting period, we completed our PAF project. We worked with stakeholders and partners around the state on several programs specifically focused on teen fathers, including specific strategies to implement fatherhood programs for teens, conduct outreach focused on teen fathers, increase father engagement and linkage to resources, and address fathers' unemployment rates. Now that this projected has finished, we will identify strategies to continue and expand partnerships with organizations that support and provide fatherhood initiatives.

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.

Objective:
By September 30, 2022, form youth advisory council and hold at least one initial meeting.

General Status on this Objective to Date:
Access to appropriate health care services is a continuing issue for adolescents in Washington and is a priority need to be addressed among the Adolescent Health team. Adolescents are often reluctant to seek health care services, and it is important to find ways to offer care in a manner that adolescents perceive as welcoming, comfortable, and responsive. This is particularly true in rural areas where providers knowledgeable about AYA-specific health concerns can be scarce.

We want to ensure adolescents have access to health care services that meet their needs in the communities they are in. 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).

We have multiple strategies planned to help us meet this objective:

- As mentioned before, we will partner with OSPI and others to implement a 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 will continue our partnership with OSPI and the Northwest Portland Area Indian Health Board to create

and convene a youth advisory council. The council will help provide insight and feedback on a number of current and upcoming projects.

- 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.

- Adolescent Health staff will continue to participate on OSPI's Exemplary Sexual Health Education steering committee to ensure that Healthy Youth Act criteria are met for all adolescent health programs. Staff will continue to provide technical assistance for the review of sexual health education curricula.

- We will continue work with partners to maximize care coordination and emphasize provider awareness of common mental health occurrences for children and adolescents.

- We will continue to disseminate information and education about youth-friendly services through existing networks and projects, including PREP, both TPP grants, and others.

Strategy:
Promote the use of evidence-based practice guidelines, like Bright Futures, among adolescent health providers.

We continue to encourage adoption of the Bright Futures Guidelines for clinical services, and will include evidence-based practices for providing a culturally appropriate environment of 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. These issues for adolescents include:

- Physical growth and development (physical and oral health, body image, healthy eating, physical activity).
- Social and academic competence (connectedness with family, peers and community; interpersonal relationships; school performance).
- Emotional well-being (coping, mood regulation and mental health, sexuality).
- Risk reduction (tobacco, alcohol, or other drugs; pregnancy; sexually transmitted infections).
- Violence and injury prevention (safety belt and helmet use, substance use disorder and riding in a vehicle, guns, interpersonal violence [fights], bullying).

In addition to continuing to promote the use of Bright Futures Guidelines, we will conduct evaluation activities (including surveys and key informant interviews) to assess the number of providers using the guidelines, whether they are experiencing barriers to using the guidelines and what those are, and what other guidelines are being used. This information will be used to target quality improvement activities around the promotion and use of best practices like these.

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 and training, and develop 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.

We explored the use of Spark Trainings for health centers and other organizations serving youth. The Spark training model was developed by AHI to meet the needs of busy clinical staff. The mini-trainings, called “Sparks,” are made to be delivered in about 15 minutes so that this meaningful professional development can occur within the context of a regular staff meeting. During our exploration process, we learned the trainings were comprehensive and effective; however, the cost of the trainings exceeded our current budget. Over the next reporting period, we will explore options to fund these trainings or identify more cost-effective options.

As mentioned before, we will continue our partnership with OSPI and the Northwest Portland Area Indian Health Board to create and convene a youth advisory council. The council will help provide insight and feedback on a number of current and upcoming projects. We hope to work with the council to explore ideas around a Youth-Friendly Services Centers of Excellence certification program.

Strategy:
Promote preventive care screening and wellness visits for adolescents and young adults.

We will support improved communications strategies to youth and parents about the importance of well visits, including social media posts such as the “Well Child Wednesdays” post below. 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:
Foster measurable quality improvements in preventive care across the health system to increase adolescent and young adult-friendly care.

We will conduct needs assessment activities such as surveys and key informant interviews 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.

One method of doing this will be creating an AYA-friendly provider certification program similar to Breastfeeding Friendly Washington. With partners and the newly formed Youth Advisory Council, the goal of this work will be to encourage organizations to promote and support AYA-friendly care through changes in their policies and procedures. We will develop a checklist of AYA-friendly services based on research and evidence, including criteria for making appointments, the waiting area, patient communications, provider visits, and follow-up procedures. There will be an application process in which the program will evaluate an organization and provide feedback if the organization is not yet considered ready for certification. Successful applicants will receive a certificate and promotion by DOH on our website and on social media.

Strategy:
Promote school-based health strategies to serve adolescent populations where they are.

Through previous and current initiatives, we developed strong partnerships with many SBHCs throughout the state that will allow us to continue to implement this strategy.

- In 2017, we convened a workgroup, led by Title V staff, for the Adolescent and Young Adult Health (AYAH) Collaborative Improvement and Innovation Network (CoIIN) Cohort #2 through the Association of Maternal

and Child Health Programs (AMCHP). This SBHC workgroup included representatives from DOH, HCA, Medicaid managed care organizations (MCOs), OSPI, the Leadership Education in Adolescent Health (LEAH) project at the University of Washington, and the Washington School-Based Health Alliance. The project examined ways to increase youth engagement in SBHCs and increase well-visits at SBHCs. We will continue to keep these partnerships, and engage new partnerships through a new state community of practice.

- As mentioned before, we will work with partners to implement SHB 1225 and create an internal office to serve existing and create new SBHCs around the state.

- We will work to secure complementary funding to SHB 1225 to support a behavioral health component for SHB 1225 and SBHC.

- We recently began participating in a learning 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.

- Additionally, we have been participating on the Healthy Students, Promising Futures 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 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.

- We will continue to partner with the Health Care Authority to: assist SBHCs to bill for services rendered to promote sustainability of centers; support efforts to increase youth engagement with SBHCs to improve and enhance services; and support legislative work around expanding SBHCs, including statewide committees in which DOH staff already participate.

Strategy:
Identify and develop methods to monitor systems and data gaps and improvements needed in adolescent health.

Our first activity will be to assess data already 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 our evaluation 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 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."

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. 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. By forming a stronger connection to AYA, we can gain insight into their needs, and, as a result, our programs can have a greater impact. We will work with our partners at OSPI, who currently have a youth advisory council, to identify best practices for recruitment and retention, communication about how youth recommendations are being used, and evaluation. Our goal is to have four quarterly meetings by the end of this five-year cycle.

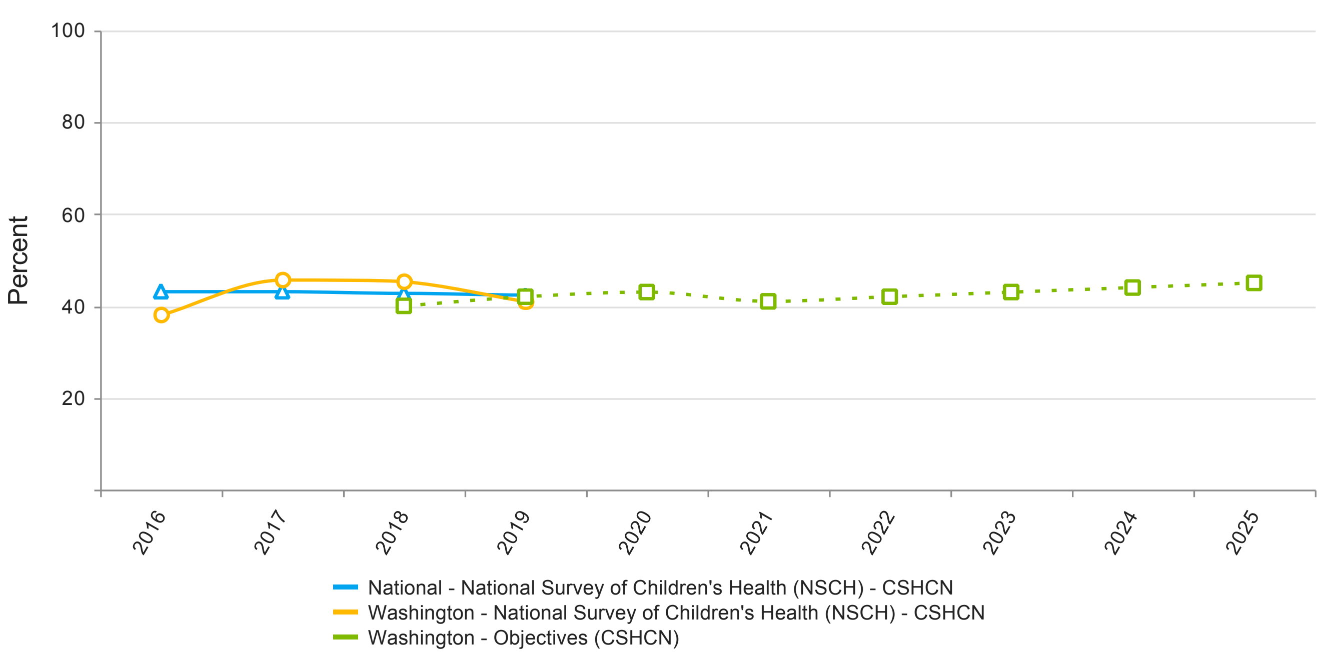
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	14.1 %	NPM 11 NPM 15
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	59.1 %	NPM 11 NPM 15
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	91.5 %	NPM 11 NPM 15
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	NIS-2016	65.1 %	NPM 15
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	66.9 %	NPM 15
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	72.0 %	NPM 15
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	89.8 %	NPM 15
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	83.3 %	NPM 15
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	2.7 %	NPM 11 NPM 15

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					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			40	42	43
Annual Indicator		38.1	45.7	45.3	40.8
Numerator		113,841	138,232	141,032	131,960
Denominator		299,109	302,213	311,138	323,785
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	41.0	42.0	43.0	44.0	45.0	46.0

Evidence-Based or –Informed Strategy Measures

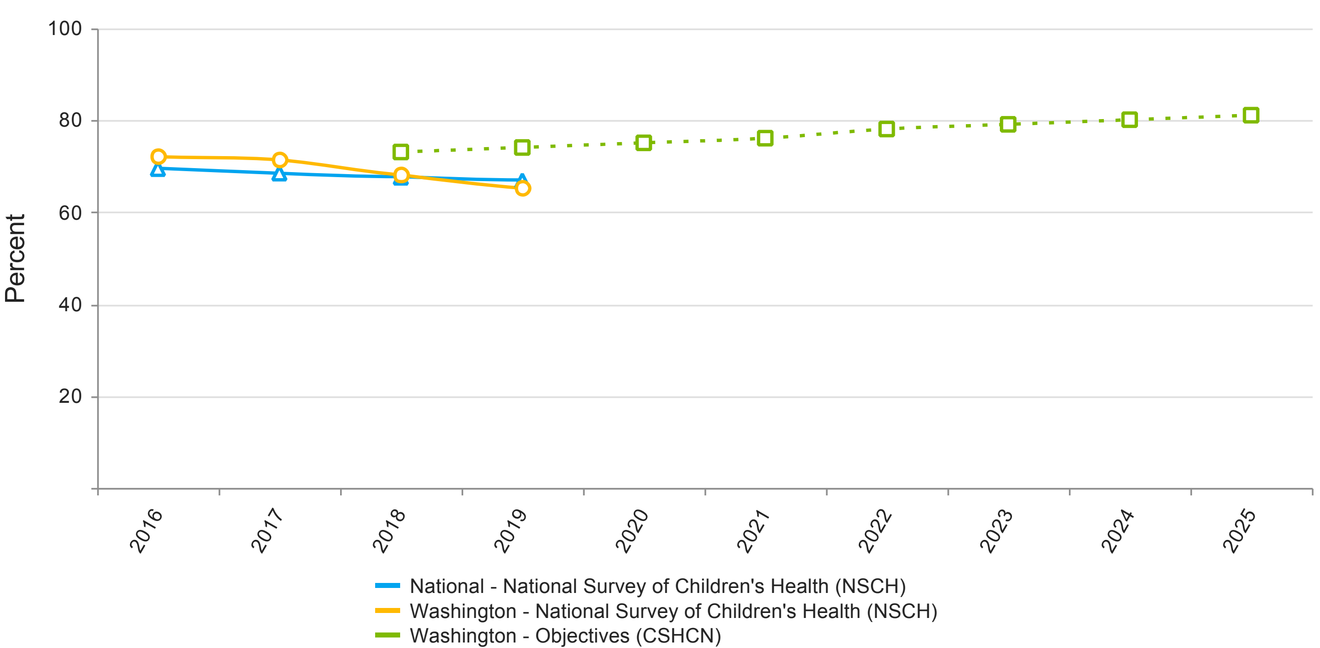
ESM 11.2 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		87.5
Numerator		14
Denominator		16
Data Source		University of Washington LEND ECHO-Autism Program
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	83.0	85.0	87.0	90.0	90.0

NPM 15 - Percent of children, ages 0 through 17, who are continuously and adequately insured
Indicators and Annual Objectives



NPM 15 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	2017	2018	2019	2020
Annual Objective			73	74	75
Annual Indicator		72.0	71.2	67.9	65.1
Numerator		1,154,504	1,148,124	1,107,284	1,068,524
Denominator		1,603,905	1,613,555	1,630,587	1,642,095
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	76.0	78.0	79.0	80.0	81.0	82.0

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
Annual Objective	
Annual Indicator	99.2
Numerator	19,268
Denominator	19,424
Data Source	Washington State Child Health Intake Form
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	99.3	99.4	99.5	99.6	99.7

State Performance Measures

SPM 10 - Suicide ideation among youth with special health care needs

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	53.1
Numerator	
Denominator	
Data Source	Healthy Youth Survey
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	55.0	55.7	56.3	56.6	56.3

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 11 and younger who receive care in a well-functioning system by 5 percent.
By September 30, 2025, increase the percentage of CYSHCN ages 12-17 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 with nutrition risk factors or nutrition related co-morbidities to inform effective nutrition interventions.

Ensure CYSHCN have access to a medical home that is either nationally certified or recognized, or with providers who self-identify as a medical home following the Standards for Systems of Care for Children with Special Health Care Needs.

Enhance and maintain health systems to improve care coordination and family navigation.

Use the Child Health Intake Form database 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.

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 from pediatric to adult specialty services.

Identify and eliminate inequities that affect the health of CYSHCN.

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

ESMs	Status
ESM 11.2 - 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 11 and younger who receive care in a well-functioning system by 5 percent.

By September 30, 2025, increase the percentage of CYSHCN ages 12-17 who receive care in a well-functioning system by 5 percent.

Strategies

Through partnerships, understand and mitigate the impact of provider shortages for CYSHCN in terms of location, type of insurance accepted, provider capacity, or if the provider is taking new patients.

Address the need for more services, support, providers, and adequate health care financing, particularly in rural communities and remote areas.

Identify strategies to improve access to affordable, quality health care for CYSHCN, regardless of location, language spoken, gender identity, race, immigration status, or insurance.

In collaboration with payers and health coverage organizations, understand and mitigate issues related to financial eligibility for health care and other support services.

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

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.

By June 2021, collaborate with surveillance and epidemiology Healthy Youth Survey leads to advocate for including questions about special health care needs in all Healthy Youth Surveys.

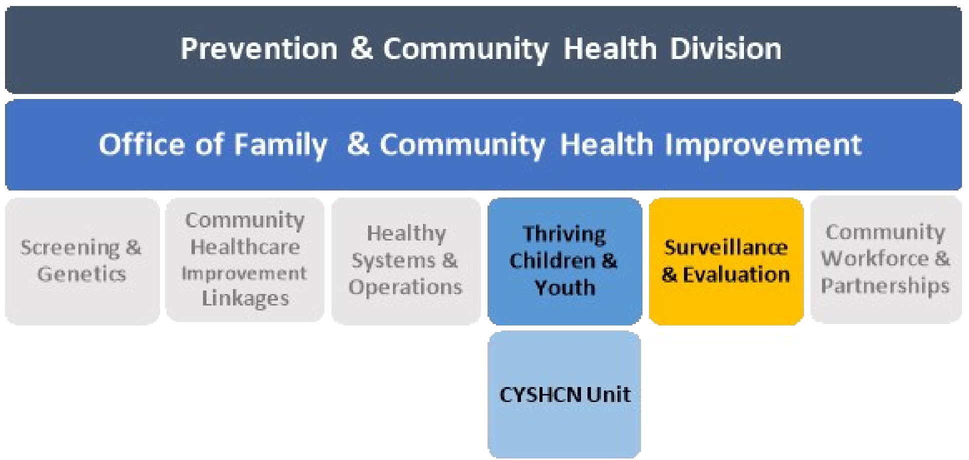
Strategies

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.

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.



Overview

The Children and Youth with Special Health Care Needs 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.

An estimated 334,992 children and youth with special health care needs (CYSHCN) ages 17 and younger reside in Washington state; this is an estimated 19.6 percent of the population of this age group (National Survey of Children's Health [NSCH] 2018-19). In 2018-2019, Washington had a similar percentage of CYSHCN ages 17 and younger at (20 percent) as the U.S. (19 percent). The number of children and youth diagnosed with special health care needs continues to grow in Washington (NSCH). 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 18,815 children in 2018, a 51 percent increase over just a five-year period. Since 2018, CHIF numbers have remained stable at 18,715 (2019) and 16,679 (2020), but the DOH CYSHCN program and partners continue to identify new access to care needs for CYSHCN.

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 FFY 2020, we concentrated much of our work on the medical home and adequate insurance national performance measures (NPMs) for CYSHCN.

According to the NSCH (2018-2019), the percentage of CYSHCN in Washington state with a medical home is only 40.8 percent, which is lower, though not a statistically significant difference from the previous 2017-2018 survey data of 45.3 percent. This is notably less than the percentage of children *without* special health care needs who have a medical home, 54.2 percent. The limited data available show significant variance in access to a medical home among CYSHCN in Washington between racial/ethnic subgroups.

The NSCH (2018-2019) shows the percentage of children with adequate insurance in Washington state is 65.1 percent. However, among CYSHCN, it is only 55.9 percent. Often parents describe barriers related to access to skilled providers. Services for complex medical or behavioral health needs may be limited or nonexistent in certain

locations, making access for families difficult. Travel to a distant provider location results in additional expense and is sometimes impractical for families, and there are often 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. *A quarter (25 percent) of Washington families raising CYSHCN stopped working or reduced working hours to provide care, compared with 20 percent nationally.* 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 CYSHCN program's block grant work includes two priority areas of work: medical home and adequate insurance. When we created the new five-year state action plan last year, we had not originally included NPM 15 – Adequate Insurance for 2021-2025. However, on reflection this year we have 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. The following sections describe progress made and programmatic highlights during FFY 2020 for these 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 in 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. We are also working on 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).

As the CHIF redesign was developed, the database administrator position in the CYSHCN program was realigned to a higher position classification and the position description was updated to add a new focus on process improvement and stakeholder engagement around the data collection needs of the program, and the utility and future opportunities in using the new cloud-based CHIF database.

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 home work has focused on improving medical home for children with autism.

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 seven additional counties. Five other counties have been developing teams, and an additional four 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 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 26 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. Eight of the 26 spokes are also currently part of SMART teams, and the number will rise in 2021 based on Autism COE trainings. 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 off of 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 July and September 2020 had over 200 participants, with over 100 potential COEs and other representatives from public health, schools, early intervention, and other community partners. At least 47 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 new 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 2020 ECHO cohort indicate that 82 percent of providers were confident in their ability to provide a medical home to patients with autism at the end of the year (this is up from 62 percent at the beginning of the year). Data also indicate significant improvement in confidence ratings over the course of the year for the 2020 ECHO cohort.

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). 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.

The CYSHCN Nutrition Consultant conducted a statewide needs assessment related to nutrition services for CYSHCN in 2017-2018. Due to an extended position vacancy, work was resumed on the Assessment of Nutrition Services for CYSHCN in the fall of 2019 and the report was published online in early 2020.

Significant time, effort, and resources were committed to conducting key informant interviews and focus groups that included CYSHCN families and pediatric health care providers, as well as surveying pediatric dietitians across the state. Existing data on nutrition risk criteria from the Women, Infants and Children Nutrition Program (WIC) were used to estimate the number of CYSHCN seen at Washington state WIC clinics.

The needs assessment 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)

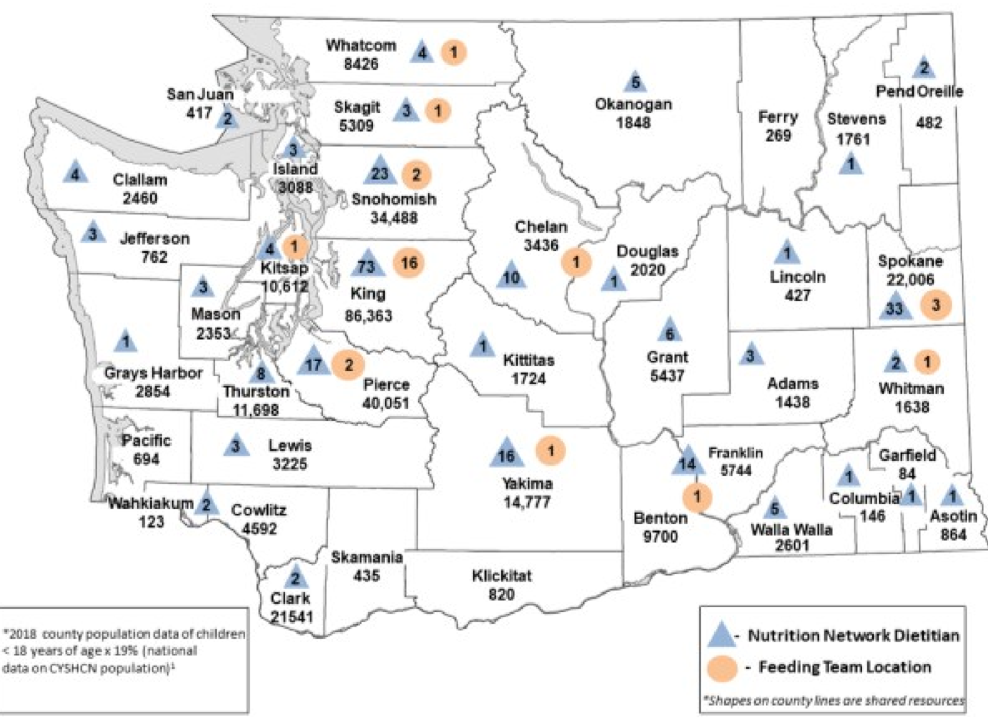
A key finding of the report was that based on existing data on nutrition risk criteria, up to 26 percent (46,574 of 180,689) of infants and children participating in Washington's WIC program in 2018 have a special health care need. This speaks to the benefit of CYSHCN training for WIC dietitians. It 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.

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 2020, a two-day training in CYSHCN nutrition was conducted, with attendance by 11 RDNs. This capacity-building work increased the number of RDNs with training in CYSHCN as part of a statewide network to 232, with at least one member serving 35 of the 39 counties. A Nutrition Network meeting was held virtually in April 2020 to provide ongoing refinement of specialized nutrition skills and resources, and an opportunity to network and collaborate on relevant projects. Additional virtual trainings were offered on Promoting First Relationships, and the Parent Child Interaction Feeding Scale. A virtual journal club was offered on atypical eating behaviors, which included Nutrition Network RDNs, CYSHCN coordinators, and feeding team members.

Based on feedback from Nutrition Network dietitians on a telehealth survey conducted in June 2020, the UW Nutrition program provided a telehealth question and answer session via Zoom to address most frequently asked questions about serving CSHCN during the pandemic. It was presented by one of the Nutrition Network members who has been conducting all of her nutrition visits via telehealth since 2017.

In the CYSHCN feeding team network, there are 30 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, one of the feeding teams that operates out of a hospital wanted to know what other hospital feeding teams were requiring of their patients prior to coming in for a swallow study (e.g., COVID-19 testing prior to appointment, restricting number of adults accompanying minor, etc.). The UW Nutrition program surveyed the Washington feeding teams on current COVID-19 testing practices prior to swallow study and shared results with all 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.

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. Each of the three teams serves children from nine to 10 counties in the eastern, central, and southwestern portions of Washington. Typically, their caseload of around 200 children is 75 percent 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 involved making author assignments, getting updated chapters from authors, and editing completed chapters. We hope to finalize this publication during FFY 2021.

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.

The CYSHCN program has explored offering fellowships or internships with the CYSHCN program to support LEND fellows to learn about the important work of Title V and especially CYSHCN. A challenge has been to clearly identify a project that aligns with the scope of a LEND fellowship. Many aspirational ideas were discussed and the CYSHCN program hopes to continue to explore this in partnership with other MCH-funded entities.

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. 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 2021.

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 percent. However, among CYSHCN it is only 55.9 percent, 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. The CYSHCN program has also increased collaboration with the DDC to partner together in improving systems. For example, the Informing Families newsletter and resource guide published by the DDC includes links to DOH's Genetics program's Down syndrome resource and information page, and has featured articles in their newsletter with contributions from the CYSHCN program. The CYSHCN Director also participates in the DDC health equity workgroup to improve health equity for children and youth with intellectual or developmental disabilities.

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 directors of neurodevelopmental centers as they developed priorities and strategies for the shift from fee-for-service to managed care, and worked to achieve the Centers of

Excellence in Neurodevelopmental Services designation recognized by HCA, which allows them to initiate services without prior authorization and affords them use of special billing codes. Technical assistance topics included contract language from other states, and how a Center of Excellence designation works.

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.

Throughout 2020, the WSLI Steering Committee worked with the National MCH Workforce Development Center (WDC) 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 Steering Committee member, looking at needs, resources, and wishes. The Steering Committee decided to host a virtual summit in late summer 2021 to promote work around health equity and family leadership and involvement, as well as to bring new agencies to the WSLI table.

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 three quarterly Communication Network meetings in FFY 2020 (the July meeting was cancelled due to many state and LHJ staff being on leave or activated for COVID-19 related work). More than 40 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. In lieu of the July meeting, a survey was administered to the LHJs that asked about their activities and challenges in their COVID-19 response. Some examples of their activities were:

- Connecting parents with resources to work with the child at home on specific behaviors and supports
- Administering developmental screenings and some M-CHATs (Modified Checklist for Autism in Toddlers) by phone
- Telehealth nursing appointments with CYSHCN clients
- Partnering with Parent to Parent, which is doing all supports virtually
- Phone, text, or Zoom conversations with parents

Some challenges reported included:

- Not getting referrals
- Adequate respite care resources to provide skilled care to meet families' needs
- Families may not have the technology they need
- People are more likely to forget telephone appointments

The meeting topics, chosen with stakeholder input, included the Nutrition Network and nutrition needs assessment, behavioral health integration, MCHBG needs assessment, and student and family rights and supports for special education services during COVID-19. 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 during 2020 due to COVID-

19.

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., data matching with Medicaid to identify CYSHCN and increase access to care coordination; activities such as 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 effectiveness 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.

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.

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 has been incorporated into the 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.

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.

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 2021. 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. This training will be followed by monthly "office hours" to consult with the clinical nutrition consultant about ongoing questions and issues. 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 *CSHCN 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.

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 *CSHCN 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 came on board in March 2021 and is engaging in planning with the Nutrition Network on increasing membership and technical assistance for members.

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 with nutrition risk factors or nutrition related co-morbidities to inform effective nutrition interventions.

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 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.

Objectives:

By September 30, 2025, increase the percentage of CYSHCN ages 11 and younger who receive care in a well-functioning system by 5 percent.

By September 30, 2025, increase the percentage of CYSHCN ages 12-17 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:

Ensure CYSHCN have access to a medical home that is either nationally certified or recognized, or with providers who self-identify as a medical home following the Standards for Systems of Care for Children with Special Health Care Needs.

Enhance and maintain health systems to improve care coordination and family navigation.

Use the Child Health Intake Form database 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.

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 from pediatric to adult specialty services.

Identify and eliminate inequities that affect the health of CYSHCN.

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

Through partnerships, understand and mitigate the impact of provider shortages for children and youth with special health care needs (CYSHCN) in terms of location, type of insurance accepted, provider capacity, or if the provider is taking new patients.

Address the need for more services, support, providers, and adequate health care financing, particularly in rural communities and remote areas.

Identify strategies to improve access to affordable, quality health care for CYSHCN, regardless of location,

language spoken, gender identity, race, immigration status, or insurance.

In collaboration with payers and health coverage organizations, understand and mitigate issues related to financial eligibility for health care and other support services.

Our continuing work with the Medical Home Partnerships Project directly addresses access to medical home, 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.
- Collect data on providers that are National Committee for Quality Assurance (NCQA) Certified medical homes and/or confident in their abilities to provide a medical home to CYSHCN
- 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 have caught up on a backlog of data entry caused by the transitions between systems, we will now shift our focus to better supporting CHIF 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 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 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. We incorporated a disability screening question into our COVID-19 Student Survey and 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.

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.

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.

Objective:
By June 2021, collaborate with surveillance and epidemiology Healthy Youth Survey leads to advocate for including questions about special health care needs in all Healthy Youth Surveys.

General Status on this Objective to Date:
Mental health and suicidal ideation are assessed biennially through the HYS, 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.

Strategy:
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 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:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

SPM 12 - Percentage of adults who did not get health care because of cost

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		13.2
Numerator		
Denominator		
Data Source		BRFSS
Data Source Year		2019
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13.0	13.0	12.6	12.2	11.8	11.5

SPM 13 - Develop outreach plan to support COVID-19 vaccination campaign efforts by March 31, 2021

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

State Action Plan Table

State Action Plan Table (Washington) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Increase capacity of the local public health workforce to strategically identify, plan for, and address the needs of women and children throughout the state.

SPM

SPM 11 - Five-year maternal and child health needs assessment process for 2026-2030 plan is initiated by September 30, 2021

Objectives

By September 30, 2021, initiate the next five-year maternal and child health needs assessment as a continuous planning process, and include local health jurisdictions throughout all stages.

Strategies

Apply implementation strategies outlined in local MCHBG health equity plans.

Foster and strengthen community and regional partnerships.

Increase emergency preparedness capacity for priority populations.

Strengthen local work force through trauma-informed care and other trainings. Track all trauma-informed trainings using same questions, retrospective pre/post knowledge/efficacy gain questions.

Improve local data collection and analysis to improve strategic planning and program support.

Support annual updates to local needs assessments in order to identify and address emerging issues.

In accordance with the Washington Foundational Public Health Services (FPHS) Functional Definitions Manual section on Maternal/Child/Family Health, DOH will work with LHJ partners to develop a prioritized prevention plan using life course expertise and an understanding of health inequities.

State Action Plan Table (Washington) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Identify and reduce barriers to quality health care.

SPM

SPM 12 - Percentage of adults who did not get health care because of cost

Objectives

By September 30, 2025, decrease the percent of adults who report in the Behavioral Risk Factor Surveillance System that they did not receive health care services due to cost.

Strategies

Identify strategies to improve access to affordable, quality health care, regardless of location, language spoken, gender identity, race, or insurance.

In collaboration with payers and health coverage organizations, understand and mitigate issues related to financial eligibility for health care and other support services.

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

Through partnerships, understand and mitigate the impact of provider shortages on communities in terms of location, type of insurance accepted, provider capacity, or if the provider is taking new patients.

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.

Promote opportunities for all people, regardless of gender identity, to have a full range of education, access, and ability to utilize health services that meet their individual needs.

Conduct environmental scan to 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.

State Action Plan Table (Washington) - Cross-Cutting/Systems Building - Entry 3

Priority Need

Identify and respond to emerging priority needs associated with public health emergencies and their effects on the maternal and child populations.

SPM

SPM 13 - Develop outreach plan to support COVID-19 vaccination campaign efforts by March 31, 2021

Objectives

By March 31, 2021, develop outreach plan to support COVID-19 vaccination campaign efforts through promotion to managed care organizations and local health jurisdictions.

Strategies

Through health promotion and education, prepare families for eventual COVID-19 vaccination availability for expanded age groups.

Increase emergency preparedness capacity for priority populations.

Monitor emerging needs and prepare for future public health emergencies.

State Action Plan Table (Washington) - Cross-Cutting/Systems Building - Entry 4

Priority Need

Improve the safety, health, and supportiveness of communities.

Objectives

By October 2021, EfC Steering Committee will learn about the Washington State Fatherhood Council's strategic plan, identify ways to coordinate with it and decide how to support their goals.

By March 2021, EfC Steering Committee will develop a collaborative, data-driven policy agenda that supports family economic security, health equity, and promotion of other key protective factors to ensure all children thrive in safe, stable nurturing relationships and environments; establishing key state Legislative priorities.

By December 2021, EfC Steering Committee will promote at least one policy to provide safe, stable, nurturing relationships and environments. Economic security, including racial equity, fatherhood initiatives and accessible, affordable childcare are areas of focus that will likely be considered for prioritization.

Strategies

Promote policies and programs that improve economic security, meet basic needs, and increase health.

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

Invest in support 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.

Expand home visiting in ways that promote resilience and address social determinants of health.

Partner with others to identify and implement solutions that support accessible, affordable, and quality childcare, including care that meet the needs of families with CYSHCN.

Identify and eliminate inequities that affect health, including those in: (1) Access to built environments such as affordable housing, transportation, and physical activity infrastructure; (2) Access to social and educational services; and (3) Access to healthy food.

Promote and support culturally and linguistically responsive strategies to connect children and families to comprehensive medical care and community resources.

National Performance Measure 15 – Adequate Insurance

Percent of children, ages 0 through 17, who are continuously and adequately insured.

National performance measure 15, adequate insurance, was placed in the Cross-Cutting domain in Washington's original 2016-2020 State Action Plan, but to be consistent with revised grant guidance in 2018 it was moved to the Children and Youth with Special Health Care Needs domain. Most of our reporting on NPM 15 is now included in the *CYSHCN Annual Report*. However, the objectives and strategies listed below were kept in the Cross-Cutting / Systems Building domain for FFY2020.

Priority:

Screening, referral and follow-up

Objective:

By September 30, 2020, promote the early identification of individuals with, or at risk of, genetic disorders, and improve the health care delivery system to effectively meet their needs.

Strategies:

Participate in agency efforts (i.e., assessment, policy development, health education, etc.) to address identified gaps in health care transformation as they relate to specialized services such as genetics.

Continue to build community partnerships and explore ways to improve the uptake of cascade testing (i.e., testing family members once a genetic mutation is found in a first-degree relative) for Centers for Disease Control and Prevention (CDC) Tier 1 conditions.

Promote the use and evaluate the effectiveness of Family Health History educational materials.

The Health Care Authority contracted with DOH for the DOH State Coordinator for Genetic Services (whose position is also partially Title V-funded) to advise HCA about authorizations for genetic services for Medicaid clients. The current agreement extends to 2023.

Medicaid covers genetic counseling and genetic testing when it is medically necessary. Multiple laboratory utilization reports indicate up to 80 percent of all genetic tests are ordered by clinicians who are not formally trained in genetics, and at least a third of these tests are inappropriate (e.g., the wrong test entirely; or a better, oftentimes less expensive test is available). Furthermore, another roughly 30 percent of tests ordered are misinterpreted or the clinician fails to retrieve the results. This creates potential for enormous resource waste as well as potential harms to clients. The state genetics coordinator alerts Medicaid and other payers to wasteful genetic testing orders they are recommended to decline (e.g., all MTHFR [methylenetetrahydrofolate reductase gene] testing and any invoices for "excessive" genetic testing).

By serving as a consultant and meeting with HCA staff periodically, we work to ensure families truly in need of these genetic services are able to access them in a timely manner, and that limited state and federal resources are spent wisely.

We and our local partners continued to:

- Work with HCA on activities related to policy and rule updates, eligibility for Medicaid coverage for children who are hospitalized for 30 days or longer, regardless of having private insurance.

- Work with partners to assist families in applying for other Medicaid waiver services so that children's medical needs are met regardless of insurance status.

- Coordinate with partners and other state agencies, such as the Office of the Insurance Commissioner, on policies that: remove barriers to benefits such as complex prior authorization requirements; and are consistent with United States Preventive Services Task Force (USPSTF) and Affordable Care Act (ACA) recommendations.

- Respond to family and provider complaints about coverage denials related to newborn hearing screening, genetic counseling or testing services, or other services that should be provided.

We also work with genetic providers in Washington at our annual meetings (with continuing education units [CEU] offered), and include presentations on cutting-edge technology for screening and diagnosis, Medicaid-related issues, and other coverage concerns. Additionally, at each meeting we disseminate data we get on service utilization, including the proportion of individuals covered by Medicaid. These data are disseminated to those who attend the meeting and starting last year, we also provide it to the larger group of genetic providers (about 200 or so) who are part of our genetic providers group network.

Other Cross-Cutting and Systems Building Work

Priority:
Health equity

Objective:
By September 30, 2020, work to assure adequate public and private health services and coverage for the maternal and child health (MCH) population that includes access to preventive care, screening, treatment, and referral.

Strategies:
Participate in interagency efforts to implement the Affordable Care Act; impact Essential Health Benefits; and blend physical, mental, and behavioral health services into comprehensive health care.

Identify barriers and solutions to addressing health equity, culturally and linguistically appropriate services (CLAS), and geographic access to primary and specialty care for the MCH population.

The previous sections of this document include many examples of our work to support equity. In addition, we and our local partners continued to:

- Work with HCA to update rules that will provide access to preventive care, screening, treatment, and referral to all pregnant people in Washington. An example: We worked to update the rule for Chapter 246-680 WAC, Prenatal Tests – Congenital and Heritable Disorders, which establishes standards for determining medical necessity for screening and diagnostic testing of congenital and heritable conditions. The State Board of Health last revised the rule in 2003. This update was a multiyear effort and was completed in June 2021. The updated rule clarifies requirements for pre- and postprocedure genetic counseling, amends requirements for

coverage of certain prenatal genetic tests, and updates and clarifies definitions.

- Work to assure access to appropriate services. Two examples: We used MCHBG funding to provide subscriptions to a Teratogen database offered to all prenatal genetic clinics in the state, used to identify information regarding harmful exposures to a fetus. We also contracted for cytogenetics services to be provided by UW Medicine for individuals who qualified for these services.

- Work to provide educational information on and maintain a landing page for Down syndrome that provides information for parents and families who have received a pre- or post-natal diagnosis of Down syndrome.

- Work with partners to collect diagnoses data for Critical Congenital Heart Disease data on infants identified through newborn screening, analyze the data, and disseminate findings and best practices through published reports to all birthing hospitals and midwifery clinics.

The Early Hearing Detection and Intervention (EHDDI) program promoted access to newborn hearing screening services for infants born out-of-hospital through providing training and equipment to midwives in rural areas and/or who serve underserved populations. The EHDDI program also supported professional development and mentorship opportunities for pediatric audiology clinics in rural areas. Local access to skilled pediatric audiologists is incredibly important in order for infants who are deaf or hard of hearing to receive timely identification and early support services.

Objective:
By September 30, 2020, improve capacity to collect, analyze, and use data to improve health equity and delivery of MCH services.

Strategy:
Determine the need for additional assessments and systems to monitor need and evaluate progress of maternal and child health activities, with a special focus on data needed to identify health disparities as well as successful efforts to achieve health equity.

DOH’s updated strategic plan is based on four foundational transformations, one focused on equity:

EQUITY, DIVERSITY, INCLUSION

We will create a diverse and inclusive workplace, engage with underrepresented communities in all decisions, and ensure equitable access to services, opportunities, and information.

Information about our efforts to address inequities and incorporate cultural humility in all our work can be found throughout this document.

In *Appendix B – Maternal and Child Health Block Grant Local Work*, we describe how we’ve incorporated use of a health equity lens in the local health jurisdiction contracts, following a pilot project initiated by attendees of the National MCH Workforce Development Center’s (WDC) Strategic Skills Institute.

To better serve all people, DOH has continued to increase the informational resources we make available in multiple languages. In addition, DOH partner organization WithinReach operates the Help Me Grow Washington Hotline, which provides resource information, health care referrals, and developmental screenings for children. Nearly all of the call center staff are bilingual, and nearly 99 percent of Spanish-language calls are completed without a third-person interpreter.

We are trying to gain a better understanding of MCH issues and emerging needs by expanding our data collection and analysis efforts. Some examples: COVID-19 Student Survey, PRAMS expansion, integration of Birth Defects Surveillance records with hospitalization records, and questions related to adverse childhood experiences on the Behavioral Risk Factor Surveillance System and Healthy Youth Survey. The *Needs Assessment Update* and *MCH Data Capacity* sections provide more details about previous and upcoming work in this area.

Priority:

Quality clinical and preventive treatment services

Objective:

By September 30, 2020, continue work on implementation of Health Transformation.

Strategy:

Continue collaboration with partner agency Health Care Authority.

Washington has been working to integrate behavioral, mental, and physical health care for a number of years. Behavioral health integration is a priority of Gov. Jay Inslee; it's also a key action included in our 2013 Washington State Health Care Innovation Plan, and an overarching goal of the Healthier Washington initiative. Title V program staff promoted, facilitated and convened workgroups in support of integrated health services, and included language, activities, and deliverables supportive of integration in our contracts where appropriate.

Information about our collaborative work with Health Care Authority and managed care organizations can be found throughout the population domain narrative sections, specifically in the *Child Health Annual Report* and in the *Health Care Delivery System* sections.

Cross-Cutting/Systems Building - Application Year

Overview

Our Cross-Cutting / Systems Building work plan involves participation of all sections of the Office of Family and Community Health Improvement.

Activities supporting the priorities, objectives, and strategies that appear in the Cross-Cutting / Systems Building section of the state action plan are described throughout this application. This section describes additional work that was not already included in previous sections.

Priority:

Increase capacity of the local public health workforce to strategically identify, plan for, and address the needs of women and children throughout the state.

State Performance Measure:

Five-year maternal and child health needs assessment process for 2026-2030 plan is initiated by September 30, 2021.

Objective:

By September 30, 2021, initiate the next five-year maternal and child health needs assessment as a continuous planning process, and include local health jurisdictions throughout all stages.

Strategies:

Apply implementation strategies outlined in local MCHBG health equity plans.

Foster and strengthen community and regional partnerships.

Increase emergency preparedness capacity for priority populations.

Strengthen local work force through trauma-informed care and other trainings. Track all trauma-informed trainings using same questions, retrospective pre/post knowledge/efficacy gain questions.

Improve local data collection and analysis to improve strategic planning and program support.

Support annual updates to local needs assessments in order to identify and address emerging issues.

In accordance with the Washington Foundational Public Health Services (FPHS) Functional Definitions Manual section on Maternal/Child/Family Health, DOH will work with LHJ partners to develop a prioritized prevention plan using life course expertise and an understanding of health inequities.

We met our objective by launching our ongoing needs assessment in January 2021, developing a set of standard questions for programs to incorporate into stakeholder discussions and surveys. Information on this is included in the *Needs Assessment Update* section. The *Other MCH Data Capacity Efforts* section includes information about ways we are expanding our access to and analysis of MCH data.

We plan to meet with local health jurisdictions in October 2021, and develop their new agreements later in the fall, to include information about how they plan to use a health equity lens to guide their work. Over the course of the next few years we will be able to incorporate activities associated with the statewide MCH needs assessment. More

information about LHJ activities is included in *Appendix B – Maternal and Child Health Block Grant Local Work*.

In response to suggestions from last year's MCHBG review, we plan to request technical assistance to develop an improved SPM that better measures the effect of our work, to be included in next year's application.

Priority:
Identify and reduce barriers to quality health care.

State Performance Measure:
Percent of adults who did not get health care because of cost.

Objective:
By September 30, 2025, decrease the percent of adults who report in the Behavioral Risk Factor Surveillance System that they did not receive health care services due to cost.

Strategies:
Identify strategies to improve access to affordable, quality health care, regardless of location, language spoken, gender identity, race, or insurance.

In collaboration with payers and health coverage organizations, understand and mitigate issues related to financial eligibility for health care and other support services.

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

Through partnerships, understand and mitigate the impact of provider shortages on communities in terms of location, type of insurance accepted, provider capacity, or if the provider is taking new patients.

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.

Promote opportunities for all people, regardless of gender identity, to have a full range of education, access, and ability to utilize health services that meet their individual needs.

Conduct environmental scan to 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.

All of the population domain sections in this application and report describe our work and planned activities to identify and reduce barriers to quality health care.

Priority:
Improve the safety, health, and supportiveness of communities.

Objectives:
By October 2021, EfC Steering Committee will learn about the Washington State Fatherhood Council's strategic plan, identify ways to coordinate with it and decide how to support their goals.

By March 2021, EfC Steering Committee will develop a collaborative, data-driven policy agenda that supports family economic security, health equity, and promotion of other key protective factors to ensure all children thrive in safe, stable nurturing relationships and environments; establishing key state Legislative priorities.

By December 2021, EfC Steering Committee will promote at least one policy to provide safe, stable, nurturing relationships and environments. Economic security, including racial equity, fatherhood initiatives and accessible, affordable childcare are areas of focus that will likely be considered for prioritization.

Strategies:
Expand home visiting in ways that promote resilience and address social determinants of health.

Partner with others to identify and implement solutions that support accessible, affordable, and quality childcare, including care that meet the needs of families with CYSHCN.

Identify and eliminate inequities that affect health, including those in:

- *Access to built environments such as affordable housing, transportation, and physical activity infrastructure*
- *Access to social and educational services*
- *Access to healthy food*

Promote and support culturally and linguistically responsive strategies to connect children and families to comprehensive medical care and community resources.

Our Essentials for Childhood program is primarily funded through CDC, MCHBG, and private foundation funding. 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.

The Title V MCH Director and Thriving Children and Youth Section Manager have met monthly to bi-monthly in 2020-2021 with the Washington Interagency Fatherhood Council Director of the Washington State Department of Social and Health Services Economic Services Administration to learn about their needs and plan collaborative action in the years to come. Selected focus areas of our needs assessment include a review of the Office of Population Research's Family Strengthening research report 2020 section on Fathering; and learning about the expansion needs of the Dad's Allies program, a facilitated and structured support group model for the healthy and regular involvement of fathers in the lives of young children. The potential licensing of peer father supports who facilitate support groups in behavioral health care settings is an area for possible action.

The Essentials for Childhood program will continue with a series of parent focus groups, started in May 2021, of parents with child welfare system involvement, or risk factors for involvement. Fifty percent identified as fathers. The focus groups are facilitated by a parent with lived experience having an infant removed by Child Protective Services, and then returned permanently to her care. The first objective of the focus groups is to learn of the community resources that helped facilitate support, and the barriers that stood in the way of support for healthy involvement in the lives of their young children. A second objective is to understand how to integrate all or a subset of these parents into a decision-making role with the Essentials for Childhood Steering Committee and Leadership Group.

In 2021, EfC partners informed and promoted an agenda of policies to promote family resilience and reduce child abuse, neglect, and other childhood trauma. Bills enacted by the state Legislature this year expand access to quality early learning, modernize and increase cash and food assistance, preserve family connections and reduce removal of children from their families, and fund evidence-based prevention programs for families furthest from opportunity.

We conducted key informant interviews with twelve subject matter expert members of the EfC Steering Committee Leadership Group, to ascertain the two policies from our policy agenda that they thought would have the most impact on the mission of providing safe, stable, nurturing relationships and environments, and preventing child maltreatment. Two state Legislative measures were prioritized for promotion in the coming year:

- Modifying child welfare standards for child removal in neglect cases from “reasonable cause” to “preponderance of evidence” to address systemic racial disproportionality in rates of child removal.

- Support enhancements of allowable practices named in the Families First Prevention Services Act (FFPSA), to include funding for family concrete needs such as housing or transportation. FFPSA is designed to prevent child maltreatment, for families with accepted referrals into the Child Protective Services system, pursuant to the Title IV-E waiver in our state.

We will carry this work forward through developing a network communication plan with our Steering Committee members and nonprofit policy partners to generate support for these and other policies with Legislators and rule makers.

Priority:
Identify and respond to emerging priority needs associated with public health emergencies and their effects on the maternal and child populations.

State Performance Measure:
Develop outreach plan to support COVID-19 vaccination campaign efforts by March 31, 2021.

Objective:
By March 31, 2021, develop outreach plan to support COVID-19 vaccination campaign efforts through promotion to managed care organizations and local health jurisdictions.

Strategies:
Through health promotion and education, prepare families for eventual COVID-19 vaccination availability for expanded age groups.

Increase emergency preparedness capacity for priority populations.

Monitor emerging needs and prepare for future public health emergencies.

We met our objective to develop an outreach plan for COVID-19 vaccination. The population domain sections in this application and report describe our work and planned activities to support vaccination efforts throughout the state.

In response to suggestions from last year’s MCHBG review, we plan to request technical assistance to develop an improved SPM that better measures the effect of our work, to be included in next year’s application.

III.F. Public Input

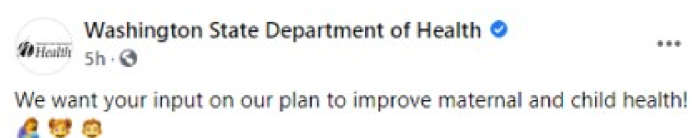
The Washington Title V program seeks ongoing input on priorities and programs from partners and stakeholders, including the public who fund and benefit from our work. We do this through advisory groups, workgroups, direct meetings with partners, working with parent and advocacy organizations, and surveying 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 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 August 4-15, 2021. Unfortunately, we did not receive any specific comments on the grant application and report material during this time. Our social media posts generated nine retweets/shares, 19 likes, four comments/replies that were not specific to the grant material, and one response email from a person who offered maternal and child health consulting services.

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 also used Twitter to promote this Spanish language material and request comment, as shown below.

¡Queremos su opinión sobre nuestro plan para mejorar la salud materno-infantil! Conozca nuestro trabajo con la subvención global para la salud materno-infantil, la cual financia programas en el estado.

Comparta sus comentarios antes del 15 de agosto: spr.ly/6012yYDRp

Translate Tweet

2:00 PM · Aug 6, 2021 · Sprinklr

We had hoped to translate the MCHBG Overview into additional languages as well, but our material was not completed early enough to do this for the public comment period before grant application. Instead, we are creating a shorter overview document to be translated into multiple languages, probably Russian, Vietnamese, Ukrainian, Somali, Korean, Tagalog, Arabic, Punjabi, and Cantonese. This will be available on our website after the grant submission and shared with community partners as an educational piece about the program and Washington's use of the grant funding.

As mentioned in the *Needs Assessment Update* section, we have initiated ongoing needs assessment activities to collect feedback from priority populations and community leaders over the next four years for the next MCH needs assessment. We have found better engagement with efforts like our 2019 Discovery Survey (1,114 responses) where we ask specific questions to gather opinions than when we make a general announcement that we are accepting public comment on prepared material. For future years, we want to explore better ways to reach out to get public input on our Title V program, and have appreciated seeing examples of other states' efforts.

Advisory Groups

Throughout this application and report, we mention a number of 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.

The Community Health Advisory Committee (CHAC) advises DOH on the implementation of policy, environmental, and systems changes in state and local public health actions to address birth disparities, sexual violence prevention, and health promotion, and has most recently focused on COVID-19. Dr. Kathy Lofy, as the State Health Officer, has been the executive sponsor of the CHAC, which includes a variety of state agency personnel, local health jurisdictions, community and tribal organization representatives, and others with an interest in public health programs. Dr. Lofy recently retired, and we await her successor to take on the sponsorship of the CHAC. The CHAC meets quarterly, is briefed on MCHBG related to reduction of maternal and birth disparities, and provides guidance on priorities and implementation of programs.

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

Strengthening Measures and State Action Plan

In feedback on the October 2020 MCH Block Grant, reviewers recommended that we strengthen some of our state performance measures (SPMs) and evidence-based strategy measures, and consider including additional SPMs in priority areas where we lacked measures. Reviewers also encouraged us to strengthen alignment of the priority needs, strategies, objectives, and measures in the state action plan. While we have strengthened connection to state performance measures for several strategies, we would like technical assistance, particularly related to measurement of policy improvements. We plan to follow up on the reviewers' recommendation to pursue technical assistance from a consultant or Maternal and Child Health Bureau resource center.

Equity, Cultural Humility, and Anti-Racism

The Department of Health has been working to address issues of equity and cultural humility in our employees and programs for several years, and much still must be done. In the last couple of years, we have added a focus of working to become an anti-racist organization, addressing policies, processes, and programs.

We are working to improve the diversity of our workforce so it better represents the diversity of people in the state. This includes changes to our recruitment and hiring practices to value lived experience comparable to other types of formal training and education. Allowance of full-time mobile working has expanded the geographic areas of our recruitment, reaching a more diverse base of candidates.

We are working to improve how we collaborate with community, particularly Black, Indigenous and people of color (BIPOC) communities, in ways that share power for decision-making to help form our programs and priorities. We are using a DOH Community Engagement Guide for this effort, and shaping our program design, evaluation, and funding processes to be more responsive to community leadership and input. We are also working to develop a community expertise reimbursement policy.

In our Essentials for Childhood statewide child abuse and neglect coalition, we are using the *Racism as a Root Cause*[1] approach as a framework to examine policy considerations. We plan to use this approach to review other programs as well.

We have initiated conversations with Region X partners about whether we may want to request technical assistance with our anti-racism and cultural humility efforts as a region, or whether Washington state should pursue an independent request. Once we have finished the regional conversation and determined our area of focus and scope, we anticipate submitting a request for assistance.

Use of Data and Data Dashboards

A third area where we would find technical assistance useful is developing and designing data dashboards for MCH programs to improve visibility and accessibility of relevant data. This would support both internal program decision-making and inform the work of other community health champions.

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[1] Malawa Z, Gaarde J, Spellen S. Racism as a Root Cause Approach: A New Framework. Pediatrics. 2021;147(1):e2020015602

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MedicaidMOU-2021.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - AppA-AbbreviationsAndAcronyms.pdf

Supporting Document #02 - AppB-MCHBG-LocalWork.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - WA-DOH-OrgChart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Washington

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 8,900,000	
A. Preventive and Primary Care for Children	$ 2,948,035	(33.1%)
B. Children with Special Health Care Needs	$ 3,041,002	(34.1%)
C. Title V Administrative Costs	$ 771,615	(8.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,760,652	
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)	$ 16,473,626	
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)	$ 17,698,731	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 34,172,357	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,120,893
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	$ 311,000
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
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 354,234
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020
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 Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 255,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 245,000
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	$ 4,000,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > TPP Innovation and Impact	$ 1,859,770

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 8,930,530		$ 8,011,365	
A. Preventive and Primary Care for Children	$ 2,874,273	(32.2%)	$ 2,225,867	(27.7%)
B. Children with Special Health Care Needs	$ 3,289,829	(36.8%)	$ 2,753,947	(34.3%)
C. Title V Administrative Costs	$ 693,780	(7.8%)	$ 531,077	(6.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,857,882		$ 5,510,891	
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)	$ 16,504,156		$ 15,584,991	
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)	$ 21,852,047		$ 16,351,318	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 38,356,203		$ 31,936,309	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 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	$ 326,530	$ 326,530
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 8,946,265	$ 4,000,000
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	$ 250,000	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 246,793	$ 246,793
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,107,164	$ 1,077,164
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Improving Services for Children and Youth with Autism Spectrum Disorder (ASD) and Other Developmental Disabilities	$ 524,464	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 5,500,000	$ 5,500,000
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) > Colorectal Cancer Control Program (CRCCP)	$ 1,297,267	$ 1,297,267
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Comprehensive Cancer Control Program (NCCCP)	$ 324,234	$ 324,234

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 970,000	$ 970,000
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Teen Pregnancy Prevention	$ 374,999	$ 374,999

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: We anticipate to fully spend out by the end of September 2021.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: We anticipate to fully spend out by the end of September 2021.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: We anticipate to fully spend out by the end of September 2021.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: We anticipate to fully spend out by the end of September 2021.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: State funds used to provided immunizations to children in the state of Washington.	
6.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Discontinue engagement due to regulation change.	

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 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 1,002,463	$ 1,250,237
2. Infants < 1 year	$ 1,002,463	$ 1,250,237
3. Children 1 through 21 Years	$ 2,948,035	$ 2,225,867
4. CSHCN	$ 3,041,002	$ 2,753,947
5. All Others	$ 134,422	$ 0
Federal Total of Individuals Served	$ 8,128,385	$ 7,480,288

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 0	$ 0
2. Infants < 1 year	$ 0	$ 0
3. Children 1 through 21 Years	$ 5,680,220	$ 5,680,220
4. CSHCN	$ 1,893,406	$ 1,893,406
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 7,573,626	$ 7,573,626
Federal State MCH Block Grant Partnership Total	$ 15,702,011	$ 15,053,914

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, Federal Total of Individuals Served**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**

Field Note:
Expect to expend variance by the end of September 2021.

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 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 89,304	$ 37,472
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 41,850	$ 9,876
B. Preventive and Primary Care Services for Children	$ 3,361	$ 0
C. Services for CSHCN	$ 44,093	$ 27,596
2. Enabling Services	$ 468,400	$ 489,379
3. Public Health Services and Systems	$ 8,342,296	$ 7,484,514
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		$ 3,276
Laboratory Services		$ 34,196
Direct Services Line 4 Expended Total		$ 37,472
Federal Total	$ 8,900,000	$ 8,011,365

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 7,573,626	$ 7,573,626
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	$ 5,680,220	$ 5,680,220
C. Services for CSHCN	$ 1,893,406	$ 1,893,406
2. Enabling Services	$ 0	$ 0
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		$ 7,573,626
Direct Services Line 4 Expended Total		$ 7,573,626
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: 82,483 **Data Source Year: 2020**

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	82,389 (99.9%)	213	193	193 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	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)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	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	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

None

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 the duration of the monitoring depends on the condition under consideration.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

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 2020

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	1,118	57.0	1.4	2.0	0.0	39.6
2. Infants < 1 Year of Age	82,710	46.2	1.5	49.2	3.1	0.0
3. Children 1 through 21 Years of Age	559,636	51.0	31.5	14.4	3.1	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	12,857	76.1	6.0	16.0	1.4	0.5
4. Others	47,078	39.9	39.9	0.0	0.0	20.2
Total	690,542					

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	84,895	No	83,656	100.0	83,656	1,118
2. Infants < 1 Year of Age	84,764	No	82,710	100.0	82,710	82,710
3. Children 1 through 21 Years of Age	1,933,806	No	1,981,429	80.0	1,585,143	559,636
3a. Children with Special Health Care Needs 0 through 21 years of age^	396,293	No	330,611	100.0	330,611	12,857
4. Others	5,592,992	Yes	5,592,992	1.0	55,930	47,078

^Represents a subset of all infants and children.

Form Notes for Form 5:

Data used to complete Forms 5a and 5b come from various sources.

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 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 2019, 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 2019.

The count of CSHCN come from the estimated population derived from the 2019 NSCH.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**

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:	**2020**

Field Note:
The percent with no insurance coverage comes from the American Community Survey and is the rate ror the population 0-17 years of age.

3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**

Field Note:
This total includes all children 1-6 years of age who received a 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:	**2020**

Field Note:
This is the total number of CSHCN served by local health.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**

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**
	Fiscal Year:	**2020**
	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:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: All newborns and their families receive educational materials in Washington State via Child Profile.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	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. the remaining 20% of individuals were over 18 years of age.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	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 havnig access to services which Title V has contributed to.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	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.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Washington

Annual Report Year 2020

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	82,710	45,830	3,794	15,851	1,067	8,975	1,249	3,878	2,066
Title V Served	1,118	621	51	214	14	121	17	52	28
Eligible for Title XIX	38,249	16,838	2,582	11,782	837	1,912	987	2,103	1,208
2. Total Infants in State	83,934	46,549	3,856	16,040	1,081	9,098	1,264	3,946	2,100
Title V Served	84,357	46,784	3,875	16,121	1,086	9,144	1,270	3,966	2,111
Eligible for Title XIX	38,749	17,042	2,615	11,927	849	1,948	1,001	2,138	1,229

Form Notes for Form 6:

Data in this form is for CY 2019, the most recent data available.

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	2022 Application Year	2020 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"	Kathleen Estes	Kathleen Estes
4. Contact Person's Telephone Number	(360) 236-3495	(360) 236-3495
5. Number of Calls Received on the State MCH "Hotline"		14,468

B. Other Appropriate Methods	2022 Application Year	2020 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	http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/MaternalandChildHealthBlockGrant	https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/MaternalandChildHealthBlockGrant
4. Number of Hits to the State Title V Program Website		640
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 Washington state Title V program does not have dedicated social media accounts, but working with the Department of Health's Center for Public Affairs, we use these DOH accounts:

Facebook: http://www.facebook.com/WADeptHealth/
Twitter: http://twitter.com/wadepthealth

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	PO 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	PO 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	PO 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 2022

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 and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.	Revised
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 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 Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Washington

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

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
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
2018	66.8	2.9	519	77,694
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
2018_2019	2.6 %	0.6 %	36,105	1,399,350
2017_2018	1.8 % ϟ	0.6 % ϟ	24,131 ϟ	1,366,434 ϟ
2016_2017	1.4 % ϟ	0.4 % ϟ	19,240 ϟ	1,358,071 ϟ
2016	1.5 %	0.4 %	20,417	1,351,429

Legends:

⚑ Indicator has an unweighted denominator <30 and is not reportable

ϟ 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
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
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
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
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
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
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
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
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
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
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
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
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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					47
Annual Indicator				69.7	69.3
Numerator				919,438	939,935
Denominator				1,318,605	1,355,481
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	59.0	70.0	70.7	71.4	72.1	72.8

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
Discussions between program and epidemiology staff resulted in a projected one percent per year increase over the next five years.

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	2017	2018	2019	2020
Annual Objective	93	93	93	93	94
Annual Indicator	87.5	92.1	92.4	91.0	92.5
Numerator	71,098	81,019	80,672	71,525	75,591
Denominator	81,303	87,977	87,274	78,591	81,714
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	93	93	93	93	94
Annual Indicator	93.4	94.5	94.2	94.1	94.1
Numerator	84,539	81,550	80,140	79,016	79,016
Denominator	90,489	86,284	85,113	83,941	83,941
Data Source	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	94.0	94.0	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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	23.2	23.5	33.1	34.8	36.5
Annual Indicator	28.0	31.6	29.1	27.6	28.9
Numerator	22,182	27,184	24,761	20,413	23,021
Denominator	79,360	86,004	84,974	74,010	79,683
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	38.3	40.2	42.2	44.3	46.5	48.8

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2021**

   Column Name: **Annual Objective**

   Field Note:
   After discussions between evaluation and program staff a continued annual increase of 5% was identified.

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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			36	29	17.1
Annual Indicator		31.9	27.7	25.6	36.2
Numerator		60,624	55,326	53,459	65,908
Denominator		190,110	199,961	209,028	182,179
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	21.3	25.5	26.3	27.1	28.2	29.3

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
Following the expected drop-off in 2020 due to COVID-19 impacts a rapid return to levels prior to the pandemic is expected. Following that a return to the prior target of an increase of 3% per year could be reestablished for 2023 and 2024 increasing to 4% for 2025. This increase reflects the prioritization and attention that program and partners are putting into this
topic.

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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			79	82	82
Annual Indicator		78.1	81.3	81.3	74.0
Numerator		424,264	432,006	432,006	405,716
Denominator		543,052	531,119	531,119	548,292
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	77.7	82.0	83.0	84.0	85.0	86.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
After a decrease of a little less than 10% from 2019 to 2020 due to COVID-19 a rebound is expected for 2021 and 2022. After this a return to a one percentage point per year is expected through 2026.

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					
	2016	2017	2018	2019	2020
Annual Objective			40	42	43
Annual Indicator		38.1	45.7	45.3	40.8
Numerator		113,841	138,232	141,032	131,960
Denominator		299,109	302,213	311,138	323,785
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	41.0	42.0	43.0	44.0	45.0	46.0

Field Level Notes for Form 10 NPMs:

1. **Field Name:** **2021**

Column Name: **Annual Objective**

Field Note:
Due to factors such as a return to more standard care practices following the COVID 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)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			73	74	75
Annual Indicator		72.0	71.2	67.9	65.1
Numerator		1,154,504	1,148,124	1,107,284	1,068,524
Denominator		1,603,905	1,613,555	1,630,587	1,642,095
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	76.0	78.0	79.0	80.0	81.0	82.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Washington

2016-2020: NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Federally Available Data				
Data Source: HCUP - State Inpatient Databases (SID)				
	2017	**2018**	**2019**	**2020**
Annual Objective			201	196
Annual Indicator	206.2	203.2	146.0	157.1
Numerator	1,360	1,803	1,311	1,429
Denominator	659,726	887,344	897,967	909,851
Data Source	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2015	2016	2017	2018

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Washington

SPM 1 - Substance use during pregnancy

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	6.2
Numerator	65
Denominator	1,048
Data Source	PRAMS
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	6.2	6.2	6.2	6.2	6.2

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
With only one year of data annual objectives are hard to determine. With an additional data program and epidemiological staff will establish future trend data. For now, a steady state, indicating no increase in drug use will be set as an objective.

SPM 2 - Provider screening of pregnant women for depression

Measure Status:	Active
State Provided Data	

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

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	87.2	87.2	87.4	87.4	87.6

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2022**

   Column Name: **Annual Objective**

   Field Note:
   Annual Objectives are preliminary.

SPM 3 - Universal developmental screening system participation

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	0.0	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:** **2022**

   Column Name: **Annual Objective**

   Field Note:
   Data for this measure is not yet available, therefore Annual Objectives cannot be set at this point.

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

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	78.3
Numerator	
Denominator	
Data Source	Healthy Youth Survey
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	78.3	78.4	78.5	78.6	78.7

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2022**

   Column Name: **Annual Objective**

   Field Note:
   Disucssions between program and epidemiological staff resulted in a decision to maintain the target at 78.3% through 2022. Starting in 2023 program outreach to advocate for and help partners to impact child mental wellness and connections to nurturing adults will be undertaken. As such an increase of 0.1 percentage point is targeted through 2026. Trends in the data will be monitored and targets revised if changes in the data are observed.

SPM 5 - Ease of receiving mental health treatment or counseling

Measure Status:	Active

State Provided Data	
	2020
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	2026
Annual Objective	55.0	56.0	57.0	58.0	59.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
This is a new question for the NSCH so historical trend data are not available. Program and epidemiological staff decided on a slight increase in the measure across the five years until 2026. As more data become available these targets may be revisited and revised.

SPM 6 - Social and emotional readiness among kindergarteners

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		74	74.4	77	77
Annual Indicator	73.2	70.2	76.7	76.7	79
Numerator					
Denominator					
Data Source	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids
Data Source Year	2015-2016	2016-2017	2017-2018	2017-2018	2019-2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	78.0	78.0	79.0	79.0	79.0	79.0

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2016**

   Column Name: **State Provided Data**

   Field Note:
   These are incomplete data because not all children were given the assessment. Therefore, our baseline may be off and we have decided to keep our targets until we can better assess with complete data.

2. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   2018 is the most recent year for which we have data. These data will be entered into the 2019 reporting year.

3. **Field Name:** **2021**

   Column Name: **Annual Objective**

   Field Note:
   Place Holder Targets.

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
Annual Objective	
Annual Indicator	59.9
Numerator	
Denominator	
Data Source	Healthy Youth Survey
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	60.0	60.1	60.2	60.3	60.4

Field Level Notes for Form 10 SPMs:

None

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
Annual Objective		
Annual Indicator		18.8
Numerator		
Denominator		
Data Source		Healthy Youth Survey
Data Source Year		2018
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.8	14.8	13.8	12.8	11.8	10.8

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.

SPM 9 - Adolescents reporting at least one adult mentor

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		69.8
Numerator		
Denominator		
Data Source		Healty Youth Survey
Data Source Year		2018
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	74.4	75.4	76.4	77.4	78.4	79.4

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
Talks between program and epidemiology staff have led to a targeted increase of one percent per year for the next five years. As more data becomes available these targets may be revised.

SPM 10 - Suicide ideation among youth with special health care needs

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	53.1
Numerator	
Denominator	
Data Source	Healthy Youth Survey
Data Source Year	2018
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	55.0	55.7	56.3	56.6	56.3

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:** **2022**

   Column Name: **Annual Objective**

   Field Note:
   If current trends continue with an increase of 1.2% per year over the next five years the rate will increase as shown. Talks with program and epidemiology staff agreed on a slowing of the increase over the next few years. For the next two years the historical increase of 1.2% per year is expected, slowing afterward to a 1% for 2024, a 0.5% in 2025 and finally a slight decrease of 0.5% for 2026, reversing the trend over time.

SPM 11 - Five-year maternal and child health needs assessment process for 2026-2030 plan is initiated by September 30, 2021

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 SPMs:

None

SPM 12 - Percentage of adults who did not get health care because of cost

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		13.2
Numerator		
Denominator		
Data Source		BRFSS
Data Source Year		2019
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13.0	13.0	12.6	12.2	11.8	11.5

Field Level Notes for Form 10 SPMs:

None

SPM 13 - Develop outreach plan to support COVID-19 vaccination campaign efforts by March 31, 2021

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 2 - Percent of 10th Graders who have a BMI between the 5th and 85th Percentile

Measure Status:					Active
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		74	74.5	70.5	71
Annual Indicator	70.8	70.8	68.9	68.9	68.9
Numerator					
Denominator					
Data Source	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2016	2016	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
DOH, along with other state agencies, including Office of Superintendent of Public Instruction and Department of Early Learning, and the Governor's Healthiest Next Generation initiative, are all working on this issue. Therefore, we feel comfortable staying with our targets.

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
These data are from 2016. The HYS is only administered on even numbered years.

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
There was no statistically significant difference between the proportions reported in 2016 and those in 2018.

4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The Healthy Youth Survey is administered in even numbered years. No new data are available.

5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The 2020 administration of the Healthy Youth Survey was not conducted due to most in-class schooling being suspended to comply with COVID-19 health safety concerns.

2018 data, the most recent available is presented here.

2016-2020: SPM 3 - Rate of Infant Mortality (per 1,000 live births) in the Native American Population

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		4.8	4.8	3.3	3.3
Annual Indicator	8.1	11.8	4.4	6.7	6.7
Numerator					
Denominator					
Data Source	Vital Stats	Vital Stats	Washington Center for Health Statistics	Washington Center for Health Statistics	Washington Center for Health Statistics
Data Source Year	2015	2016	2017	2018	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2016**

Column Name: **State Provided Data**

Field Note:
Please note: we are also monitoring Black infant mortality data: there were 7.3 deaths per 1,000 live births in 2015 among Black infants.

Our goal is the overall state rate of 4.8 deaths per 1,000 live births because we aim to have no disparities in infant mortality in our state.

2. **Field Name:** **2020**

Column Name: **State Provided Data**

Field Note:
Data for this measure not yet available. Most recent data will be entered until updated data becomes available.

2016-2020: SPM 4 - Percent of 10th Graders Who Report Adverse Childhood Experiences

Measure Status:				**Active**
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			40.1	40.1
Annual Indicator			15.3	15.3
Numerator			622	622
Denominator			4,064	4,064
Data Source			Healty Youth Survey	Healty Youth Survey
Data Source Year			2018	2018
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The 2020 administration of the Healthy Youth Survey was not conducted due to most in-class schooling being suspended to comply with COVID-19 health safety concerns.

2018 data, the most recent available is presented here.

2016-2020: SPM 5 - Rate of Infant Mortality (per 1,000 live births) in the Black Population

Measure Status:				Active
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			3.3	3.3
Annual Indicator			9.7	9.7
Numerator				
Denominator				
Data Source			WA State Center for Health Statistics	WA State Center for Health Statistics
Data Source Year			2018	2018
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data for this measure not yet available. Most recent data will be entered until updated data becomes available.

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
Annual Objective		
Annual Indicator	67.3	66.4
Numerator		
Denominator		
Data Source	WA PRAMS	WA PRAMS
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	43.0	51.0	51.5	52.0	52.5	52.6

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data from 2018 PRAMS

67.3% (63.9%-70.5%; 95% CI) of respondents had a preventive health care visit in the year prior to becoming pregnant with their most recent infant.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data from 2019 PRAMS

66.4% (63.3%-69.6%; 95% CI) of respondents had a preventive health care visit in the year prior to becoming pregnant with their most recent infant.

3.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
Data reported in 2020 were collected in 2019, therefore not reflecting the decrease in in-person visits caused by the COVID-19 pandemic. Objectives for 2021 were set to account for the decrease in visits anticipated in the 2021 data, collected in 2020. From that low a recovery was anticipated as reflected in the increasing objectives from 2022 onward through 2026.

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

Measure Status:	Active

State Provided Data

	2016	2017	2018	2019	2020
Annual Objective		26	46.1	57	58
Annual Indicator	43.3	43.4	55.3	57.9	59.2
Numerator	26	33	42	44	45
Denominator	60	76	76	76	76
Data Source	DOH	DOH	DOH	DOH	DOH
Data Source Year	2016-17	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	60.0	61.0	63.0	64.0	65.0	66.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
We have recently added criteria for birthing centers to become Breastfeeding Friendly. Therefore, our new denominator (for the next year) will be 78 total eligible facilities (including the 60 eligible (civilian) hospitals during the current year plus 18 birthing centers). Because we are adding birthing centers, we have adjusted our targets accordingly.

2.	**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.

3.	**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

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

Measure Status:	Active

State Provided Data	
	2020
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

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	59.8	60.4	61.0	61.6	62.2

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**

Field Note:
Discussions between program and epidemiology staff resulted in a decision to increase the percentage covered by 1 percentage point per year by 2026 depending on the success in recruiting new facilities into the program.

ESM 6.1 - Number of ASQs provided by WithinReach to callers

Measure Status:					Active
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			381	1,135	904
Annual Indicator	686	529	1,113	834	785
Numerator					
Denominator					
Data Source	WithnREACH	WithinREACH	WithinREACH	WithinREACH	WithinREACH
Data Source Year	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	1,113.0	1,135.0	1,158.0	1,181.0	1,205.0	1,230.0

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:	**Annual Objective**

Field Note:
DOH proposes a modest gain of one quarter of the loss from this past year (2020) in the period 2020-2021, followed to a return to the number screened in 2018-2019 by 2021-2022. At that time, it is hoped the prior target of an increase of 2% per year could be reestablished.

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

Measure Status:	Active

State Provided Data

	2017	2018	2019	2020
Annual Objective			700	43,478
Annual Indicator			42,625	39,071
Numerator				
Denominator				
Data Source			Washington State Health Care Authority	Washington State Health Care Authority
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	44,782.0	46,126.0	47,510.0	48,935.0	50,403.0	51,915.0

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: **Annual Objective**

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.

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

Measure Status:	Active

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

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	61.0	62.2	62.8	64.1	65.4

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.

2. **Field Name:** **2022**

   Column Name: **Annual Objective**

   Field Note:
   Given the work being done to promote developmental screenings statewide it is hoped that the percent receiving them during a Home Visiting session will likewise increase. Therefore a modest increase of 2% per year is forecast from 2022 to 2026.

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
Annual Objective		
Annual Indicator	67.8	67.8
Numerator		
Denominator		
Data Source	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	60.0	68.0	69.4	70.8	72.2

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
Discussions between program and epidemiological staff resulted in the following targets. According to other decreases in direct care causes by the COVID-19 pandemic a drop of approximately 30% in visits is expected to be seen for 2020, recovering in 2021 and back to pre-pandemic numbers by 2023. From there on an increase of 2% per year was targeted through 2026.

ESM 11.2 - 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
Annual Objective		
Annual Indicator		87.5
Numerator		14
Denominator		16
Data Source		University of Washington LEND ECHO-Autism Program
Data Source Year		2020
Provisional or Final ?		Final

Annual Objectives

	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	83.0	85.0	87.0	90.0	90.0

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2021**

Column Name: **Annual Objective**

Field Note:
The annual objective of 80% increasing to 90% by 2026 was identified after consultation with evaluation and program staff. The baseline data for 2020 included a smaller cohort with many participants who reported confidence in supplying a medical home on entry to the training. It is expected that the cohort for 2021 will include individuals with less experience which may reduce the percent. Surveillance staff will monitor the data and revise targets as necessary.

ESM 15.1 - 15.1 Increase the percentage of CYSHCN who report having insurance when receiving services

Measure Status:	Active

State Provided Data	
	2020
Annual Objective	
Annual Indicator	99.2
Numerator	19,268
Denominator	19,424
Data Source	Washington State Child Health Intake Form
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	99.3	99.4	99.5	99.6	99.7

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2022**

   Column Name: **Annual Objective**

   Field Note:
   Talks between program and epidemiological staff arrived at a target of increasing the total with insurance by 0.1 percentage point per year until a 100% rate is reached. This rate is aspirational. Along with the total insured program activites will also evaluate the adequacy of insurance among the CYSHCN population receiving service to assure that availablity of coverage is complimented by quality of that coverage.

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.2 - Title V effort to influence key policies that impact either the rate or quality of preventive medical visits for women of childbearing age in Washington

Measure Status:				Active
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			10	10
Annual Indicator			1	10
Numerator				
Denominator				
Data Source			WA State Department of Health	WA State Department of Health
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
This was a developmental ESM.

2016-2020: ESM 1.3 - Title V progress on influencing key policies that impact either the rate or quality of preventive medical visits for women of childbearing age in Washington

Measure Status:				**Active**
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			1	1
Annual Indicator			1	3
Numerator				
Denominator				
Data Source			WA Department of Health	WA Department of Health
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 7.2.1 - Number of Teens in Cars campaigns

Measure Status:				Active
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			1	1
Annual Indicator			1	0
Numerator				
Denominator				
Data Source			WA Dept of Health	WA Dept of Health
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   This measure was discontinued. No new data were collected.

2. **Field Name:** **2020**

   Column Name: **State Provided Data**

   Field Note:
   Program work transitioned from the Safe Kids Teens in Cars curriculum to Impact Teen Drivers. No more Safe kids Teens in Cars events were held.

2016-2020: ESM 10.1 - Percentage of school-based health centers (SBHCs) able to bill for services rendered.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		80	85	85	85
Annual Indicator	79	85	85	85	85
Numerator					
Denominator					
Data Source	DOH	DOH	DOH	DOH	DOH
Data Source Year	2016-17	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
We have exceeded our goal because of the opportunity to address SBHC billing as a statewide issue rather than SBHC by SBHC. However, we cannot assume this trend will continue at this rate; targets are set accordingly.

2016-2020: ESM 11.1 - Percentage of Medicaid-enrolled children and youth with special health care needs receiving services funded by the state Title V CYSHCN program whose records are matched with the state Medicaid (Health Care Authority- HCA) database

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		75	99.9	99.9	100
Annual Indicator	98.4	99.8	99.8	99.8	99.8
Numerator			13,177	13,177	13,177
Denominator			13,198	13,198	13,198
Data Source	DOH	DOH	Washington State Dept. of Health	Washingto State Department of Health	Washingto State Department of Health
Data Source Year	2016-17	2017-2018	2018	2018	2018
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
We anticipate some new challenges with data-matching this coming year given the CHIF redesign described in the narrative, and also because we will be getting previously unreported data from our neurodevelopmental centers (NDCs), which will allow us to continue our Q/I work. Therefore, we have not significantly adjusted our ESM targets.

2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
At the time of submission of the Block Grant, data from 2019 were not yet available. 2018 data are presented here.

3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Staffing changes resulted in this measure not being tracked during the past year. Submitted are the data from 2018, the most recent available.

2016-2020: ESM 15.2 - Title V effort to influence key policies that impact insurance adequacy for WA CYSHCN.

Measure Status:				**Active**
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			10	10
Annual Indicator			1	0
Numerator				
Denominator				
Data Source			WA Dept of Health	WA Dept of Health
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Due to personnel changes during the prior year, data for this measure were not collected. This measure has been retired at the end of the present cycle.

2016-2020: ESM 15.3 - Title V progress on influencing key policies that impact insurance adequacy for WA CYSHCN.

Measure Status:				Active
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			1	1
Annual Indicator			1	0
Numerator				
Denominator				
Data Source			WA State Department of Health	WA State Department of Health
Data Source Year			2019	2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1. **Field Name:** **2020**

   Column Name: **State Provided Data**

   Field Note:
   Due to personnel changes during the prior year, data for this measure were not collected. This measure has been retired at the end of the present cycle.

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:	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 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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of children who needed mental health care and did not have difficulty in getting it.</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 respondents to WA NSCH who indicate that they did not have difficulty getting care.</td></tr><tr><td>Denominator:</td><td>The total number of respondents to WA NSCH.</td></tr></table></td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Related to HP2030 AHS-6.2 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Reduce the percentage of 10th grade students with special health care needs who report having suicidal ideation.</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>Related to HP2030 MHMD-02 Reduce suicide attempts by adolescents.</td></tr>
<tr><td>Denominator:</td><td>The total number of 10th grade students who are identified as having a special need in the Healthy Youth Survey.</td></tr>
</table></td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Related to HP2030 MHMD-02 Reduce suicide attempts by adolescents.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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:	Active
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 - Percentage of adults who did not get health care because of cost
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
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 13 - Develop outreach plan to support COVID-19 vaccination campaign efforts by March 31, 2021
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
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 Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 2 - Percent of 10th Graders who have a BMI between the 5th and 85th Percentile
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Increase the number of adolescents with a BMI that is considered in the healthy range.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The population estimate of the number of tenth grade students with a BMI between the 5th and the 85th Percentile **Denominator:** The total population of tenth grade students sampled in the HYS
Healthy People 2020 Objective:	Related to HP2020 NWS-10.3: Reduce the proportion of Adolescents ages 12-19 years who are considered obese.
Data Sources and Data Issues:	Data Sources: The data come from the Healthy Youth Survey administered by Washington State DOH in cooperation with the Washington State Department of Social and Health Services and the Washington State Office of the Superintendent of Public Instruction. The survey is administered every other year to youth enrolled in public schools, grades 6, 9, 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: The survey makes use of self-reported data.
Significance:	Growing rates of adult obesity have been associated with growing rates of chronic disease in the population. Preventing the development of obesity and unhealthy weight in adolescence will help curb the growing number of individuals who suffer chronic illness, especially those who develop those illnesses earlier in their lifespans, including during adolescence.

2016-2020: SPM 3 - Rate of Infant Mortality (per 1,000 live births) in the Native American Population
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Reduce the disparities in Native American infant mortality in Washington compared with other populations.
Definition:	**Unit Type:** Rate **Unit Number:** 1,000 **Numerator:** The number of deaths among Native American children less than one year of age. **Denominator:** The total number of live births to women identified as Native American on their newborn's birth certificate file.
Healthy People 2020 Objective:	Related to HP2020 MICH-1.3: Reduce the rate of all infant deaths.
Data Sources and Data Issues:	Data Sources: The data come from Washington Vital Statistics records, Birth Certificate file and the Linked Birth-Infant Death file. Data Issues: Small numbers of births and deaths in these populations can make interpretation of the year-to-year changes in the rate difficult. Multi-year trend analysis will be needed to determine success on this measure.
Significance:	For the past decade infants born to Native American women in Washington State have been at a higher risk of death in their first year of age than those of other races/ethnicities. While the absolute number of deaths may make up a small fraction of the total of infant deaths in Washington, the disparity between rates of infant mortality need to be addressed.

2016-2020: SPM 4 - Percent of 10th Graders Who Report Adverse Childhood Experiences
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Decrease the percent of Washington 10th graders who report adverse childhood experiences.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 10th graders indicating positive responses to questions relating to adverse childhood experiences in the Healthy Youth Survey. **Denominator:** Total number of 10th graders completing the Healthy Youth Survey.
Healthy People 2020 Objective:	Related to HP2020 MHMD-4.1: Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs)
Data Sources and Data Issues:	The data come from the Healthy Youth Survey. administered by Washington State DOH in cooperation with the Washington State Department of Social and Health Services and the Washington State Office of the Superintendent of Public Instruction. The survey is administered every other year to youth enrolled in public schools, grades 6, 9, 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: The survey makes use of self-reported data.
Significance:	Childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. As such, early experiences are an important public health issue. 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.

2016-2020: SPM 5 - Rate of Infant Mortality (per 1,000 live births) in the Black Population
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Reduce the disparities in Black infant mortality in Washington compared with other populations.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of deaths among Black children less than one year of age. **Denominator:** The total number of live births to women identified as Black on their newborn's birth certificate file.
Healthy People 2020 Objective:	Related to HP2020 MICH-1.3: Reduce the rate of all infant deaths.
Data Sources and Data Issues:	The data come from Washington Vital Statistics records, Birth Certificate file and the Linked Birth-Infant Death file. Data Issues: Small numbers of births and deaths in these populations can make interpretation of the year-to-year changes in the rate difficult. Multi-year trend analysis will be needed to determine success on this measure.
Significance:	For the past decade infants born to Black women in Washington State have been at a higher risk of death in their first year of age than those of other races/ethnicities. While the absolute number of deaths may make up a small fraction of the total of infant deaths in Washington, the disparity between rates of infant mortality need to be addressed.

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:	Active
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of births at Breastfeeding Friendly facilities.</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 births to WA resident mothers in facilities certified as Breastfeeding Friendly</td></tr>
<tr><td>Denominator:</td><td>The total number of resident births in WA.</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The data will come from WA Birth Certificate. Breastfeeding Friendly facilities will be identified by DOH staff.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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:	Active
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:	Active
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

Measure Status:	Active
Goal:	Increase the percentage of low-income or at-risk children who receive a developmental screen during Home Visiting encounters.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of children given a developmental screen as part of HVSA's Aligned Measures criteria. **Denominator:** Number of eligible children to be screened.
Data Sources and Data Issues:	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.
Evidence-based/informed strategy:	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.
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 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.

Measure Status:	Active
Goal:	Increase the percent of adolescents in school districts with active DOH-supported interventions who have accessed health care in the past year.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** 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 **Denominator:** The number of adolescent respondents to HYS in school districts with DOH coordinated funding for adolescent health programs
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 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.
Significance:	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.

ESM 11.2 - 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
ESM Subgroup(s):	CSHCN
Goal:	Increase the percent of CYSHCN who have access to third party paid insurance.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of CYSHCN who indicate they have insurance on their Child Health Intake Form. **Denominator:** The total number of CYSHCN who have a Child Health Intake Form filled out
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 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.2 - Title V effort to influence key policies that impact either the rate or quality of preventive medical visits for women of childbearing age in Washington
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	This ESM will track and measure promotion effort to influence key policies and practices that improve either the rate or quality of preventive medical visits for women of childbearing age in Washington in a given year.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of sub-phases in the policy model in which the Title V program has worked on in the reporting year **Denominator:** Number of sub-phases in the Policy Influence model (15)
Data Sources and Data Issues:	Data for this ESM will come from WA DOH Title V staff tracking the number of sub-phases which the program has worked on during the reporting year.
Significance:	Many federal, state and local policies impact the rate and quality of preventive medical visits for women of childbearing age in Washington, and Title V rarely has direct decision-making authority over those policies or the establishment of new policies. Title V programs work to influence those policies and related outcomes through convening stakeholders and decision-makers; providing technical assistance and training on existing policies; educating and informing stakeholders and assisting decision-makers to review and evaluate existing policies, identify alternatives and implement new and existing policy. This measure will enable Title V to monitor effort on influencing key policies impacting the rate and quality of well-women medical visits in a given year, while promoting an evidence-informed approach to policy influence that will shed light on which activities undertaken by Title V entities result in policy improvement. The measure is based on and aligns with major theories of policy development and implementation, including but not limited to Ripley (in McCool, D.C., ed. Public Policy Theories, Models and Concepts (1995)) and Anderson (Anderson, J.E. Public Policymaking 6th ed. (2006). Additional information on this approach is detailed in the CYSHCN domain plan, under the title, Adequate Insurance Coverage and Health Care Access for MCH Consumers.

2016-2020: ESM 1.3 - Title V progress on influencing key policies that impact either the rate or quality of preventive medical visits for women of childbearing age in Washington
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	This ESM will track and measure progress on influencing key policies and practices that improve either the rate or quality of preventive medical visits for women of childbearing age in Washington in a given year.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of sub-phases in the policy model in which progress was made during the reporting year. **Denominator:** Number of sub-phases in the Policy Influence model (15)
Data Sources and Data Issues:	Data for this ESM will come from WA DOH Title V staff tracking the number of sub-phases in which there has been progress made during the reporting year.
Significance:	Many federal, state and local policies impact the rate and quality of preventive medical visits for women of childbearing age in Washington, and Title V rarely has direct decision-making authority over those policies or the establishment of new policies. Title V programs work to influence those policies and related outcomes through convening stakeholders and decision-makers; providing technical assistance and training on existing policies; educating and informing stakeholders and assisting decision-makers to review and evaluate existing policies, identify alternatives and implement new and existing policy. This measure will enable Title V to monitor progress on influencing key policies impacting the rate and quality of well-women medical visits in a given year, while promoting an evidence-informed approach to policy influence that will shed light on which activities undertaken by Title V entities result in policy improvement. The measure is based on and aligns with major theories of policy development and implementation, including but not limited to Ripley (in McCool, D.C., ed. Public Policy Theories, Models and Concepts (1995)) and Anderson (Anderson, J.E. Public Policymaking 6th ed. (2006). Additional information on this approach is detailed in the CYSHCN domain plan, under the title, Adequate Insurance Coverage and Health Care Access for MCH Consumers.

2016-2020: ESM 7.2.1 - Number of Teens in Cars campaigns

2016-2020: NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	DOH will be able to measure the effects of its outreach among communities (specifically in schools) to promote safe driving among teens.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of campaigns held in state **Denominator:**
Data Sources and Data Issues:	The source of these data is the Injury Prevention program tracking the number of grants offered per year, along with the grantee providing a report on how many children/families participated in the event.
Significance:	Much of the work being conducted on injury prevention in this age group is being done through these safety campaigns. This measure will allow Washington to have better knowledge of the frequency of these interventions, as well as the numbers of students reached by them.

2016-2020: ESM 10.1 - Percentage of school-based health centers (SBHCs) able to bill for services rendered.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To gauge the percentag of SBHCs which are able to bill Medicaid and other insurance for the full suite of services they provide their patients
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of SBHCs trained on how to bill Medicaid for services **Denominator:** Number of eligible SBHCs to be trained on how to bill Medicaid for services
Data Sources and Data Issues:	The source of the data would be program staff at OHC tracking the numbers of trainings and outreach they did with eligible clinics. Definitions of which clinics would be eligible and what a “successful” training/TA session will have to be developed.
Significance:	Many adolescents, especially high risk youth in vulnerable populations, may have a harder time accessing the medical care system due to many issues (lack of transportation, social isolation, complex life-situations) and might find accessing health care more convenient at school or other settings in which they are more comfortable. Increasing the number of places where such individuals can access care, not just to family planning/STI services, but also mental/behavioral and more general physical health would benefit all. This would be greatly facilitated by reimbursement to the clinics for these services. An increase in the numbers/percent of clinics trained and aided in getting reimbursed would make such a system of care more available.

2016-2020: ESM 11.1 - Percentage of Medicaid-enrolled children and youth with special health care needs receiving services funded by the state Title V CYSHCN program whose records are matched with the state Medicaid (Health Care Authority- HCA) database
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To track the percentage of CYSHCN who complete a CHIF form are also included in the State Medicaid database as eligible for services.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of served by Title V CYSHCN (CHIF database) minus private insurance only, having P1 number, successfully matched in HCA database (after sent to HCA). **Denominator:** Number served by Title V CYSHCN (CHIF database) minus private insurance only
Data Sources and Data Issues:	CHIF (Washington State Title V Children with Special Health Care Needs Program Data System) P1-ProviderOne (Washington State Medicaid Client Data) PRISM (Washington State Medicaid Risk Identification and Assessment Data System) Note: some will have P1 number, some will not
Significance:	As more CYSHCN transition into Medicaid managed care, it is important to have transparent policies and practices in place to assure attention to their needs, as well as compliance with federal requirements that impact both Title V and Title XIX. These data will enable us to evaluate the degree (percent of) CYSHCN who come to their attention and who also are included in the Medicaid system and flagged for the receipt of appropriate services. This will help facilitate the appropriate care for these individuals within a Medical Home model.

2016-2020: ESM 15.2 - Title V effort to influence key policies that impact insurance adequacy for WA CYSHCN.
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
Goal:	To increase adequacy of insurance for children and youth with special health care needs (CYSHCN) in Washington State. This ESM will track and measure Title V effort to influence key policies that impact insurance adequacy for WA CYSHCN.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of sub-phases in the policy model in which the Title V program has worked on in the reporting year. **Denominator:** Number of sub-phases in the Policy Influence model (15)
Data Sources and Data Issues:	Data for this ESM will come from WA DOH Title V staff tracking the number of sub-phases which the program has worked on during the reporting year.
Significance:	Many federal, state and local policies impact insurance adequacy for CYSHCN, and Title V rarely has direct decision-making authority over those policies or the establishment of new policies. Title V programs work to influence those policies and related outcomes through convening stakeholders and decision-makers; providing technical assistance and training on existing policies; educating and informing stakeholders and assisting decision-makers to review and evaluate existing policies, identify alternatives and implement new and existing policy. This measure will enable Title V to monitor effort on influencing key policies impacting insurance adequacy while promoting an evidence-informed approach to policy influence that will shed light on which activities undertaken by Title V entities result in policy improvement. The measure is based on and aligns with major theories of policy development and implementation, including but not limited to Ripley (in McCool, D.C., ed. Public Policy Theories, Models and Concepts (1995)) and Anderson (Anderson, J.E. Public Policymaking 6th ed. (2006). Additional information on this approach is detailed in the CYSHCN domain plan under the title, Adequate Insurance Coverage and Health Care Access for MCH Consumers.

2016-2020: ESM 15.3 - Title V progress on influencing key policies that impact insurance adequacy for WA CYSHCN.
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
Goal:	To increase adequacy of insurance for children and youth with special health care needs (CYSHCN) in Washington State. This ESM will track and measure Title V progress on influencing key policies that impact insurance adequacy for WA CYSHCN.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of sub-phases in the policy model in which progress was made during the reporting year. **Denominator:** Number of sub-phases in the Policy Influence model (15)
Data Sources and Data Issues:	Data for this ESM will come from WA DOH Title V staff tracking the number of sub-phases in which there has been progress made during the reporting year.
Significance:	Many federal, state and local policies impact insurance adequacy for CYSHCN, and Title V rarely has direct decision-making authority over those policies or the establishment of new policies. Title V programs work to influence those policies and related outcomes through convening stakeholders and decision-makers; providing technical assistance and training on existing policies; educating and informing stakeholders and assisting decision-makers to review and evaluate existing policies, identify alternatives and implement new and existing policy. This measure will enable Title V to monitor progress on influencing key policies impacting insurance adequacy while promoting an evidence-informed approach to policy influence that will shed light on which activities undertaken by Title V entities result in policy improvement. The measure is based on and aligns with major theories of policy development and implementation, including but not limited to Ripley (in McCool, D.C., ed. Public Policy Theories, Models and Concepts (1995)) and Anderson (Anderson, J.E. Public Policymaking 6th ed. (2006). Additional information on this approach is detailed in the CYSHCN domain plan under the title, Adequate Insurance Coverage and Health Care Access for MCH Consumers.

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 2020

	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	Quarterly	1		
2) Vital Records Death	Yes	Yes	Monthly	0	Yes	
3) Medicaid	Yes	No	Quarterly	3	No	
4) WIC	Yes	No	Semi-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	Quarterly	45	Yes	
8) PRAMS or PRAMS-like	No	Yes	Annually	18	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None