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

Maternal and Child Health Block Grant

2024 Application and 2022 Report

Washington State Department of HEALTH

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Maternal and Child Health Services Title V Block Grant

Washington

FY 2024 Application/ FY 2022 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

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

July 19, 2023

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 2024 Maternal and Child Health Block Grant Application and the Federal Fiscal Year 2022 Maternal and Child health Block Grant Annual Report submitted electronically in the Title V Information System.

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

Sincerely,

Katie Eilers, MPH, MSN, RN
Director
Office of Family and Community Health Improvement
Title V Maternal and Child Health Director
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Katie.Eilers@doh.wa.gov

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: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

III.A.1. Program Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

- Support COVID-19 vaccination campaign efforts

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

- We pass most of the MCHBG funding through to 34 local health jurisdictions (LHJs) and 1 local hospital district. We do this to improve local public health systems and provide MCH services across the state. One of the block grant requirements is to use at least 30 percent of the funding on preventive, primary care, and family support services for CYSHCN. For this reason, we ask each LHJ to include this work in their annual action plan. LHJs can use their remaining funding on a menu of options that support the state priorities included in our grant application, and for foundational maternal and child health services.

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

- LHJs have moved away from direct services to the CYSHCN population and are increasing their focus on systems level improvements. The CYSHCN Program updated the Focus of Work for CYSHCN coordinators at LHJs to highlight opportunities for them to engage with the systems that serve CYSHCN in their communities and participate in statewide activities to improve the system of care for CYSHCN. We aligned these strategies with the new CYSHCN strategic plan which was developed with input from families, LHJs, and providers. It incorporates key elements from the new CYSHCN Blueprint. DOH has opened a dialogue with LHJs over the past year, and will continue these conversations over the next year, to look at our MCHBG funding distribution model and requirements. We will review our current requirement that all LHJs do some work to serve CYSHCN. identify ways to leverage efficiencies and better meet statewide needs. This process will also be a part of the five-year Needs Assessment effort.

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

- Washington works to prevent maternal deaths using a blend of state and federal funding. The state convenes a state Maternal Mortality Review Panel to review all cases of maternal deaths. This panel determines contributing factors and develops recommendations for preventing deaths. In 2023, the department issued a report to the legislature summarizing key findings and recommendations for prevention of maternal morbidity and mortality, using 2014-2020 data. Their findings highlight several racial and socioeconomic inequities that have contributed to these deaths. This report serves as strategic guidance for future investments in maternal health.

- Our perinatal health unit is working with many partners to transform our systems of substance use care, especially as it affects pregnant individuals and newborns. Our continued work on the state's Washington State Opioid and Overdose Response Plan and related resources, and the Promoting Healthy Outcomes for Pregnant Women and Infants bill (Substitute Senate Bill 5835) includes developing strategies to prevent neonatal abstinence syndrome and other effects of opioid misuse and standardization of care for infants born with symptoms of withdrawal. Through cross-agency partnerships with the Department of Children, Youth and Family and the Health Care Authority, we have created a pathway where substance-affected birthing parent and newborn receive tailored referrals to free wrap around services following a Plan of Safe Care as an alternative to report to child welfare. Additionally, state partners have created a billing code for eat/sleep/console – a best practice in rooming-in care for the birth parent and infant. Finally, the department continues to offer Certification to hospitals for becoming a Center of Excellence for Perinatal Substance Use.

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

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

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

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

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

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

The COVID-19 pandemic clearly illustrated the harmful effects of failing to adequately fund public health. In response, the state budget was increased to better support foundational public health services in WA, amounting to $77 million in the current 2024-2025 biennium and $100 million in future biennia. Over time, using the resources at the state and local levels will strengthen work in specific programmatic areas. These include communicable disease control, environmental public health, maternal and child health, chronic disease and injury prevention, and access to care. Resources will also help with infrastructure to support information systems and laboratory capacity, and capabilities like assessment, communications, emergency planning, policy and planning, community partnership development, and leadership development. Much of the Foundational Public Health Services (FPHS) MCH investments in the state will be dedicated to local governmental public health, providing much needed support to a chronically underfunded body of public health work.

The MCHBG provides core funding support that we leverage to maximize our investments, both at the state and local level, in maternal, child, and adolescent health services. Whenever possible, we embrace a braided funding model that combines MCHBG with state general funds and other grant funding. LHJs receive 58% of Washington's Title V funding to provide services based on a menu of options aligned with our state priority needs. Less than ten percent of our grant supports contracts with health care and community service organizations working with the Department of Health on state priorities. The rest supports statewide maternal and child health services, surveillance and evaluation, statewide needs assessment and planning, high priority policy initiatives, and addressing underfunded priorities.

Throughout 2020 and 2021, the 35 LHJs in Washington redirected staff from regular MCHBG duties to respond to the COVID-19 pandemic. In 2022 this situation started to ease after vaccines became available. Many LHJs continued to need extra staff to respond to the pandemic. The COVID-19 pandemic has also led to increased staff turnover and some difficulty in filling open positions – a significant challenge that persists to the timing of this report. As LHJs entered into a recovery period, some reflected on the positive impact of new partnerships developed from the Covid-19 response, deeper ties to community, and a stronger understanding of the physical needs of families. LHJs have slowly transitioned use of Title V funds away from Covid-19 to meet the local needs of their communities, some of which have changed or exacerbated because of the pandemic. Moving into the next reporting period, LHJs will be working diligently to use their Title V funds in complement to FPHS MCH investments, shoring up local infrastructure to serve these populations.

III.A.3. MCH Success Story

LHJ partners in our state have shown great innovation and community partnership in their MCH work, as evidenced in Pierce County, where the MCHBG staff have channeled their focus and energy into partnerships, community engagement, and health equity in order to strengthen systems to support MCH populations across domains.

MCHBG-funded staff support the Pierce County Perinatal Collaborative (PCPC), a 501(c)3 non-profit, by convening the Board of Directors, and in partnership with the Board facilitating General Membership meetings. The Collaborative addresses needs such as prenatal education, lactation support, nutrition, safety, and behavioral health, and reaches over 1,000 mailing list members (including about 600 active members) who represent about 100 different agencies.

Staff also share time and expertise in the Pierce County Breastfeeding Alliance, a committee of the PCPC, which includes Black birth workers, doulas, health equity advocates, and healthcare providers. With impacts from the pandemic, this Alliance has experienced some delays in their work and reduced membership, but staff remain committed to strengthening this Alliance and with it the lactation supports that Pierce County needs. Staff are developing community lactation support as leaders in statewide and local LIFE initiatives, and supporters of a local Peer Breastfeeding Counselor (PBC) initiative. The LIFE program is “a voluntary designation program recognizing the important role hospitals play in supporting breastfeeding and chestfeeding.” Pierce County has been an integral local champion of this statewide effort, by supporting hospitals and clinics to pursue and obtain the highest level possible of LIFE designation. Pierce County’s PBC initiative involves developing and sustaining culturally competent PBC training and support, with a focus on populations with lower breastfeeding rates to eliminate disparities.

Staff also support county-wide Baby Lounges, including culturally and linguistically diverse Baby Lounges, through connections with local partners Family Connects Pierce County (Family Connects) and Pierce County Early Childhood Network (PCECN). Baby Lounges (both virtual and in-person) are “a safe space for all families with babies [including pregnant/expecting families and families with children ages 0-1] to connect and learn together with other parents,” and to ask a health professional their questions. Family Connects is a resource to “bridge the gaps between families, providers, and community resources to ensure [families] have the support [they] need to grow and thrive.” PCECN is “a collective decision-making network lead by partners from multiple organizations who have a shared commitment to supporting children and families in Pierce County to reach a place where they are thriving.” The network is one of 10 active Washington Communities for Children regions, and connects over 400 partners, bolsters family access to local resources, and includes 7 Action Teams working to make change for families. LHJ staff join these community partners in strengthening systems of care for families and expecting parents in ways that are culturally and linguistically responsive.

III.B. Overview of State

Demographics, Geography, and Economy

As of April 1, 2022, Washington had an estimated population of 7,864,400. This is an increase of 97,475 people over the prior year and a 1.3% gain, compared to a 0.8% gain the previous year. The highest growth occurred in the five largest metropolitan counties (Clark, King, Pierce, Snohomish, and Spokane), accounting for 67% of the state's population growth (Washington State Office of Financial Management [OFM]).

The April 1, 2022, population estimate for Washington's incorporated cities and towns is 5,156,008, an increase of 78,773 people from the prior year. The top 10 cities for population growth, in descending order, are Seattle, Bellingham, Lake Stevens, Lacey, Vancouver, Pullman, Spokane Valley, Tacoma, Ridgefield and Spokane (OFM).

Births in Washington achieved a record high of 90,489 in 2016. In general, they have been trending down since then. In 2021, there were 83,899 births to Washington residents, a 1% increase from 2020's 83,101 births, and a 7% decrease from 2016's high (Department of Health [DOH] Birth Certificate Data).

In 2022, an estimated 19.8% of the state's population, or 1.56 million, were female of reproductive age (15 to 44). There were approximately 1.3 million children under the age of 18 in the state, making up 22.8% of the state's residents (OFM).

Washington is gradually becoming more racially and ethnically diverse especially in major urban population centers. The percentage of state residents identifying themselves as Hispanic or Latino grew from 11.2% in 2010 to 14.5% in 2022, while the percentage identifying as non-Hispanic Asian grew from 7.3 to 10.3%. Non-Hispanic American Indian/Alaska Native residents decreased from 1.3% to 1.2% while non-Hispanic White residents also decreased from 72.7% to 62.9%. (OFM) Increasingly, people giving birth identify themselves as more than one race on their infant's birth certificate, with that category increasing 28 percent since 2012 (DOH Birth Certificate Data).

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

Washington is home to 29 federally recognized Indian tribes, each with varying populations and land areas, and 7 non-federally recognized tribes. In 2022, the American Indian/Alaska Native population of Washington State was 92,672 (OFM). The state has two urban Indian health organizations and 4 recognized American Indian organizations in the Pacific Northwest.

Geographically, the state is divided by the Cascade Range, resulting in a notable difference in climate and geography between the two regions, with the west being wetter with a moderate climate and the east being drier with a more extreme climate. The northwest quadrant of the state is also split into two distinct land areas by Puget Sound. The most densely populated region of the state is on the west side of Puget Sound, where seven of the state's 10 most populous cities are located, including Seattle, Tacoma, Bellevue, Kent, Everett, Renton and Federal Way. Vancouver, the fourth largest city in Washington, is in the far southwest of the state, across the Columbia River from Portland, Oregon and part of its recognized metropolitan statistical area. Many residents of Vancouver receive

services in Portland. Residents of Clarkston in Asotin County in the southeast corner of the state have a similar dynamic with Lewiston, Idaho, across the Snake River.

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

Washington has a highly diversified economy. It is a leading national producer of agricultural commodities, including apples, pears, wheat, milk, potatoes, hops, asparagus, berry crops and forest products. Non-agricultural industries include aerospace, clean energy technology, information and communication technology, online sales, life/health sciences, maritime, and military/defense sectors. The University of Washington in Seattle and Washington State University in Pullman serve as research institutes for the state. It is the most foreign-trade-dependent state in the United States according to the Washington International Trade Association.

Washington's seasonally adjusted unemployment rate June 2023 was 3.8%, compared to 3.9% in June 2022. Over the prior year Washington State added an estimated 117,900 jobs. From May 2023 to June 2023 total nonfarm employment increased by 11,900 jobs. Industries gaining the most jobs were leisure and hospitality (8,900), education and health services (4,600), government (3,100), construction (1,700), financial activities (1,000) and professional and business services (500). Retail trade, a sector which disproportionally employs women and lower income workers experienced the greatest loss (-2,800) jobs over the prior month. (Washington Employment Security Department, Monthly Employment Report).

Health Status of Maternal and Child Populations in Washington State

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

In February 2023, 2,295,654 people in Washington had access to Medicaid services, including 916,702 children under age 19. HCA contracts with managed care organizations to provide physical and behavioral health care services.

COVID-19 Pandemic in Washington

Washington state recorded the first officially identified case of SARS-CoV-2 infection in the United States on January 21, 2020. On March 23, 2020, Gov. Jay Inslee issued a stay-at-home order to help to control the spread of the virus. Washington did not see the same degree of infection rates many other states did, in large part due to the "Stay Home, Stay Safe" campaign. Through the remainder of 2020 and early 2021, statewide regulations on public

gathering, space capacity limits, and facial coverings changed based on current conditions. The state launched the "Healthy Washington – Roadmap to Recovery" campaign in January 2021, which outlined a phased recovery plan using a regional approach. On June 30, 2021, the state moved beyond this recovery plan to allow for full reopening of services. In April 2022 the general indoor mask mandate was lifted. In April 2023, the last statewide mask mandate was lifted.

As of July 2023, Washington has experienced over 1,968,000 confirmed cases and 15,939 COVID-19-related deaths, while 79.3% of Washingtonians 6 months or older have had at least one dose of vaccine and 71.7% have completed the primary series (WA COVID-19 Data Dashboard). Disparities in vaccination rates remain, especially in rural communities. Vaccine uptake in younger Washingtonians tends to lag 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/African American, American Indian/Alaska Native, and Native Hawaiian or Pacific Islander communities' especially hard hit. DOH surveys infection rate, recovery rate, hospitalization rate, mortality, and vaccination by race/ethnicity, and reports on the disparate impact to communities of color. Updated data and analysis are available on the DOH COVID-19 website; an example report is COVID-19 Morbidity and Mortality by Race, Ethnicity and Spoken Language in Washington State.

Statutory Environment for Public Health

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

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

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

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

DOH Transformational Plan

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

The Transformational Plan is available online. The plan focuses five foundational Priorities.

- Health and Wellness: Supporting all Washingtonians' opportunity to attain their full physical, mental and social health and wellbeing potential.
- Health Systems and Workforce Transformation: Assuring that all Washingtonians are well served in health ecosystem that robust and responsive and at the same time promoting transparency, equity and trust.
- Environmental Health: Ensuring a broad range of health environments; natural, built and social.
- Emergency Response and Resilience: All Washington communities have the information and resources they need to build resilience in the face of myriad public health threats and are well-positioned to prepare for, respond to, and recover from emergencies and natural disasters.
- Global and One Health: All Washingtonians live in ever-connected environments that recognize and leverage the intersection of both global and domestic health as well as the connections of humans, animals, and the environment.

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

In the last biennium, the Governor recently established the Office of Equity which is focused on "everyone in Washington having full access to the opportunities, power, and resources they need to flourish and achieve their full potential and there is equity and justice for all, for the next seven generations and beyond." The Office of Equity is helping cabinet state agencies to shift our systems and processes to be more embedded in principles of equity. DOH is working towards implementing the Pro-Equity Anti-racism framework, an expectation of all cabinet agencies. This framework involves beginning with a baseline equity assessment and building a strategic action plan from that baseline.

Healthier Washington

Washington has been implementing the Healthier Washington initiative, a Medicaid Transformation project, for almost a decade. The Health Care Authority received a five-year renewal of the Medicaid Transformation Project, which focuses on expanding coverage and access to care, ensuring people receive the right care, advancing whole-person primary, preventive and home and community-based care, and accelerating care delivery and payment innovation focused on health-related social needs.

Dismantling Poverty

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

Title V Workforce

The total number of DOH full-time equivalent (FTE) positions funded by MCHBG federal funding is 18.72 FTE. This represent about 43 individuals, as most positions are funded from multiple sources. This is about the same as last year's level of 18.79 FTE. We were pleased to have Alex Padilla join the Title V team as the Acting Deputy Director of the office, which includes oversight of the management of MCHBG budget and expenditures.

Health Care Infrastructure

Most of the health care delivery system in the state is in urban areas along the Interstate 5 corridor in western Washington and Spokane near the Idaho border. There are 93 acute care hospitals and 1,419 primary care clinics across Washington. Among these, the large rural areas of the state are served by 39 critical access hospitals (24 beds or less), eight rural hospitals (49 beds or less), 80 Federally Qualified Health Centers and 127rural health clinics. Currently, DOH provides licensing and regulation of approximately 11,000 health care facilities and 463,000 health care providers, including physicians, nurses, dentists, pharmacists, emergency medical technicians, mental health counselors, and other health care professionals. https://doh.wa.gov/about-us/programs-and-services/executive-office-prevention-safety-and-health/health-systems-quality-assurance

Washington has 56 public hospital districts, which are local government entities that run hospitals, clinics, and home health services. Nearly half of all hospitals are part of Public Health Districts. Forty-four districts have hospitals, the others provide other services such as organizing emergency medical services, providing urgent care services and

nursing homes. Often, they provide the only access to such services in isolated areas. Independently elected board members guide public hospital districts. The Association of Washington Public Hospital Districts includes this information on their website.

There are three dedicated children's hospitals, located in the three major urban centers of Seattle, Tacoma, and Spokane. Many other hospitals see pediatric patients, especially for less specialized care. Over 1,200 pediatric health care providers practice in the state according to the Washington Chapter of the American Academy of Pediatrics. The Washington Academy of Family Physicians reports, on their website, approximately 3,950 family physician members in the state.

In relation to maternity services access in rural areas of the state, only 41 percent (15 of 39 hospitals) of Critical Access Hospitals (CAHs) offer obstetrical labor and delivery services. Of the 15 CAHs that do offer labor and delivery services, five deliver fewer than 100 births per year. Laboring mothers may lack the transportation to drive a longer distance to a hospital with L&D services, or face delivering in an Emergency Department. On average it is 34 miles to the nearest labor and delivery service for those communities that lack OB L&D services in the local CAH.[1] Of the seven larger rural hospitals in WA, one, Astria Toppenish, closed L&D services this past year. In total, Washington has 54 hospitals that provide labor and delivery services.

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

National Accreditation

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

Title V in DOH

The Title V program is in the Prevention and Community Health (PCH) division of the Department of Health. Most of the Title V activities are within PCH's Office of Family and Community Health Improvement (OFCHI), and the OFCHI Director is the state's Title V Maternal and Child Health Director. Washington's Title V Children with Special Health Care Needs Director position is also within OFCHI. Organization charts are included in the Appendix. Additional information about how Washington's Title V program is organized, and how our work is directed and supported by the agency, is included in the "State Title V Program Purpose and Design" section.

III.C. Needs Assessment
FY 2024 Application/FY 2022 Annual Report Update

III.C. 1. Needs Assessment Update

Ongoing Needs Assessment Activities

Surveillance and Evaluation (SE) Section and Program activities

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

The SE Section leads Title V data activities, including the updating MCH Data Report chapters, domain-specific data dashboards through the Washington Tracking Network, data presentations, including the annual presentation to the Washington State Perinatal Collaborative, and responding to data requests from internal and external partners. Data sources used in product development typically include birth certificates, death certificates, and survey data from PRAMS, Healthy Youth Survey, BRFSS, and NSCH. Program specific data sources include the Child Health Intake Form (CHIF) and the Early Hearing Loss Detection Diagnosis and Intervention (EHDDI) data system.

The SE Section is co-leading the development of the 2025 5-Year Needs Assessment. Initial activities include developing the needs assessment workgroup structure within OFHCI, development of timelines and roles, and identification of key needs assessment activities.

The SE Section has worked closely with OFCHI programs to incorporate on-going needs assessment activities into their program structure. For example, the CYSHCN program has incorporated listening sessions with families into their on-going work. In 2023, the listening sessions focused on families with children with Type 1 Diabetes, with additional listening sessions planned on a quarterly basis with rotating topics. In December 2022, the Adolescent Health program administered a youth survey, with a focus on qualitative questions to better understand their views on routine health care visits. Topics included access to care and the extent to which care was youth-friendly and addressed the needs of traditionally marginalized and overlooked populations. A survey was also developed to better understand the needs of providers who serve adolescents, with implementation planned for the summer 2023. The Adolescent Health program has developed a rotating Youth Advisory Council, the first phase of which ended in the Spring of 2023. SE is currently analyzing data from the first cohort, with the second cohort in recruitment. The Women's Health and Perinatal program developed a community engagement and education campaign in mid-2022, concentrating on substance use issues. This campaign was informed by feedback from community health workers and individuals with history of substance use. The community advisory group for the Birth Equity Project identified priority communities and developed guidance for engaging African American/Black populations. The project also gathering information about engaging the Black African immigrant/refugee populations as a distinct group. The Child Health program engaged with SE to expand their use of existing quantitative data, such as the Healthy Youth Survey, to inform themselves on the 6–11-year-old age group. The program has also become familiar with statewide surveillance data and initiatives that focus on positive childhood experiences.

Home Visiting Needs Assessment

The 2020 Home Visiting Needs Assessment report highlights persistent racial and ethnic disparities among families with young children, particularly among American Indian and Alaskan Native, Black or African American, Native

Hawaiian or Pacific Islander, and Hispanic populations. Geographic disparities were found in in Yakima, King, Pierce, Spokane, Snohomish, and Benton counties, especially in urban areas. The next Home Visiting Needs Assessment is scheduled to take place in 2030.

2023 Maternal Mortality Review Panel Report

In February of 2023, The Washington State Maternal Mortality Review Panel released its report on maternal deaths 2017-2020. Findings from the report included a lower overall maternal mortality rate in WA than in the nation but identified that 80% of pregnancy-related deaths in WA were preventable. The panel determined that there were a group of contributing factors which, if altered, may have prevented the pregnancy-related deaths.

Identified factors include:

- Harmful points of contact with health, social service, law enforcement, and criminal justice systems.
- Gaps in clinical skills and quality of care, including gaps in recognizing and responding to OB emergencies.
- Unavailability of patient-centered, trauma-informed care, removed of bias, racism, and judgement, offered in accessible and culturally appropriate context.
- Lack of screening/follow up for risk factors like behavioral health conditions, violence, low social support.
- Lack of care coordination/continuity of care, lack of access to behavioral health resources and issues of bias and racism in health care settings.

Contributing to these risk factors were social and structural determinants of health such as underlying racism and lack of access to stable and affordable housing. Prioritized recommendations included undoing racism and bias, addressing mental health and substance use disorder, enhancing health care quality and access, strengthening clinical care, meeting basic human needs, and addressing and preventing violence.

The full report is available here: Maternal Mortality Review Panel Report.

III.C.1.b. Update of Health Status Among MCH Populations

In 2020, an estimated 10.2% of all Washingtonians, and 12.6% of those under 18 years old, lived in poverty (<125 percent federal poverty level [FPL] (American Community Survey, 2020).

In 2021, about 10% of women 18-44 years of age in Washington reported poor or fair physical health, compared to 14% of the total adult population. An estimated 34% of women 18-44 years of age reported having been diagnosed with depression. This is higher than the percent of depression reported in the total population of adults in Washington, at 23%. Approximately 63% of women of childbearing age had a medical check-up in the past year, compared with 66% for the total adult population, and 11% of women of childbearing age did not receive medical care due to cost, compared to 8% for the total adult population. (2021 Behavioral Risk Factor Surveillance System [BRFSS])

Impacts of COVID-19 Pandemic

In February 2023 Washington State began its third year of the COVID-19 Pandemic. As in prior years, its effects continued to be felt in different ways by the MCH population. In the fall of 2022, most public schools returned to in-person learning, marking the first time many school-aged children went back into classrooms physically. In March of 2022 the state lifted the indoor mask mandate, allowing individuals to assess their risk and act accordingly. In April of 2023 the statewide mask mandate for health care settings was lifted. For data on COVID infections, deaths, and vaccinations, please see the State Overview section.

Working Toward a Better Understanding of MCH Needs

We are continuing to develop the Child Health Intake Form (CHIF) data system to better capture and use data related to CYSHCN in the state, which are used to improve services. The Universal Developmental Screening data system, called Strong Start, is being pilot tested and there is a planned statewide rollout for the fall of 2023. Strong Start allows for the reporting of developmental screening results by parents, as well as providers. The Birth Defects Surveillance data system development continues, with the work with an outside vendor leading the development. Our next step will be to import legacy birth defects data, using machine learning approaches to deduplicate data. The Oral Health program, in partnership with the SE section, is currently conducting the Basic Screening Survey (previously Smile Survey) on a statewide basis. Twenty-one counties are also having individual surveys conducted.

Our Title V and Office of Family and Community Health Improvement (OFCHI) staff are exploring and developing new methods to bring data and information to our stakeholders in a more accessible and engaging way. As part of its core functions, the SE Section is developing data dashboards, featuring adolescent, perinatal, and CYSHCN data. An additional standardized data report template has been developed, which incorporates contextual information on data findings as well as highlighting lived experience. OFCHI is engaged in trainings and discussions to increase awareness and inclusion of voices and opinions from marginalized communities, including communities of color, to inform our work and priorities.

III.C.1.c. Changes in Title V Capacity

OFCHI has begun training in the use and implementation of the Family Engagement in System Assessment Tool (FESAT) approach to family engagement in some of its program work. OFCHI has begun work with a FESAT coach and joined in a Community of Practice group. Nikki Dyer, the Family Engagement Coordinator for the CYSHCN program, is the lead on this initiative. OFCHI will leverage this tool to receive more direct feedback from the families it is working with to better improve service delivery in its Title V initiatives.

III.C.1.f. Changes in Organizational Structure and Leadership

In 2022 the OFCHI created a new section, Data Collection and Reporting, to more effectively address the data and research needs of the office. The new section houses the Home Visiting Program, PRAMS survey operations and the Maternal Mortality Epidemiologist, all of whom were previously part of the Surveillance and Evaluation section.

Martha Skiles heads up the new section as its Senior Epidemiologist. Under her direction are:

PRAMS Survey and Operations, with the following positions:

- PRAMS Manager
- PRAMS Operations Manager
- PRAMS Epidemiologist
- 2 Interviewers (0.8 FTE, and 0.5 FTE)
- Data Manager

Home Visiting with the following positions:

- Program Manager
- Home Visiting Epidemiologist
- Data Quality Epidemiologist

Maternal Mortality Epidemiologist

All positions are 1.0 FTE, unless otherwise indicated.

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

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

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

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$8,930,530	$8,011,365	$8,900,000	$7,569,106
State Funds	$7,573,626	$7,573,626	$7,573,626	$7,573,626
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$16,504,156	$15,584,991	$16,473,626	$15,142,732
Other Federal Funds	$21,852,047	$16,351,318	$12,716,080	$12,719,080
Total	$38,356,203	$31,936,309	$29,189,706	$27,861,812

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$8,900,000	$6,630,809	$9,242,405	
State Funds	$7,573,626	$7,573,626	$7,573,626	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$16,473,626	$14,204,435	$16,816,031	
Other Federal Funds	$17,698,731	$17,698,731	$13,831,634	
Total	$34,172,357	$31,903,166	$30,647,665	

	2024	
	Budgeted	Expended
Federal Allocation	$9,305,490	
State Funds	$7,573,626	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$16,879,116	
Other Federal Funds	$15,402,961	
Total	$32,282,077	

III.D.1. Expenditures

III.D. Financial Narrative

III.D.1. Expenditure Narrative

At the time of this writing, Washington has expended an estimated $6,630,809 of the $8,811,411 of Title V Maternal and Child Health Block Grant (MCHBG) funding awarded for federal fiscal year (FFY) 2022

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

$672,879	10%	Pregnant women
$672.878	10%	Infants
$2,192,652	33%	Children 1 through 21 years
$2,376,828	36%	Children and youth with special health care needs

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

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

$20,120	<1%	Direct services
$325,255	3%	Enabling services
$6,285,434	97%	Public health services and systems

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

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

Contracts Distributing Title V Funding

59% of the budget for FFY 2022, or $5,054,429, 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 2022 are also described within this narrative.

Local Health Jurisdictions

DOH contracted with 35 LHJs and one hospital district to ensure funding supported maternal and child health (MCH) programs in all areas of the state. Key areas of work in these contracts included support for children and youth with special health care needs (CYSHCN), universal developmental screening, adverse childhood experiences, healthy weight, breastfeeding, and Nurse Family Partnership. LHJs could choose projects aligned with any of the areas of work listed above, but because such a large proportion of our funding goes to LHJs, we required each to use some

funding toward services for CYSHCN. This helped ensure that statewide we met the 30% requirement of funding for this population domain. 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
2020-2025 State Performance Measures (SPMs) 1, 2, 3, 5
Priorities: 1, 2, 3, 4, 5, 6, 7, 8, 9

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, 6, 10,
SPM 1, 2, 5,
Priorities: 1, 2, 3, 5, 6, 7

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, 6, 11, 15
SPM 3, 5
Priorities: 1, 2, 4, 8

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 NPMs 11, 15
Priorities: 2, 8

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: 8

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, 15
Priorities: 8

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, 15
Priorities: 1, 2, 8

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: 6

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 Priority: 1

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 Priority: 1

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.

Supports NPM: 11
Priority: 1

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. This funding is critical to ensuring Washingtonians receive This Title V funding, braided with additional federal and state grants and investments, allows for a robust, collaborative, and nuanced approach to protecting and improvement the health of Washingtonians.

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

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

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

The flexibility allowed to use MCHBG funding in ways that best meet the maternal and child health needs identified by each state has been invaluable as we persist in the recovery phase following the pandemic. The Title V structure allows us to invest in local solutions to regional challenges, as well as implement state-level policy, environmental and systems solutions.

III.D.2. Budget

III.D.2. Budget Narrative

Washington made an allocation assumption of an estimated $9,305,490 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:

$1,887,021	Salaries and benefits
$6,273,559	Contracts
$141,610	Goods and services
$110,448	Travel costs
$0	Capital equipment
$141,611	Intra-agency costs (e.g., employee workspace, computer, computer support)
$751,241	Administrative costs. The Department of Health Prevention and Community Health division provisional indirect rate is 30.5 %.
$9,305,490	**Estimated total allocation**

The federal investment in services benefitting specific populations:

$954,352	11%	Pregnant women
$954,352	11%	Infants
$3,216,534	34%	Children 1 through 21 years
$3,250,985	34%	Children and youth with special health care needs

The federal investment from the perspective of service level:

$116,847	1%	Direct services
$533,750	6%	Enabling services
$8,654,893	93%	Public health services and systems

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

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

Contracts Distributing Title V Funding

Of the $6,273,559 budgeted for contracts, most of that, $5,143,804, is budgeted to distribute to local health jurisdictions (LHJs) throughout the state, as described in the first paragraph below. The additional contracts in our budget are also described here.

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

community resiliency building, healthy weight, injury prevention, breastfeeding, immunizations, improving perinatal health through coalitions and home visiting, and addressing health equity. LHJs can choose projects aligned with any of the areas of work listed above. See **Appendix B – LHJ Bodies of Work Overview** for additional information about these contracts and work.

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

WithinReach: Manage the Help Me Grow Washington Hotline (the state's MCH toll-free telephone line), which promotes healthy starts and ongoing wellness, and prevents illness and injury through outreach that improves access to health benefits, resources, and information. Efforts are targeted to Medicaid-eligible pregnant women, children, and families. With one call, people can connect with a variety of services to support their health including services for CYSHCN. The hotline data and technical infrastructure integrates with the information available through WithinReach's online support. Support is provided directly by staff in English and Spanish, and additional resources and tools are used to support other non-English-speaking callers. WithinReach offers no-cost developmental screening and will now provide referral pathways to partnering physicians and clinics to directly connect families with services and resources.

Supports NPM 1, 4, 6, 11, 15; SPMs 3, 6
Priorities:
Identify and reduce barriers to quality health care.

Improve the safety, health, and supportiveness of communities.

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

Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

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

Supports NPM 11; SPM 4, 6
Priorities:
Improve the safety, health, and supportiveness of communities.

Promote mental wellness and resilience through increased access to behavioral health and other support services.
Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

University of Washington, Center on Human Development and Disability – Nutrition Program: Assure access to quality nutrition services across the state by: (1) Expanding workforce capacity through the development

and support of a network of trained Registered Dietitian Nutritionists to provide nutrition services to CYSHCN, (2) Promoting the availability of quality, community-based nutrition and feeding team services for CYSHCN within the context of a medical home, (3) Acting as a resource for pediatric nutrition information for CYSHCN including available services, guidelines, standards of practice, and evidence-based procedures, (4) Implementing aspects of national Standards for Systems of Care for CYSHCN across training and other venues to include topics such as, (a) care that is family-centered and culturally sensitive, and (b) access to affordable care through insurance and other systems of financing, and (5) Assisting in the evaluation of needs and barriers across the state for access to these services.

Supports NPMs 11, 15
Priorities:
Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.

Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

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

Supports NPMs 6, 11; SPMs 3, 5, 10
Priorities:
Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve people's health across the life course.

Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

Partners for Action, Voices for Empowerment (PAVE) Family to Family Health Information Center: Use the knowledge and experience of families and project partners with expertise in federal and state programs, and public and private health care systems, to work with families to increase the 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, 15, SPM 10
Priorities:
Improve the safety, health, and supportiveness of communities.

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

Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

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

Supports NPM 1, 4; SPM 2
Priorities:
Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.

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

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

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

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

Supports priorities:
Improve prenatal, infant, and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.

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

State Match of Federal Title V Funds

The Title V Maternal and Child Health Block Grant requires a dual federal-state investment, at least a $3 match in non-federal funds for every $4 of federal MCHBG funds expended, and maintenance of effort from 1989.

Washington's 1989 maintenance of effort amount is $7,573,626, and that is our state match amount.

We provide this state match through two primary sources:

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

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

Impacts of Federal Title V Funding

Title V provides dedicated funding for state and local health jurisdictions to focus on foundational maternal and child health services. This funding is critical to ensuring Washingtonians receive This Title V funding, braided with additional federal and state grants and investments, allows for a robust, collaborative, and nuanced approach to protecting and improvement the health of Washingtonians.

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

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

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

The flexibility allowed to use MCHBG funding in ways that best meet the maternal and child health needs identified by each state has been invaluable as we persist in the recovery phase following the pandemic. The Title V structure allows us to invest in local solutions to regional challenges, as well as implement state-level policy, environmental and systems solutions.

III.E. Five-Year State Action Plan

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

State: Washington

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

III.E. Five Year Action Plan

Introduction

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

The Office of Family and Community Health Improvement is dedicated to enhancing the health and wellbeing of individuals, families, and communities. The office works with local health jurisdictions, tribal public health partners, community-based organizations, health systems, health care providers, and other state agencies. The state's Title V Maternal and Child Health (MCH) Director, Katie Eilers, is the Director of OFCHI.

OFCHI is led by a group of seasoned public health professionals who have deep expertise in their subject matter, much of which is relevant to our work on the MCH block grant. In 2021, the OFCHI leadership team developed guiding principles for our office, which provide insight into how we approach our responsibilities and self-accountability as public servants:

- We are committed to equity as it is foundational to wellness for all people. This commitment requires intentionality, including sharing power with community.
- We recognize our internal and external systems are fundamentally biased and we commit to identifying and addressing system failures in serving community. We hold ourselves accountability to improvement over time.
- We value coalition building and partnership within and across governmental agencies, external sectors, and with our tribal partners, as a means to solve complex problems.
- We center community in all of our work, because they hold the expertise to help us understand health issues important to them, and solutions to address these issues.
- We are committed to prevention because it builds wellness over time and reduces suffering.
- We are committed to improving access to quality clinical and community services because we recognize that inclusive systems are essential in achieving healthy communities.
- We have an important role in public health and health systems innovation, in partnership with community, and wherever possible, we pursue policy and systems improvement as key drivers of sustainability
- We specialize in data and are data driven, so that our work is meaningful and relevant. We continue critical data collection efforts and ongoing needs assessments; and strive to create new ways of collecting and analyzing data with through innovations data systems.

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

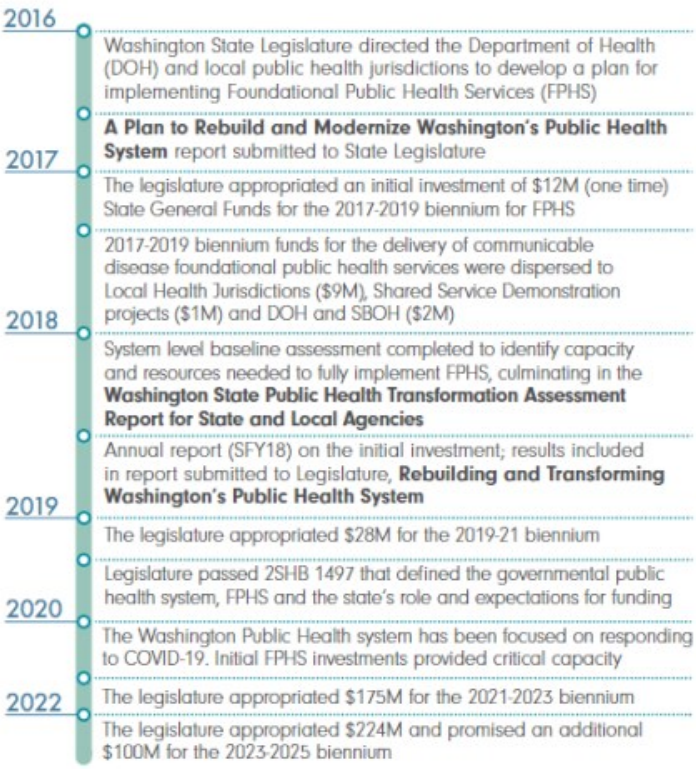
Our strategy to put Title V Maternal and Child Health Block Grant (MCHBG) funding to best use in Washington includes emphasis on the areas described below.

Ensure foundational public health services related to maternal, child and family health are delivered:

Foundational public health services (FPHS) 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.

In 2007, the Washington state legislature established legislation that supported investment in foundational public health services across the state, with a directive to the Department of Health to collaborate with local public health to

develop a plan for implementing FPHS in 2016. A steering committee comprised of representatives from the four branches of governmental public health (state department of health, local health jurisdictions, state board of health, and tribal health) advises the Office of Financial Management on priority FPHS investments for funding. The table below outlines the evolution of FPHS in our state, including funding investments:



In the 2021-23 biennium, FPHS investments were allocated to support critical MCH foundational services. Each LHJ in the state received workforce development funds (totally $10 million per year) and OFCHI around $750,000 per year to support the Pregnancy Risk Assessment Monitoring System (PRAMS) and funds to expand MCH surveillance and evaluation capacity by 1.0 full time person. Additionally, several LHJs and the department received core funding so support local child death reviews and statewide coordination of child death data. We anticipate the next biennium will include allocation for Tribal PRAMS.

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

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

OFCHI has taken several important steps to build from these core principles. In relation to ensuring our systems become more equitable and centering community expertise in our work, in the past few years we have transitioned to standing up community advisory boards to advise our funding priorities, program design and implementation, and policy recommendations. We established three new community advisory boards – the Youth Advisory Committee, Health Equity Zone Community Advisory Council, and the Birth Equity Advisory Council - and redesigned the Community Health Advisory Council to have stronger community representation. We continue to provide backbone support to the Community Health Worker Leadership Committee, which is committed to investing in community-based workforce infrastructure across the state. Other important equity investments include OFCHI staff serving as part of the leadership team to improve our community compensation policies, collaborating with our contracting office to create technical assistance opportunities for small community-based organizations new to state and federal funding, and continuing to shift our hiring policies to ensure greater diversity in staffing.

Promote a healthy start in life: We prioritize this commitment in two fundamental ways:

- **Investing in critical periods of development to advance health and equity:** We use a life course perspective to guide our programmatic and funding decisions, recognizing that the timing of exposures and experiences (both adverse and positive) during development can have profound influences on health trajectories, lifelong health, and health equity. This perspective leads us to emphasize investments in critical periods of development, including the prenatal, early childhood, and adolescent periods.
- **Improving systems of care** across the continuum of perinatal health and social services, through investing in Early Childhood Comprehensive Systems, adopting Standards for Systems of Care for Children and Youth with Special Health Care Needs, and promoting systematic screening, preventive visits and referrals for infants, children and youth. Washington prioritizes universal developmental screening, readiness for kindergarten, preventive health visits, immunizations, and other measures supporting children's healthy starts in life.

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

In preparation for our needs assessment and new state action plan, we have begun to create additional space to enhance our state-local strategic framing around MCH by creating a workgroup of LHJ MCH leaders, the MCH Director, the MCH Epidemiologist, MCHBG Coordinator and our Thriving Children and Youth Manager. This workgroup is tasked with outlining a workplan for LHJ engagement in the needs assessment, including soliciting feedback from LHJs on how they would like to present the needs of their communities for the needs assessment. Discussions also include planning for a statewide strategic MCH framing conference, during which we collectively hope to develop priorities relevant to the upcoming five-year action plan.

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.

Priority investments for the MCHBG relate to data system integration of birth defect surveillance, universal screening,

hospital discharge records and vital statistics. In the coming years with the support of FPHS funds the state will be rolling out a Child Wellness survey, adapted from the Seattle-King County's Best Starts for Kids survey. We are also collaborating with LHJs to enhance local PRAMS imputations and improve tracking of child death data. Improvements in surveillance and analysis will continue to inform how we best apply our resources to address exacerbated and emerging MCH 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.

Investments in policy

We routinely explore legislative implications of our work, which can relate to rulemaking, rule revisions, agency request legislation, and tracking of the wide variety of health-related bills presented by the legislature. We partner with other state agencies, local public health, and subject-specific coalitions to support and create policies that better serve the MCH population. In the past few years, this has included expansion of Medicaid coverage to 1 year post-partum, reimbursement structures for doulas, implementing legislation to create a school based health office at the department, assuring protection of the full scope of sexual and reproductive health services established in Washington state law, informing providers across the state about changes in scope of practice, and bringing forth recommendations for prenatal genetic screening rule changes. Moving forward, we will be exploring expansion of Medicaid coverage for inpatient days to treat substance use disorder at birth, reimbursement structures for community health workers, and deeper fiscal investment in school based behavioral health services.

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

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

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

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

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

2020 and 2021 have been challenging years for staff retention and workforce development. We continue to experience staffing adjustments resulting from the significant amount of staffing transition resulting from the Covid 19 response. We have spent the past 12 months resettling and growing staff as our MCH work has expanded and are delighted to bring in people with new expertise and lived experiences. Several examples of this are:

- The Perinatal Team was pleased to welcome Shanell Brown a temporary public health nurse consultant with a strong background and interest in equity. She assists with the Birth Equity Project (BEP) supporting the BEP advisory committee, LGBTQI2S+ doula training, and projects to support black breastfeeding.
- The Adolescent and Young Adult Health Unit was thrilled to welcome two new members in the summer of 2022. Nicole Casanova, the Performance Coordinator, has experience in women's sexual and reproductive health from both the programmatic and evaluation perspectives, designing human-centered healthcare experiences, facilitating and leading multidisciplinary teams, translating research into practice and sustaining community partnerships, specifically among underserved and underrepresented communities. Morgan Nelson, the Behavioral Health School Based Health Center Coordinator, brings with them exceptional authenticity, humility, and a well-honed sense of community engagement. They have extensive experience working on the ground in communities who have been historically and intentionally marginalized. Both Nicole and Morgan bring a deep knowledge of cultural humility and health equity, based on lived experience as well as previous community health work.
- Bella Mendez joined the Child Health team in September 2022. She received her master's in social work from the University of Washington and specialized in the field of multigenerational practice in June 2018. Her primary interest areas include early childhood development, behavioral and community health. Bella is especially passionate about increasing access to prevention services and education for all families. She comes to PCH from the Office of Public Affairs and Equity (OPEA), where she previously worked as an equity and social justice strategist on the Community Relations and Equity team. She was born in Michoacan, Mexico, but has lived in Washington state most of her life.

As we enter into a season where Covid 19 funding sunsets, we may witness an overall shrinking of investments in public health funding, and we are trying to ready ourselves for that possibility.

The total number of DOH full-time equal (FTE) positions funded by MCHBG federal funding is 18.72 FTE. This represents 43 individuals, as multiple sources fund most positions. This is slight decrease from last year's level of 17.79 FTE (portions of 40 positions). Title V activities are the predominant focus of the Office of Family and Community Health Improvement, shown in the attached organization chart.

Recruitment and Retention

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

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

We promote and use the Association of Maternal and Child Health Programs (AMCHP) and National MCH Workforce Development Center (WDC) workforce development resources.
Over the past several years, DOH has adopted “outward mindset” as our core culture and performance strategy, and we have incorporated it into our agency strategic plan as one of four key transformation areas. This concept is based on “The Outward Mindset: Seeing Beyond Ourselves; How to Change Lives and Transform Organizations,” a book by the Arbinger Institute. Our mindset is the lens through which we see our work, our relationships, and the world. Outward mindset training asks participants to shift from focusing on their own goals and objectives to having an outward mindset, with a focus on the organization as a whole. It helps individuals change the way they work with and relate to people and see how their behaviors and actions affect others. In addition to improving the internal organizational culture, this training seeks to improve the way we collaborate with others and provide services to the public. All DOH employees participate in outward mindset training, and supervisors attend outward leadership training.

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

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

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

- Building Trust in Local Public Health for Rural Communities
- Expanding Syndromic Surveillance Program through Tribal Health System Partnerships
- Thriving in Place for Older Adults
- Mental Health and the Public Health Workforce
- Rethink the Drink
- Public Health WINS for the future
- Moving Beyond Fentanyl
- Monkeypox and the Risk of New Zoonotic Threats
- Learning to Lead Adaptively

Staff participate in several other training programs, conferences, and education systems. A significant number of MCH connected staff participated in the nation AMCHP conference held virtually in 2022. The Section Manager for Thriving Children and Youth also participated in the AMCHP affiliated State Adolescent Health Coordinators meeting

in Minneapolis in September 2022.

Staff have also been participating in Family Engagement in Systems Assessment Community of Practice and coaching sessions, beginning Fall 2022.

The Child Health Team completed the AMCHP Coordinated Intake and Referral Systems survey (March 2022) and in follow-up discussions internally and with AMCHP and ECCS partners. In March 2023, this team presented about the WA State ECCS initiative at the Title V - ECCS partner meeting. This was a coordinated meeting between AMCHP and the ECCS TA Center to facilitate and strengthen connections between Title V program and ECCS project staff.

For the Adolescent Health and Young Adult team, staff have participated in a number of technical assistance trainings, workgroups, and conferences including:

Technical Assistance and Training

- Webinars offered by the Reproductive Health National Training Center (RHNTC) and Mathematica, focused on adolescent sexual health and program evaluation
- Tribal Public Health Partnerships (3-part series offered by DOH Tribal Relations)
- DOH Equity and Social Justice Office Hours
- Healthy Native Youth Community of Practice webinars
- Completed trainings/education materials provided by NNSAHC's website - Home - National Network of SAHC (nnsahc.org)
- Institute for Healthcare Advancement Health Literacy Specialist training
- Adolescent Pregnancy Prevention (APP) topical training
- Adolescent Brain Development and Trauma
- Office of Population Affairs (OPA) affinity group serving Tribal communities
- SBHC small workgroup calls
- NPM 10 - Adolescent well visit workgroup calls
- Bimonthly State Adolescent Health Coordinators Calls for Regions 8, 9, and 10
- Healthy Students Promising Futures peer collaboration and workgroup meetings focused on expanding Medicaid in schools.
- HCA Children and Youth Behavioral Health Work Group – School-based Behavioral Health and Suicide Prevention
- Washington State Public Health Associaton Conference 2022
- OPA Innovation Exchange (Washington, DC) 2023-presentation
- AMCHP 2023 (virtual)-poster presentation
- Annual Conference on Adolescent Health (AHI, virtual) 2023-presentation
- Tribal Public Health Conference (Durant, OK) 2023-presentation
- School-Based Health Alliance Conference-presentation
- Washington School Health Summit

Finally, other trainings for staff have included Essentials for Childhood monthly webinar and trainings associated with a Reverse Site Visit, Healthy Outcomes from Positive Experiences (HOPE) Summit, Science of the Positive workshop (with The Montana Institute), various webinars. podcasts, readings.

OFCHI leadership convenes all managers within the Office on a quarterly basis. In addition to providing operational updates and training, we often invite a subject matter expert to deepen our learning on issues important to how we

work. Topics have recently included equity in contracting, the intersection of historical trauma with tribal health outcomes, the history of systemic racism in the United States and influence on health of BIPOC communities, and our tribal engagement processes. In addition to these opportunities for leaders, all staff are invited to join monthly Equity and Social Justice Office Hours, as well as Prevention and Community Health Office hours. Both of these spaces provide rich training and networking opportunities for staff. Finally, each Fall, all staff are invited to participate in Policy 101 training, with additional deeper modules for staff expected to create draft legislation and conduct active bill review on these processes.

Ideally, each employee develops an individual training plan with their supervisor as part of their annual performance development plan. In addition to the learning resources mentioned in this section, it can also include attendance at local and national topical training sessions and conferences, as resources allow. Examples include the AMCHP Conference and the American College of Medical Genetics and Genomics Annual Meeting. Some employees maintain professional association memberships that relate to their field of work. Equity training and interactive staff development help create positive teaming and high morale/productivity.

Current and Anticipated Training Needs

The following needs have been identified by specific work groups and teams, some of these are ongoing training needs:

- Leadership coaching and mentorship, for navigating challenging workloads and team dynamics. Foundational Public Health Services orientation and technical assistance, for internal and external partners, including local public health MCH leaders
- Continued training around telehealth and teleintervention, particularly for our EHDDI program and partners and our Sexual and Reproductive Health program and partners.
- Federal and state policy training on rulemaking and the role of federal decisions on state level legislation.
- Equity and social justice training, including how to center community expertise in program planning and funding distribution, as well as diversity in staffing.
- Resiliency framing for maternal, child, adolescent health work. How to implement a shift in focus from deficit models to strength and hope-based approaches
- Growing staff morale amidst staff burnout, challenging partnership relationships, navigating the increasingly complex public health landscape, and continued agency-level changes
- Results-based accountability and systems-thinking training—how to apply these approaches to complex initiatives
- Training on implementation of the Blueprint for CYSHCN
- Implementing and maintaining quality improvement efforts in clinical and non-clinical settings
- Coordinating and leveraging HRSA funded initiatives such as MCHBG, ECCS and now ECDHS
- Trainings on Adolescent Health Well Visits

Innovations in Staffing Structures and Key Training Partnerships

We have continued our intentional routine engagement with partners for shared learning and leveraging of efforts in our program planning and policy work. These include meeting monthly with colleagues at the Department of Children, Youth and Families regarding alignment between our MCHBG, Essentials for Childhood initiative, Early Childhood Comprehensive System work, and the statewide Early Learning Coordination Plan (led by DCYF). Similarly, we continue meeting monthly with the WA Chapter of the American Academy of Pediatrics to collaborate around community health workforce investment in the pediatric and perinatal provider settings and universal developmental screening. We connect regularly with the Health Care Authority, which administers Medicaid, to align the MCHBG with policy initiatives (such as Medicaid expansion for additional days of inpatient substance use

disorder treatment at the time of birth) and systems improvements (like determining funding mechanisms for community health workers and doulas). Our teams also participate in several legislatively mandated workgroups, including the Children and Youth Behavioral Health Workgroup and the Dismantling Poverty workgroup, both of which provide opportunities for our agency to promote the unique health needs and challenges of the maternal, infant, child, and adolescent health populations.

- Staff facilitate several different coalitions in the state, all of which provide rich collaborative learning environments and opportunities for unique partnership engagement. Under the leadership of our new Thriving Children and Youth Section Manager, we have continued to expand state and local partners to the Essentials for Childhood steering committee, and have reconvened our Data Workgroup, which is focused on expanding our understanding of resiliency as it relates to mitigation of trauma impact. Our Community Partnership and Engagement team facilitates two important community coalitions – the Community Health Worker Leadership Committee, which advises state agencies on community-based workforce infrastructure, and the Health Equity Zone Community Advisory Committee, which directs the department on the implementation of legislation concerning the creation of health equity zones. Our Youth Advisory Council members meet with DOH's Adolescent Health staff on a regular basis to discuss adolescent and young adult health topics; their insight helps guide public health work to make sure that Department of Health (DOH) strategies are relevant, accessible, and youth friendly. Our Birth Equity Advisory committee meets monthly to guide to development and implementation of the Birth Equity Project (BEP). This has included developing eligibility requirements for grantees and identifying new organizations to receive funding. They have partnered with the BEP evaluator to develop an evaluation framework for the program and will continue to serve as an accountability measure for grantee work.

We continue to contract with the University of Washington (UW) to host the Washington State EHDDI Learning Community (WSELC), which supports professionals across disciplines and across the state to connect, share ideas and results, and learn from each other through both in-person and virtual interactions. The WSELC aligns professionals around common goals and best practices to support children who are deaf and hard of hearing and their families. Professionals involved in this learning community include newborn hearing screeners, pediatric audiologists, family resource coordinators, and early intervention providers who serve infants born in Washington.

We also convene the EHDDI Advisory Group, which is dedicated to identifying gaps in services and supports for families experience hearing loss, and addressing these gaps through partnership expansion, policy improvement, and streamlining care across childhood. Similarly, we host the statewide Critical Congenital Heart Disease (CCHD) Workgroup which is focused on challenges, gaps, and barriers to effective CHHD screening and diagnoses in Washington.

The Genetic Services program has convened a Prenatal Genetics Task Force with the primary objective of developing comprehensive guidance for non-genetic healthcare providers offering prenatal genetic tests to their patients. This guidance includes recommendations on which tests to offer, when to offer them, and criteria for appropriate follow-up care. The Task Force comprises a diverse group of subject matter experts, including genetic counselors, family medicine and obstetrics providers, midwives, payers, and Department of Health staff.

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

We use a variety of strategies to communicate information, training opportunities, and news to the broader Title V workforce and partners in Washington. For example, the Genetics program publishes its bimonthly eBlast that goes out to a listserv of genetic providers statewide who work on genetics across the lifespan, including pregnant women, infants, and children. The eBlast contains information on current trainings, programs, relevant information on policies,

legislation, education, and job postings for genetic services positions in Washington (sent in by partners). Our Community Consultants host monthly topical calls for LHJ partners and quarterly networking calls for LHJ MCH leads. They also send a biweekly email with links to resources, trainings, and job opportunities. 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 partnerships and involvement. In the 2022 DOH Strategic Plan engagement is called out as a cornerstone value of the agency and integral to our work. 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. Health equity has always been integral in Title V work, but the focus on health equity and anti-racist work continues to be emphasized across DOH. Family and community partnerships play a vital role in ensuring work is equity focused and rooted in community solutions that are working.

DOH has a paid Family Engagement Consultant (FEC) position in its Title V Children and Youth with Special Health Care Needs program. This position is staffed by a person with lived experience using Title V services across several domains. The FEC provides leadership for inclusion of family and community perspectives in policy and program development, oversees caregiver 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.

Direct engagement with families provides vital, real-time information about the challenges and opportunities families face in receiving services and supports regarding needed health care and social determinants of health. The FEC creates connections between Title V staff and families, including families of children and youth with special health care needs, to facilitate this process. The FEC champions seeking families across the Title V domains, including youth and youth with special health care needs.

The FEC manages the public CYSHCN inbox and serves as a point of contact for individuals seeking assistance who call or email the CYSHCN program at DOH. The Nutrition Consultant helps connect families to diagnostic and treatment funds; a limited pot of funds is available through the CYSHCN program and serve a payor of last resort for families needing assistance with care and services. Several families reached out in 2022 about moving into Washington and were connected with local services to ease their out-of-state move.

Family Listening Sessions

The CYSHCN team collaborated with Parent to Parent (P2P) in the summer and fall of 2021 to gather real-time information about family experiences during the COVID-19 pandemic and vaccine roll-out. 7 programs, serving a total of 8 counties, self-selected to participate in hosting family listening sessions with their multicultural groups, serving Spanish-speaking families, Black families, and Hebrew-speaking families. Most programs facilitated the information gathering in focus group or town hall type settings, with some choosing to facilitate these discussions in individual encounters. Questions for these P2P sessions included ongoing MCHBG Needs Assessment questions as well as questions about emergent needs and fears during the pandemic and vaccine roll-out at a time when COVID-19 vaccines were available to the adult population only.

Feedback from the multicultural P2P listening sessions is still being analyzed and will be compiled into a separate report in early 2024, alongside feedback from other listening sessions held in 2021 and 2023. Some of the highlights from these sessions include issues around specialist wait lists and availability, a lack of empathy from providers for families dealing with diagnosis and cultural and linguistic differences, access to mental health care and support services for the whole family in addition to needs resulting from social determinants of health such as housing, safety, food insecurity, and much more.

The FEC and other CYSHCN staff collaborated with Department of Children, Youth, and Families' Early Supports for Infants and Toddlers (ESIT) program to put together a virtual listening session focused on families of children

receiving early intervention services. This was created after work done promoting the continuation of state funding for the state's Neurodevelopmental Centers (NDCs) in the summer of 2021. The listening session occurred in November 2021 via Zoom. 12 parents of children birth to age 5 were present to talk about their experiences with early intervention services and transitioning to Part B services.

Questions asked were part of ongoing MCHBG Needs Assessment information gathering. Additional questions were included to gather feedback to inform focus of work efforts based on CYSHCN team's new strategic plan. Information gathered will be summarized in a report alongside the P2P feedback. One of the biggest takeaways from the session was a lack of qualified providers for primary as well as specialty care resulting in lengthy waiting lists and families taking on the burden of finding a provider who accepts their insurance and is taking on new clients, particularly in receiving specialty therapies. Wait lists, cost, services being offered in a virtual format only during the pandemic restrictions, and lack of providers were the biggest issues collected from this group.

Youth Engagement

In fall and winter 2021, the FEC collaborated with the Adolescent Health Coordinator and other staff involved in adolescent health and reproductive health care work to create the new Youth Advisory Council (YAC). The goal of the new YAC was to have regular, direct contact with young people throughout Washington State to help inform work for this population across programs, including Adolescent Health, Children and Youth with Special Health Care Needs, and Reproductive Health. 40 diverse young people were selected to participate in the first year of the YAC. This group was consulted in the process of planning for the second iteration of the YAC beginning in August 2022. For more information about the Youth Advisory Council please see the Adolescent Health Annual Report.

Fatherhood

Fatherhood is a growing topic of interest within Child Health and Children and Youth with Special Health Care Needs programs. The FEC is part of the Washington Fatherhood Council and serves as a systems partner and fatherhood ally. The CYSHCN contractor Washington State Fathers Network is also connected to the Fatherhood Council and comes to the table to champion fathers of children with special health care needs, see more below. Child Health has a seat at the table, as well as the Women, Infants, and Children (WIC) program. In 2022, Child Health supported several father focused events in partnership with the Washington Fatherhood Council, many collaboratively designed and led by family and community leaders.

- 5 Provider Learning Sessions were held from February to July 2022. The Provider Learning Sessions are knowledge and skills building sessions offered to the professional provider network in order to improve understanding and effectiveness when engaging fathers and father figures.
- Community Cafes were held in Cowlitz, Pierce, and Spokane counties to learn about gaps in fatherhood supports.
- 7 Dad Allies Learning Sessions were held to provide a place for fathers and father figures to come together virtually and discuss their experiences and needs around a selected topic.
- The 4th Annual Fatherhood Summit in May 2022 was held virtually.

Universal Developmental Screening

Strong Start, Washington's new universal developmental screening data system, went live in September 2021. This data system currently allows parents and caregivers to children birth to age five and their pediatricians and other health care providers a single place to keep track of developmental screening assessment scores, such as the Ages and Stages Questionnaire, regardless of where the child lives and moves throughout the state. With the launch of Strong Start, staff have begun outreach efforts to educate and promote the data system's use.

The Strong Start team has two staff members dedicated to community outreach and education in order to promote

the launch and utilization of the data system. Staff gave presentations to several programs in late 2022 including the South Puget Sound Community College's childcare program, Catholic Charities of Yakima, and the Washington Community for Children conference, which is partnered with our Help Me Grow effort. Flyers were also distributed to families through childcare centers in Lincoln County. More outreach efforts are planned for 2023.

For more information about the developmental screening program and Strong Start please see the Perinatal and Child Health Annual Reports.

Early Childhood

DOH was awarded an Early Childhood Comprehensive Systems (ECCS) grant in August 2021. Through the ECCS program, DOH and partners aim to build state capacity and infrastructure that strengthen parent/caregiver and early childhood systems to improve individual and family well-being. Amplifying the voices of family leaders is central to implementing the ECCS program. In August 2022, ECCS supported a focus group for families and caregivers of children, from prenatal to age 3. This focus group was planned and facilitated in partnership with a family leader and consultant with experience in the child welfare system.

Findings of the focus group were published in a summary report to share with partners. Key themes focused on factors that promote early childhood and well-being: relationships and nurturing environments, access to quality care, and community resources and services. Additionally, barriers to families were identified including lack of access to health services, stigma and negative experiences, and fragmented systems. The goal of the ECCS initiative is to integrate services of care for early childhood and address these barriers.

Community Based Organization Partnerships

PAVE

Partnerships for Action Voices for Empowerment (PAVE) is a community-based organization which houses Washington's Family to Family Health and Information Center (F2F) along with other family-serving programs including the Parent Training and Information, Lifespan Respite WA, and Specialized Training of Military Parents programs. PAVE's F2F receives Title V funding directly from the Maternal and Child Health Bureau. DOH provides additional Title V funding in order to extend their reach throughout the state and provide collaborative leadership and support to the Washington Statewide Leadership Initiative (WSLI) collaborative, described below.

Two staff members at PAVE serve as family navigators for families of children with special health care needs who connect through the Online Help Request forms as well as through referrals and self-referrals from providers, physicians, and families. Staff partner with two rural hospitals and local clinics on the Olympic Peninsula as well as hospitals in Seattle to support rural 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). The team at PAVE supported 1,398 families through a total of 4,786 contacts in connecting to services and training opportunities. 2,569 families were provided with individualized assistance through the family navigators, another 809 were given information through public presentations and outreach events. The biggest areas of need for these families continue to be in accessing a medical home and navigating disconnected systems or accessing community services.

PAVE supports families impacted by mental and behavioral health regionally and at the state level, through systems-building, supporting connections, and providing stipends to family members and youth self-advocates to be able to attend and participate in the Family, Youth, and System Partners Round Table (FYSPRT). A staff member serves as the systems tri-lead for the Salish FYSPRT.

PAVE has been connected with the Clallam Resilience Project that is founded on neurobiology, epigenetics, adverse childhood experiences (ACEs), and resilience (NEAR) sciences since 2020. Staff presented on family resilience and trauma-informed provider support for CYSHCN to the Clallam Resilience Project in spring 2022. PAVE is also working with the Peninsula Early Childhood Coalition around best practices for inclusion of children impacted by disability and special health care needs. Staff also convene the Strengthen Families Locally meetings for Bremerton and Port Angeles/Sequim on the Olympic Peninsula.

Staff at PAVE work closely with several tribes on the Olympic Peninsula, serving as trusted entities around health needs and disability. They are exploring how to bring a culturally appropriate parenting class to the Lower Elwha Tribal Nation. Conversations have started with Quileute Tribal Nation to create conversation circles for young families with children who may have or are at risk of disability and chronic conditions. Staff are also developing a resource and outreach plan for LGBTQIA2S+ young and young adults around equity in care.

DOH partnered with PAVE and Seattle Children's Hospital on a collaborative improvement and innovation network (CoIIN) project for children with medical complexity. The CoIIN project was funded for a fifth year to focus on sustainability and dissemination efforts in 2022. Much of the work around increased navigational supports for families through peer partners has continued through the DOH and PAVE contractual partnership. PAVE took on the role of family lead in an application for a research mini-grant focused on care coordination, awarded in the summer of 2022.

Parent to Parent

Parent to Parent (P2P) is family-led organization that uses a peer-to-peer, evidence-based model to promote family well-being and belonging. There is a P2P program in every county of Washington State, with some programs serving multiple counties. PAVE and DOH partner to support P2P through funding and technical assistance. Title V dollars support ongoing training and development for P2P coordinators and staff through an annual statewide training weekend and multicultural coordinator/program establishment and support.

2022 presents a unique year for P2P and other organizations providing direct services to families due to the Omicron Surge through the winter and the slowly lifting COVID-19 pandemic measures in Washington. The 2022 Annual Training: Just Keep Swimming was held virtually and focused on mindfulness and self-care in addition to work supporting multicultural families and families transitioning from birth to 3 services. 47 Coordinators attended the training. Planning for the 2023 Annual Training started and a location was secured, anticipating the ability to resume in-person events. In addition, 13 programs were supported in obtaining Zoom subscriptions, including additional subscriptions for programs with multicultural coordinators and programming, to support families in more remote areas and families needing flexibility of technology due to a variety of reasons.

Title V funds also support the continuation and growth of P2P's multicultural coordinators. Continuation dollars supported 11 programs with multicultural coordinators serving 19 counties across the state. Additionally, a program in Central Washington serving two counties with a substantial migrant farm worker population and Spanish-speaking population was awarded funding to establish a new multicultural program. Leadership for the multicultural coordinators is supported with regular virtual meetings to allow coordinators a chance to share their challenges, wins, and experiences and learn from others across the state. The Statewide Multicultural Coordinator also supports efforts for the annual training logistics and programming, bringing a vital voice to the planning table. She also serves families directly with 42 unique contacts and 71 interactions with families needing multicultural and/or multilingual services in 2022, as well as providing leadership and support to other multicultural coordinators. Here are a few quotes and anecdotes from families served by these programs:

> "I have 2 children with autism, since my child have been little, I have received a lot of support from PEACE [P2P in Clark County], thank God and thank PEACE my children have plenty of help and support like DDA,

social security, school, they also have helped me with Christmas and many other things. I am very grateful to you all, I love them like family, I feel very support and listened to. Thank you!" – M, translated

A is a widow with two sons on the Autism Spectrum. One son is in his first year of a transition program, the other is in his final year at high school. The family is Spanish speaking and challenged by navigating systems and resources without enough first language support. A is very isolated in her predominantly English-speaking town. Mix in the isolation of the pandemic and you can imagine her loneliness. However, with our monthly Skagit P2P virtual parent connection events, A is feeling more connected than before. She doesn't need to find a caregiver to watch her sons and saves time and money using the virtual platform. A faithfully attends each month and offers encouragement to other parents joining in. She is ready and willing to help other parents even as she faces new seasons with her own sons. We are so grateful for A.

"The Parent to Parent Program has helped me grow as a person, a mother, and to be there if another mom needs me. I want to thank all the people (and organizations) that support and fund Parent to Parent. Thanks to their support I am growing and learning so I can then pass the light onto another parent who is just starting like I was. Parent to Parent has become part of my family. We are moms that understand each other and rejoice with each of our children's achievements. I feel privileged to be in these groups." – I, mother of 2 children with special needs, translated.

Washington Statewide Leadership Initiative

The Washington Statewide Leadership Initiative (WSLI) is a collaborative of family-led and family-serving organizations and systems partner champions from DOH and Early Supports for Infants and Toddlers, our state's birth to 3 program. The purpose of WSLI is to facilitate collaborative, family-centered partnerships between small community-based organizations and leverage a shared commitment to elevating family voices and training families to take on leadership and advocacy roles in their communities, state, and nation. WSLI serves as a central hub, connecting Washington's Title V program with a variety of non-profit and family-led community-based organizations from across the state serving our culturally, linguistically, and geographically diverse families, including those with special health care needs. The collective impact structure of WSLI helps to facilitate stronger partnerships. It also broadens the reach of the Title V CYSHCN program into geographically underserved communities.

In August 2021, WSLI hosted two grant writing workshops aimed at family-led organizations and offered free of charge. The workshops focused on presenting the steps of finding and writing a winning grant proposal. The information was presented in an everyday plain language format to make it accessible to family leaders who may have never written a grant previously. There were 110 registrations between the two sessions offered.

The FEC continues to curate and disseminate a weekly bulletin aimed at promoting family leadership and partnership through trainings and events in collaboration with WSLI. The information shared draws from national, statewide, and regional opportunities, including resources and events from the Association of Maternal and Child Health Programs (AMCHP), Family Voices, the Lucile Packard Foundation, and Washington-based organizations.

Washington State Fathers Network

Title V contractor Washington State Fathers Network (WSFN) receives funding to support health education and peer-to-peer programming for fathers, father-figures, and male-identifying caregivers of CYSHCN across the state. WSFN has 12 local chapters around the state that provide a space for dads to gather and share their experiences as fathers of children with disabilities and/or chronic health conditions. WSFN held their annual conference virtually in the summer of 2022, providing attending fathers with a legislative update and a workshop on using stories for advocacy purposes, both sessions were well received.

WSFN continues to be a strong advocate for fatherhood in the state, as well as for issues surrounding families of CYSHCN. Starting in June 2021, WSFN began hosting monthly webinars on a variety of topics, these continued throughout 2022. Topics featured included housing options, guardianships and trusts, supporting bilingualism for children with special needs, special education advocacy tips, and many others, recordings of the webinars are hosted here. Additionally, the Director of the WSFN holds a seat at the Washington Fatherhood Council table as a father and fatherhood champion. He participated in the agenda planning for the 2022 Fatherhood Summit and Provider Learning Series described above.

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

Surveillance and Evaluation and Data Collection and Reporting Sections

Surveillance and Evaluation (SE) and Data Collection and Reporting (DCR) are sister sections in the Office of Family and Community Improvement (OFHCI). In October 2022, the PRAMS and Home Visiting units, along with our Maternal Mortality Epidemiologist, moved from SE into a new section, DCR. This change has created additional MCH epidemiology leadership, supervisory, and management capacity for the office. This change has been welcomed by section staff, managers and OFCHI.

The role of SE and DCR is to gather, analyze, interpret, and report on data that describe the health status, health care, behaviors, and other issues related to maternal and child health. Our goal is to provide strategic data and information to guide public health policy and programs that serve the populations of Washington. Equity, Innovation, and Engagement (EIE) are cornerstone values, and equity is centered in all the work of DCR and SE. Both sections partner closely with OFCHI programs, the Center for Health Statistics, Office of Innovation and Technology, and others.

SE provides program evaluation, data management, analysis, and technical assistance to almost all programs within OFCHI. SE leads the Birth Defects Surveillance System (BDSS), provides epidemiological capacity to Washington's Child Death Review and Universal Developmental Screening Data System. SE, in partnership with MCH program managers and other partners, leads the design, implementation, data analysis, and reporting for the Five-Year MCH Needs Assessment. New and experienced epidemiology staff regularly participate in the MCH Epidemiology Training Course supported by the MCH Bureau.

DCR leads and manages the Pregnancy Risk Assessment Monitoring System (PRAMS), Home Visiting data system, provides epidemiological capacity for Washington's Maternal Mortality Review Panel, and has provided technical assistance in MCH epidemiology to the COVID in Pregnancy Registry, located in the Center for Data Science at DOH. DCR leads the development of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Needs Assessment. In previous years, MCHBG was used to support PRAMS operations staff; in 2022 state funds were identified and dedicated to PRAMS, including the development of a full time PRAMS Epidemiologist.

Analytic Positions in SE and DCR: FTE, Classifications, and Qualifications

Of the approximate 25 permanent FTE in SE and DCR, 20 are MCH epidemiology staff. Epidemiology staff are funded through MCHBG (2.8 FTE); State Systems Development Initiative (SSDI) (0.7 FTE); MIECHV and state Home Visiting Funds (4.0 FTE); other federal grants (4.7 FTE); and by state and other funds (6.8 FTE). Of the 20 epidemiology positions, 18 are currently filled. Additional non-permanent staff include two full-time Council of State and Territorial Epidemiologist (CSTE) fellows, and a 0.5 FTE Health Services Consultant working on data product planning and development. SE frequently supports public health and epidemiology graduate students from the University of Washington in the completion of their practicum, as well as hosting students for the MCH Graduate Student Epidemiology Program (GSEP). SE is currently hosting a GSEP who is focusing on adolescent health.

The analytic staff classifications in SE include Epidemiologist 1 (2.0 FTE), Epidemiologist 2 (10.0 FTE), Epidemiologist 3 (6.0 FTE), and Sr. Epidemiologist (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.

Title V MCH Analytic Staff

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

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 covered by Title V support the analytic needs of the Title V population domains, BDSS, and MCH Needs Assessment activities. The Epidemiologist 3 positions supported by Title V provide advanced analytics and program evaluation skillsets, leadership for the Five Year MCHBG Needs Assessment and BDSS, staff supervision, and unit, section and office leadership. The Senior Epidemiologist position supported by Title V in SE provides supervision of unit supervisors and leadership in SE and OFCHI.

Current Workforce Capacity

While all of SE and DCR analytic staff focus on MCH issues, the majority are categorically funded by federal grants, state funds, or Home Visiting funds. One of our challenges is to accommodate new bodies of work, especially those with limited or no funding, and piecing together funding sources to create full-time positions.

Emerging Needs

Emerging and continuing needs within SE and DCR sections include increasing our ability to develop complex data linkage, data systems, reports, and on-line dashboards; increasing PRAMS data access and utilization; and building the BDSS Program. We are currently finalizing our first report using a new report template, which was developed to better integrate health equity and lived experience into MCH Data Reports.

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

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

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

The DOH Surveillance and Evaluation (SE) and Data Collection and Reporting (DCR) sections continue 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 the Washington state MCH Data Report chapters and contributed to our planned perinatal health indicators dashboard. Further, SSDI helped develop, support, and assess both structural and process measures to address the national performance measures, as well as the continued improvement and reporting of state performance measures and evidence-based strategy measures.

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

We are continuing ongoing qualitative data collection model to understand emergent needs, both in general and in relation to COVID-19. Through our ongoing interactions with partners and stakeholders, we are integrating key questions into facilitated discussions, program evaluation plans, ongoing program evaluation and needs assessment activities, 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. These questions have been incorporated into regular reporting of Local Health Jurisdictions and Birth Equity Project community sites, among others. 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.

Data products developed by SSDI-supported staff include MCH Data Report Chapters and a presentation to the Perinatal Advisory Board.

Data Linkage, Birth Defects Surveillance, Neonatal Abstinence Syndrome and Perinatal Substance Use Disorder

The first phase of the new state-wide Birth Defects Surveillance (BDSS) data system should be completed by the end of the year. In addition, we are currently working with our Center for Health Statistics (CHS) to link both historic and new birth defects records to vital statistics data. The initial linkage should be complete by September 30, 2023.

In addition, CHS staff have updated their methodology for linking birth certificate data with hospitalization discharge data. Once available, these data will inform our understanding of perinatal opioid use and maternal morbidity in Washington.

DCR, in partnership with CHS is in the final stages of linking 10 years of Washington PRAMS data with the Washington Comprehensive Hospital Abstract Reporting System (CHARS). The final dataset will include PRAMS and hospitalization data at time of birth for birthing parent and infant. In addition, CHS will include hospitalization data for birthing parent approximately 10 years before the birth, and/or hospitalization data after the birth for both birthing person and infant, based on available data. All activities will be completed by DOH staff dedicated to this project. This project is scheduled to be completed by September 30, 2023.

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 who have expressed interest in this dataset. 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 DCR, SE, 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 (SE) and Data Collection and Reporting (DCR) sections.

Pregnancy Risk Assessment Monitoring System

In addition to receiving Association of State and Territorial Health Officials (ASTHO) funding to link PRAMS with hospitalization data, the PRAMS program implemented the COVID Vaccine Supplement for births in 2021-22 and continues to implement the Opioid Supplement since 2019. The intent is to gather adequate numbers of responses for stratified and other analyses. These data will provide new and important information for Prevention and Community Health's Office of Immunizations and OFCHI's neonatal abstinence work. In the coming year, we will be collaborating with the American Indian Health Commission in developing the sampling plan and structure for Tribal - specific PRAMS.

Birth Defects Surveillance System

Surveillance and Evaluation Section (SE), along with OFCHI leadership and partners across the agency, are currently working with a vendor on the development of new Birth Defects Surveillance (BDS) data system. We anticipate the first phase of the new BDS data system will be completed by the end of 2023.

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. In partnership with Center for Health Statistics, BDS data are being linked to existing birth, death, fetal death, and hospitalization records for increased data quality and case ascertainment.

Universal Developmental Screening Data System

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

Home Visiting Data Management

DCR staff, through funding from the Department of Children, Youth, and Families, provide data management, reporting, and evaluation work for the Home Visiting Services Account. This involves maintenance of a home visiting data system that compiles and processes data from multiple data systems and programs. Priority work in the coming year will focus on implementing new recommendations from the Home Visiting Advisory Committee, including streamlining data collection on the part of the home visiting implementing agencies; creating space for family, community and agency engagement in understanding and using the data; and continued development of a comprehensive data infrastructure. The current system is a patchwork of databases that is neither sustainable nor adequate for the growing needs of home visiting. An assessment of future data infrastructure options with recommendations from June 2022, is guiding decisions moving forward on best data infrastructure investments for Washington.

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

III E 2 b iv MCH Emergency Planning and Preparedness

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

DOH holds key responsibilities in this plan, including:

Primary agency for:

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

Support agency for:

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

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

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

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

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

Prior to COVID-19, Title V staff have been involved in emergency activations for other communicable disease outbreaks as well. All staff in the Division of Prevention and Community Health are expected to be available for reassignment for emergency response – this is included as standard language in position descriptions within the division.

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

Emergency Planning and Preparedness Work at the Local Level

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

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

In Spring of 2023, through the Region X AMCHP monthly call, Cheryl Levine, former director of the At-Risk Individuals Program in the Administration for Strategic Preparedness and Response, provided a training on the Health and Human Services Child and Adolescent Emergency Planning Toolkit for Title V staff. The toolkit was designed to improve the capacity for addressing the access and functional needs of MCH populations in emergency preparedness, response, recovery, and mitigation activities. Key components of the toolkit include basic emergency planning steps for specific populations – pregnant individuals, postpartum individuals, lactating parents, infants, and young children. In the coming year, we plan to share this resource with local partners as we share emergency planning responsibilities across the state.

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:

Coverage Type	Employer	Non-Group	Medicaid	Medicare	Military	Uninsured
Children 0-18	50.7%	3.7%	39.4%	NA	NA	3.1%
Adults 19-64	64.1%	6.8%	16.5%	1.4%	2.0%	9.2%
Non-Elderly 0-64	60.5%	5.9%	22.8%	1.0%	2.2%	7.6%

Henry J Kaiser Family Foundation estimates based on Census Bureau's American Community Survey, 2021.

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. Six local health jurisdictions use MCHBG funding to support their participation in their regional ACH. The DOH and the 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.

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.

DOH:

- 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 2022 to address barriers.

- **In 2022 the Well-care Visit Workgroup hosted two Clinic Project**: The two Clinic Projects worked with all the MCOs who serve their community to increase Well-Care Visit rates for their clinics. Together they provide care for 25,000 Medicaid-enrolled children. Both clinics reconciled their Medicaid Patient population completely with all of the MCOs, reconciled the care gap reporting for each of the MCOs and then each identified tests of new strategies to increase the response of families to get their children in for a well-care visit.
    - The Columbia Basin Health Association (CBHA) Clinic Project tested new strategies to increase completion of Well-Care Visits, including methods and times of outreach and a point-of-care incentive in the Othello area of Eastern Washington. As part of the project, the clinic is tried an innovative approach to get young adults (ages 18-21) in for annual appointments and the workgroup is learning something about what may influence young adults to complete their Well-Care Visits. A $60 gift card upon completion increased the number of patients 18-21 who scheduled when reminded and reduced the no-show rate for those scheduled.
    - The University of Washington Medical Group Clinic Project is testing new methods of customizing text reminders and new ways for patients to be able to confirm their appointment or reschedule within a texting system rather than being required to go to the clinic portal. Early reporting indicates that being able to schedule an appointment without needing to access the portal is more effective in getting patients scheduled

Washington Statewide Clinic Webinar: In Fall 2023 DOH is planning a refresher webinar on Tips for getting parents to schedule and attend Well-care Visits. We will share tips found pre pandemic, lessons learned from the Fall 2022 projects and from One day Clinic Well-care Visit Events being hosted in the summer and early fall 2023. It will also cover billing tips that may have gotten lost as new staff were hired in the last few years.

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 10,000 flyers to parents of children who may need well visits. For the last few years DOH has highlighted that provider/physicians can assist with behavioral concerns. In 2022 we tested to see if electronic distribution of flyers was equally effective in reaching parents and leading to action as the historically effective paper flyers. Flyers were distributed through childcare centers statewide but in 4 counties paper flyers were provided while other counties got electronic flyers and content for a newsletter, whichever the childcare center chose to use. We then looked at the rates of visits by county and examined the results. Electronic flyers were equally effective as paper flyers. The partnership with Child Care Aware resulted from key conversations with the Department for Children, Youth, and Families; Help Me Grow; and Essentials for Childhood.

BIPOC Health Equity Youth Mental Health Access Project

In April of 2022 the five MCOs began working collaboratively to reduce inequity in mental health service utilization. Washington State has developed a Mental Health Service Rate Measure that pulls data from a wide variety of sources and creates a denominator of Medicaid Patients with an identified mental health need in the last 24 months and then using claims data counts the number of those patients who have received mental health care in the past 12 months. The rates of the BIPOC populations (based on self-identification) vary by timeframe and community. The workgroup is focused on populations where the population's rate is at least 3% lower that the statewide rate. For

2023 we are focused on the Asian, Hispanic and Native Hawaiian/Pacific Islander communities.

Early Childhood Comprehensive Systems: Since late 2021, DOH has led the state's Early Childhood Comprehensive Systems: Prenatal-to 3 Health Systems Integration initiative, funded by HRSA and MCHBG. Health care provider outreach and engagement are key elements of this initiative, Strategies include supporting a Health Care Provider Outreach manager at WithinReach to increase health care provider engagement and connection to the state's Help Me Grow WA coordinated intake and referral system, and contracting with the Washington Chapter of the American Academy of Pediatrics (WCAAP) to conduct a statewide landscape scan of health care practices and convene health care policy and system leaders for a policy summit (Fall 2023) with an aim to increase equitable access to integrated, family-centered health care for young children and families in Washington State.

Safe Deliveries Roadmap Substance Use Learning Collaborative: DOH has partnered with the Washington State Hospital Association since the launch of their Safe Deliveries Roadmap. Topics have included hypertension, elective c-section, and neonatal levels of care. The current topic is substance use and includes training and coaching on medication of opioid use disorder, eat sleep console, plans of safe care, and screening for substance use and other behavioral health disorders. Each topic area has step-by-step instructions to help hospitals implement changes and improve care for people who are pregnant and have a substance use disorder. This learning collaborative, hosted by WSHA and DOH, will enable hospitals to become certified Centers of Excellence in Perinatal Substance Use as well as qualify them for Medicaid Incentives.

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

Medicaid in Washington

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

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

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

In the 2022 legislative session, Senate Bill 5693 directed the HCA to establish a two-year grant program for primary care clinics to embed community health workers as part of care teams working with children and youth birth through age 18. The bill also directs the DOH to establish a curriculum and provide training for CHWs in primary care clinics serving children and youth birth through age 18 to support the grant. This work aligns with our Title V strategies to promote equitable access to care, particularly behavioral health care for children and teens.

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. Please note that we have negotiated a new agreement with HCA beginning July 2023 which focuses solely on adolescent health (this contract will be including in next year's report).

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 14 – agreement
GVS19968	Improve access to and availability of genetic counseling, evaluation and related medical services to Medicaid clients. Provide DOH genetics expertise,	Page 17 – agreement

	including consultation and reporting, to HCA staff.	
GVS24425	Interagency reimbursement agreement for prenatal diagnosis genetic counseling services.	Page 17 – agreement
GVS23567	Interagency reimbursement agreement for maternal and infant health activities associated with Perinatal Regional Networks (PRNs) and Pregnancy Risk Assessment Monitoring System (PRAMS) data services.	Page 14 – agreement
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 3 – 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 19 – 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 19 – agreement
GVS23372	Data share agreement to support maternal mortality review.	Page 16 – agreement

Medicaid Section 1115 Waiver – Medicaid Transformation Project

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

- Integrate physical and behavioral health
- Convert 90 percent of Medicaid provider payments to reward quality of care

- Improve health equity so all can benefit
- Increase and improve services that support our aging population

In July 2022, the HCA and Department of Social and Health Services submitted a renewal application for the transformation project. Several existing projects will continue or expand as part of the waiver, including expansion of work around substance use disorder and mental health services. The proposal includes new programs such continuous Apple Health enrollment for children, reentry coverage for continuity of care, and Apple Health postpartum coverage expansion. Several of these new programs are critical to maternal, child and adolescent health and well-being, and DOH MCH staff will proactively collaborate with HCA and DSHS around these initiatives. At the time of this report, this renewal was approved (June 30, 2023).

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

State Action Plan Introduction

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

We continue to use the state action plan narrative as a living document to summarize our work, updating objectives as they are fulfilled and adding new work that naturally builds from completed objectives. In this introduction, we highlight some of the ways we are responding reviewer comments (Fall 2022), which may not be fully represented in the action plan.

One recommendation from our last Title V (Fall 2022) review was to more intentionally engage LHJ and Tribes in the planning and implementation of MCH work. As we intensify our needs assessment planning, we have created several opportunities with these two sectors to collaborate. With our LHJs, we have convened a team of MCH LHJ leaders to ensure stronger state-local strategic framing for MCH investments, stemming from our needs assessment. We also have scheduled several needs assessment planning conversations with LHJ leaders to discuss what resources they will need to meaningfully tell the story of their local landscape and how we can leverage their existing surveillance and epidemiological resources to provide input to the needs assessment. In terms of tribal engagement, we have made presentations to tribal health care leaders regarding Title V, and created listening sessions with tribal representatives around MCH needs and recommendations for investment on behalf of indigenous people.

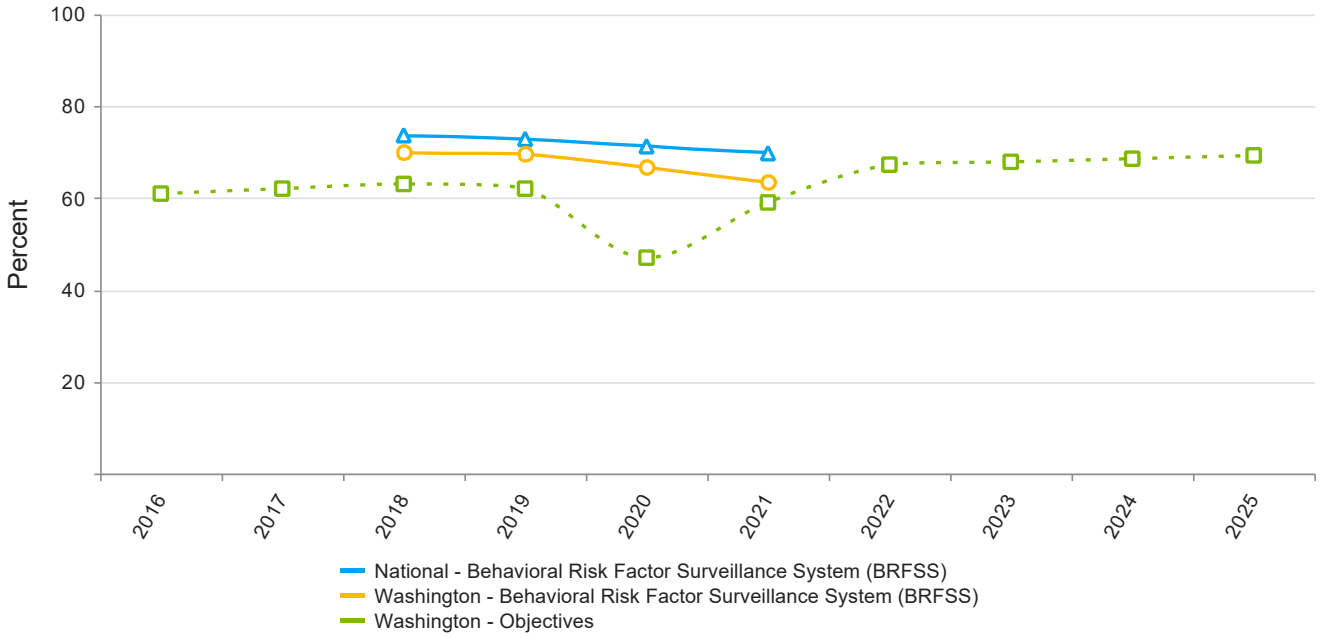
Reviewers last year highlighted the needs for attention to rural areas in our state, where access to services for children with special health care needs and the maternal/infant population are scarce. This past year, Toppenish Hospital, which served the rural community in and around the Yakima Nation, closed its maternity services. This was mirrored by closures of maternity services in western Idaho due primarily to the inability to maintain and recruit maternity and pediatric service providers, which places additional potential demand for services on eastern Washington providers. In response to the growing access threat in rural areas for pregnant and postpartum individuals and infants, the department has partnered with the Rural Collaborative, a rural hospital membership organization, the Washington State Hospital Association and the Health Care Authority to explore immediate steps to fill existing gaps and prevent further closures. In spring 2023, partners convened a half day exploratory meeting with c-suite and provider representatives from several rural hospitals to discuss the nature of the crisis and explore steps that can be taken without the influx of significant financial resources to assure high quality care is available through their hospitals. Discussion focused on innovative training approaches to assure skills maintenance and more effectively using rural midwives to their full scope of practice. Since then, additional conversations have focused on licensing, leveraging existing grant pools for rural access, and creating a rural hospital stipend for maternity services. We will continue these conversations in the coming year.

Reviewers also highlighted the recommendation to continue to prioritize the nutritional and food security needs of children with special need and pregnant individuals. Our report and action plan show how we are addressing unique CYSCHN nutritional needs through nutrition workforce training and network development, improved care coordination for infants with nutritional needs, and targeted approaches to addressing specific nutrition-related needs, such as for children with Type I diabetes.

Women/Maternal Health

National Performance Measures

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



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			47	67.2	67.2
Annual Indicator		69.7	69.3	63.4	63.4
Numerator		919,438	939,935	885,803	885,803
Denominator		1,318,605	1,355,481	1,397,128	1,397,128
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2021	2021

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

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

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			43	67.9
Annual Indicator	67.3	66.4	67.2	66.4
Numerator	57,910	56,386	55,844	55,702
Denominator	86,047	84,918	83,101	83,889
Data Source	WA PRAMS	WA PRAMS	WA PRAMS	WA PRAMS
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	68.6	69.3	70.0

State Performance Measures

SPM 1 - Substance use during pregnancy

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			15
Annual Indicator	16.1	14.9	15.7
Numerator	13,672	12,382	13,172
Denominator	84,918	83,101	83,899
Data Source	WA PRAMS	WA PRAMS	WA PRAMS
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	15.0	15.0

SPM 2 - Provider screening of pregnant women for depression

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			88.3
Annual Indicator	87.2	88.3	87.1
Numerator	74,048	73,378	73,076
Denominator	84,918	83,101	83,899
Data Source	WA PRAMS	WA PRAMS	WA PRAMS
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	88.3	88.3	88.3

State Action Plan Table

State Action Plan Table (Washington) - Women/Maternal Health - Entry 1
Priority Need
Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.
NPM
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Objectives
By Sept 2023, maintain communications and guidance documents for COVID and pregnancy/birth/postpartum/children to reflect up-to-date COVID data and understanding, to include racial disparity considerations.
By December 2022, distribute health promotion materials in relation to Senate Bill 6128 passed by the Washington State Legislature to expand Medicaid coverage to one year postpartum.
Through September 2025, 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.
Through September 30, 2025, 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.
Through September 2025, support implementation of community birth worker projects that address racial disparities in birth outcomes.
Through September 2025, continue to collaborate with Tribal partners to meet the needs of Tribal communities impacted by maternal mortality through additional listening sessions and data quality improvement.
By December 2023, support access to prenatal genetic services and technical assistance and disseminate data and trends on prenatal genetic services to stakeholders.

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

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

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

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

SPM

SPM 1 - Substance use during pregnancy

Objectives

By September 30th, 2024, and in partnership with the Child Welfare Division at the Department of Children, Youth, and Families, Within Reach and the Washington State Hospital Association, implement the state's new portal and policy for infants who are born substance exposed, including promotion of supports for the substance-affected mother/infant dyad.

Strategies

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

Provide training for clinical staff providing care at birthing hospitals

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

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

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

Priority Need

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

SPM

SPM 2 - Provider screening of pregnant women for depression

Objectives

Through September 30, 2025, building from the completion of the revised maternal mortality review panel report to the Washington State Legislature, covering the deaths that occurred to women during pregnancy or within one year of pregnancy, inclusive of deaths resulting from suicide, substance overdose, homicide, and deaths that occurred out of state, and covering data from 2014-2020. The report will include identification of gaps and issues contributing to preventable, pregnancy-related deaths in the maternal behavioral health system and recommendations for improvement. Recommendations will address disparities and health equity improvements to reduce maternal mortality and will include contributions from our tribal and Indigenous partners.

Through September 2025, ensure 80 percent of birthing hospitals in Washington state have established processes to universally screen everyone giving birth for substance use disorders and perinatal mood and anxiety disorders as part of the Alliance for Innovation on Maternal Health (AIM) patient safety maternal mental health protocols.

By September 2025 we will continue to review cases of maternal mortality in Washington by facilitating meetings with the Maternal Mortality Review Panel. We will provide training opportunities for the panel on health equity and align our work with the CDC.

Strategies

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

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

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

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

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

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

Explore implementation of Maternal Levels of Care in Washington state.

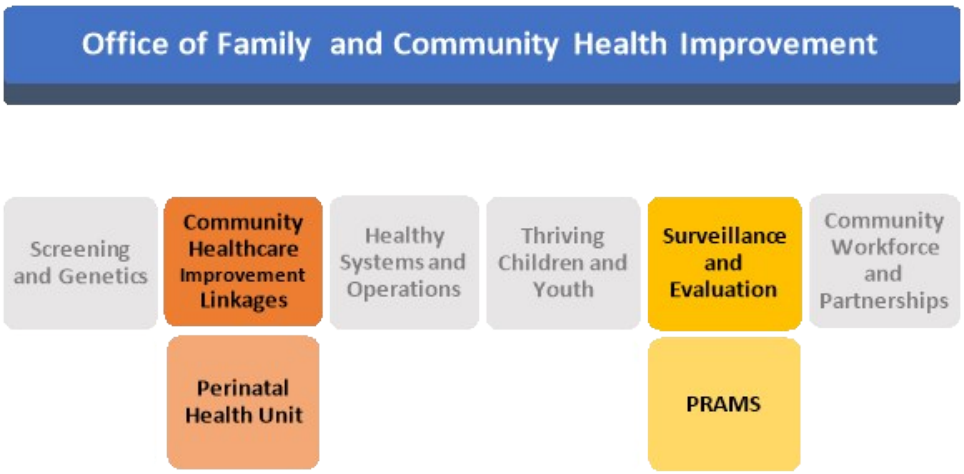
Promote standardized depression, anxiety, and substance use screening across the life course.

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

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

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

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



Women and Maternal Health Domain Narrative

Overview

The women's and maternal health program at DOH are 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. This section also includes the Sexual and Reproductive Health Unit, which supports the Title X Program in Washington. This program supports a network of 16 contracted partners that operate 94 clinics across Washington state. They offer direct clinical services and education around family planning, contraception and interconception health, pregnancy testing with nondirective counseling, and the testing and treatment for sexually transmitted infections.

The Perinatal program has a long history of supporting the DOH's our vision of equity and optimal health for all through working with others to improve the health of all people in Washington State, especially those that are pregnant and parenting. The work done by DOH and our partners is based on the perspective of the life course health development, which explains how individual health develops over a lifetime and is impacted by the cumulative effect of multiple drivers of health in all areas of life. This approach recognizes that we can promote the health of all individuals by positively impacting the health of women and pregnant people. We are actively working to ensure the health of all Washingtonians through our work in this area.

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

Much of our work is informed by the recommendations developed by the Maternal Mortality Review Panel (MMRP/Panel), established into law in 2016 and made permanent in Washington in 2019. The Panel reviews maternal deaths that occur during pregnancy or one year postpartum. Based on this review, the Panel develops

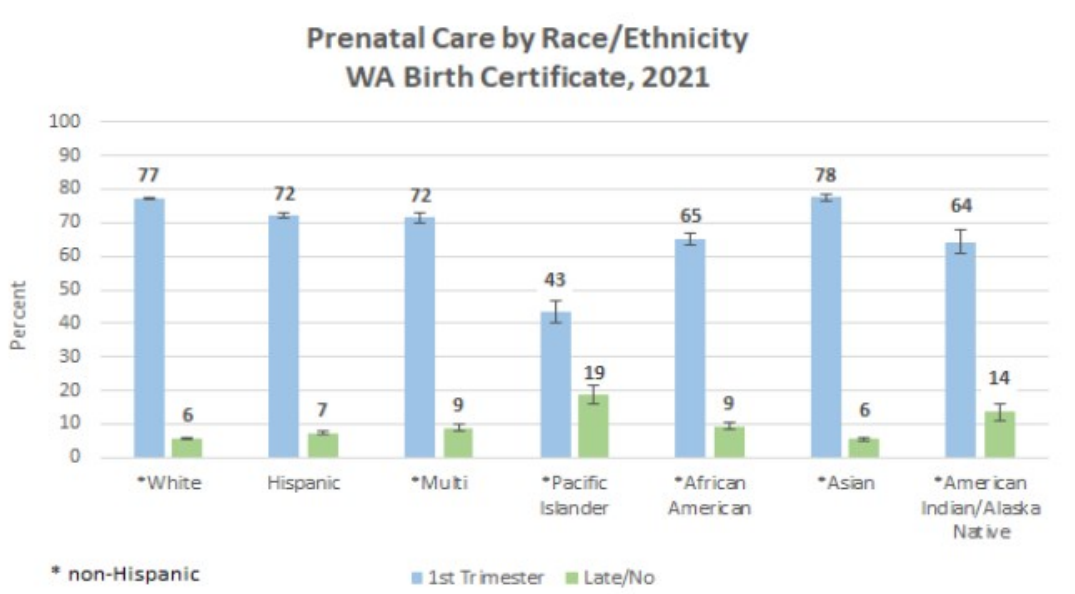
recommendations to policymakers, state agencies, and health care providers to help improve perinatal health and prevent future maternal deaths and reduce maternal morbidity. This ensures our programs are data-informed and based on the input of multiple statewide experts.

In 2021, an estimated 1.5 million women of reproductive age (15 to 44) in Washington made up about one-fifth of the total population. The following data on racial breakdowns are from 2020, the most recent year for which estimates are available. White non-Hispanic women comprised 62% of women of reproductive age in 2011; this decreased to 57% in 2020, an 8% decline. The population of American Indian/Alaska Native women also decreased over this period, decreasing from 1.6% to 1.3%. Groups whose populations of women of reproductive age increased include Hispanic, 20%; Asian, 11%; Black/African American; 5%, Native Hawaiian/Pacific Islander 1.6 %, and individuals identifying as more than one race (multiracial), 35%. The largest population increases from 2011 to 2020 were to Native Hawaiian/Pacific Islander, with a 47% increase, multiracial, by 35%, and Asian by 21%.

In 2021, 63% of individuals of childbearing age in Washington received a medical check-up the previous year, compared to 66% in the general adult population. About 10% of women in Washington aged 18-44 reported poor or fair physical health. 34% of women 18-44 reported having been diagnosed with depression. This is higher than the % of depression reported in the general population of adults in Washington, at 23%. (BRFSS)

Between 2012 and 2021, the total birth rate among people of childbearing age in Washington decreased by 14%. This drop is most pronounced among individuals ages 15 to 17 (65% decrease), ages 18 to 19 (52% decrease), and ages 20 to 24 (36% decrease). During the same time, birth rates among individuals ages 35 to 39 (12% increase) and ages 40 to 44 (25% increase), suggesting a shift in age among pregnant people giving birth. Trends in births and pregnancies are not identical across racial and ethnic groups. The total pregnancy rate, which includes births, fetal deaths, and abortions, decreased from 78 to 66 pregnancies per thousand pregnant people from 2012 to 2021.

In 2021, receipt of first-trimester prenatal care varied by insurance coverage and by race and Hispanic ethnicity. Persons with Medicaid-funded deliveries started PNC later than persons with non-Medicaid-funded deliveries, 67% vs. 79%. NHOPI, Black/African American and American Indian/Alaska Native pregnant people were less likely to begin prenatal care in the first trimester than individuals in other racial/ethnic groups. NHOPI individuals were far more likely to receive no prenatal care or start care in the 3rd Trimester than all other groups. (see graph) (WA Birth Certificate).



Women and pregnant individuals are also choosing to give birth differently. From 2012 to 2021, deliveries by a Doctor of Medicine or a Doctor of Osteopathic Medicine decreased by 11%, while deliveries by licensed midwives increased by 23%. Deliveries in birthing centers increased by 49%, and home births increased by 24%.

Symptoms consistent with postpartum depression were reported by 12% of individuals in 2021. This does not represent a significant change from 10% reporting symptoms in 2012. 17% of respondents with Medicaid coverage reported symptoms consistent with depression, compared with 10% of respondents who did not have Medicaid. In 2012, 14% of respondents with Medicaid coverage and 7% of respondents not receiving Medicaid reported such symptoms. Neither represents a significant change. (PRAMS)

Diabetes during pregnancy increased by 68% from 2012 to 2021, including a 71% increase in gestational diabetes. Among all pregnancies, about 13% of expectant individuals experienced some form of diabetes, either gestational or pre-existing. Hypertension during pregnancy increased 81% over this same period, impacting, as with diabetes, approximately 13% of pregnancies. Greater than recommended weight gain during pregnancy, as defined by the 2009 Institute of Medicine recommendations, has increased significantly over the past decade, from 47% of individuals in 2012 to 54% in 2021.

National Performance Measure 1 – Well-Woman Visit

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

In 2021, 63% of women received a preventive medical visit within the past year. This was slightly less than the target of 67.2%. 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. Since 2018 the rate has fallen from 70% to 63%, a statistically significant decrease (BRFSS).

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

The DOH needs assessment found that many individuals lacked Medicaid coverage after pregnancy, preventing them from accessing services like behavioral health to address postpartum depression. In 2021, Washington state

policymakers cited the MMRP's report in Senate Bill 5068 to **extend Medicaid coverage to 12 months postpartum**. This bill was passed and signed by the governor in 2021. In 2021, Medicaid expanded postpartum coverage to be automated and extended to 12 months after the end of pregnancy. Starting July 2022, this coverage became permanent in Washington and includes obstetric/postpartum care and all healthcare services covered by Medicaid. The After Pregnancy Coverage has been announced, and the related information is available to the public on the HCA's website. DOH has worked with HCA to promote awareness of this coverage by sharing information and training opportunities with our provider and local health networks.

In addition to Medicaid coverage, there is a need to provide sustainable access to community birth worker support like doulas and lactation specialists. In 2021, legislation was passed to create a credentialing system for doulas. While no current legislation enables doulas to reimburse Medicaid, HCA is working on developing potential payment options, which will expand on the newly developed credentialing system.

State Performance Measure 1 - Substance use during pregnancy

In 2021 16% of respondents indicated they had used an intoxicating substance during their most recent pregnancy. Some of the substances identified, such as cannabis, are legal in Washington State, while others, such as cocaine or off prescription use of opioids, are not. Cannabis was the most commonly reported substance used. (PRAMS)

State Performance Measure 2: Provider screening of pregnant women for depression

In 2021 87% of respondents indicated they had been screened by a provider for symptoms and/or signs of depression during their most recent pregnancy. (PRAMS)

We have developed 2 state performance measures to track work related to behavioral health and pregnancy.

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

Alliance for Innovation on Maternal Health (AIM) – Birthing Hospital Quality Improvement DOH and WSHA continue collaborating on AIM implementation efforts. In 2021, we created the Perinatal Substance Use Disorder Learning Collaborative. This collaborative worked with 13 hospitals to pilot test the Obstetric Care for Women with Opioid Use Disorder patient safety bundle. In 2022, this bundle was expanded to include training and support for all substances, not just opioids.

The Perinatal Substance Use Disorder Learning Collaborative now supports over 80% of birthing hospitals in Washington by providing monthly educational webinars and peer-coaching calls. It also helps hospitals become certified as a Center of Excellence for Perinatal Substance Use. This certificate awards and recognizes hospitals that follow best practices when caring for people and infants impacted by substance use.

In addition to AIM, DOH is working on several 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, which provides urgent assistance to local communities who experience a drug-related public health event, and Title V staff leads the workgroup that addresses the perinatal child impact. This workgroup intends to address the needs of women, transgender, gender fluid, pregnant, and parenting people impacted by substance use.

The workgroup has several areas of focus, including:

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

Support for families with infants exposed to substances

In partnership with DCYF, we have worked to clarify and expand state policy related to the federal 2016 Child Abuse Prevention and Treatment Act (CAPTA) regulations that require states to report aggregate data on all infants born substance exposed and create a program so infants born exposed to substances without any safety risks can receive voluntary wraparound services through an outside agency (WithinReach) without a report being filed with Child Protective Services. DCYF provided training through the AIM perinatal substance use initiative. WithinReach has begun meeting with birthing hospital staff to initiate trainings with clinicians and to support hospitals in updating their policy/guidance for the notification or report of infants who are born substance exposed.

The HCA launched new billing codes to support birthing hospitals to implement the eat/sleep/console model of care for infants being monitored and treated for withdrawal. The model centers mothers and birth parents as the most essential elements of care and initiates nonpharmacological supports as the first line of treatment. The billing codes allow the hospital to bill for an administration day rate to provide mothers/birth parents with a room and meals while caring for their babies. Hospitals can also bill separately for any medication(s) mothers/birth parents need, e.g., not leaving the hospital to get their methadone from a methadone clinic when that medication is prescribed.

Overdose Campaign

To respond to the overdose crisis being experienced nationally and in Washington state, DOH launched a communication campaign for overdose awareness and prevention during pregnancy. The campaign provided education on harm reduction strategies to prevent overdose, fentanyl education, connection to substance use services during pregnancy, and access to naloxone. The campaign generated:

- 31.4 million impressions
- 5.5 million completed video views
- 33k clicks back to the landing page
- The social ads had 3,291 engagements, 198 shares, and 24 saves
- Reached 1,094,166 people, an average of 11.5x

- **Digital Video #1 -** Video received just under 7 million impressions and 5.6 million completed views (613k for the Spanish version)
- **Display Banners -** Our display banners received 12 million (1.3 million for Spanish) impressions and 13,224 clicks (1,659 Spanish).
- **Facebook/Instagram -** The social ads generated over 12.5 million (more than 4.6 million Spanish) impressions and 9,893 clicks (2,926 Spanish).

State Summit

The workgroup also coordinated our 3rd state summit providing training and networking for clinical and community substance use providers, child welfare workers, and court attorneys. The training was offered virtually and in person, with 564 people registered to attend the training.

Provider Training and Engagement

DOH funded 5 community mini grants to increase the providers' knowledge and skills about the patients' and their families' behavioral health conditions during and after pregnancy and the available treatment and resources. These projects support maternal Medication Assisted Treatment (MAT) programs and increase perinatal peer support groups and services.

DOH partnered with the University of Washington (UW) to launch a pilot program to train and support members of primary care clinics to address perinatal suicide risk and substance use overdose. Aspects of this suicide risk reduction care include screening for suicide risk (identifying risk factors and the use of screening tools), evaluating the severity of identified risks, 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 UW team will recruit participating facilities to receive training to develop and carry out their own site-specific perinatal suicide risk improvement component with and measuring and reporting clinic screening and care rates.

Additional Work Supporting Women's/Maternal Health

Maternal Mortality Review Panel

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 (MMRP) to conduct a multidisciplinary review of all maternal deaths in Washington. The law sets out to identify factors associated with maternal deaths and make recommendations for system changes to improve perinatal health care services in the state. It 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 3 years.

The MMRP is a diverse and multidisciplinary group of over 80 people across the state. This group includes clinicians and non-clinicians, physicians, midwives, social workers, behavioral health experts, health equity experts, pathologists, advocates for people affected by intimate partner violence, doulas, community health workers, Indigenous/Tribal health representatives, patients, and patient advocates. With staffing and support provided by DOH, the MMRP reviews pregnancy-associated deaths (death of a person during pregnancy or within 365 days after pregnancy from any cause). It distinguishes which of those deaths were pregnancy-related (a subset of the above deaths that occurred from a cause complicated by pregnancy, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiological effects of pregnancy). Among pregnancy-related deaths, the MMRP identifies which deaths were preventable, meaning some change to clinical, social, or equity-related factors at any stage might have been able to prevent the death. The MMRP then identifies factors that contributed to preventable pregnancy-related deaths and makes recommendations for changes at the patient, provider, facility, community, or systems level to prevent similar deaths in the future. Recommendations also include ways to address

bias and discrimination in cases where the MMRP identifies these factors as playing a role.

Report Findings

By September 2022, the MMRP and DOH staff had completed an early draft of its 3rd report of findings and recommendations from the MMRP (later published in February 2023). The MMRP completed a review of those cases in March 2022 and began focusing on prioritizing recommendations for the upcoming report.

In June 2022, the MMRP held meetings to prioritize among its many recommendations based on 2017–2020 deaths. It organized recommendations into 6 topic areas which became the following categories: (1) addressing **racism, discrimination, bias, and stigma** in perinatal care; (2) increasing **access to mental health and substance use disorder prevention**, screening, and treatment for pregnant and parenting people; (3) **expanding equitable and high-quality health care access** by improving care integration, expanding telehealth services, and increasing reimbursement; (4) strengthening the **quality and availability of perinatal clinical and emergency care** that is comprehensive, coordinated, culturally appropriate, and adequately staffed; (5) **meeting basic needs of pregnant and parenting people** by prioritizing access to housing, nutrition, income, transportation, child care, care navigation, and culturally relevant support services; and (6) preventing violence in the perinatal period through survivor-centered and culturally appropriate coordinated services.

The MMRP and DOH staff completed data analysis for the 2014–2020 deaths report, preparing to publish these findings in the upcoming report. The analysis found that 80% of pregnancy-related deaths were preventable, reflecting the MMRP's growing understanding of preventability as inclusive of social factors rather than primarily or exclusively clinical factors. Trend data showed that overall pregnancy-associated mortality in Washington state has remained relatively stable in recent years and did not increase in 2014–2020. However, disparities persist—particularly for American Indian/Alaska Native, Black and African American, Native Hawaiian or Pacific Islander, rural communities, and people covered by Medicaid. Leading underlying causes of pregnancy-related deaths were behavioral health conditions (predominantly by suicide and overdose), hemorrhage, and infection.

Tribal Collaboration

In 2021 and 2022, we continued supporting and building on a collaboration with the American Indian Health Commission that grew out of a presentation about the findings from our December 2019 report. The commission works on behalf of the 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.

We supported the commission in coordinating a series of listening sessions with tribal and urban Indian health leaders and communities. The purpose of the listening sessions, as defined by the commission, was:

1) To hold gatherings in Tribal and Urban Indian Communities to hear concerns about the health of Native pregnant, birthing, and postpartum people in a safe, non-judgmental, and confidential space, where the words, concerns, fears, and hopes of participants are heard and honored.
2) To update Tribal and Urban Indian Health leaders on the issues of Native maternal mortality and morbidity, including concerns from their communities, to inform their recommendations for the 2023 Maternal Mortality Review Panel Report to the Legislature.
3) To reduce maternal mortality disparities in American Indian and Alaska Native (AI/AN) people in Washington State until they are eliminated.

By September 2022, after holding multiple listening sessions, the commission began drafting an addendum to the

maternal mortality report, later published as a part of that report in February 2023. DOH Perinatal Unit staff provided support and consultation throughout and met with the commission monthly.

Second-Generation MMRP

Completing reviews of 2020 cases in March of 2022 and completing the meetings to prioritize recommendations in the summer of 2022 marked the end of the second MMRP's service period. By September 2022, DOH staff and lead MMRP members began developing an application process for the 3rd MMRP. Applications opened later in fall 2022. Goals included increasing representation from tribal and urban Indian communities and communities disproportionately impacted by maternal mortality and morbidity and increasing other specific expertise areas on the MMRP.

Health Equity

We continue to center health equity in our maternal mortality review process and the work we produce. We ensured that equity and social determinants of health-focused perspectives were valued when facilitating MMRP case review meetings. We asked whether interpersonal or systemic discrimination and bias played a role and whether a death was preventable from an equity and social determinants of health perspective. We prioritized equity with a strong focus on antiracism in our process of narrowing down recommendations for selection in the report. While planning for the recruitment of MMRP's 3rd iteration, we developed outreach plans to focus on organizations and networks whose work centers communities experiencing disproportionate burdens of maternal mortality and morbidity, racism, and inequities.

Expanded Scope of Review

In addition to adding a review of deaths related to suicide and accidental overdose, we have continued expanding the scope of the overall review. We have included deaths from homicide where domestic violence and/or behavioral health conditions were also involved and deaths that occurred to Washington residents out of state. This expansion was based on feedback from the MMRP, CDC, and 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 domestic violence and law enforcement to assist us with reviewing homicide deaths.

The new MMRP has successfully reviewed maternal deaths from 2017 and 2020 and deaths that occurred out of state from 2014-2020. Our most recent report was published in early 2023 and included data on 2017-2020 maternal deaths. Information and recommendations related to the impact of COVID-19 on maternal deaths (based on the maternal mortality review findings) were also included.

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 5 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 timely way and increase activities for implementing the MMRP's recommendations as outlined in reports. These activities included hiring a program coordinator, prioritizing which recommendations to focus on for the next year, planning a stigma and bias training for perinatal care providers, and continuing work on a Centers of Excellence for Perinatal Substance Use certification program.

DOH manages contracts with 4 regional perinatal centers in Washington to coordinate and implement state and regional quality improvement projects to improve pregnancy and newborn outcomes.

WithinReach Parent Support Hotline

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

WithinReach's ParentHelp123.org resource website had 29,992 page views with 23,245 total unique page views in calendar year 2022.

WithinReach's Help Me Grow Washington (HMG-WA) Hotline is the state's maternal and child health hotline. During federal fiscal year (FFY) 2022, the hotline received and responded to 13,506 calls. Questions relating to food and nutrition resources generated the greatest number of inbound calls and resulted in 5,163 food assistance referrals and 5,715 referrals to WIC. Additional referrals were made for pregnancy-related services and determinants of health, including 654 referrals for housing assistance.

WithinReach provides health information in multiple languages for people whose first language is not English. During FFY 2022, the HMG-WA hotline received 1,186 phone calls in Spanish. The hotline averaged 365 non-English calls per quarter. Nearly all call center staff are bilingual, and nearly 99% of Spanish-language calls are completed without a third-person interpreter.

Local Health Jurisdictions Women and Maternal Health Work

Many of the LHJs chose to work on efforts to **collaborate with local community Maternal Child Health coalitions, hospitals, managed care organizations, and provider groups serving pregnant/postpartum women and infants to increase referrals and ensure eligible women and individuals have access to breast/chestfeeding information, mental and behavioral health, and necessary counseling and referrals.**

Seven LHJs selected activities to support this goal this program year. These included Benton-Franklin, Klickitat, Okanogan, Skagit, Tacoma-Pierce, Whatcom, and Yakima. Work with the breast/chestfeeding, including the Breast/chestfeeding coalitions, is listed in the Perinatal/Infant Health Domain. Breast/chestfeeding efforts include collaborating with community resources to serve pregnant and post-partum people to increase capacity for and access to lactation support. The following examples articulate county efforts related to this strategy that support the Women/Maternal Health Domain:

The majority of LHJs working on this strategy facilitated a variety of coalition meetings. **Benton-Franklin** conducted meetings with community partners, including Planned Parenthood, Catholic Youth and Family Services, Domestic Violence Services, and the Women's Mission to gauge interest in developing a workgroup focused on birth outcomes/perinatal health. This LHJ also worked with Performance Management and the CYSHCN Coordinator to identify the impacts and referral sources for postpartum people and infants diagnosed with Neonatal Abstinence Syndrome or Substance Exposed Newborns.

Klickitat held approximately 20 - 25 meetings with local partners to share and discuss approaches, concerns, and data related to the mental health needs of pregnant/postpartum individuals. Meeting attendees included OBGYNs, pediatricians, home health workers, behavioral health providers, peer counselors, health dept nurses, and community members with lived experience. These meetings helped LHJ staff build partnerships, gather, and share needed data

to develop a consistent community approach to address the mental health needs of pregnant/postpartum individuals.

In **Okanogan**, the LHJ staff participated in Perinatal Task force meetings and focused on increasing access to mental health and substance use disorder counseling and referrals. In **Skagit,** the focus has been on providing support for pregnant people and ensuring access to breast/chestfeeding information. The staff arranged for their Promotora to join a new WIC Breastfeeding Peer Counselor training to build relationships and acquaint them with ways to support infant feeding needs in their work, particularly with agricultural workers. The LHJ is planning to offer CMEs for health care providers during Breastfeeding Month in partnership with DOH Lactation and Infant Friendly Feeding Environments campaign.

For **Tacoma-Pierce**, the focus was on staffing and supporting the efforts of the Perinatal Collaborative of Pierce County (PCPC). The PCPC supports professional practice improvement and improvements in systems of perinatal health care. Services addressed by PCPC include prenatal education, breastfeeding support, nutrition, safety, and behavioral health. The LHJ staff collaborated with the PCPC Board of Directors to convene quarterly PCPC meetings to promote interagency communication and cooperation.

The LHJ serving **Whatcom** County chose to develop a local community standard of care around perinatal and infant mental health. This standard of care intends to increase community awareness of perinatal mood and anxiety disorders and normalize seeking support and skill-building during the transition to parenthood, expand and facilitate access to culturally responsive peer support for parents prenatal to 5 years postpartum. It will also help increase community capacity to therapeutically identify, refer, and treat families experiencing perinatal mood and anxiety disorders by providing training and consultation opportunities for different providers, including for health care, mental health, early learning and home visiting providers. This LHJ employed multiple means to address these activities, including providing training to community members, health care providers, and service providers, convening focus groups, and attending meetings of coalitions and other community serving organizations.

Yakima chose to identify existing community resources and find service and resource gaps. They worked with community partners serving pregnant and postpartum people to promote community resources and education, participated in local workgroup/meetings promoting the importance of perinatal and postpartum support services, to develop a pathway for breast/chestfeeding that assists the transition from hospital/home to assure all birthing individuals can receive breast/chestfeeding assistance if needed. They participated in local and statewide meetings to identify ways to support the coalitions and create local resources so that breast/chestfeeding assistance/education are equitable for all mothers. This LHJ also identified behavioral/mental health services available for all perinatal people and used the information to create a perinatal resource and referral handout. Finally, Yakima worked to identify who is receiving the Perinatal Mood and Anxiety Disorder screening and when they are receiving it. They also identified the tools that providers are using for the PMAD screening.

Identify strategies to improve access to affordable, quality health care, regardless of location, language spoken, gender identity, race, sexual orientation, or insurance status.
Mason county selected this strategy as one of their bodies of work. The LHJ connected with community providers to identify gaps and plan for serving the family planning and nutrition needs in their community after the loss of WIC and Planned Parenthood. The staff of this LHJ also worked on identifying and promoting supports for Spanish and Latin American indigenous language (Mam from Guatemala and Q'anjob'al from Guatemala and Mexico) speakers in their service population.

Other LHJs chose to work on **increasing connection to support services for parents, implementing and promoting fatherhood inclusion opportunities and support resources and promoting inclusion of**

additional people taking parenting roles, such as foster parents, grandparents, kinship care.

The LHJ serving **Cowlitz** chose to achieve this strategy by gathering information about community resources for fathers, attending Cowlitz Café Fatherhood Council Meeting, and sharing information about the importance of providing information to fathers. For example, LHJ staff attended the "Perinatal Mental Health Screening and Referrals for Moms and Dads in Cowlitz County"training. This training provided an opportunity to learn skills to make effective referrals for mothers and fathers who might be experiencing perinatal mood and/or anxiety disorders. Staff reported that the training was inclusive of fathers and highlighted their unique needs and the available resources that can be incorporated into future work with fathers.

Snohomish LHJ also chose to promote fatherhood inclusion opportunities with community partners. Their staff worked on exploring county groups already working with people in parenting roles (such as foster parents, grandparents) to identify ways to partner with them on CYSHCN issues.

In **Spokane**, the LHJ staff collaborated with Community Minded Enterprises (Help Me Grow lead) to assess existing referral practices of medical providers into community-based programming. Staff identified strengths, challenges, and opportunities to develop an integrated health and social services system to meet the needs of parents/caregivers of young children (ages birth-5). The LHJ disseminated findings and recommendations among community partners. Their staff promoted the use of home visiting services and the importance of creating social connections with other parents and trusted adults by using the existing peer support groups and community cafes. They also shared linkages to services that meet unique client or subpopulation gaps in care to address the impact of 'pair of ACEs' on equitable health outcomes. Staff implemented and promoted fatherhood inclusion opportunities and support resources.

Another focus for this LHJ was to develop and provide information on community-based parenting enrichment activities to cross-sector health and social services providers to increase the connectivity of parents/caregivers to services. Staff promoted including additional people in parenting roles, such as foster parents, grandparents, and kinship care providers. This LHJ also worked to identify and engage representatives from local home visiting programs to assess and compile information about each program's participation referral criteria. They developed an intra-agency referral process, centering the client's needs, and used a strengths-based approach to match them with the most appropriate program offerings.

Women/Maternal Health - Application Year

Women and Maternal Domain Plan for FY2024

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

State Performance Measures:
Substance use during pregnancy.

Provider screening of pregnant women for depression.

Objective:
By September 30, 2024, and in partnership with the Child Welfare Division at the Department of Children, Youth, and Families, WithinReach and the Washington State Hospital Association, implement the state's new portal and policy for infants who are born substance exposed, including promotion of supports for the substance-affected mother/infant dyad.

Strategies:

- Provide training for clinical staff providing care at birthing hospitals.
- Support efforts to address and mitigate individual and community effects of substance use.
- Build on efforts to identify the scope of impacts of substance use, including inequities, at the local and state level.
- Improve the care of infants with neonatal abstinence syndrome (NAS) and neonatal opioid withdrawal syndrome (NOWS).

In response to the Opioid Epidemic, Washington State created a state Opioid Taskforce and an Opioid and Overdose Response Plan (WA State - Opioid Response Plan). The Pregnant, Parenting, Children and Families (PPCF) workgroup is connected to the state's taskforce and works to address the impact of substance use on families. The MCHBG partially funds the coordination of this workgroup.

The workgroup's current initiatives intend to transform our systems of substance use care so parents can receive treatment without being separated from their children. During pregnancy/birth/postpartum, this means:

- Transforming prenatal care so anyone pregnant and using substances can easily get into prenatal care and substance use care, regardless of their ability to stop using substances or the stage of their pregnancy.
- Transform the provision of care at birth:
  - Make sure mothers/birth parents who are stable in recovery at birth room in with their babies and provide non-pharmacological supports for infant withdrawal.
  - Mothers/birth parents who aren't stable in recovery at birth can receive MOUD/withdrawal support/substance use treatment at the birthing hospital with their baby and then be directly transferred to residential/outpatient treatment without being separated from their baby.
- Streamlined access to intensive outpatient treatment models that provide housing and/or residential treatment that allows parents to bring their children with them.
  - Residential treatment models need to be in more communities and be able to accommodate fathers/partners and more children.
- Housing access:
  - Residential treatment wait times are currently 4-6 weeks, parents and children need housing while they wait to go to treatment. (Some LHJs are reporting they are putting people in hotels while they wait for treatment beds.)

    - Direct transfer to permanent housing when discharging from outpatient treatment/residential treatment. Transitioning to dyadic or couplet care at birth.
- Expanding hospital inpatient days and creating Medicaid payment for services.
- Establishing best practices, including withdrawal/stabilization care for mothers/birthparents and eat/sleep/console for infants.
- Increasing collaboration and communication between child welfare, birthing hospitals, and parents, when families are child welfare involved.
- Connecting families to services.
- Educating families and providers on harm reduction strategies for substance use and what to do for an overdose.

Projects we are supporting as we work to implement these changes are:

- Partner with the Health Care Authority to create payment structures for withdrawal/stabilization care at birth for mothers and birth parents using substances.
- Provide training and TA support for care providers disseminating the best practice lactation with substance use guidelines that DOH published in June 2023.
- Convene housing experts to strategically plan and develop cost estimates for a housing program for families impacted by substance use.
- Cross-walk the policies identified through the PRISM workgroup with PPCF's priorities.
- Convene the PPCF workgroup and maintaining the statewide website.
- Looking at policy changes needed to support birthing hospitals to dispense naloxone to all parents discharged after delivery.
- Resource WithinReach to build a self-referral portal, so mothers and birth parents who use substances during pregnancy can access a plan of safe care services during pregnancy.
- Support WithinReach and the Department of Children, Youth, and Families (DCYF) in training clinicians at birthing hospitals about Washington's new policy and program for mandated reporters so they know if a notification or report is needed when an infant is born substance exposed.

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

The report has been published, and we will continue to work on implementing its recommendations, as detailed below.

Objective:
Through September 30, 2025, building from the completion of the revised maternal mortality review panel report to the Washington State Legislature, DOH staff will share the findings widely with partners and community members around the state and participate in conversations about ways to involve community members in implementing recommendations. DOH will also include applying lessons learned from the AIHC listening sessions in our work to implement the report's recommendations.

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 the 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 (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 panel (MMRP/Panel) is to understand the root cause of maternal mortality and morbidity and the inequities therein, so DOH 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 MMRP comprises of clinical and non-clinical professionals from across Washington and from diverse racial/ethnic, geographic, and professional backgrounds. Members include perinatal psychiatrists, addiction medicine providers, perinatal social workers, community organizations, patients, and patient advocates.

To meet these goals, the department and MMRP 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, identify the issues and factors that contributed to them, and make recommendations to prevent such deaths in the future. The panel and the department use analyses of data and findings to prioritize evidence-based recommendations for health care and systems changes. The department submits those findings and recommendations to policymakers for consideration in a legislative report every 3 years.

To date, the Panel has reviewed maternal deaths from 2014-2020. This includes deaths from substance overdose, suicide, and domestic violence. The most recent report, published in February 2023, included findings from deaths through 2020. This report's findings included:

From 2014–2020, 224 people died within one year of pregnancy. Of these deaths, 97 were determined to be pregnancy related. The Panel determined 80% of pregnancy-related deaths were preventable—a high percentage that reflects the Panel's growing understanding of clinical, social, and systems factors that can be changed to help prevent pregnancy-related deaths.

There were 15.9 pregnancy-related deaths per 100,000 live births from 2014–2020 in Washington, lower than the U.S. rate of 18.6 pregnancy-related deaths per 100,000 live births in this timeframe. Leading underlying causes of pregnancy-related deaths were behavioral health conditions (32%), predominantly by suicide and overdose. Other common causes included hemorrhage (12%) and infection (9%).

Most pregnancy-related deaths occurred after the end of pregnancy:

- 27% occurred during pregnancy
- 11% occurred during delivery
- 31% occurred 2–42 days after pregnancy
- 31% occurred 43 days to one year after pregnancy

Disparities persisted, with communities of color, rural communities, and people with Medicaid coverage bearing a disproportionate burden of maternal mortality. The Panel identified discrimination, bias, and interpersonal or structural racism in 49% of preventable pregnancy-related deaths from 2017–2020. The rate of all pregnancy-associated deaths for non-Hispanic Black/African American people and non-Hispanic Native Hawaiian and Pacific Islander people was more than 2.5 times the rate of death among non-Hispanic White people. Among non-Hispanic American Indian and Alaska Native people, it was 8.5 times greater than the rate of death among non-Hispanic white people.

Factors identified by the MMRP to have contributed to preventable deaths from behavioral health conditions included:

- Gaps in clinical skills and quality of care contributed to the high percentage of preventable maternal deaths, including gaps in recognizing and responding to obstetric emergencies.
- Lack of screening or appropriate follow-up for risk factors such as behavioral health conditions, violence, and insufficient social support
- Lack of care coordination or continuity of care
- Lack of access to health care and behavioral health treatment
- Issues of bias and discrimination affecting referrals and use of clinical standard procedures

Contributing factors were exacerbated by social and structural determinants of health, such as housing instability and systemic racism.

Work has already begun to publicize the findings and recommendations of the report and spark conversations about implementing the recommendations based on these findings. However, this work has only recently started since the report was released in February 2023. There has been high interest among the public and partners in the increased percentage of pregnancy-related deaths considered to be preventable, particularly in how this reflects an improved understanding of preventability and the opportunity to take action.

Additionally, more work is needed to continually improve our understanding of how to create a systemic change that addresses the root causes of disparities, including racism, and to eliminate those disparities. It is essential to conduct comprehensive maternal mortality reviews of these types of deaths to continue supporting our implementation of recommendations and determine where interventions are needed most.

In the upcoming 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:

- Support the newly recruited 2023–2025 MMRP cohort, which has increased health equity expertise, lived experience, and other expertise areas and affiliations.
- Provide access to health equity and anti-racism learning and other educational opportunities for the MMRP.
- Work with the CDC to align practices of identifying discrimination, racism, bias, and stigma in the deaths we review to make recommendations for change using data from the maternal mortality review work. This includes participating in monthly workgroups/meetings and collaborating 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.

- Continue to learn from and share information with other states' maternal mortality review processes to improve our focus on health equity.
- Consult with agency health equity experts to implement and evaluate a health equity training/learning plan for all MMRP.

Move forward with a next stage of the listening sessions with the American Indian Health Commission (AIHC) and hope to learn more about how to better collaborate with these partners. This includes supporting AIHC in helping entities (including the MMRP) apply the findings from the appendix AIHC provided in the 2023 MMRP report. DOH will also work with AIHC to conduct listening sessions with all of the Tribes around the state to discuss the results of the MMRP and to gather feedback on the report recommendations, discover what individual communities are already doing, and to gain an understanding of the interest of Tribal communities for a Tribally lead MMRP.

Now that the 2023 report has been released, DOH staff will share the findings widely with partners and community members around the state and participate in conversations about ways to involve community members in implementing recommendations. DOH will also include applying lessons learned from the AIHC listening sessions in our work to implement the report's recommendations.

Implementing MMRP recommendations:
Planned activities to implement recommendations from the MMRP report:

Smooth Transitions*:* The Washington State Perinatal Collaborative supports the Smooth Transitions program through funding from the CDC. Smooth Transitions, a program of the Foundation for Health Care Quality, enhances the safety of hospital transfers and will bring together community midwives, hospital providers and staff, and EMS personnel to build a collaborative model of care. Smooth Transitions will begin work on protected case reviews related to transfers, pilot an EMS learning module simulation training, and develop resources for midwives, birth centers, and hospitals through our support.

Substance Use Disorder and Lactation Guidelines: DOH finalized Substance Use Disorder (SUD) Lactation Guidelines in May 2023. Once the guidelines are complete, we will work with the DOH communications team to develop and disseminate materials for providers and patients over the next year. We will distribute the guidelines to statewide partners and integrate them into the Perinatal SUD Learning Collaborative toolkit.

Blue Band Initiative: DOH will pilot test the Blue Band project, which addresses pre-eclampsia and postpartum post hypertension. Through the Washington State Perinatal Collaborative, DOH will build a resource website and assist hospitals in the implementation of the blue band project.

TeamBirth: In March 2023, WSHA will begin implementation of TeamBirth with its first cohort. According to WSHA, "**TeamBirth aims to target poor maternal and newborn outcomes that occur as a result of those failures by providing a framework for shared decision making and amplifying the birthing person's voice".** Over the next 3 years, Washington state birthing hospitals will participate in 1 of 4 cohorts. Each cohort will receive personalized training, support, and materials for implementation in their facility.

Objective:
Through September 2025, ensure 80 percent of birthing hospitals in Washington state have established processes to universally screen everyone giving birth for substance use disorders and perinatal mood and anxiety disorders as part of the Alliance for Innovation on Maternal Health (AIM) patient safety maternal mental health protocols.

Strategies:

- 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 increasing 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 nationally by severe maternal morbidities each year.[3] The CDC estimates that one in 8 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 2014-2020, at least 80% of pregnancy-related deaths were preventable. The leading causes of pregnancy-related deaths were associated with behavioral health conditions, including suicide and accidental overdose. According to our Pregnancy Risk Assessment Monitoring System (PRAMS) data, in 2018, 11% of women interviewed expressed experiencing postpartum depression symptoms.

In October 2022, DOH was awarded a federal grant to enhance our Perinatal Quality Collaborative and our ability to implement perinatal quality improvement initiatives. Through this grant, the PQC will support AIM initiatives and other projects related to perinatal substance use.

Through the PQC, DOH and WSHA collaborate on AIM implementation efforts. In 2021, DOH and WSHA created the Perinatal Substance Use Disorder Learning Collaborative. This collaborative worked with 13 hospitals to pilot test the Obstetric Care for Women with Opioid Use Disorder patient safety bundle. In 2022, this bundle was expanded to include training and support for all substances, not just opioids.
The Perinatal Substance Use Disorder Learning Collaborative now supports over 80% of birthing hospitals in Washington by providing monthly educational webinars and peer-coaching calls. It also helps hospitals become certified as a Center of Excellence for Perinatal Substance Use. This certificate awards and recognizes hospitals that follow best practices when caring for people and infants impacted by substance use. These criteria will include verbally screening every person giving birth for substance use disorders and perinatal mood and anxiety disorders, and implementing hospital policies and support for pregnant and parenting individuals who screen positive for a substance use disorder. Additionally, WSHA and DOH launched a Perinatal Substance Use Learning Collaborative that offers monthly learning sessions and a toolkit of resources to support hospitals in implementing bundle components and becoming a Center of Excellence for Perinatal Substance Use.

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

National Performance Measure:

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

Objective:
Through September 2025, collaborate with community birth experts from the doula, home visiting, nursing, and community health worker workforce, to identify a process for birth equity priorities and funds distribution and program development in line with anti-racist values.

Strategies:

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

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

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

To address disparities in birth outcome among communities of color, particularly the Black/African American, and American Indian/Alaska Native community, DOH has committed to funding projects that directly support community birth worker projects serving those communities.

DOH conducted a series of listening sessions and worked closely with a community advisory board to identify investment areas. The listening sessions highlighted the systemic racism that birth workers and birthing families experience in Washington’s Western medical establishments. Themes from these listening sessions included:

- Racism creates barriers to care and prevents the delivery of culturally appropriate care.
- Racism negatively affects the physical, emotional, and spiritual health of birth workers and the families they serve.
- Our systems have undermined the credentials of birth workers and failed to recognize lived experience as an asset.
- There is a deep need for allyship, mentorship, and co-conspirators within the birth worker community.

Our community advisory board further defined birth equity as:

- Birthing people are healthy and can have a birth the way they want it.
- Birthing people are treated as experts in their own care, and their concerns are taken seriously.
- Birthing people have access to resources without fear of discrimination, violence, or deportation.
- Birthing people have access to care that incorporates both Western medicine and traditional practices.
- Birthing people have access to doulas and midwives.

Based on this feedback, DOH has contracted with 6 community-based organizations that provide wraparound, culturally appropriate care for pregnant and parenting families. Throughout the next year, DOH will support these partners in implementing their projects.

- Contractors will work collaboratively with a DOH evaluator to create an evaluation plan and define what success will look like for their project.
- Host summits twice a year to encourage networking between grantees and sharing best practices.
- Identify areas for technical assistance to support grantee success.
- Support grantees in developing sustainability plans for their projects.
- Provide fiscal support to ensure timely payment for deliverables.

DOH will also continue to meet with the community advisory committee. The meetings will serve as an opportunity for community accountability and awareness of DOH investments and to provide feedback on other DOH projects.

The funded partners are:

Ayan Maternity Health Care Support provides culturally relevant wraparound perinatal support services and professional development opportunities to East African immigrants and refugees in King County. Their project will include a 6-week perinatal class on pregnancy and wellness, labor and delivery, maternal mental health, and preparing for parenthood. They will use the grant funds to provide doula services, lactation support, childbirth education, and early parenting support to clients. Funds will also support annual workshops to build workforce capacity and educational opportunities for East African doulas.

BLKBRY offers culturally responsive, evidence and practice-based interventions to reduce the effects of structural racism for families in the Burien area. BLKBRY strives to fill the gaps of missing culturally responsive care and resources in Black/African American reproductive, perinatal, lactation support, and Black/African American infant and toddler health care. This grant funding will support no-cost classes for Black/African American pregnant and birthing people and access to Black/African American-owned reproductive and perinatal products. BLKBRY will use the funds to continue staff education, expand doula and lactation support to Black/African American pregnant and birthing families, and cultivate community spaces to support and share information about birthing work.

Nisqually Tribal Health and Wellness Center serves American Indian/Alaska Natives living in Thurston County and Nisqually Tribal Members and their families. They plan to expand their perinatal health services to include postpartum doula care, group prenatal care classes, lactation education, a dental program, and a Traditional Healing program. Their project will launch new initiatives, including training birth workers on Indigenous Lactation Counseling and developing a new perinatal mental health program.

Shades of Motherhood serves Black/African American mothers, people of color, and their infants in Spokane. They support people in overcoming barriers to care and health equity. Shades of Motherhood centers Black/African American mothers and birthing people through education, empowerment, and community to reduce health inequities. Their program will expand access to peer support, childbirth education, lactation support, reproductive support, perinatal mental health support groups, and birthing and perinatal supplies. They will also host community outreach events to help connect Black/African American families to resources and promote birth equity awareness in the Spokane community.

Spokane Tribal Network is partnering with Həlmxiłp (Cedar Circle) Indigenous Birth Justice (HIBJ) to improve reproductive health in rural and urban areas in and around Spokane. The Spokane Tribal Network is a non-profit based on the Spokane Indian Reservation. HIBJ is a new Native-led non-profit with a vision to ensure all American Indian/Alaska Native people experience culturally responsive reproductive health without passing the burden of trauma from one generation to the next. Through this partnership, their project will support doula services to urban and rural families, ceremonial training, and birth advocacy. They will also offer prenatal and postpartum culture-based group care to pregnant American Indian/Alaska Native families. Grant funds will help support interested American Indian/Alaska Native community members to become doulas, birth advocates, and ceremonial mentors.

Global Perinatal Services has expanded their services for Black/African American birthing families in King County. These wraparound services include childbirth education classes, pre and postnatal lactation education, doula services, and parent support groups.

Objective:
Through September 30, 2025, 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.

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. Significant barriers made this amendment unfeasible at this time. The minimum standards within this law are general, and this proposed amendment would open the door for a change in the scope towards more specialized standards. It could take years to progress and have minimal impact on the reach of training materials.

DOH staff continue to explore opportunities to promote awareness around perinatal behavioral health and suicide prevention.

In spring 2021, DOH released a request for applications to fund projects that meet the MMRP's recommendation to "increase knowledge and skill of providers, patients, and families about behavioral health conditions during and after pregnancy, and the treatment and resources that are available for support." These projects aim to support maternal Medication Assisted Treatment (MAT) programs, increase perinatal peer support groups and services, and offer provider trainings to improve perinatal behavioral health skills. DOH will continue to support and offer TA for the community grants through August 2024. We will assess the success of the grants through monthly check-ins and quarterly reports that grantees will submit outlining their progress toward their goals and objectives.

In partnership with the University of Washington Department of Medicine, DOH will continue to offer the MMRP ECHO (Extension for Community Healthcare Outcomes) series for Washington State providers. The CME-accredited program addresses mortality risks and provides education to improve care for perinatal patients. They will include components that guide the evaluation of the severity of any identified risk, preparing a risk mitigation plan, and initiating a team-based care approach within the care setting. Participants will learn to address causes of maternal mortality as identified in the 2023 Maternal Mortality Review Panel report – with sessions focused on behavioral health, and suicide risk and accidental overdose.

Objective:
By December 2025, continue to collaborate with tribal partners to meet the needs of Tribal communities impacted by maternal mortality through additional listening sessions and data 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.

There is increased interest in and work around establishing a tribal review committee or subgroup of the existing MMRP that reviews tribal-related maternal deaths. As part of this work, DOH is exploring whether this endeavor is something tribal communities want and what resources and supports they need. Part of this exploration would be determining whether this would be a subgroup of the MMRP, an enhanced supplemental part of the existing MMRP process (but not distinct or separate), or a distinct process from the MMRP.

We will work closely with our DOH tribal liaison and other tribal partners to plan what an exploration would entail. It may include a series of key informant interviews or focus groups with tribal leaders and health-related organizations to explore options, goals, and priorities of a tribal-led review. We would also identify the types of resources, funding, and technical assistance necessary to support such an effort and the potential challenges and barriers that would need to be addressed.

Additionally, DOH has limited access to tribal clinic health records and tribal law enforcement records related to the death of a pregnant person within a year of their death. While this data is important for a comprehensive case review of maternal death, it raises questions about privacy and data sovereignty.

To gather more information and context about what barriers exist to gathering tribal data and what factors impact whether tribes and urban Indian health organizations grant permission to DOH to request tribal records, we will engage in internal and external data consultation. This may include discussion with the DOH tribal liaison and initiating conversation with tribal leaders and members, as well as consulting with experts in the field of data collection and privacy. We will review and apply the guidance and recommendations found in the Addendum Report from the American Indian Health Commission to direct our consultative process. We will also use this project to better understand tribal perspectives on including interviews in our case narrative development process and how we would include the findings from these interviews in our case narratives. Ultimately, the decision about whether or how to collect this data should be guided by a commitment to transparency, data sovereignty, and respect for tribal nations and their unique cultural values and traditions. We are committed to respecting these rights and working collaboratively with tribal nations to develop data-sharing agreements or processes that reflect their priorities and values.

Objective:
By December 31st, 2023, support access to prenatal genetic services.
By December 2023, collect and analyze service utilization data on patients utilizing prenatal genetics services, and disseminate the information to our stakeholders.

- **Strategy:**
  In collaboration with our clinical partners, assure access to prenatal genetic services in rural and/or underserved communities.

- Provide technical assistance by offering all prenatal genetics providers a paid subscription access to the

Teratogen Information System Database (TERIS) to better assess risks of medications and exposures during pregnancy.

- Disseminate data and trends on service utilization of prenatal genetic services to stakeholders.

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[1] Centers for Disease Control and Prevention. (2019). Pregnancy Mortality Surveillance System. Reproductive Health. Found at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Freproductivehealth%2Fmaternalinfanthealth%2Fpmss.html

[2] Singh GK. Maternal Mortality in the United States, 1935-2007: Substantial Racial/Ethnic, Socioeconomic, and Geographic Disparities Persist. A 75th Anniversary Publication. Health Resources and Services Administration, Maternal and Child Health Bureau. Rockville, Maryland: U.S. Department of Health and Human Services; 2010. Found at: https://www.hrsa.gov/sites/default/files/ourstories/mchb75th/mchb75maternalmortality.pdf

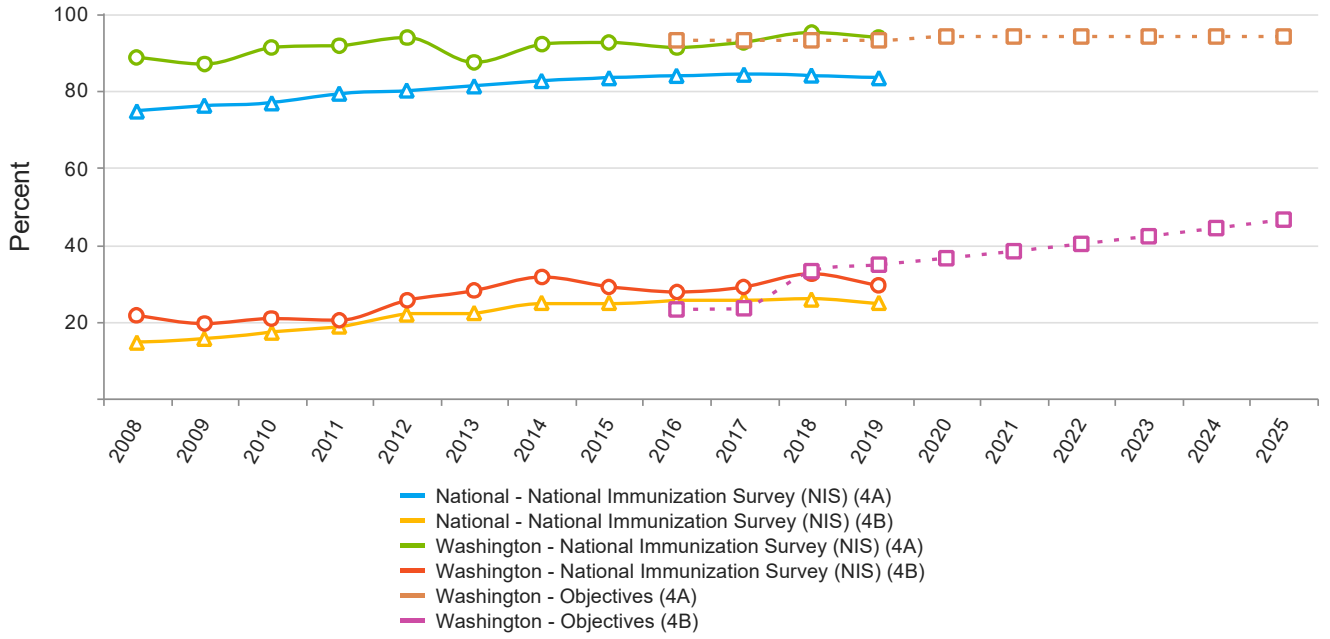
[3] Callaghan, W. M., MacKay, A. P., & Berg, C. J. (2008). Identification of severe maternal morbidity during delivery hospitalizations, United States, 1991-2003. *American Journal of Obstetrics and Gynecology*, *199*(2), 133. Found at https://www.sciencedirect.com/science/article/abs/pii/S0002937807023320

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

Perinatal/Infant Health

National Performance Measures

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	93	93	94	94	94
Annual Indicator	92.4	91.0	92.5	93.7	93.7
Numerator	80,672	71,525	75,591	74,617	74,617
Denominator	87,274	78,591	81,714	79,628	79,628
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2019	2019

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	93	93	94	94	94
Annual Indicator	94.2	94.1	94.1	94.4	93.8
Numerator	80,140	79,016	79,016	77,512	76,241
Denominator	85,113	83,941	83,941	82,148	81,299
Data Source	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate
Data Source Year	2018	2019	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	33.1	34.8	36.5	40.2	40.2
Annual Indicator	29.1	27.6	28.9	29.5	29.5
Numerator	24,761	20,413	23,021	22,749	22,749
Denominator	84,974	74,010	79,683	77,059	77,059
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2019	2019

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

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator		20.3
Numerator		12
Denominator		59
Data Source		DOH
Data Source Year		2022
Provisional or Final ?		Final

Annual Objectives			
	2023	2024	2025
Annual Objective	34.0	44.0	54.0

State Performance Measures

SPM 3 - Universal developmental screening system participation

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			0
Annual Indicator			0
Numerator			
Denominator			
Data Source			DOH
Data Source Year			2023
Provisional or Final ?			Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	0.0	0.0	0.0

State Action Plan Table

State Action Plan Table (Washington) - Perinatal/Infant Health - Entry 1
Priority Need
Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.
NPM
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Objectives
Annually, partner with at least eight local health jurisdictions to offer perinatal home visitation services to low income women in local communities, supporting well-newborn visits, on-schedule vaccination, and breastfeeding initiation/sustenance.
Continue to promote awareness and training opportunities to health care providers on provider bias and disparities on an ongoing basis.
By September 20, 2025, in partnership with Child Protective Services at the Department of Children, Youth, and Families and Help Me Grow, finalize piloting the diagnostic definition for neonatal abstinence syndrome as a central component to improve care of substance-affected newborns in Yakima and Pierce counties.
By December 31, 2023, complete the development of a new data system for the Birth Defects Surveillance System (BDSS), which will combine birth defects reporting data from providers and facilities with existing information from vital statistics, including birth, death, fetal death, and hospital discharge data.

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

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

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

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

Priority Need

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

SPM

SPM 3 - Universal developmental screening system participation

Objectives

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

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

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

By February 1, 2024, launch statewide roll-out of implementation phase of new developmental screening program, working with early childhood partners as part of a statewide effort to increase developmental screening rates and connection to responsive services.

By December 2023, support access to pediatric genetic services and disseminate data and trends on clinical genetic services and CCHD hospital summary reports to stakeholders.

Strategies

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

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

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

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

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

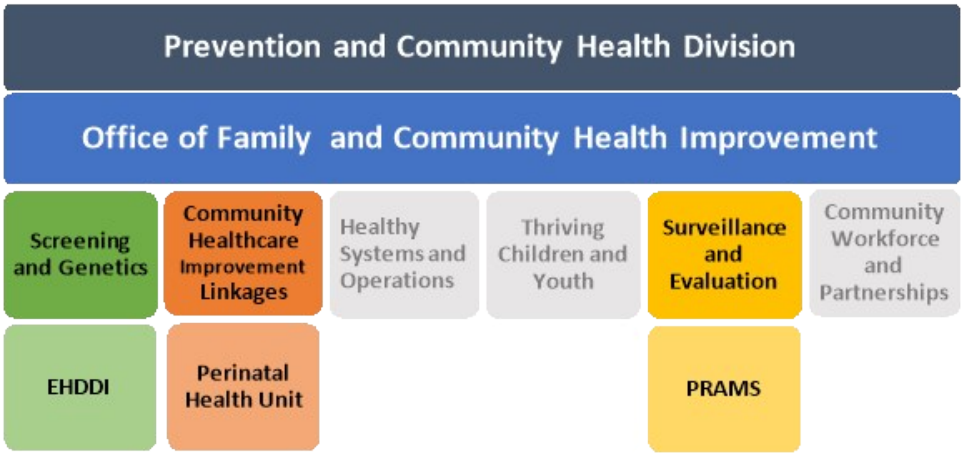
Engage partners and stakeholders, including those in historically marginalized communities, to promote the value of universal developmental screening and use of the data system. Provide training and technical support to data system end users. Conduct data analysis and generate reports to inform decision-making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

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

Support access to pediatric genetic services.

Conduct data analyses and create summary reports for birth hospitals and midwifery clinics on Critical Congenital Heart Disease (CCHD) diagnoses data.

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



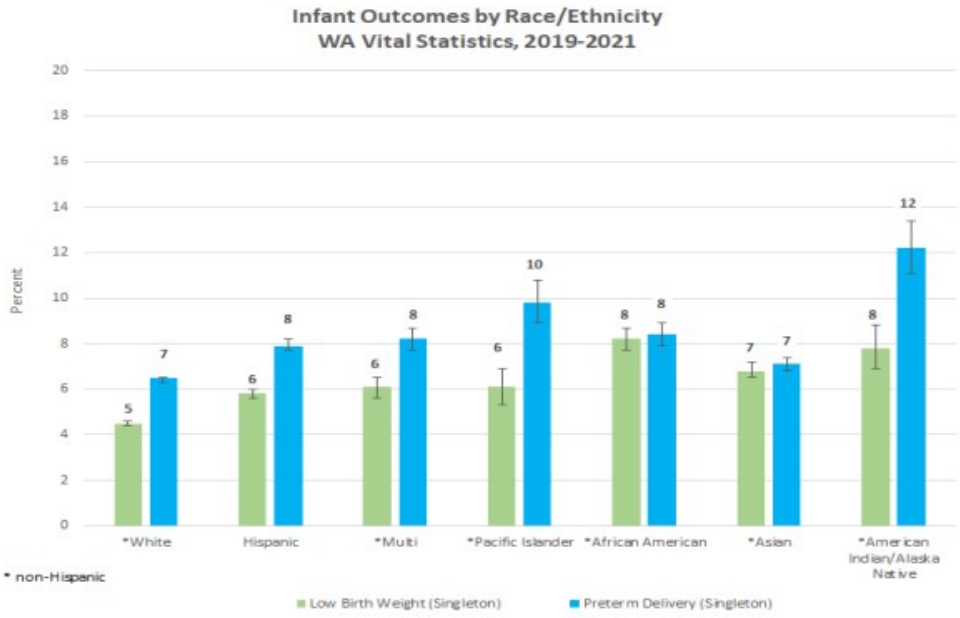
Perinatal and Infant Health Domain Annual Report

Overview

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

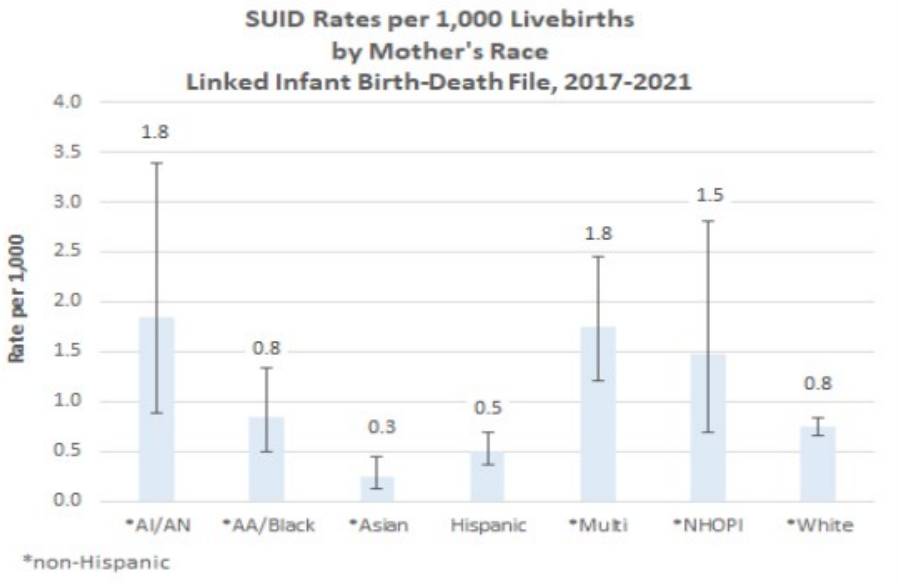
In 2021, there were 83,899 births to Washington residents. In 2021, 57% of births were to white, 20% to Hispanic, 11% to Asian, 5% to Black/African American, 1% to American Indian/Alaska Native, 1.5% to Native Hawaiian or other Pacific Islander, and 5% to multiracial people. Births have become more racially diverse over the past 10 years, decreasing among white and American Indian/Alaska Native, while increasing among Asian, Black/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). Low birth weight among singleton deliveries was highest among American Indian/Alaska Native, 9%, Black/African American, 8%, and Asian and Native Hawaiian/Pacific Islander, both at 7%. Singleton Pre-term deliveries were more common among American Indian/Alaska Native, 13%, Native Hawaiian/Pacific Islander 11%, and Black/African American, 9%. Infant mortality (infant deaths per 1,000 live births) also demonstrated disparities. Using a 5-year roll-up of data, non-Hispanic Asian had the lowest rate of any group in the state at 2.8/1,000. Black/African American, at 8.3/1,000, and American Indian/Alaska Native at 7.4/1,000, were the two highest rates. But given the small absolute numbers (e.g., 40 over 5 years for non-Hispanic Native American/Alaska Native), their confidence intervals are wide and, in some cases, overlap with other groups, indicating an inherent instability in the estimate itself.



In 2021, 88% of non-Medicaid-covered mothers reported placing infants to sleep on their back (the preferred method for minimizing the risk of sudden unexpected infant death [SUID]), compared with 78% of Medicaid-covered mothers, as statistically significant difference. Infants sleeping on stomach, a known risk factor for SUID, was reported by 3% of Medicaid-covered and 4% of non-Medicaid-covered individuals, not a statistically significant difference. (PRAMS)

The overall SUID death rate has remained steady at 0.7 per 1,000 infants since 2019. Using a 5-year roll-up from 2017 to 2021, the SUID rate per 1,000 infants significantly differed among 2 racial and ethnic groups. The non-Hispanic Asian rate, 0.3 per 1,000 births, was lowest among all groups. The non-Hispanic Native American/Alaska Native rate, 1.8 per 1,000 births, was the highest. Other racial/ethnic groups are shown in the graph below.



The Perinatal Health unit offers resources and technical assistance to parents, childcare, foster care, group care,

juvenile and correctional institutions, community action groups, and others on how to prepare to and to keep infants safe and healthy. We work with many organizations to promote health care standards for infants and pregnant women.

The DOH Screening and Genetics Section contains 3 programs relevant to infant and perinatal health. The Genetic Services program promotes early identification of individuals with, or at risk of, genetic disorders or birth defects. and connects people with the health and social services resources they need. And the Universal Developmental Screening (UDS) program is home to Washington state's Strong Start UDS system, a secure web application where parents and providers can track their children's developmental screenings. The Early Hearing Detection, Diagnosis and Intervention (EHDDI) program ensures that infants who are deaf or hard of hearing are identified and enrolled in early support services as early as possible. The EHDDI program's goals follow the national recommendations that every child receive a hearing screening by one month of age, those who do not pass screening receive a diagnostic evaluation by three months of age, and infants identified as deaf or hard of hearing are enrolled in early support services by six months of age.

In 2021, 99% 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% in 2011 to approximately 66% in 2021 by 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 after not passing their newborn hearing screening from 24% in 2011 to 5% in 2021 (as of October 2022). However, challenges still exist in the Washington state EHDDI system. For example, too many infants do not receive timely diagnostic evaluations. In 2021, only 52% of infants identified as deaf or hard of hearing were identified by 3 months of age, as is nationally recommended.

PRAMS is a survey conducted by DOH's Surveillance and Evaluation section and the Centers for Disease Control and Prevention (CDC). This survey gathers information from new mothers about their experiences before, during, and after their most recent pregnancy. In this report PRAMS data are used as Performance Measures in and of themselves, as well as to augment other data sources used for Performance Measures, such as the National Immunization Survey.

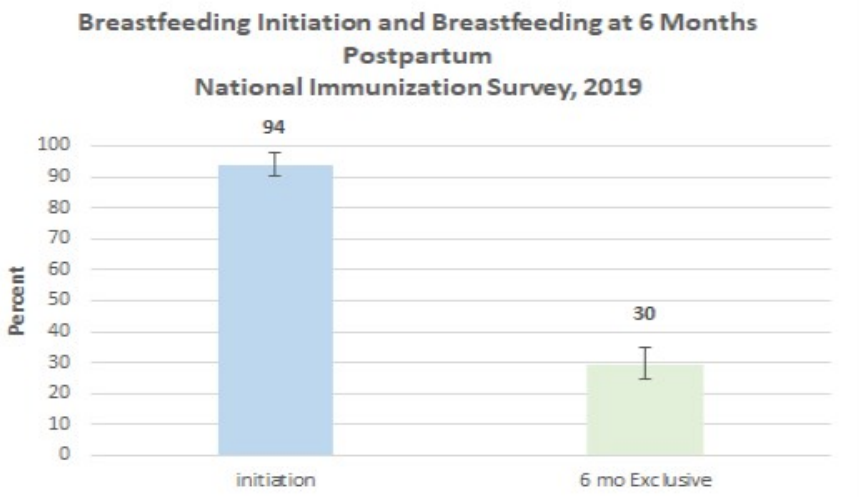
National Performance Measure 4 - Breastfeeding

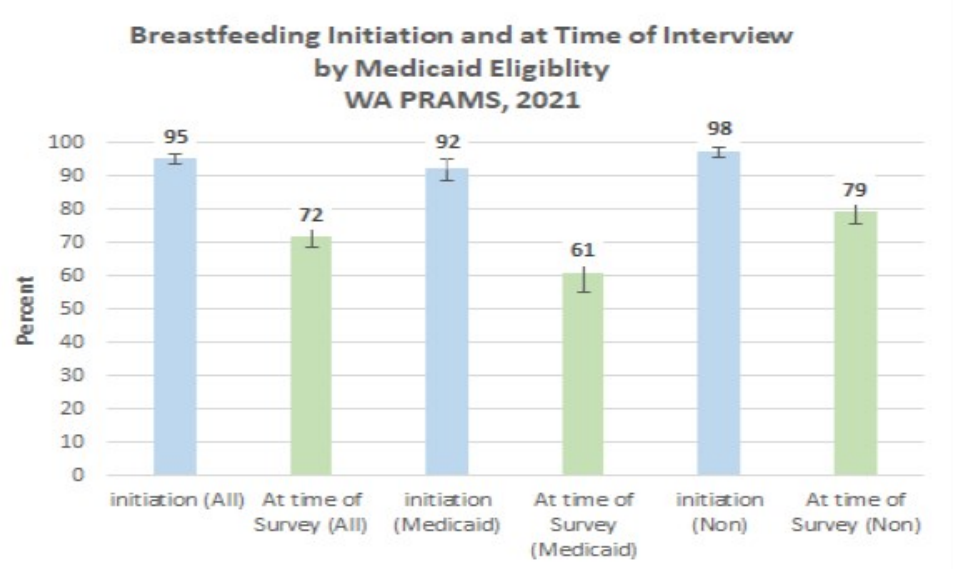
Percent of infants who are ever breast/chestfeeding

For 2018, the most recent year for which data are available, 94% of infants in Washington State were reported to have initiated breast/chestfeeding. (National Immunization Survey [NIS]) According to the WA PRAMS survey in 2021 95% of respondents reported to have initiated breast/chestfeeding. (PRAMS)

Percent of infants breastfed exclusively through 6 months.

For 2018, the most recent year for which data are available, 30% of infants in Washington State were exclusively breast/chestfed for 6 months. (NIS) According to the 2021 WA PRAMS survey, at the time of interview, typically 2-4 months post-partum, 72% of respondents reported current breast/chestfeeding. Disparities between respondents who had their delivery paid for by Medicaid were evident with respondents eligible for Medicaid much less likely to be feeding at this time, 61% vs. 79%, then those who were not. (PRAMS)





According to the 2020 CDC Breastfeeding Report Card, data on Washington State showed the percentage of infants born in 2017 who were ever breastfed was 92.5%, an increase from 87% in 2013 before the Breastfeeding Friendly Washington program launched. The percentage of infants who were exclusively breastfed through 6 months was 28.9%, compared to 28.0% in 2013. These rates are above the national average. In 2022, DOH updated its state report on postpartum breastfeeding, which addresses overall breastfeeding rates and rates for specific populations, including those receiving Medicaid benefits, racial and ethnic populations, and by maternal age.

Hospitals play an important role in supporting breast/chestfeeding. 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 several years ago that becoming a Baby-Friendly designated hospital may be administratively and financially challenging for facilities. Therefore, we designed the Lactation and Infant Feeding-Friendly Environments (LIFE), a no fees program, to promote and support breast/chestfeeding in our state, even for hospitals with financial barriers to becoming Baby-Friendly.

In late 2015, DOH launched the LIFE recognition program for hospitals. We started the same program for free-

standing birth centers in early 2016. In 2017 we launched a clinic program for all health care facilities serving pregnant and breast/chestfeeding parents or breast/chestfed babies and children.

Our evidence-based strategy measure (ESM) is the percentage of eligible LIFE certified hospitals, clinics, and free-standing birth centers (59 total) that have been enrolled. At present LIFE has enrolled 12 out of 59 eligible facilities. This includes 9 of 37 hospitals and 3 of 8 free standing birth centers. At the time of submission there were 4 more hospitals and 4 clinics that were in the process of enrolling. Those are expected to come on board in 2023 and 2024.

LIFE, along with Breastfeeding Workgroup, coordinates breast/chestfeeding related activities in our state. The workgroup includes representatives from the American Indian Health Commission (AIHC), the Breastfeeding Coalition of Washington and local breastfeeding coalitions, the Women, Infants, and Children Nutrition Program (WIC), and Title V staff, including the Perinatal/Infant Nurse Consultant. The Lactation Friendly Environments Coordinator, in the Healthy Eating and Active Living Program, manages this program. Their responsibilities include:

- Manages the Lactation and Infant Friendly Environments project
- Helps implement the local strategies for Physical Activity and Nutrition program, managing contracts and providing professional consultation to communities
- Facilitates Lactation Workgroup
- Works with internal and external partners to improve lactation support throughout the state, prioritizing populations experiencing disparities in breast/chestfeeding rates and maternal and child health
- Assists in developing, implementing, and reporting on grant applications for the CDC, Maternal and Child Health Block Grant, and WIC USDA grants
- Provides professional consultation to partners to improve lactation support and accessibility in worksites, healthcare settings, and communities

- Develops communication products for communities and agency leadership on related best practices as described on the DOH Lactation website
- Conducts policy analysis, including state bill analysis, related to lactation
- Our Children and Youth with Special Health Care Needs (CYSHCN) program continued contract activities with nutritionists at the UW Institute on Human Development and Disability to promote and support access to registered dietitian nutritionists and interdisciplinary feeding teams trained in working with families with CYSHCN including infants experiencing feeding difficulties. In 2022 the Washington Legislature passed E2SSB 5702, which requires health plans and Medicaid to provide coverage for donor human milk and human milk derived products prescribed for inpatient use. The bill also requires the department to develop minimum standards (RCW 43.70.645) to ensure milk bank safety for human milk and human milk derived products.
- Access to human milk improves health outcomes for infants, including a reduced risk of infections and sudden infant death syndrome. The legislation seeks to provide access to human milk and human milk derived products for the state's medically fragile infants and to ensure safety of human milk and human milk derived products.

The Watch Me Grow System continued to include breast/chestfeeding information to families with young children in regular mailings to parents. These mailings include a wide variety of information for new parents. Local WIC agencies continued to provide breast/chestfeeding education and support. Title V staff continued to disseminate information to the public on the importance of breast/chestfeeding, including through social media and our webpage.

Birth Defects Surveillance System

The Washington State Birth Defects Surveillance System (BDSS) began in 1986 as an active statewide surveillance system. In 1992, BDSS changed to a passive surveillance system that relies on hospitals to report cases of children with birth defects. About 40 priority facilities report to the Washington BDSS monthly. BDSS monitors the occurrence of the sentinel 9 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. They can 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, accounting for 22% of infant deaths in 2021.

The current BDSS data system is over 20 years old and has never been fully functional. The development of a new BDSS data system will provide timely and complete birth defects data for Washington and integrate the use of health information exchange (HIE).

We experienced unexpected delays in the BDSS data system development in 2022 and early 2023. However, data system development is currently progressing, and we anticipate importing legacy birth defects data into the new system by the end of the year. In addition, the Center for Health Statistics is currently developing data linkage processes that will link BDSS data with birth, death, fetal death, and hospital discharge data on a monthly basis, at minimum. This work is anticipated to be completed by the end of the year. Linking data will allow for more complex analyses and a better understanding of the risk factors associated with birth defects in Washington. We expect that the linkage to vital statistics data may also identify a small number of children with birth defects born in facilities that do 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 overarching goal of the BDSS is to decrease or mitigate the impact of birth defects on children, families, and communities.

State Performance Measure 3 - Universal Developmental Screening system participation

Universal Developmental Screening

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 DOH's request for funding to develop a statewide data system to track developmental screening of children birth through age 5 – Strong Start system. The project was funded through September 2021 using a 90/10 match from Centers for Medicare and Medicaid (CMS). The 2021 Legislature approved general state funding for ongoing maintenance and support.

The system went live in fall 2021 and DOH began a focused soft launch with the Washington Chapter of the American Academy of Pediatrics (WCAAP) Bright Futures Learning Collaborative with two community health centers. Additionally, outreach began to Help Me Grow partners, Local Health Jurisdictions (LHJs), and Tribal partners and communities. This marked the beginning of a phased implementation, with plans for a statewide rollout in 2023.

The Legislature approved additional funding in the 2021-2023 biennium for UDS system maintenance and operation and to create a dedicated UDS program within the Office of Family and Community Health Improvement. The UDS program was established in April 2022 with the appointment of a 1.0 FTE Program Manager. Two 1.0 FTE program staff were hired and onboarded: UDS System Support Consultant and UDS Education and Outreach Consultant in July 2022. A .50 FTE epidemiologist also supports the program. A Business Analyst from DOH Health Technology Solutions provides as-needed support for ongoing maintenance and operations of the data system.

The program staff have been actively engaged in outreach across the state. They are developing communication materials and working with the UDS system vendor to make ongoing improvements. They meet monthly with key state partners such as Help Me Grow and the Department of Children, Youth and Families. They're also offering technical training in Spanish and English to potential users to help them understand the new system.
The UDS program promoted the system to LHJs and tribal leaders at the Washington State Public Health Association in October 2022. Before the statewide rollout, the program anticipates doing UDS pilots with some partners in 2023.

Early Hearing Detection, Diagnosis, and Intervention

The EHDDI program works to ensure that all infants born in Washington state receive their newborn hearing screening. This screening helps identify infants who are deaf or hard of hearing and enroll them in early support services. Infants with hearing differences who do not receive early support by 6 months are at increased risk for cognitive, language, and emotional delays and are less likely to be on track with their peers for kindergarten readiness.

Our EHDDI funding has been at risk for several years because of changes in federal guidelines. For this program, not receiving adequate funding 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. DOH conducted stakeholder engagement through connecting with our internal and external partners, including the EHDDI Advisory Group and Midwives Association of Washington State (MAWS). We discussed the challenges of not having a sustainable funding mechanism and the possibility of establishing a newborn hearing screening fee by statute to support the EHDDI program. Our partners expressed strong support for the EHDDI program's work and efforts to identify sustainable funding. MAWS shared concerns about an additional newborn screening fee, siting that while insurance or the birthing individual should cover the screening fee, midwives do sometimes end up with the cost. DOH currently supports midwives in obtaining hearing screening equipment through a lending program and provides training to midwives on how to use equipment and report results to the EHDDI program. Midwives hoped that this support would continue and could even be strengthened in the future.

Informed by our conversations with partners, we worked with DOH leadership and the policy team to draft a budget request for the 2023 legislative session with a justification to fully fund the EHDDI program using state funds. We also explored amending Washington's newborn screening mandate to add a section requiring hospitals, birthing facilities, or providers attending a birth outside of the hospital to perform newborn hearing screening, record and report the results to the department, and, if necessary, refer the newborn for appropriate services. This would provide the regulatory incentive for providers to conduct newborn hearing screening and report results to the EHDDI program and help improve screening rates and the EHDDI program's ability to ensure infants receive timely services.

The EHDDI program also submitted a funding proposal to receive Foundational Public Health Services (FPHS) dollars to upgrade the EHDDI data system. The goal of the FPHS effort is to use ongoing funding from our State Legislature to achieve full funding and implementation of a limited set of core statewide public health services. This includes improving data systems to deliver more equitable and effective services. We hope to use FPHS funds to support the modernization and maintenance of the EHDDI system. Improvements to the system would include a more accessible and functional design for our external users and improved data linkages with our partners, such as Vital Statistics and the Ealy Support for Infants and Toddler's Program (ESIT) program, which administers Washington's Part C of the Individuals with Disabilities Education Act (IDEA).

Additional Work Supporting Perinatal/Infant Health at the Local Level

Black Infant Health - Health Ministers Program Contract

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

Birth Equity Project

To address disparities in Washington's Black/African American and American Indian/Alaska Native birthing communities, DOH has implementing the Birth Equity Project. This program funds community designed programs that address access to care, reducing the experience of racism, and supporting community birth workers. In order to make meaningful investments, DOH worked with three contractors to better understand both community needs and how DOH can create funding opportunities that do not perpetuate racism in health care. This work led to statewide listening sessions with the priorities communities, and an evaluation of DOH's fiscal and contracting process. During this time period, DOH also developed a Birth Equity Advisory Committee. This group is composed of birth workers and birthing people from the priority communities. They have helped develop the eligibility and requirements for funding proposals and set strategic direction for birthing work at DOH. Currently, the Birth Equity Project funds six multiyear grantees doing community-based work to improve the birthing experience for BIPOC families, as well as short term projects aimed at improving access to lactation education and training for doulas serving the queer community. The Birth Equity Advisory Committee continues to set strategic direction for the program, as well as other DOH perinatal programs.

Perinatal Substance Use

In response to the Opioid Epidemic, Washington State created a state Opioid Taskforce and an Opioid and Overdose Response Plan (WA State - Opioid Response Plan). The Pregnant, Parenting, Children and Families (PPCF) workgroup is connected to the state's taskforce and works to address the impact of substance use on families. A central component the Response Plan is to implement Eat/Sleep/Console (ESC) at birthing hospitals around the state andgather data on neonatal abstinence syndrome. ESC teaches birthing hospital staff to focus less on withdrawal symptoms, but instead of the infant is able to eat, sleep and be consoled. Instead of sending the infant to the NICU, they let the infants stay with their parents. This practice has resulted in significantly fewer infants needing morphine and medication, less time in the hospital and a better experience for the family.

To help hospitals adopt the ESC model, and provide withdrawal care for the mother or birth parent, the Washington State Hospital Association (WSHA) and the Department of Health (DOH) are offering training and support through a program called the Safe Delivery Roadmap.

In 2021, the Safe Delivery Roadmap program created the Perinatal Substance Use Disorder Learning Collaborative. This collaborative worked with 13 hospitals to pilot the Obstetric Care for Women with Opioid Use Disorder patient safety bundle. In 2022, this bundle was expanded to include training and support for all types of substances, not just opioids.

The Perinatal Substance Use Disorder Learning Collaborative now supports over 80% of birthing hospitals in Washington by providing monthly educational webinars and peer-coaching calls. It also helps hospitals become certified as a Center of Excellence for Perinatal Substance Use. This certificate awards and recognizes hospitals that follow best practices when caring for people and infants impacted by substance use.

Additional Work Supporting Perinatal Health at the Local Level

Local Health Jurisdictions Perinatal Work

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

Seven LHJs participated in the Nurse Family Partnership program to support infants and moms. Nurse Family Partnership is an evidence-based community health program that improves pregnancy outcomes by partnering with moms from early in the pregnancy through their child's second birthday. LHJs that participated are Clark, Kitsap, Lewis, Skagit, Tacoma-Pierce, Thurston, and Yakima (Yakima Valley Memorial Hospital District). These LHJs support 6 FTEs in NFP, .15 FTE Promotora, .4 FTE support staff, and .4 FTE BHS. Many LHJs participating in the

NFP prioritize first-time mothers, teen mothers, and mothers within communities with a history of systemic marginalization, including Black, Indigenous, Spanish speaking, and low-income. Nurse Family Partnership has had proven results in reducing preterm births, decreasing the incidence of hypertensive disorders during pregnancy, increasing the spacing between pregnancies, reducing child abuse and neglect, reducing ER visits for child accidents and poisonings, decreasing the incidence of child behavioral and intellectual problems, and increasing the rate of childhood immunizations.

Another 7 LHJs participated in activities, practices, and policies to promote breast/chestfeeding in worksites, schools, institutions, and health care settings. These were Grant, Kitsap, Kittitas, Sea-King, Skagit, Snohomish, and Tacoma-Pierce. Their activities included engaging with local and statewide Breastfeeding/Chestfeeding Coalitions, training sessions, and conferences. LHJ staff focused on childcare and breast/chestfeeding. They updated and created new breast/chestfeeding policies to support early learning providers who have children in care who drink human milk (Sea-King), set up a small survey for lactating families regarding the support they have received to continue breast/chestfeeding, and how employers support breast/chestfeeding in the workplace (Kitsap). Some worked with the Breastfeeding Coalition and community partners to provide consultation to worksites and other community settings to promote baby-friendly spaces and policies, using strategies outlined by the CDC (Skagit). A few provided educational materials from Breastfeeding Coalition of Washington and the Breastfeeding Coalition of Snohomish County, education classes for childcare providers on the benefits of breastfeeding/chestfeeding, education supporting human milk in childcare environments (Snohomish) to community groups, employers and schools, and shared lactation newsletter articles with childcare providers. Others supported hospitals and clinics to achieve the highest designation level to become Lactation and Infant Feeding-Friendly Environments (LIFE) through DOH (Tacoma-Pierce) and built partnerships with medical providers and hospitals more broadly (Grant). Some focused on becoming more trauma-informed as an organization (Kittitas) and promoting equity and antiracism by publicizing antiracism training and events with childcare workers and lactation consultants (Sea-King). Some focused their work on increasing access for families, whether to supportive programs for those with mental health and substance use disorders (Okanogan) or to breast/chestfeeding information, counseling, and referrals (Kitsap).

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

Perinatal and Infant Health Domain Application Year

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

State Performance Measure 3:
Universal developmental screening system participation.

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

The Title V program will support these efforts by implementing the DOH outreach plan and emphasizing positive vaccine messaging. We will collaborate with community partners at local health jurisdictions to help combat vaccine resistance through partnerships with home visitors, community health workers, care coordinators in managed care organizations, and community leaders in the nonprofit sector. In the future, we will combine these efforts with flu vaccine messaging to reduce the overall respiratory disease in the community and reduce the stress on the health care system.

We are also working with Medicaid managed care organizations in a formal performance improvement project to increase well-child visits rates. This is a vital area of focus for the next few years because of significant decreases in well-child visits and immunization rates during the COVID-19 pandemic. More information about this work is available in the Child Health Annual Report section.

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

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

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

Federal funds historically used to support the EHDDI program are no longer sufficient. 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 most at risk for not receiving services include children born to people in rural areas who are 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. An underfunded EHDDI program could mean 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.
During the 2023 legislative session, state funds for the EHDDI program were signed by the governor after the 2023 Legislative session, which provides the EHDDI program the necessary funds to support its core program services. This includes funding our data system, hosting our statewide learning community, improving family engagement and support, and staff for follow-ups for infants needing hearing or early support services.

Between October 2023 and September 2024, the EHDDI program will collaborate with partners to implement the core services of the EHDDI program and conduct quality improvement activities to strengthen our systems and ensure equitable access to services. The program also received Foundational Public Health System (FPHS) funding to modernize the EHDDI data system. We will work with our vendor and internal and external partners to upgrade the system, including improved data linkages with birth certificate records and the ESIT program.

Objective:
By December 2023, support access to pediatric genetic services and disseminate data and trends on clinical genetic services and CCHD hospital summary reports to stakeholders.

By December 2023, collect and analyze service utilization data on patients utilizing pediatric genetics services, and disseminate the information to our stakeholders.

By December 2023, complete the analysis of Critical Congenital Heart Disease diagnoses data from July 2015-December 2022, create a hospital summary report, and disseminate this information to stakeholders.

Strategy:
- In collaboration with our clinical partners, assure the provision of and access to pediatric genetic services in rural and/or underserved communities.

- Conduct data analyses and create a summary report for birth hospitals and midwifery clinics on critical congenital heart disease (CCHD) diagnoses data.

- Disseminate data and trends on service utilization of pediatric genetic services and the CCHD hospital summary report to stakeholders.

Objective:
By December 31, 2025, complete a statewide gap analysis for perinatal substance use services, and align this analysis with county-level maternal and infant data.

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

Developing sustainable and multidisciplinary perinatal behavioral health services in large rural areas and culturally diverse communities is challenging. Failure to identify service gaps can lead to action plans and decisions that do not fully address the needs of patients and providers, especially among pregnant and postpartum individuals and populations farthest from opportunity. 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.

This gap analysis will primarily focus on conducting an ecological scan. It will include mapping existing perinatal substance use providers, behavioral health clinics, and community . The goal of the scan is to identify gaps in services for the perinatal population and better understand the delivery and access to perinatal substance use services statewide. We will support connection into and between clinical and community services. We will identify communities lacking multidisciplinary perinatal behavioral health services in their area and determine if it is ecologically linked to maternal and infant outcomes. This determination will enable us to create a model to deliver perinatal behavioral health services in our primary populations that considers their burden, context, and integration.

We have collected the assessment data and will generate an analysis in the coming year. Early data show that 19 counties have 5 or fewer local service organizations, 19 counties have more than 5 organizations providing services. One county has 166 service providing organizations. Generally, rural areas have fewer services in their communities. Considering the population density, more analysis is needed to look deeper into the wait times to access services and the distance to perinatal specialists. Our findings show that the eastern side of the state (east of the Cascades) lacks any Chemical Using Pregnant Women programs.

To ensure a comprehensive analysis, we collaborated with cross-agency state partners. Together, we have determined the data measures to include in the analysis and to connect outcomes. These include maternal recovery and foster care placement, local resources such as housing, supportive prenatal/postpartum care, dyadic care at birth, and community services.

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

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

Strategies:

- Engage partners and stakeholders, including those in historically marginalized communities, to promote the value of universal developmental screening and the 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 disparities and work with historically marginalized communities to develop tailored outreach and education.

DOH established a dedicated UDS program in April 2022 to promote developmental screening and support the new statewide data system, officially named Strong Start, to track developmental screenings of children from birth through age 5 in Washington state. Program staff worked with the vendor to refine the Strong Start system and conducted active education and outreach throughout the state. Small pilot projects were implemented 2023 in 2 community health clinics through a contract with the Washington State Chapter of the American Academy of Pediatrics (WCAAP) and in 2 LHJs as Maternal Child Health Block Grant Special Projects.

DOH plans a statewide rollout of Strong Start in the Fall of 2023. Various factors will guide the strategies of this rollout. These include findings of the pilots mentioned above, input from key state partners, a report from a tribal consulting firm contracted to hold multiple listening sessions with American Indian/Alaska Native communities, consultation with diverse parents, providers, and early childhood entities throughout the state, and a roadmap developed by the UDS Program team in June 2023.

In FFY 2024, planned activities include conducting additional Strong Start pilots, continue refining the system's interoperability with the Health Information Exchange (HIE). Plan also include expanding the user base to include childcare and early learning providers in addition to the health care providers and parents/legal guardians and explore future opportunities to expand interoperability to include early childhood data systems outside of HIE.

Health equity is at the forefront of UDS strategic planning. DOH anticipates planning and implementing UDS projects to focus on the populations and communities with demonstrated disparities in access to developmental screening and supportive services.

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

National Performance Measure 4*:*
Percent of infants who are ever breastfed.

Percent of infants breastfed exclusively through 6 months.

Objective:
Annually, partner with at least 8 local health jurisdictions to offer perinatal home visitation services to low-income women in local communities, supporting well-newborn visits, on-schedule vaccination, and breast/chestfeeding initiation/sustenance.

Strategies:

- Promote breast/chestfeeding 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. However, home visiting is still a vital support for many families. For LHJs, Adverse Childhood Experiences (ACEs) is an optional focus area for their contracts, and home visiting is called out as an ACEs prevention and mitigation strategy. A total of 7 LHJs are receiving MCHBG funding devote a portion of their funds to home visiting, primarily through the Nurse Family Partnership (NFP) program. MCHBG supplements staff time – 7 cover a portion of the NFP nurse time, ranging from 0.5 FTE to 0.9 FTE. An additional 4 LHJs were working with partners to implement trauma informed practices and policies and 3 LHJs were working on fatherhood inclusion and support activities. Because the LHJs directed their staff to COVID-19 response over the past year (2021-2022), we did not require them to revise their plans for the new contract year. The same plans remain in place until the pandemic response is no longer the primary focus of LHJ efforts.

LHJs continue to explain how they used a health equity lens when designing their plans for the upcoming contract year. Two mention the importance of having a Spanish-speaking nurse doing home visits. Three mentioned home visits as an avenue for increasing equity.

Yakima County 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 community services, the hospital provides home visits to identified families, using the evidenced-based Strengthening Families Framework to promote and build protective factors.

During the COVID-19 pandemic, home visiting has been modified. LHJ partners report successfully maintaining contact with families via Zoom and other platforms. Some have found great success with this approach. They have commented that families who struggle to make in-person visits find keeping virtual appointments easier. Home visiting nurses also got creative to meet with families individually, having distanced appointments on front porches and in local parks. Because home visiting provides fundamental, evidence-based, and informed support for parents and young children, we will continue to prioritize investing MCH funds in this work at the LHJ level.

Breast/chestfeeding and lactation support have become an increasingly popular strategy, with 7 LHJs now pursuing these efforts. The pandemic has made this work more difficult, as most local coalitions suspended their meetings, and individual support for mothers was forced to be done virtually. How delivering these services and supports will transition remains to be seen.

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

Strategies:

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

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

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

In October 2022, DOH was awarded a federal grant to enhance our Perinatal Quality Collaborative (PQC) and our ability to implement perinatal quality improvement initiatives. Through this grant, the PQC will support the Alliance for Innovation on Maternal Health (AIM) initiatives and other projects related to perinatal substance use.

DOH and WSHA collaborate on AIM implementation efforts through the PQC. In 2021, DOH and WSHA created the Perinatal Substance Use Disorder Learning Collaborative. This collaborative worked with 13 hospitals to pilot test the Obstetric Care for Women with Opioid Use Disorder patient safety bundle. This bundle was expanded in 2022 to include training and support for all types of substances, not just opioids.

The Perinatal Substance Use Disorder Learning Collaborative now supports over 80% of birthing hospitals in Washington by providing monthly educational webinars and peer-coaching calls. It also helps hospitals become Center of Excellence for Perinatal Substance Use certified. This certificate awards and recognizes hospitals that follow best practices when caring for people and infants impacted by substance use. These criteria will include verbally screening every person giving birth for substance use disorders and perinatal mood and anxiety disorders, and implementing hospital policies and support for pregnant and parenting individuals who screen positive for a substance use disorder. WSHA and DOH also launched a Perinatal Substance Use Learning Collaborative that offers monthly learning sessions and a toolkit of resources to support hospitals in implementing bundle components and becoming a Center of Excellence for Perinatal Substance Use.

Objective:
By Sept 30, 2025, in partnership with Child Protective Services at the Department of Children, Youth, and Families (DCYF), Within Reach and the Washington State Hospital Association implement the policy and definitions for infants exposed to substances, as well as prepare for and implement a statewide launch of the referral portal.

Strategies:

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

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

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

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

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

The portal and program have been piloted in 2 counties and are being piloted in 13 additional hospitals. Statewide implementation launch plans to begin in 2022 are in development. Training on the portal has been done through the Safe Deliveries Roadmap Substance Use Learning Collaborative. Participating hospitals joined monthly webinars, one of which was focused on the portal and updated definitions. They also were able to join a coaching call with peers to talk through the implementation. This early stage has uncovered a greater need to train hospitals, beyond the initial sessions. DOH is currently working with DCYF to develop additional training opportunities.

Objective:
By December 31, 2023, complete the development of a new data system for the Birth Defects Surveillance System (BDSS) and complete initial data linkages between BDSS data and data from vital statistics, including birth, death, fetal death, and hospital discharge data. By September 30, 2024, refine ongoing data linkages to occur at regular

intervals and train BDSS epidemiologists in the maintenance of these linkages.

Strategies:

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

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

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

Birth defects have a significant public health impact, and result in increased morbidity and mortality, long-term disability, the need for developmental services and special education, and economic and emotional impacts on the family. Birth defects are a leading cause of infant death, accounting for 22% of infant deaths in 2021.

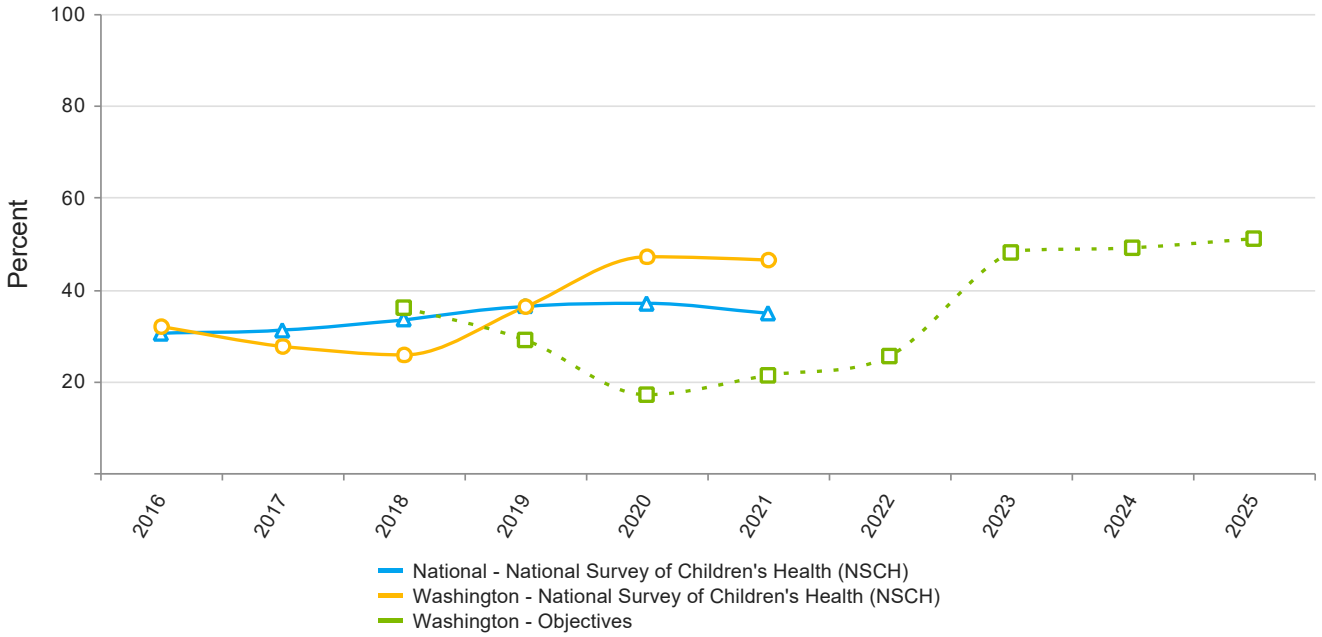
The current BDSS data system is 23 years old and has never been fully functional. The development of a new BDSS data system will provide more timely and complete birth defects data for Washington and integrate the health information exchange (HIE). With access to timely data, the new system will allow for data linkages with vital statistics, including birth, death, fetal death, and hospital discharge data. The linked data will allow for more complex analyses and a better understanding of the risk factors associated with birth defects in Washington. .

The new data system will help us meet the Washington BDSS goals, 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 and their families.

Child Health

National Performance Measures

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



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	36	29	17.1	25.5	25.5
Annual Indicator	27.7	25.6	36.2	46.4	46.4
Numerator	55,326	53,459	65,908	102,689	102,689
Denominator	199,961	209,028	182,179	221,286	221,286
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	48.0	49.0	51.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	643	498
Numerator		
Denominator		
Data Source	Washington State Help Me Grow	Washington State Help Me Grow
Data Source Year	2020-2021	2022
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	550.0	605.0	665.0

State Performance Measures

SPM 5 - Ease of receiving mental health treatment or counseling

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			55
Annual Indicator	53.9	53.4	43.2
Numerator	108,903	109,574	87,700
Denominator	202,046	205,382	203,009
Data Source	NSCH	NSCH	NSCH
Data Source Year	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	56.0	57.0	58.0

SPM 6 - Social and emotional readiness among kindergarteners

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	74.4	77	77	78	78
Annual Indicator	76.7	76.7	79	77.4	78.8
Numerator	60,266	60,266	64,553	53,759	60,617
Denominator	78,574	78,574	81,713	69,456	76,940
Data Source	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids
Data Source Year	2017-2018	2017-2018	2019-2020	2020-2021	2022-2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	79.0	79.0	79.0

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

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	86.1	86
Numerator	1,387,536	1,372,316
Denominator	1,611,540	1,595,716
Data Source	NSCH	NSCH
Data Source Year	2019-2020	2020-2021
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	86.5	87.0	87.5

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

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

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

By September 30, 2024, identify improved methods to track the proportion of children who are receiving timely developmental screenings

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

Strategies
Provide leadership, staffing, and funding support for the ongoing development and implementation of the statewide Help Me Grow WA system and related collaborative statewide initiatives that include explicit focus on connecting families to developmental screening and resources.
Communicate developmental screening and developmental milestones information through a variety of social media and virtual/live modalities.
Incorporate Vroom™ brain building tips and other child development resources in Watch Me Grow Washington mailings.
Promote utilization of Strong Start Universal Developmental Screening data system with all health care provider practices serving young children in Washington State.
Promote Strong Start with state and local partners that work closely with families of children birth through age five, and provide training and technical assistance, as well as information about resources and supports related to early childhood development.
Continue coordination between Strong Start and Help Me Grow WA to ensure alignment of developmental screening data systems and services.
Encourage the coordination of pediatric screening efforts, results, and referrals among clinical care settings, medical homes, child-care settings, schools, and other organizations.
Explore options to improve availability and usability of Medicaid data provided through HCA-DOH mutual data share agreement.
Explore data agreements with other insurers or other sources to track developmental screening rates.
Incorporate developmental screening data from Strong Start UDS data system.
Promote routine well-child visits and recommended preventive care in early and middle childhood (birth to age 11). Activities include Patient/Parent education (communications campaign, social media posts, school flyers, public education ads, etc), and provider education (webinars, communications, clinic collaborations, etc.).
Partner with pediatric and primary care clinic systems to engage over-due or unestablished members/children into the practice to receive well-child visits.
Establish partnerships with early learning focused organizations and school-based health centers to identify and deploy collaborative activities to improve well-child visits.

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

NOMs

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

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

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

Priority Need

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

SPM

SPM 5 - Ease of receiving mental health treatment or counseling

Objectives

Through January 2025, implement the early childhood comprehensive systems strategic plan in collaboration with state partners and families.

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

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

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

Strategies

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

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

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

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

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

Support interventions to address suicide ideation among children, especially among children who are involved in child welfare systems, LGBTQIA2S+, BIPOC.

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

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

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

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

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

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

Provide state leadership and coordination for development of an integrated and comprehensive early childhood system of services and supports through the Early Childhood Comprehensive System: Health Systems Integration project and other related state initiatives, such as Essentials for Childhood, State Early Learning Coordination Plan, and Pritzker's Prenatal-to-3 Children's Initiative.

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

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

Work with families and state partners to identify and address ongoing structural barriers within state systems that impact the ability of families to access supports for themselves and their children. Prioritize efforts to eliminate barriers for families who identify as Black, Indigenous, People of Color, immigrant, or LBGTQ+ members; families of children with special health care needs; families who live in rural or geographically isolated areas; and families who experience trauma of parental incarceration, child welfare system involvement, homelessness, substance use disorder and mental illness, and other adverse experience

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

Priority Need

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

SPM

SPM 6 - Social and emotional readiness among kindergarteners

Objectives

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

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

Strategies

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

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

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

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

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

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

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

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

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

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

Priority Need

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

SPM

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

Objectives

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

By October 1, 2023, develop a sustainability plan to continue progress on strategies and actions identified in collaboration with Essentials for Childhood partners.

By March 31, 2024, develop a positive community norms campaign or educational awareness campaign focused on child well-being in the context of their families and communities.

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

By June 30, 2024, develop an approach to measure and monitor community contextual resilience/community factors that reduce or mitigate childhood adversity and support positive child and family well-being outcomes.

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

By September 30, 2024, launch a communications campaign focused on supporting middle childhood mental well-being (ages 6-11 years), including addressing impacts of social media use and bullying.

Through September 2025 and beyond, establish a comprehensive state Child Fatality Review Program to identify preventable factors contributing to child deaths, develop recommendations for addressing these factors, and create state and local prevention plans.

Strategies

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

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

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

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

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

Incorporate learnings from the Inventory of What Works (to reduce child maltreatment/increase family resilience) Project for state and local prevention planning.

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

Determine scope and scale of positive community norms campaign.

Develop and test messaging, identify message dissemination strategies to support related areas of interest (e.g., ACEs, trauma-informed/healing centered services).

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

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

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

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

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

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

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

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

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

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

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

Identify and support evidence-based practices to prevent and reduce the harmful impacts of bullying and social media on children.

Conduct research on need for and feasibility of communications strategy related to social media and bullying in middle childhood.

Facilitate coordination and shared learning among Local Health Jurisdiction Child Death Review programs.

Provide technical assistance to local Child Death Review (CDR) teams.

Develop and implement processes for reviewing local CDR findings and creating recommendations for addressing preventable factors contributing to child deaths.

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

Child Health Domain Narrative

Overview

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

Child health is viewed holistically through a life course development perspective, covering the physical, mental, emotional, behavioral, and spiritual aspects of child well-being in alignment with the phases of development. It is also considered in the socio-ecological model, recognizing the influence of family, community, societal and systemic factors on children's well-being. Child health strategies include universal approaches (e.g., promotion of developmental screening, comprehensive system development) and more tailored approaches to address the needs of children and families who are furthest from opportunity due to social, economic, or geographic factors. A central focus of our work is identifying and addressing the historical and ongoing impacts of systemic racism on children's health. We continue to promote the importance and availability of well-child visits, increasing and tracking the rate of developmental screenings, and addressing child mental health concerns. Through our many partnerships with state agencies, local health jurisdictions, community-based organizations, and different entities, we promote relational health and positive childhood experiences (PCEs) and work towards the preventing and mitigating child maltreatment and adverse childhood experiences (ACEs).

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

Our unit works together with other DOH units to address the priority needs of the child population (ages 1-11 years). In addition to the work within OFCHI, several additional 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 breast/chestfeeding for a healthy start. The Immunizations and Watch Me Grow Health Promotion System manages a universal vaccine program. It sends child health and safety information to all families with young children in Washington by mail and e-mail. The Oral Health program promotes access to oral health care and prevention of

dental disease and oversees the Smile Survey to collect data on the oral health of children in Washington. Collectively, these programs contribute to our shared vision of safe, healthy, and thriving children.

During FFY22, significant staff changes included a new Thriving Children and Youth section manager, a new Child Health Unit supervisor, and 2 new staff to support child health work. Personnel processes and onboarding led to some delays and modifications in planned work.

Data Overview of Child Health Population

In 2020, the most recent year for which reliable data exists, the Washington population of children 1 to 11 was estimated to be 1,037,834, or about 22.2% of the total state population. The population of children 1 to 5 was estimated at about 4.4% of the total; ages 6 to 11 were about 9.4%. In general, Black, Indigenous, and people of color (BIPOC) populations have a proportionally larger population of young children than the white, non-Hispanic population.

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

In 2021 Washington had a rate of uninsured children under six years of age that was lower than the national rate, 3% vs. 5%. Families continued to report barriers to accessing coverage, including difficulties navigating the enrollment process. Over 34% of children were covered by public health insurance (Medicaid, CHIP or other state/federal plan) with another 5% covered by a combination of private and public insurance. (KIDS COUNT), Having public only coverage can sometime make it more difficult for families to find a doctor who accepts their health insurance, make an appointment, and/or obtain specialist care (Medicaid and CHIP Payment and Access Commission [MACPAC]).

In 2020-2021, an estimated 46% of children in Washington ages 9 to 35 months received a developmental screening, similar to the 2019-2020 rate of 47%. The national rate for 2020-2021 was 35%. This is a statistically significant difference. In 2020-2021, approximately 66% of families needing care coordination in Washington received it, compared with the national rate of 70%, this was not a statistically significant difference. (NSCH).

In calendar year 2021, the rates for children having received the full recommended vaccine series is listed in the table below.

Age group	Recommended series	% complete
19-35 months	4:3:1:3:3:1:4	57.4
4-6 years	5:3:4:2:4:4:2	41.8
11-12 years	1:1:1	33.2
13-17 years	1:1:UTD	41.5

Washington's Title V program served 1,936,588 children, adolescents, and young adults, ages 1 to 21, in 2021. 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 and responsive supports, and services and systems improvements that support the whole child, whole family, and whole community. We also continued our work on many MCHBG objectives to meet the immediate needs created by the COVID-19 pandemic.

Child Health Priority 1: Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course.

Within this priority, the Child Health unit and other DOH units work to address the following National Performance Measure:

1. **Percent of children, ages 9-35 months, who received developmental screening using a parent-completed tool in the past year.**

The intent of this focus is to ensure early identification and intervention for developmental needs. Work in this priority area also includes broadly promoting child preventive care through well-child visits and immunizations and integrating and connecting health systems into the broader early childhood system (i.e., early learning, social services, child welfare) in Washington state.

Increasing Child Well-Visits and Vaccinations

During FFY22, DOH continued to promote well-child visits to increase the uptake of well-visits and immunizations to pre-COVID levels or greater. Routine child well-visits are a primary strategy to increase developmental screening and other preventive health services, like immunizations. Well-visit promotion work was largely housed within the OFCHI Health Systems Unit. The unit works together with the Health Care Authority (HCA) to coordinate joint Practice Improvement Projects (PIP) between all 5 Medicaid Managed Care Organizations (MCOs) in WA State (Amerigroup, Molina, Coordinated Care, United Healthcare, and Community Health Plan of WA. The PIP for calendar years 2021-2023 has focused on improving child well-visit rates, with an emphasis on children ages 3-11 years.

Progress

During FFY22, DOH worked on the following objective:

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

Launching Child Well-Visit Communications Campaign

As part of the collaborative Practice Improvement Project with MCOs, we gathered information from families about barriers to well-child visit utilization. We then developed a Request for Proposals to plan, implement, and evaluate a social marketing/communications campaign to increase awareness of the importance and value of scheduling well-

care visits. This work included promoting immunizations to bring children up to date on missed vaccination opportunities during COVID-19. DOH contracted with C+C, an award-winning vendor with significant experience promoting vaccinations during COVID-19, to develop materials. C+C developed flyers promoting well-child visits and immunizations to parents of different age groups (infants/toddlers, children, adolescents, and young adults). These flyers in English, Spanish, Russian, and Vietnamese were distributed through schools and early childhood providers. Information for health care providers, including "Tips to Raise the Rate of Well-Care Visits" and "Personalized Messages for Ages 3-11," were distributed to clinics through MCOs. Social media messages were shared through Instagram, Facebook, and other channels. All materials, including a short video ad for families and information for providers, were posted on the DOH website: Child and Adolescent Well-Care Visits | Washington State Department of Health. The campaign development began in FFY22, with ads and social media messages occurring in November and December of 2022. We also worked with MCOs and health care clinics to host special Spring and Fall events to increase well-visits, using HCA incentives for the clinics. Evaluation of the campaign and other strategies is in progress.

Promoting Early Identification of Child Developmental Needs through Developmental Screening and Data System Development

Increasing developmental screening for all young children remains a priority for DOH. During FFY22, DOH launched the Strong Start Universal Developmental Screening Data System and increased programmatic capacity to support the system rollout to health care providers and parents, including hiring a program manager and 2 program staff to focus on data systems and community/health care provider outreach.

Progress

In FFY22, DOH had 3 primary objectives related to developmental screening and made progress on each objective.

- **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.**

- **By September 2025, increase parent, public, and health professional awareness of developmental milestones and evidence-based well-childcare through communication strategies.**

Completing Universal Developmental Screening data system development and launch

We have 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 the lack of a statewide system to track early screenings and referrals.
With support from the state legislature, the system went live in the fall of 2021. DOH began a focused soft launch with the Washington Chapter of the American Academy of Pediatrics (WCAAP) Bright Futures Learning Collaborative with two community health centers. Additionally, outreach began to Help Me Grow WA (HMG WA) partners, Local Health Jurisdictions (LHJs), and Tribal partners and communities. This marked the beginning of a phased implementation, with plans for a statewide rollout in 2023.

In early 2022, the Legislature approved additional funding for Universal Developmental Screening (UDS) system maintenance and operation and to create a dedicated UDS program within OFCHI. The UDS program was

established in April 2022 with the appointment of a 1.0 FTE Program Manager. Two 1.0 FTE program staff were hired and onboarded-- UDS System Support Consultant and UDS Education and Outreach consultants in July 2022.A .50 FTE epidemiologist and a Business Analyst from DOH Health Technology Solutions support the program to provide as-needed support for ongoing maintenance and operations of the data system.

The program staff have been actively engaged in outreach across the state, developing communication materials, and working with the UDS system vendor to implement ongoing improvements. Staff meet monthly with key state partners, like HMG WA and the Department of Children, Youth, and Families. Training and technical assistance in Spanish and English have been offered to guide potential users about the new system.

Local Health Jurisdictions have also done significant work on UDS. A summary of their efforts can be found at the end of this report.

Maintaining statewide parent help hotline for developmental information

DOH continues to use MCHBG funds to support a contract with WithinReach to maintain the state HMG WA parent hotline and resource/referral system that assists families in completing a developmental screening and connecting to other resources. In 2022, WithinReach received and responded to 13,506 calls. HMG WA provided 41,913 referrals in 2022; developmental support was the second most common type of referral (second to basic needs). WithinReach's ParentHelp123.org website data showed 29,992 page views with 23,245 total unique page views in 2022. WithinReach's hotline and website resources are described further in the Women/Maternal Health Annual Report.

Communicating developmental screening and well-visit information to families

DOH continues to utilize a robust child health promotion tool, Watch Me Grow Washington | Washington State Department of Health (formerly Child Profile). Watch Me Grow Washington has been DOH's primary method for delivering important health and safety information by mail to Washington state families for more than 20 years. We send over 1.5 million mailings per year, reaching 98% of families with children from birth to 6 years. DOH distributes mailers to families at scheduled intervals based on child age and in correlation with the American Academy of Pediatrics recommended schedule of well-child visits through this program. Mailers offer information about developmental milestones, immunizations, nutrition, oral health, parent health and other materials, and connections to HMG WA and other resources. Child Health staff worked with Watch Me Grow Washington to incorporate Vroom™ brain building tips into mailers to 84,426 families of toddlers from October 2021 through September 2022. Mailers also included well-visit promotion information from the social media/communications campaign project described in the section on Child Well-Visits above.

Tracking screening rates

DOH tracks developmental screening rates primarily for children on Medicaid through a HCA-DOH data share agreement. Among children covered by Medicaid, 11% received a developmental screening in 2020 and 14% in 2021. County-specific screening percentages in 2021 ranged from 1% (Okanogan County) to 29% (Pacific County).

Promoting Health Systems Integration into Broader Early Childhood Systems

During FFY22, the Child Health team focused on launching the HRSA Early Childhood Comprehensive Systems (ECCS): Prenatal-to-Three Health Systems Integration initiative, a 5-year project beginning in August 2021. This initiative blends HRSA ECCS and MCHBG funds to advance effective integration, collaboration, and asset sharing to strengthen maternal and early childhood systems.

Progress

In FFY22, DOH added a new objective related to early childhood health systems integration:

- **Through January 2023, develop an early childhood comprehensive systems (health systems integration) strategic plan in collaboration with state partners and families.**

Early Childhood Comprehensive Systems Planning

Initial efforts centered on building the foundation to carry out the work plan activities necessary to ensure quality and equitable access to perinatal and early childhood systems of care for the P-3 population. We engaged in strategic conversations to: (1) understand barriers to participating on the ECCS advisory council, (2) determine related initiatives (e.g., WA State Essentials for Childhood, Washington Prenatal-3 Coalition, Preschool Development Grant Birth through Five, etc.) with complementary aims, and implement meeting strategies to coordinate/promote systems, programs, and policies, (3) strategize about opportunities to amplify community/caregiver voice in the development of early childhood programs and services with specific efforts to improve access for Black, Indigenous, and people of color (BIPOC) and rural populations.

To guide the ECCS implementation, we explored several potential approaches to establish an inclusive and representative governing body. During this process, we learned of concerns around the capacity to participate in additional meetings and the potential for duplication across existing bodies already serving prenatal-to-3 initiatives. Collaborating with community-based and state partners, we determined that coordinating the ECCS work with existing bodies was the most promising strategy for initiating the ECCS work. Partners also shared a desire to revisit advisory structures as implementation progressed.

Development of a Systems Assets and Gaps Analysis (SAGA) of the current maternal and early childhood systems of care was initiated to explore the extent to which the health sector is integrated into early childhood systems and identify strengths and gaps in advancing early developmental health and well-being. Through SAGA, several cross-sector strategic planning documents were identified and assessed to determine points of distinction and areas of alignment with the ECCS initiative.

Washington's Early Learning Coordination Plan (ELCP), a shared vision and plan co-created by a broad coalition of families, community members, and state partners to advance equitable early childhood outcomes in Washington state, emerged as an ideal framework to build statewide capacity and grow the integration of maternal and early childhood systems of care including health systems with a focus on early developmental health and family well-being. We worked on the ECCS strategic plan to demonstrate the alignment of ECCS activities with the ELCP framework (e.g., outcomes, goals, strategies). Key outcome areas of the ELCP include:

- powerful communities and responsive systems
- strong, stable, nurturing, safe, and supported families; and
- healthy children and families.

Family engagement activities were ongoing throughout the reporting period. Initially, efforts included a series of conversations with an established community leader with lived experience and expertise in collaborating with parents/caregivers to inform strategies for intentionally amplifying the voices of parents/caregivers in the ECCS program. We partnered with the same community leader to co-design and host a focus group in August 2022. The purpose of the focus group was to learn how to strengthen and build systems (health care, childcare) for pregnant/parenting families and those caring for and raising young children at the community and state level that center families. The following insights about equity considerations emerged from the focus group:

- Regarding access to health services, participants shared that inflexible scheduling, long waitlists, inconvenient locations, and lack of access to providers who accept state insurance were barriers.

- Participants expressed feeling shame around requests for mental health support, treatment for substance use disorder, and resources for concrete supports (i.e., food).
- Increasing access/availability of family navigators arose as an opportunity to help families connect to resources, including state-sponsored health care.
- Expanding eligibility to paid leave programs and easy application processes were also identified as areas of opportunity.

Following the focus group, the facilitator reviewed the notes summarizing the discussion and shared them with participants to ensure accuracy. We created a summary document detailing key findings and shared it with participants, the facilitator, and other ECCS partners like the Preschool Development Grant Project Director, the WA Prenatal-to-3 Coalition, and the Family Voice Learning Network Lead supporting the Washington Communities for Families Coalitions.

Centering family and community voice and expertise remain a key focus in work supported by the CHU and OFCHI. The CHU team has also explored more approaches to support meaningful family and community engagement in ECCS and other child health initiatives. For example, CHU staff began participating in an effort supported by the Association of Maternal and Child Health Programs to receive technical assistance on implementing the Family Engagement in Systems Tool.

A central component of the ECCS initiative is to increase the participation of health providers (e.g., pediatricians) in statewide coordinated intake and referral systems (CIRS). In Washington, Help Me Grow Washington (HMG WA) serves as the identified CIRS. The ECCS funds supported a Health Care Provider Outreach manager position at WithinReach, the state affiliate for HMG WA. The Health Care Provider Outreach manager conducted outreach activities to establish partnerships with child health providers and statewide associations/networks (e.g., Washington Chapter of the American Academy of Pediatrics) to increase awareness of the HMG WA system and the number of providers included in the statewide resource directory. Communication materials and trainings were developed and delivered. Additionally, opportunities and proposed solutions to improve technical systems functionality to enhance statewide systems linkage and closed-loop referral pathways were identified.

ECCS funds also supported the Washington Communities for Children work, a network of early childhood coalitions committed to improving the well-being of children, families, and communities. WCFC helped coordination among the 10-region-based early childhood coalitions to support identifying local culturally appropriate services/support to include in the HMG WA resource directory and extend partnerships between local HMG WA systems and local health care providers. Focused work occurred with a cohort of 4 partners serving small rural populations (an ECCS population of focus) to develop a low-cost, replicable process for enabling the local collection of resource information to exchange with HMG WA.

Child Health Priority 2: Promote mental wellness and resilience through increased access to behavioral health and other support services.

Within this priority, the Child Health Unit and other units worked to address the following State Performance Measures:

1. **Percent of sixth grade students who have an adult to talk to when they feel sad or hopeless, and**
2. **Ease of receiving mental health treatment or counseling.**

Preventing and Mitigating Adverse Childhood Experiences to Improve Child Mental Health and Resilience

During FFY22, work in this area focused less on individual interventions related to connecting children to caring

adults and more broadly on efforts to reduce Adverse Childhood Experiences and to strengthen families at the community and system level. This involved: 1) collaborating with Essentials for Childhood partners to identify policy and programmatic direction in anticipation of the upcoming 2023 legislative session and new EfC grant funding cycle, 2) continuing our work to identify current state landscape of programs and policies to prevent and mitigate the social, emotional, and behavioral health impacts of Adverse Childhood Experiences (including child abuse and neglect) to determine where to focus future attention, and 3) strengthening our focus on racial equity and the underlying social and economic conditions that impact child and family well-being and resilience.

Progress

In FFY 22, DOH had 3 primary objectives related to ACEs and resilience and made progress on each of the objectives with modifications in timelines due to staffing capacity. These included:

- **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. (This objective was carried forward and modified into FFY 22 due to limited data staffing capacity in 2021).**

Completing Inventory of Policies and Programs

From June-September 2021, DOH (in collaboration with the Essentials for Childhood Initiative) funded “Inventory of What Works”, to better understand the different community, state, and national programs, policies, and practices that exist in Washington state and LHJs to promote family resilience and prevent abuse/neglect for children ages 0-5 years. In mid-2022, we contracted with Camber Collective to refresh the work to date and develop a set of next step recommendations based on an assessment of the Statewide Inventory and LHJ assets (4 LHJs); identify any immediate data gaps to develop strategic options on how to strategically utilize information, and key operational next steps.

Based on a review of the 2021 inventory, the following insights emerged through phase 2 of the Inventory of What Works project:

- A wide variety of child and family programs and services focused on the direct service level exist within Washington state, with potential gaps at the community capacity building and policy/systems development level.
- There is a need to better understand where existing programs are being implemented across regions (e.g., Western, Central, or Eastern WA).
- Washington state has a set of programs considered national fidelity-based models (e.g., Nurse-Family Partnership, Circle of Security, Family Spirit Home Visiting Program, Parents as Teachers, etc.) that can be customized, funded, and implemented in specific regions of the state. An opportunity exists to better understand the breadth of current community-based implementation for these national programs and then identify ways more communities can apply for funding and assistance in implementing national fidelity-based models. Similarly, efforts are needed to support emerging effective community-based programs that could be evaluated as an evidence-based practices and funded for large-scale implementation.

- While the current inventory includes some equity definitions (racial equity, economic equity, geographic equity), these are insufficient from a strategic planning or policy standpoint on identifying programs and practices to address systemic and structural inequities. Recommend using a targeted universalism approach to address the gaps.
- There are significant ongoing efforts at DOH, DCYF, HCA, Governor's office, and other agencies related to the policies and programs for early childhood (B-5). There is an opportunity to better coordinate across agencies to reduce duplication and improve coordination.

Consultants suggested the following future strategic efforts:

- **Systems mapping** of all WA state agency-related efforts (projects or initiatives) that touch early childhood resilience to help improve coordination, align success outcomes, and ultimately sharpen an overall Theory of Change / Theory of Action.
- **Reporting and tracking** of ongoing cross-agency initiatives. Potentially aligning all early childhood resilience efforts to the 5 CDC Child Abuse and Neglect strategies (i.e., economics, social norms, health and education, parenting skills, and interventions).
- **Identifying internal/external facing information and audiences** for outputs and assets of the Inventory, including 1) LHJs and community partners and 2) other state-wide agencies, and 3) community organizations and families.
-

DOH will consider findings and recommendations as we move forward with the EfC work, and next steps with the inventory.

Advancing Policies and Programs to Strengthen Family Economic and Community Resources/Supports

Based on the Inventory of What Works Project findings, DOH worked with Essentials for Childhood partners to focus EfC conversations on racial equity and prioritized ACEs prevention/resilience strategies for building community capacity and advancing policy/systems-level change. The EfC partners met quarterly for Steering Committee meetings and bi-monthly for Leadership Group meetings.

Key accomplishments included:

- Incorporated a facilitated equity activity in all EfC Steering Committee and Leadership Group meetings.
- Updated the Child Abuse and Neglect Prevention State Action Plan with a focus on 4 primary buckets of work: Collaboration and Partnership, Child and Family Supports and Services, Community Capacity and Norms, and Policy and System Change strategies.
- Highlighted and supported DCYF's Strengthening Families Locally Project within EfC.
- Planned for and secured Maternal Infant Opiate state funding to conduct a Community Resilience/Protective Factors Measurement Project. The intent of the project is to develop an approach to measure and monitor community level protective factors associated with the reduction and mitigation of childhood adversity and intergenerational transmission of trauma. This project is scheduled to be completed during FFY23-24.
- Prepared for 2023 Legislative Session by developing a policy approach including the launch of a series of EfC Policy Working Sessions and creation of a policy framework in November 2022. We did not pursue a policy agenda in 2022 due to the short session.
- Began exploration of opportunities to evaluate and monitor implementation of state family support programs resulting from state policy action, such as Paid Family and Medical Leave Program, to understand and reduce barriers to access and utilization of these programs, including structural barriers associated with racism.

DOH continued to provide technical assistance to the LHJs on child health and development. We supported LHJs in community-level planning and initiatives to prevent ACEs and promote resiliency. Eleven of our state's 35 LHJs chose to conduct activities related to trauma-informed services and ACEs prevention as a strategy for their FFY22

contracts. Some have focused on providing education to LHJ staff and community partners on trauma informed practices, programs, and policies; others engaged in general community awareness on approaches to prevent ACEs and promote resilience.

Increasing Child Maltreatment and ACEs/PCEs data

DOH continued to increase the availability, access to, and use of ACEs, child maltreatment, and child well-being data. We decided not to create a stand-alone EfC data dashboard due to challenges with accessing some child maltreatment data from other agencies.

During FFY22, DOH surveillance and evaluation and child health staff.

- Relaunched the EfC Data Workgroup.
- Re-evaluated and updated child maltreatment, family well-being evaluation metrics, and EfC work.
- Identified data sources and website links for child maltreatment and other child/family well-being data. Complied the list to share with EfC partners and formatted for inclusion on new EfC web pages (planned for 2023).
- Began research for and initial work on a child maltreatment data brief.

DOH surveillance and evaluation staff participated in developing a WA ACES Index through the Fall of 2021 administration of the state Healthy Youth Survey for children/youth in the 6th, 8th, 10th, and 12th grades. This new index included questions addressing exposure to some of the 10 original ACEs and other issues associated with childhood trauma, such as being a victim of bullying and experiencing family housing insecurity. 2021 WA ACEs data was released in 2022 and is available on the Healthy Youth Survey website.

To increase data and information about preventable child deaths to guide prevention planning in Washington, initial planning for a new state Child Death Review process, in partnership with Local Health Jurisdictions (LHJs), began in Fall of 2022. State Foundational Public Health Services funds were allocated to support LHJs' work in this area.

Improving Access to Behavioral Health Services and Supports

During FFY22, as staffing capacity increased, Child Health became increasingly involved in efforts to address growing child and youth mental health concerns. The primary focus during this time was coordinating with other internal and external entities working in this area.

Progress

In FFY22, DOH staff pursued the following objective:

- **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.**

Coordinating Child/Youth Behavioral Health Efforts Across DOH and Partner Agencies

Child Health staff were involved in cross-agency efforts related to child/youth behavioral health. Efforts included participating and contributing to cross-divisional Behavioral Health coordination meetings with DOH internal staff to elevate children and youth mental health needs, cross-agency meetings hosted by the Division of Behavioral Health and Recovery Prenatal-to-25 staff related to the implementation of new child/youth behavioral health legislative requirements (such as School Based Health Center program and funding). Staff also followed the work of the state Child and Youth Behavioral Health Work Group (CYBHWG) and subcommittees (i.e., Prenatal-to-Five, K-12, Workforce) and began attending and contributing to the CYBHWG Strategic Plan Advisory Group meetings, which launched in August 2022.

Promoting Standardized Screening Tools and Interventions for Mental Health and Suicide Ideation

Work on child/youth mental health screening and child/youth suicide prevention was primarily concentrated within the

Adolescent Health Unit as they worked on establishing the new School Based Health Center Program and the OSHC Injury and Violence Prevention Section as they rolled out the 988 National Suicide Prevention Lifeline and the evidence-based Sources of Strength youth suicide prevention curriculum. While there was limited capacity within Child Health to make progress on mental health screening and suicide ideation for younger children in FFY22, there are plans to address this in future years with an emphasis on school settings: elementary age/middle school age groups.

Enhancing Access to Child Behavioral Health Services through Health Care Practice Improvements
DOH staff participated in several efforts to enhance access to and utilization of child behavioral health services. Three specific efforts included the launch of the pediatric Community Health Worker (CHW) pilot program, the child mental health-focused Health Equity Performance Improvement Project with Medicaid Managed Care Organizations, and the planning and awarding of School Based Health Center (SBHC) grants, including specific grants to enhance behavioral health services through existing SBHCs.

CHW Pilot Program: In the 2022 legislative session, the Children and Youth Behavioral Health Workgroup's Behavioral Health Integration into Primary Care subgroup and the Washington Chapter of the American Academy of Pediatrics' (WCAAP) First Year Families steering committee (members include DOH Title V staff) provided legislative priority recommendations included for funding non-licensed professionals, such as health navigators or CHWs, in pediatric primary care settings. Rationale for this recommendation included: rising behavioral health concerns, delays in accessing mental health services, and improving care coordination across primary care and behavioral health services. Advocates for health equity indicated CHWs are critical to supporting clinics in culturally and linguistically relevant services in primary care clinics and medical homes. The result of legislative advocacy was **Engrossed Substitute Senate Bill 5693, Section 211 (103)**, which directed the Health Care Authority (HCA) to establish a two-year grant program for primary care clinics to embed CHWs as part of care teams working with children and youth birth through age 18, develop and submit legislative reports on the impacts of the grant program, and explore longer term reimbursement in collaboration with key partners. The bill also directed DOH to establish a curriculum and provide training for CHWs in primary care clinics serving children and youth from birth through age 18 to support the grant. To comply with the legislation, the DOH Community Workforce and Partnerships Section within OFCHI established a contract agreement with WCAAP to support training curriculum development and hired new program staff to assist the effort. Implementation of the CHW grant program to clinics started in early 2023. CHWs will focus on either Early Relational Health (birth-age 5) or K12 Mental Health (age 5-18).

Child Mental Health Care Utilization Performance Improvement Project: In early 2022, the DOH Health Systems Unit partnered with Medicaid Managed Care Organizations to form a Health Equity Performance Improvement Project Workgroup to address racial and ethnic disparities in Washington State Mental Health Penetration rate among children aged 6-17. The Workgroup considered multiple aspects of mental health care delivery, evidence-based outcomes, and systemic mental health biases faced by vulnerable members of our populations. The Workgroup sought input from communities and enrollees regarding mental health inequities and service disparities.

Child behavioral health care provider shortages and reduced availability of service appointments driven by the COVID-19 pandemic were of concern, as was evidence of racial/ethnic disparities for those with conditions that warranted mental health services and those who actually received services ("Mental Health Service Rate"). The Workgroup aimed to close any race/ethnicity disparities among children aged 6-17 of greater than or equal to a 3% difference from the Statewide average of 67.5% for the Mental Health Service Rate (MHSR) through targeted communications, provider, and community partnerships, and designing the Youth Mental Health Access Project by March 31, 2023.

During the first year of the project (2022), the Workgroup:

- Collected and analyzed data to understand identified disparities and identify regions of focus.
- Designed and distributed a provider survey to understand how behavioral health and primary care providers communicate and collaborate to serve young people with mental health concerns, including the perceived barriers.
- Developed tailored communications in partnership with the Community Health Worker Coalition for Migrants and Refugees, and DOH-driven campaigns to reduce mental health stigma.
- Designed Youth Mental Health Access Project curriculum to promote MCO/clinic partnerships to increase outreach to youth with gaps on the Mental Health Service Rate, prioritizing youth from communities with an identified disparity.

SBHC Program, including behavioral health grants: Further information about this effort is outlined in the Adolescent Health Domain. One of the 17 SBHC grants is for an SBHC in an elementary school serving primarily low income and BIPOC children in the Seattle area.

Assessing Middle Childhood (ages 6-11 years) Needs related to Mental Well-being and Resilience

Child Health staff began an assessment of middle childhood needs with an emphasis on mental well-being and resilience. This grew from concerning data on depression, anxiety, suicidal ideation, and bullying in elementary-age children. Staff conducted an initial review of data related to children ages 6-11, including examining the HYS 6th grade data. This will be an area of focus in FFY23 and 24.

Child Health Priority 3: Optimize the health and well-being of children and adolescents, using holistic approaches

Within this priority, the Child Health Unit and other units worked to address the following State Performance Measures:

- **Percent of incoming kindergarteners who demonstrate the social and emotional characteristics appropriate to their age**
- **Family resilience composite measure (measure added in FFY22)**

Promoting Positive Parenting Skills and Norms

During FFY22, work in this area focused on projects promoting positive parenting skills and norms, as strategies to increase healthy early child development, family well-being, and resilience. These projects and staff time used blended funding from MCHBG, Essentials for Childhood, and private funds.

Progress

During FFY22, DOH had 3 primary objectives focused on promoting positive parenting:

- **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. (This objective was postponed until early 2022 due to issues with staffing capacity and contracting delays)

Activation of Vroom™ Tools and Resources

For the past 3 years (through April 2022), DOH Child Health partnered with the Bezos Family Foundation (BFF) to share Vroom™ brain-building tips and tools with families across Washington State through contracts and trainings with early learning and health providers and direct distribution to families through health promotion mailings. While the BFF funding officially ended in April 2022, Vroom™ remained part of ongoing work through Essentials for Childhood to enhance parenting skills to promote healthy child development. Technical assistance, learning opportunities, and funding were available to support Vroom™ promotion in several communities across the state.

Key activities during the reporting period included:

- Collaborated with 7 community-based subcontractors to incorporate Vroom into their work with families of young children. Each subcontractor implemented an activation plan to leverage existing capacity, resources, and partnerships. For instance, Snohomish Health District coordinated with ChildStrive. This organization works with families and community partners to support young children's success in daily life to incorporate Vroom strategies/resources into several family-serving programs (e.g., Nurse-Family Partnership, Parents as Teachers). Monthly emails, including a Vroom tip in English and Spanish were sent to service providers.
- Engaged state-level partners to integrate Vroom into their parent-family/provider engagement strategies. For example, program partners at the DCYF (i.e., home visitors and child welfare early learning navigators) continued to share Vroom resources with families. HMG WA also added Vroom information to a web page of resources on child development.
- Received data on local efforts to promote Vroom. More than 5,000 Vroom materials were distributed to over 500 families between January and April 2022. During the same period, 163 partners participated in Vroom trainings.
- Disseminated and promoted Vroom to partners across the state using the Vroom Brain Building distribution, including 2,893 subscribers.

Positive Social Norms Campaign (delayed start)

Shifting social norms toward positive parenting approaches and community support for parents and families is increasingly associated in research with the optimization of protective factors and resilience for parents, children, and youth of all ages. In the Summer of 2022, DOH contracted with The Montana Institute (TMI), an organization that helps communities and organizations apply the Positive Community Norms approach to grow healthy norms and positive protective factors, to conduct an assessment and determine the initial need for and feasibility of a social norms campaign to promote positive parenting focused on early relational health and brain development in alignment with current research. This work was accomplished by 1) interviewing key stakeholders in Washington to identify Positive Community Norms (PCN) campaigns that seek to increase positive parenting in parents of children aged 0-8; 2) identifying existing data sources that could potentially be used to develop a statewide PCN campaign and 3) reviewing social media and existing published literature for evidence and/or evaluations of existing campaigns.

Although an abundance of positive parenting resources and messages were identified, the assessment did not uncover any campaigns that 1) identified positive norms, 2) identified misperceptions of the norms, and 3) messaged positive norms to counter misperceptions to grow more positive behaviors and outcomes. A total of 14 potential data sources were also assessed to support developing a statewide PCN campaign. While some data sources included measures to identify possible positive parenting norms (such as reading with children), none of the data sources reviewed provided the data needed to develop a PCN campaign with fidelity.

Based on the assessment findings and TMI's experience in other states, they recommended that primary research in Washington be conducted to develop, implement, and evaluate a PCN-positive parenting campaign for parents of children aged 0-8. Further discussion of goals and desired outcomes is necessary to determine the focus of future survey work, which could include questions related to numerous positive parenting practices, PCEs, and HOPE. Plans are in place to continue this work in FFY23.

Family and Community-Based Primary Prevention and Well-Being Promotion

During FFY22, this area focused on elevating the needs of fathers in child and family well-being promotion and promoting strengths-based protective factor and resilience frameworks with community partners.

Progress

In FFY22, DOH had 1 broad objective in this area:

- **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.**

Promoting Family Resilience through Fatherhood Inclusion

Fathers are often left out of conversations about family well-being. Intentional efforts for fatherhood inclusion are needed to support the vital role that fathers play in promoting child and family well-being. During this reporting period, DOH Child Health partnered with the Department of Social and Health Services (DSHS) colleagues to support fatherhood inclusion activities through the Washington Fatherhood Council. Along with active participation on the Fatherhood Council Steering Committee, DOH Child Health contributed funding resources and support for:

1. Dad Allies Provider Learning Series (virtual) trainings for service providers, including:
    a. Early Relationships Matter: The Parallel Journeys of Fathers and Their Children Across the Early Years (February 2022; 181 registered)
    b. Queer Dads, Myths and Factors; gay parenting (March 2022; 152 registered)
    c. Parenting Together; Even if You're Not (April 2022; 88 registered)
    d. Strategies for Helping Unmarried Parents Establish Co-Parenting Agreements (July 2022; 191 registered)
2. Fathers Matter Community Cafes for fathers to assess fatherhood support needs.
    a. Cowlitz County Café (March 2022; 25 participants)
    b. Re-entry Fathers Café-Pierce County (April 2022; 18 participants)
    c. Spokane Fathers Matter Café (May 2022; 24 participants)
3. 4th Annual Statewide Fatherhood Summit (May 24-26, 2022)
    a. 3 half-days, 248 participants, included international, national, and local voices with a broad background in a variety of critical issues for fathers.

Adverse Childhood Experiences/Resilience Community of Practice

In 2019, as part of the state Essentials for Childhood Initiative, DOH began convening an ACEs and Resilience Community of Practice (CoP), which brought together community and state partners to learn and share approaches to reducing child, family, and community adversity and promoting resilience. While this group continued to meet virtually during the first year of the COVID-19 pandemic, convenings were put on hold in 2021 to reassess the need and structure of the initiative. Staffing and community partner capacity to support this work led to a continued pause during 2022.

While the group remained on pause, DOH staff pursued an opportunity to bring together previous ACE/Resilience CoP members in a learning session focused on the Science of the Positive. In August 2022, ACEs/Resilience CoP

participants were invited to attend a 2-hour interactive workshop led by The Montana Institute, which provided an overview of the Science of the Positive, Positive Community Norms, and Healthy Outcomes from Positive Experiences (HOPE) frameworks and how they can be used in harmony to promote child development, grow Positive Childhood Experiences, and promote a healing-centered approach to help children and adults increase resiliency. The workshop included current research findings and applications of these frameworks. It allowed participants to consider and discuss how they might advance these applications in their own unique contexts. A total of 335 people from communities across the state registered for the workshop. Approximately 150 participated in the workshop. Others were able to view the recorded version after the session. Evaluations were overwhelmingly positive and indicated high engagement and value from the session. Evaluation respondents also expressed interest in similar future events.

Shortly after the workshop, EfC members discussed the potential value of convening smaller, more targeted communities of practice. Interest grew in establishing a Local Health Jurisdiction Community of Practice focused on the HOPE framework. During Fall 2022, DOH Child Health staff applied for and were granted additional staff capacity to support an LHJ HOPE CoP through the DOH Workforce Pathways Program.

Additional Work Supporting Child Health at the Local Level

Many LHJs opted to conduct activities in support of improving child health. LHJs selected activities related to the UDS system rollout, supporting nutrition and physical activity best practices in schools, community centers and other programs accessed by children, supporting community partners in utilizing trauma-informed practices and policies, participating in statewide coalitions to promote the importance of maternal and child health, and monitoring emergent needs and helping families, especially those with children with special health care needs, and improving their emergency preparedness. The following paragraphs summarize the efforts of LHJs in each of these areas.

Universal Developmental Screening (UDS)

Ten LHJs chose to work on the UDS system, including Chelan-Douglas, Columbia, Garfield, Grant, Jefferson, Lincoln, Mason, Seattle-King, Skagit, and Whatcom. Of these LHJs, several conducted outreach to pediatric providers within their communities to gauge their readiness to participate in the UDS rollout. One LHJ (Chelan-Douglas) surveyed childcare providers and found a desire for more training on conducting screenings and the UDS system. Providing training to communities is also an activity that will increase in importance during the coming year as DOH prepares to fully implement the UDS system. The LHJs continue to meet with DOH UDS staff and participate in state peer-to-peer calls, webinars, and other activities.

Healthy Nutrition and Physical Activity Best Practices

Four LHJs (Garfield, Seattle-King, Spokane, and Wahkiakum) selected activities under this strategy to support best practices in schools, before-and after-school programs (including Safe Routes to School), early learning programs, youth community centers, and community settings accessed by children. Approaches included:

- Attended school wellness council/committee with the school district to find out what they (and families) are interested in changing, and share expertise on best practices, including models from the CDC.
- Reviewed childcare center menus, for centers and for family home childcare providers. The reviews were followed up with suggestions to meet Child and Adult Care Food Program (CACFP) nutritional suggestions or substitutes for certain food groups. Additional menu ideas were provided. Food costs and food insecurity were identified as areas of concern for childcare programs due to the economic effects from COVID-19.
- Provided an outline of best nutrition and physical activity practices to add to monthly newsletters for early learning center directors and staff. LHJ staff shared farm to early learning resources with Child Care Aware of Eastern Washington to include in their newsletter updates. Met quarterly with school and Early Childhood Education and Assistance Program (ECEAP) staff to discuss approaches to ensure adequate healthy

nutrition can be accessed by families in the communities that may be experiencing food insecurity. LHJ staff met with school and ECEAP representatives to determine how they could provide support to meet the food needs of families in need. For example, staff are working to set up a sustainable plan to get food that can provided on weekends and over breaks for those in need. LHJ staff are also assisting in finding programs/businesses that can be accessed and what agreements may be put in place to ensure continued food availability for families.

Trauma-Informed (TI) Services/Adverse Childhood Experiences (ACEs)

Of the 35 LHJs, 11 (Adams, Asotin, Benton-Franklin, Columbia, Cowlitz, Grays Harbor, Kittitas, Northeast Tri-County Health District, Sea-King, Snohomish, and Spokane) chose to conduct activities related to TI services and ACEs. These LHJs chose a wide variety of approaches to conducting this work including:

- Collaborated with providers to provide training on ACEs, including strategies to prevent ACEs.
- Provided education to LHJ employees on TI practices, programs, and policies. Encouraged communication between staff members on methods to educate providers within the community.
- Implemented an internal TI agency policy.
- Educated staff on integrating TI approaches into existing work.
- Collaborated with schools and community partners to assess the need for staff and/or community trainings around ACEs/Resilience/TI approaches.
- Planned and implemented local resilience trainings for school staff and other adult influencers, in collaboration with local partners.
- Developed and implemented an assessment of existing programs, organizations and coalitions in the larger community that aim to prevent ACEs and promote resilience.
- Increased the number of opportunities for LHJ staff, community service providers, and/or community members to learn about ACEs, complex trauma, brain science and resilience.
- Conducted “grand rounds” style meetings during which community providers (health care workers, childcare providers) met to share, build community, and collaboratively problem solve about ACEs and trauma and connect providers with the growing body of resources for building resilience.
- Facilitated discussions and provided support to help childcare providers and families understand the importance of how ACEs and complex trauma affect children.
- Met with providers supporting families to understand the community resources to help them build resilience, healthy coping, and prevent ACEs.
- Provided education about “pair of ACEs” and Healthy Outcomes from Positive Experiences (HOPE) via presentations, tailored trainings, and listserv information sharing to cross-sector community partners working with pregnant people and families with young children (0-5).
- Promoted the mitigation and prevention of ACEs by providing education on HOPE and sharing resources from “Project Pinwheel”, a webpage created with the “Our kids: Our business” child abuse and neglect prevention coalition. The main messaging includes information about how the community can support parents so that children grow, play, and learn in safe and nurturing environments.

Maternal and Child Health Coalitions and Task Forces

Four LHJs (Grays Harbor, Skagit, Spokane, and Wahkiakum) chose to work on activities in support of this strategy. The LHJs chose activities such as:

- Continuing participation in local, regional, and statewide early learning coalition meetings.

The LHJs believe that involvement and engagement with these groups will continue to help inform services and highlight the need for local MCH programs, work, and resources. LHJ staff use the information shared at these

coalition meetings to continue to educate their staff and other local groups such as Boards of County Commissioners and Accountable Communities of Health.

MCH Emergency Preparedness Capacity

Three LHJs (Cowlitz, Okanogan, and Whitman) chose to conduct activities in support of this strategy. Activities included:

- Acted as surge capacity during public health emergencies and sharing resources with CYSHCN families, including planning for emergencies.
- Attended quarterly local/regional North Central Accountable Communities of Health (NCACH) meetings and ensured families of children with special health care needs had information about emergency preparedness, like having a physical address on file for EMS purposes.
- Used the Community Health Needs Assessment to look specifically for COVID-related gaps in service and barriers to care in the MCH and CYSHCN communities in the county.

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

Child Health Domain Plan for FY2024

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

National Outcome Measures
Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Percent of children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Background:
Several different units within DOH OFHCI and other DOH support work in this priority area. The primary focus of work is improving the utilization and quality of preventive health care for children, including early identification and intervention for developmental needs, and enhancing the integration of early childhood health systems into the broader early childhood system in Washington state.

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

Strategies:

- Provide leadership, staffing, and funding support for the ongoing development and implementation of the statewide Help Me Grow WA system and related statewide initiatives that include explicit focus on connecting families to developmental screening and resources (e.g., Pritzker Children's Initiative).

- Communicate developmental screening and developmental milestone information through a variety of social media and virtual/live modalities, such as site visits with local health jurisdictions, Watch Me Grow Washington, DOH Facebook and other social media channels, and referrals.

- Incorporate Vroom™ brain building tips and other child development resources in Watch Me Grow Washington mailings.

Status of this Objective
Ensuring early identification of child developmental needs, connecting children with developmental concerns to early intervention resources, and promoting healthy early child development remain high priorities for Child Health, particularly for children experiencing social and economic adversity. Along with working with health care providers on developmental screening practices and data collection (see next Objective), DOH staff participate in leadership groups for statewide initiatives, such as the Pritzker-funded Children's Initiative/Prenatal-to-3 Coalition. These include increasing participation in developmental screening for young children from low-income families through the Help Me Grow WA system as one of 4 primary goals. We are also using a variety of communication channels to increase parent/caregiver awareness of developmental milestones and ideas for promoting healthy brain development, like sharing science-informed tips and tools such as those available through the Bezos Family Foundation (BFF)'s Vroom™ initiative. We include Vroom™ resources, available in English and Spanish, in Watch Me Grow Washington mailings to families of toddlers and provide technical assistance and support to Washington Communities for Children to promote Vroom tools with state partners, including regional/local Early Learning Coalitions.

We anticipate having resources to support including Vroom™ materials in mailers to families through June 2024. DOH will continue to promote these materials and links to Help Me Grow WA resources through the updated Child Health WA Portal website (currently under development, with an expected launch date of July 2023).

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

Strategies:
- Promote utilization of Strong Start Universal Developmental Screening data system with all health care provider practices serving young children in WA state.

- Promote Strong Start with state and local partners that work closely with families of children birth through age five. DOH will provide training and technical assistance, as well as information about resources and supports related to early childhood development.

- Continue coordination between Strong Start and Help Me Grow WA to ensure alignment of developmental data systems and services.

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

Status of this Objective
DOH established a dedicated UDS program in April 2022 to promote developmental screening and support the new statewide data system, officially named Strong Start, to track developmental screenings of children birth through age 5 in Washington state. Program staff worked with the vendor to refine the Strong Start system and conducted active education and outreach throughout the state. Small pilot projects were implemented in 2023 in 2 community health clinics through a contract with the Washington State Chapter of the American Academy of Pediatrics (WCAAP) and in 2 local health jurisdictions (LHJs) as Maternal Child Health Block Grant Special Projects.

The UDS program promoted the Strong Start system to LHJs and tribal leaders at the Washington State Public Health Association conference in October 2022 and anticipates conducting UDS pilots with some partners in 2023

before the statewide rollout in the Fall of 2023. The strategies will be informed by the results of the above-mentioned pilots, input from key state partners, a report from a tribal consulting firm contracted to hold multiple listening sessions with American Indian/Alaska Native (AI/AN) communities, consultation with diverse parent, provider, and early childhood entities throughout the state, and a roadmap developed by the UDS Program team in June 2023.

Activities planned for FFY24 include additional Strong Start pilots, continued refinement of the Strong Start system, including the interoperability with the Health Information Exchange (HIE), expanding the user base to include childcare and early learning providers along with the existing user base of health care providers and parents/legal guardians, and exploring future opportunities to expand interoperability to include early childhood data systems outside of HIE.

Objective:
By September 30, 2024, identify improved methods to track the proportion of children who are receiving timely developmental screenings

Strategies:

- Explore options to improve availability and usability of Medicaid data provided through HCA-DOH mutual data share agreement.

- Explore data agreements with other insurers or other sources to track developmental screening rates.

- Incorporate data from Strong Start UDS data system.

Status of this Objective
Availability of accurate data about the proportion of children in Washington state receiving timely developmental screening and referral remains challenging. This makes it difficult to determine if there are particular populations or geographic areas to concentrate the outreach efforts on. DOH has developed a data share agreement with the HCA that provides the number of children screened yearly. The work to update this agreement to include more information on Medicaid-covered children who have had developmental screenings is ongoing. Currently, UDS is in a testing/approach phase. While the Strong Start data system may assist with this challenge over time, DOH staff will continue exploring options to get more meaningful data, like billing information from health care providers and other methods.

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

Strategies:

- Promote routine well-child visits and recommended preventive care in early and middle childhood (birth to age 11). Activities include Patient/Parent education and provider education.

- Partner with pediatric and primary care clinic systems to engage over-due or unestablished members/children into the practice to receive well-child visits.

- Establish partnerships with early learning focused organizations and school-based health centers to identify and deploy collaborative activities to improve well-child visits.

Status of this Objective
DOH has continued to promote routine well-child visits through a communication campaign and a formal Practice Improvement Project with Medicaid Managed Care Organizations (MCOs) and HCA partners. While the focus on child well-visit promotion will wrap up at the end of 2023 calendar year, materials developed during the campaign will remain available, and lessons learned will be shared. New Medicaid MCO Practice Improvement Projects related to homelessness and Emergency Room follow-up will launch in 2024.

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

State Performance Measures*:*
Social and emotional readiness among kindergarteners.

Ease of receiving mental health treatment or counseling.

National Outcome Measures*:*
Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Background
Work under this priority is focused on increasing access to a comprehensive and integrated system of services and supports for young children and their families to promote healthy social-emotional development and resilience, and expanding access to specific behavioral health services and supports for children and their families.

Objective:
Through September 2025, implement early childhood comprehensive systems (health systems integration) strategic plan in collaboration with state partners and families (MODIFIED)

Strategies:
- Provide state leadership and coordination for development of an integrated and comprehensive early childhood system of services and supports through the Early Childhood Comprehensive System project and other related state initiatives, such as Essentials for Childhood, State Early Learning Coordination Plan, and Pritzker's Prenatal-to-3 Children's Initiative.

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

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

- Work with families and state partners to identify and address ongoing structural barriers within state systems that impact the ability of families to access supports for themselves and their children. Prioritize efforts to eliminate barriers for families who identify as Black, Indigenous, People of Color, immigrant, or LBGTQIA2S+

members; families of children with special health care needs; families who live in rural or geographically isolated areas; and families who experience trauma of parental incarceration, child welfare system involvement, homelessness, substance use disorder and mental illness, and other adverse experience.

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

Status of this Objective
In late summer 2021, DOH was awarded a 5-year HRSA Early Childhood Comprehensive Systems (ECCS): Health Systems Integration grant. Through this funding source, we support Help Me Grow WA to expand health care provider engagement in the coordinated access and referral network and support for integrating local resource information into the centralized state resource database at WithinReach. Key deliverables of this initiative are an Early Childhood Comprehensive Systems Strategic Plan and meaningful parent/family engagement in systems change.

To date, DOH staff have leveraged ECCS and MCHBG resources to:
- Complete an Early Childhood Systems Assets and Gaps Analysis.
- Provide funding to WithinReach to support a Health Care Provider Outreach Manager position to increase health care provider engagement in Help Me Grow WA system development and improve the connection of families to HMG WA resources through health care provider practices.
- Partner with an established community leader to facilitate a focus group of parents/caregivers to learn how to strengthen and build systems that center families for pregnant and parenting families and those caring for and raising children (ages 0-3) at the community and state level.
- Provide funding to WA Communities for Children and local/regional early learning coalitions to identify and connect local resource and referral information to the HMG WA statewide resource and referral directory.
- Complete an ECCS strategic planning document in alignment with the State Early Learning Coordination Plan (a shared state early childhood vision created through extensive family, community, and state partner engagement across multiple sectors) rather than creating a stand-alone plan.
- Strengthen connection with the WA Chapter of the American Academy of Pediatrics (WCAAP) and associated First Year Families group through a contract (May-Sept 2023) to conduct a landscape scan of health care practice and policy/financing summit in September 2023.
- Provide funding to Washington Family Engagement to assess existing family engagement efforts across the state to inform strategies for further engagement within early childhood systems work.
- Prepare an application for Zero to Three's Early Child Developmental Health Systems funding opportunity, to enhance coordination of early childhood health resources at the local level in geographic areas with higher rates of child and family poverty.

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

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

- Support training for clinical and community health workforce on early relational health concepts and promotion

of parent and child social-emotional skill development.

- Promote routine use of social determinants of health screening tools such as evidence-based Safe Environment for Every Kid (SEEK) or Survey of Well-being of Young Children (SWYC) tool in pediatric health care settings, with referrals to resources through Help Me Grow WA or local coordinated access and referral programs.

Status of this Objective
Health care providers are uniquely positioned to promote early relational health to enhance infant and early child social-emotional development. Providers can also help identify social and economic challenges facing families that may be causing stress and negatively impacting parent-child relationships and mental well-being and linking them to needed supports. DOH is partnering with the WA Chapter of American Academy of Pediatrics (WCAAP) and the "First Year Families" initiative to assess existing practices and opportunities to expand focus on early relational health and identify social and economic factors impacting child and family well-being. As of May 2023, we are contracting with WCAAP to engage a physician champion and diverse health care providers in early childhood health systems development, conducting a landscape scan of statewide health care practice to identify current efforts, barriers, and opportunities to promote equitable, family-centered care for children and families (prenatal to age 3), and convening state policy and financing leaders to develop a roadmap for policy and financing solutions to address barriers to care. Specific attention to health care practices and policies that focus on parental mental health and substance use, early relational health, and screening/referral for Social Determinants of Health is an expectation in the contract agreement with WCAAP. DOH staff anticipate using the findings of the health care practice landscape scan and policy/financing recommendations to guide work in FFY24, including developing provider trainings as appropriate.

As part of a 2-year Pediatric Community Health Worker (CHW) pilot program funded in part by the state legislature in the 2022 session, DOH was directed to develop and implement training for primary care clinic-based CHWs focused on early relational health and K-12 mental health. DOH Community Workforce and Partnerships Section staff are working with WCAAP to create and implement the new training, which is expected to be completed by June 2023. DOH continues to partner with HCA, WCAAP, and others to explore longer-term Medicaid reimbursement for CHWs, and broader opportunities to support clinical and community based CHW workforce. DOH is leveraging MCHBG funds to support ongoing staffing for maternal and child health focused CHW workforce development efforts through FFY25.

Objective:
From January 2021 through September 2025, work with partners to expand availability and access to behavioral health services for children ages 11 and under and families.

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

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

- Support interventions to address suicide ideation among children, especially among children who are

involved in child welfare systems, LGBTQIAS+, Black, Indigenous, and People of Color

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

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

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

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

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

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

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

Status of this Objective

Access to behavioral health services and supports for children, youth, and their families remains a challenging issue and a top state priority. DOH staff from Child Health and other units are participating in the state Child and Youth Behavioral Health Strategic Plan Advisory Council meetings to inform the development of the legislatively mandated state behavioral health strategic plan for children and youth. Staff also work closely with partners at HCA to coordinate Infant and Early Childhood Mental Health initiatives. DOH Child Health staff coordinate with other programs within the Thriving Children and Youth Section, broader OFCHI and across DOH on child behavioral health issues, including connections with the Perinatal, Adolescent Health, CYSCHN, Health Systems, Injury and Violence Prevention, and Prevention and Community Health Division Policy Team. In 2022, DOH convened an Agency Behavioral Health Workgroup to articulate the public health role in mental illness and SUD prevention, focusing on children and youth. In 2023, Prevention and Community Health Division leadership has requested additional coordination across OFCHI and OHSC on child and youth behavioral health issues to ensure a cohesive approach.

In May 2023, the Child Health Unit brought on a new staff member with a background in social work with marginalized youth. This added capacity will allow us to direct more attention to child and youth behavioral health issues. Staff will continue participating in cross-agency and cross-sector efforts to expand access to behavioral health services while bringing the upstream prevention perspective to these conversations. Areas of particular concern that we will focus on in FFY24 include: the impacts of social media and social isolation/disconnection on child/youth mental health; bullying behaviors in middle childhood, given the significant correlations between bullying and mental health problems. And access to culturally specific services to better meet the needs of Black, Indigenous, and People of Color, immigrant, and rural children, especially those identifying as LGBTQIA2S+ or involved in the child welfare system/foster care.

Objective:
By September 30, 2024, launch a communications campaign focused on supporting middle childhood mental well-being (ages 6-11 years), including addressing impacts of social media use and bullying (MODIFIED)

Strategies:

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

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

- Identify and support evidence-based practices to prevent and reduce the harmful impacts of bullying and social media on children (NEW)

- Conduct research on need for and feasibility of communications strategy related to social media and bullying in middle childhood (NEW)

Status of this Objective:
In December 2022, DOH Child Health staff, in partnership with Surveillance and Evaluation staff, initiated an assessment of middle childhood needs emphasizing on mental health and well-being.

Mental health was identified as an area of focus based on the prevalence of outcomes, including suicidal ideation, attempted suicide, and the Children's Hope Scale observed in results from the 2021 Healthy Youth Survey. The assessment focused on these outcomes and risk and protective factors for mental health and well-being. Protective factors included having a trusted adult and opportunities and rewards for prosocial involvement at the community and family levels. Bullying, low commitment to school, and availability of and attitudes toward drug use at the community and peer-individual levels were identified as risk factors.

Findings to date reveal a marked difference in the prevalence of mental health outcomes, and known risk and protective factors, between 6th and 8th graders. 6.2% of students in 6th grade reported low overall hope, compared to 9.2% of 8th graders. Preliminary findings suggest a high prevalence of certain risk factors, such as low commitment to school (58.1%) and having been bullied in the past 30 days (31.6%) among 6th graders, as well as a higher prevalence of risk factors related to drug use among 8th graders than among 6th graders. Results also showed a lower prevalence of protective factors for mental health among 8th graders than among 6th graders. For example, 59.7% of 6th graders reported having adults to turn to when feeling sad or hopeless, whereas 51.7% of 8th graders reported having this type of support.

These early findings collectively highlight middle childhood as a potential period of interest, particularly regarding changing environmental factors that may mitigate or adversely impact mental health outcomes.

In April 2023, the American Psychological Association released a Health Advisory on Social Media Use in Adolescence. The report indicates that social media risks to healthy development are likely greater in early adolescence due to biological and neurological changes before puberty. Beginning in FFY23 and continuing into FFY24, Child Health staff will explore the need for and feasibility of a communications campaign or other strategy to reach health care and other service providers, families, and children regarding the risks of social media use and

approaches to mitigate risks. This work will include examining research on corporate social media practices, the normalization of suicide and bullying behaviors through social media, and their impacts on child development and well-being in the pre-puberty years.

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

State Performance Measure
Family resilience composite measure (NSCH)

Background:
Work in this priority area focuses on supporting community and system-level approaches to reduce child and family adversity, and promote family and community resilience, particularly in the early childhood period. A new objective related to child fatality review and prevention planning has been added.

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

Strategies:

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

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

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

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

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

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

- Incorporate learnings from the Inventory of What Works (to reduce child maltreatment/increase family resilience) Project for state and local prevention planning. (MODIFIED)

- Convene Communities of Practice to promote shared learning and increase connections between community and state partners working on ACEs, PCEs, and resilience.

Status of this Objective: As of May 2023, DOH Child Health continues to convene the Essentials for Childhood (EfC) partners through quarterly Steering Committee and bi-monthly Leadership Group meetings. Over the past year, EfC partners have had robust discussions about the future direction of EfC and reiterated their commitment to the work, with a focus on promoting equitable outcomes for young children and families. Strengthening Families Locally, an initiative sponsored by partner agency, the Department of Children, Youth, and Families, was highlighted.

In connection with EfC work, DOH Child Health staff actively participate in efforts to elevate the inclusion of fathers and the needs of fathers in child and family health program planning. Ongoing activities (including into FFY24) include:

- Coordinating with partners at DSHS on father inclusion efforts, including active participation on the Washington Fatherhood Council Steering Committee.
- Providing funding support for Dad's Ally Series and Annual Fatherhood Conference (2022)
- Supporting the development of an ongoing MOU with DSHS to support fatherhood inclusion in DOH and other state agency programs and services.

In August 2022, DOH contracted with a consultant to review the Inventory of What Works project to-date and suggest the next steps. Recommendations included:

- **Systems mapping** of all WA state agency-related efforts (projects or initiatives) that touch early childhood resilience to help improve coordination, align success outcomes, and ultimately sharpen an overall Theory of Change / Theory of Action.
- **Reporting and tracking** of ongoing cross-agency initiatives. Potentially aligning all early childhood resilience efforts to the 5 CDC Child Abuse and Neglect strategies (i.e., economics, social norms, health & education, parenting skills, and interventions).
- **Identifying internal/external facing information and audiences** for outputs and assets of the Inventory, including 1) LHJs and community partners and 2) other state-wide agencies, and 3) community organizations and families.

Since 2019, DOH has convened an ACEs/Resilience Community of Practice (CoP). This was paused in 2021 during the COVID-19 pandemic. Due to ongoing challenges with limited staffing and partner capacity, staff decided to continue the pause on reconvening the large cross-sector group. However, DOH staff worked with The Montana Institute to host a Science of the Positive workshop in August 2022 with robust attendance from ACEs and Resilience Community of Practice participants.

Despite the continued pause on the broader ACEs/Resilience CoP, a new approach focused on smaller and more intentional Communities of Practice, specifically for advancing the Science of the Positive and the Healthy Outcomes from Positive Experiences (HOPE) framework emerged through discussion with partners. DOH staff are working with Local Health Jurisdiction HOPE champions to support an LHJ HOPE CoP, which launched in early 2023. DOH applied for and received additional staffing support for this work through the DOH Workforce Pathways Program, and staff are completing the HOPE facilitator training. This work will continue and grow in FFY24. Plans include working with LHJ partners to develop and implement a HOPE workshop for the annual state public health conference in Fall 2023. We are exploring the possibility of supporting additional reach of the HOPE framework within DOH and with other partner groups, including tribal groups, if interested.

Objective:
By March 31, 2024, develop a positive community norms campaign or educational awareness campaign focused on focused on community support for children and families. (MODIFIED)

Strategies:

- Determine scope and scale of positive community norms campaign.

- Develop and test messaging, identify message dissemination strategies to support related areas of interest (e.g., ACEs, trauma-informed/healing centered services).

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

Status of this Objective

In August 2022, DOH contracted with The Montana Institute (TMI) to conduct a feasibility assessment of a norms campaign focused on positive parenting. The work included assessing existing campaigns and the availability of norms data. The assessment determined insufficient current norms data about positive parenting to support a Washington state campaign. Based on the information from the feasibility assessment, DOH established a new contract with TMI in early 2023 to develop a process for collecting baseline norms data. Based on feedback from partners, we decided to shift from a focus on norms related to individual parents and positive parenting practices to a broader focus on community norms related to supporting parents and families (e.g., community support for ALL families, norms around parent help seeking, and service utilization). The pilot survey's initial development and testing are expected to be completed by September 2023. Given the impending end of EfC funding, staff are working to identify additional resources to continue the project and work with communities to launch the positive community norms campaign in FFY24.

Objective:

By June 30, 2024, develop an approach to measure and monitor community contextual resilience/community factors that reduce or mitigate childhood adversity and support positive child and family well-being outcomes (MODIFIED)

Strategies:

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

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

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

Status of this Objective:

The lack of available data to guide work in advancing child and family well-being has created challenges in bringing attention to the issues and measuring and monitoring the success of child health-related interventions at the population level. In early 2023, DOH staff, including Child Health staff, began participating in the planning and 2024

roll-out of a new statewide “Child Wellness Survey” based on the successful King County Best Starts for Kids Child Health Survey. This survey, which will eventually capture data for children ages 6 months to age 11 years, is made possible by state Foundational Public Health Services investments. The initial plan is to focus on a survey for the 6 month-5-year-old population due to challenges with sampling methodology for the 6–11-year population. Parents complete the surveys.

In 2021, DOH and partners launched the first Washington HYS ACEs index (WAH-ACE) through the Fall 2021 Healthy Youth Survey (HYS) administration. https://www.askhys.net/AboutData from this new index became available in late 2022. This index includes a compilation of questions about feeling safe at school, experiencing bullying and dating violence, witnessing violence, experiencing physical and emotional abuse, and having household economic challenges (housing/food security). There are strong correlations between a higher ACEs index and youth mental health (depression/suicidality) concerns.

Along with understanding and measuring individual child and family resilience factors, community partners and state policymakers have expressed interest in exploring the measurement of protective factors within communities (e.g., community cohesion, caring for others, presence of high levels of unmitigated trauma, etc.) that mitigate the risk of childhood adversity and intergenerational transmission of trauma.

During the past year, DOH Child Health staff have:

- Partnered with the Center for Child and Family Well-being at the University of Washington to host a half-day interactive Research-to-Real World forum on Community Protective Factors in November 2022. Twenty Essentials for Childhood partners, researchers, and community advocates attended this event.
- Developed an interagency agreement with Washington State University to identify modifiable community-level protective factors for preventing childhood adversity and reducing intergenerational transmission of ACEs. This study intends to recommend an approach to measure and monitor these community-level factors through developing and implementing new population-based survey questions/tools or other mechanisms. Phase 2 of this work is expected to be completed in June 2024. Staff are currently exploring funding options to support another phase of this project.

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

Strategies:

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

- Use a racial equity lens to prioritize economic stability strategies that address economic inequities experienced by Black, Indigenous, and People of Color children and families.

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

- Continue work with state and local partners to improve access to and navigation of family supports and services (including economic supports) through development of state and local coordinated access and

referral networks (Help Me Grow WA and related local efforts)

Status of this Objective

Reducing family and economic stress is essential to improving well-being and promoting optimal health. Fortunately, Washington is at the forefront of states advancing key family economic support policies, including Paid Family and Medical Leave and Working Families Tax Credits. The state is also leading in addressing poverty as a state priority, with the creation of the Dismantling Poverty Plan, a Governor-supported and community-driven plan to address root causes of poverty and promote individual and family economic security. Key work in this area is connected to the Essentials for Childhood Initiative, which receives funding support from the CDC and MCHBG. In particular, EfC partners have identified opportunities to improve family well-being and reduce child adversity through advocacy for new economic and parent support policies (e.g., Guaranteed Basic Income) and strategies to increase equitable access to existing family support policies, e.g., Paid Family and Medical Leave, After-Pregnancy Coverage (extension of Medicaid coverage up to 12 months post-partum).

Over the past year, DOH staff have advanced work in this area through:

- Working in partnership with EfC to develop a Policy Strategy Framework and monitor legislation in alignment with the framework. The framework outlines 4 policy priority areas: 1) Family Economic Supports/Basic Needs, 2) Parent/Parenting Supports (including parental behavioral health), 3) Supportive Communities, and 4) Responsive/Trauma-Informed Systems. The framework also calls out the need to evaluate and monitor the implementation of existing policies to ensure equitable access and utilization of benefits.
- Hosting a series of Policy Working Sessions with EfC partners and DOH policy staff including a review of legislation as it advanced through the 2023 session.
- Leveraging state youth mental health funding to launch a Paid Family and Medical Leave (PFML) Implementation Evaluation Project, focused on identifying facilitators and barriers to using PFML benefits for mental health care for either a parent or a child.
- Joining with other state agency and community partners connected to the Dismantling Poverty Plan in a 2-day meeting (May 2023) on Aligning Toward Justice, Co-Governance, and Well-being to represent DOH/EfC child and family focused-work.
- Participating in the Pritzker Prenatal-to-3 Coalition, focused on increasing access to and utilization of family services, including concrete supports for basic needs, for families with young children.
- Participating in the state Early Learning Advisory Council, which advises on implementing Fair Starts for Kids Act and recommends funding allocation to enhance access to childcare, including expanded eligibility for state childcare subsidies and other supports.
- Participating in Pierce County Family Connects Community Advisory Board to learn about the Family Connects pilot project in Pierce County and the challenges families and systems face to meeting their basic needs. This participation intends to inform broader home visiting/family support efforts.
- Continuing support of Help Me Grow WA expansion and strategic planning processes.
- Coordinating with HCA, DCYF, and WithinReach/Help Me Grow WA staff on joint policy priorities and projects.

DOH staff will continue to work with partners to support the implementation of joint policy strategies while ensuring compliance with federal, state, and agency rules for policy advocacy. DOH staff will also continue participating in state efforts to improve the Help Me Grow WA system, connect families with needed supports, and expand access to supportive services like home visiting and childcare. We will also prioritize efforts to eliminate barriers for families who identify as Black, Indigenous, People of Color, immigrant, or LBGTQIA2S+ members, families of children with special health care needs, families who live in rural or geographically isolated areas, and families who experience

the trauma of parental incarceration, child welfare system involvement, homelessness, substance use disorder and mental illness, and other adverse experiences.

Objective:
By October 1, 2023, and ongoing, implement sustainability plan to continue progress on child and family well-being strategies and actions identified in collaboration with Essentials for Childhood partners. (MODIFIED)

Strategies*:*

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

Status of this Objective
Our current 5-year grant from CDC for the Essentials for Childhood initiative ends in August 2023. Over the past 4.5 years, we have leveraged various funding sources, including MCHBG, to support strategies aligned with this initiative. A new funding opportunity for the continuation of EfC work was announced in April 2023. Unfortunately, some requirements related to ACEs/PCE surveillance did not align with WA state processes, and the DOH team decided not to apply for this opportunity.

The EfC Steering Committee came together in April 2023 for a planning retreat to set the stage for continued work. This included refreshing the EfC vision and purpose and an interest in advancing a movement toward "flourishing children and families" with increased involvement of community leaders and continued centering on equity. Staff work with EfC partners through the end of August 2023 and beyond to inform and implement the sustainability plan.

Objective:
Through September 2025 and beyond, establish a comprehensive state Child Fatality Review Program to identify preventable factors contributing to child deaths, develop recommendations for addressing these factors, and create state and local prevention plans. (NEW)

Strategies:

- Facilitate coordination and shared learning among Local Health Jurisdiction Child Death Review programs. (NEW)

- Provide technical assistance to local Child Death Review (CDR) teams. (NEW)

- Develop and implement processes for reviewing local CDR findings and creating recommendations for addressing preventable factors contributing to child deaths. (NEW)

Status of this Objective
In 2022, DOH Child Health and other staff (OFCHI Surveillance and Evaluation and OSHC Injury and Violence Prevention) began supporting a CDR Community of Practice with Local Health Jurisdictions that have chosen to work on CDR as part of enhanced state Foundational Public Health Services funding. DOH's role is primarily facilitation and connection to state and national resources, such as the National Center for Fatality Review and Prevention, including identifying and coordinating training opportunities.

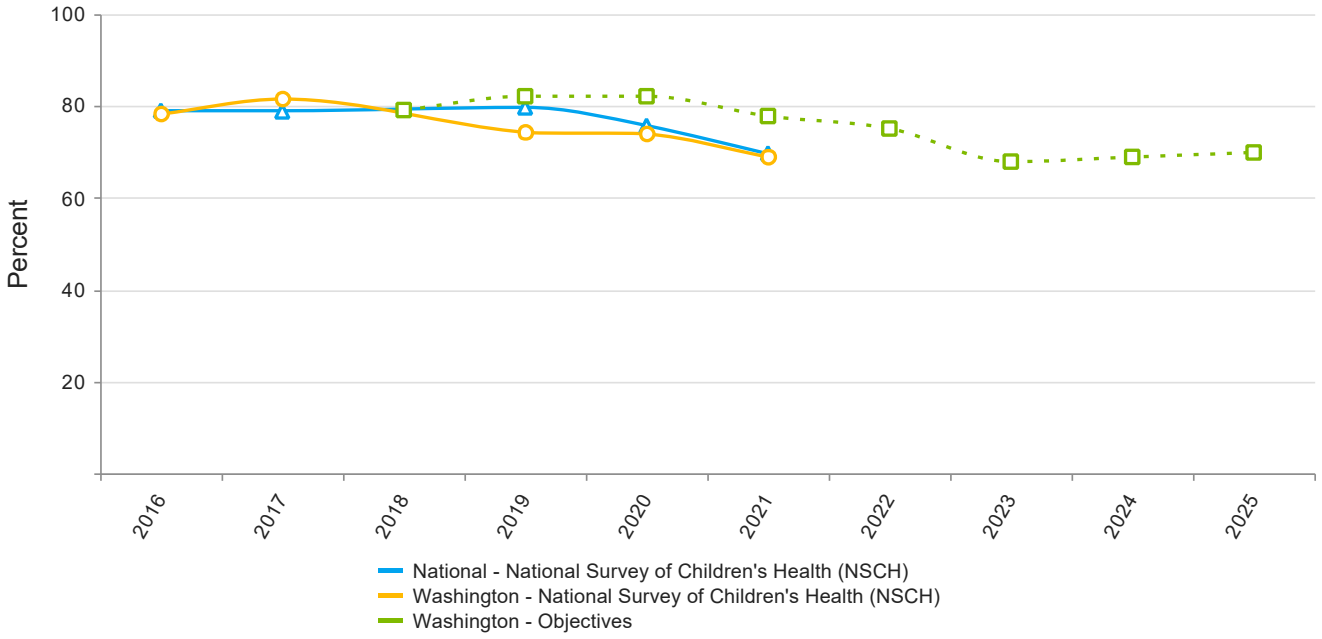
During FFY24, DOH staff will explore longer-term opportunities to strengthen this work, including a process (e.g., Child Fatality Review Panel, like the Maternal Mortality Review Panel) to compile and review local findings, explore

patterns of preventable factors contributing to child deaths, and develop state recommendations for prevention. DOH staff will continue to support local teams in this work.

Adolescent Health

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	79	82	82	75	75
Annual Indicator	81.3	81.3	74.0	68.9	68.9
Numerator	432,006	432,006	405,716	384,050	384,050
Denominator	531,119	531,119	548,292	557,597	557,597
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	67.8	68.8	69.8

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			50	69.9
Annual Indicator	68.4	68.4	69.2	69.2
Numerator	56,854	56,854	58,466	58,466
Denominator	83,120	83,120	84,488	84,488
Data Source	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2018	2021	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	70.6	71.3	72.0

State Performance Measures

SPM 7 - Percentage of tenth grade students who have an adult to talk to when they feel sad or hopeless

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			60.5
Annual Indicator	59.9	60.4	60.4
Numerator	49,792	51,027	51,027
Denominator	83,120	84,488	84,488
Data Source	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2021	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	60.6	60.7	60.8

SPM 8 - Percentage of tenth grade students who report having used alcohol in the past 30 days

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			15.8	14.8
Annual Indicator		18.8	8.4	8.4
Numerator		15,627	7,097	7,097
Denominator		83,120	84,488	84,488
Data Source		Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year		2018	2021	2021
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	13.8	12.8	11.8

SPM 9 - Adolescents reporting at least one adult mentor

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			74.4	66.5
Annual Indicator		69.8	65.3	65.3
Numerator		58,018	55,171	55,171
Denominator		83,120	84,488	84,488
Data Source		Healty Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year		2018	2021	2021
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	68.0	69.0	70.0

State Action Plan Table

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

Priority Need

Identify and reduce barriers to quality health care.

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By September 30, 2025, develop and provide technical assistance for school-based health centers and adolescent health providers so they report the ability to appropriately bill insurance for 50 percent of services delivered.

By September 30, 2023, have a sustainable comprehensive sexual health network focused on youth from historically underserved communities.

By September 30, 2023, conduct an Adolescent Health needs assessment to learn more about adolescent experiences with health care; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.

By September 30, 2023, discuss key health topics with the Youth Advisory Council to learn more about their thoughts, ideas and recommendations for health needs and gaps. By September 30, 2023, identify/develop strategies and interventions to increase access to healthcare services for young people that are based on the ideas and recommendations of the Youth Advisory Council.

By September 30, 2023, partner with youth volunteers to develop and implement an adolescent health promotional campaign using social media.

Strategies

In collaboration with payers and health coverage organizations, understand and mitigate issues related to financial eligibility for health care and other support services.

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

Conduct needs assessment to identify existing strengths and gaps in data, as well as top barriers for adolescents and young adults in seeking health care services.

Ensure all adolescents and young adults, regardless of race, ethnicity, sexual orientation, and gender identity, have a full range of education, access, and ability to utilize health services that meet their individual needs.

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

ESMs	Status
ESM 10.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
NOM 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 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

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

Priority Need

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

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By September 30, 2022, form youth advisory council and hold at least one initial meeting and by September 30, 2023 discuss adolescent well visits and adolescent and young adult care and services.

By September 30, 2023, conduct an Adolescent Health needs assessment to learn more about adolescent experiences with adolescent and young adult well visits, and transition care; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.

By September 30, 2023, partner with the Washington School Based Health Alliance and the Health Systems Transformation Team to present information about School-Based Health Centers, and their importance in improving access to health care and well visits for adolescents.

By September 30, 2022, award grants to plan, start, and improve school-based health centers throughout Washington, primarily in communities that have been historically underserved. This objective has been completed.

Strategies

Include adolescents in this work through strategies such as building and supporting a youth advisory council, and identify other meaningful ways to engage the population to be served.

Collaborate with internal and external partners to identify and implement solutions that support accessible, affordable, and quality childcare, including care that meet the needs of families with CYSHCN.

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

ESMs	Status
ESM 10.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 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 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

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

Priority Need

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

SPM

SPM 7 - Percentage of tenth grade students who have an adult to talk to when they feel sad or hopeless

Objectives

By September 30, 2023, conduct an Adolescent Health Provider needs assessment to learn more about provider experiences with behavioral health screenings and risk assessments; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.

By September 30, 2022, award nine or more grants to SBHCs for behavioral health services.

By September 30, 2023, partner with youth volunteers to develop and implement an adolescent behavioral health awareness campaign using social media.

By September 30, 2025, provide accessible trainings for SBHC providers on trauma informed care, adolescent friendly services, and discussing sensitive topics. By September 30, 2025, implement efforts to expand trainings to additional adolescent and young adult friendly providers.

By September 30, 2022, discuss mental and behavioral health with the Youth Advisory Council to learn more about their thoughts, ideas and recommendations for behavioral health needs and gaps, including stigma around BH care and suicide prevention. This objective has been completed.

By September 30, 2025, identify/develop behavioral health interventions for young people based on the ideas and recommendations of the Youth Advisory Council.

By September 30, 2023, conduct an Adolescent Health needs assessment among youth to learn more about adolescent experiences with medical and behavioral health care; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.

Strategies

Improve the knowledge and ability of health care professionals to deliver comprehensive evidence-based/informed services, including integrated mental health and chemical dependency screening and interventions for adolescents and young adults.

Promote standardized depression, anxiety, and substance use screening that are adolescent and young adult-friendly.

Take action to reduce stigma surrounding adolescent and young adult behavioral health conditions and implement trauma-informed services specific to adolescents and young adults in community services and health care systems.

Expand access to and the quality of behavioral health services in SBHCs.

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

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

Priority Need

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

SPM

SPM 8 - Percentage of tenth grade students who report having used alcohol in the past 30 days

Objectives

By September 30, 2025, increase the number of school-based health centers with licensed mental health services by 5 percent.

By September 30, 2023, hold at least 10 Youth Advisory Council meetings, where behavioral and mental health care – including substance use among youth– are discussed.

By September 30, 2022, collaborate with internal and external partners (including OSPI and S/E) to identify strengths and gaps in data, and define strategies to address them. This objective has been completed.

By September 30, 2023, provide funding to support health campaigns in SBHCs that promote awareness/reduce stigma around adolescent substance use.

Strategies

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

Build on efforts to identify scope of impacts of substance use, including inequities among adolescents and young adults from priority populations.

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

Priority Need

Improve the safety, health, and supportiveness of communities.

SPM

SPM 9 - Adolescents reporting at least one adult mentor

Objectives

By September 30, 2025, reduce the percentage of 10th grade students receiving our interventions who reported that someone they were dating limited their activities, threatened them, or made them feel unsafe by 10 percent (from 9.5 to 8.5 percent).

By September 30, 2025, continue to work to align violence prevention efforts with partners, including DOH Injury and Violence Prevention and the Office of the Superintendent of Public Instruction (OSPI)

By September 30, 2025, continue to promote resources and information about, and support projects that promote healthy relationships for young people.

By September 30, 2025, continue to participate in OSPI's monthly School Safety and Student Wellbeing Workgroup to align efforts with agency partners.

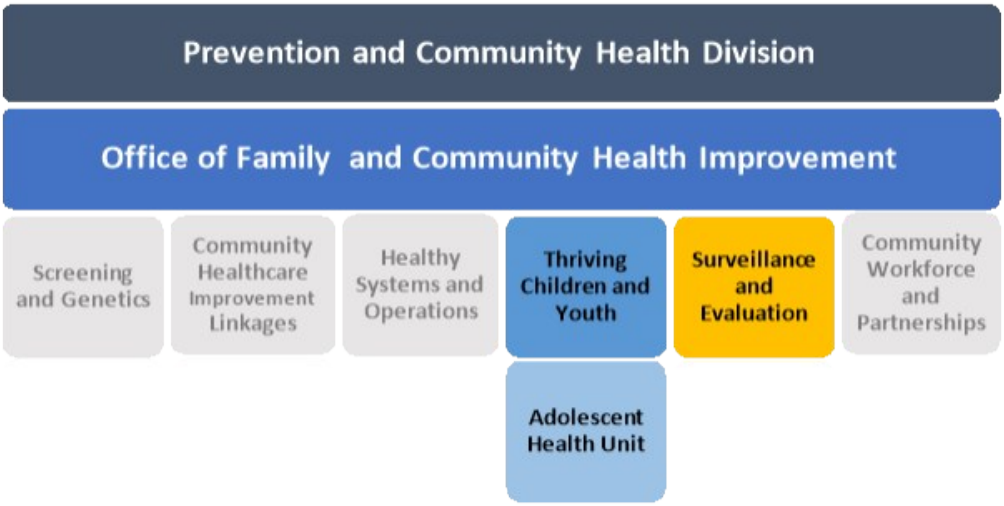
Strategies

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

Align violence prevention efforts with partners, including DOH Injury and Violence Prevention and the Office of the Superintendent of Public Instruction (OSPI)

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

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



Adolescent Health Domain Annual Report

Overview

The Adolescent Health unit at the Department of Health (DOH) sits in the Thriving Children and Youth section of the Office of Family and Community Health Improvement in the Division of Prevention and Community Health. This 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 among priority populations.

We strive to be human-centered, collaborative, inclusive, data-driven, and innovative. Program goals include youth access to quality age-appropriate health care services and coverage; 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.

Adolescent Health Programs

Our state action plan for adolescent health focuses on the following priorities: supporting youth behavioral health care; improving access to and the quality of adolescent and young adult health care; supporting sexual and reproductive health and education and access to appropriate services; and improving access to and experience with sexual health care.

The Adolescent Health Team addresses selected priorities, performance measures and strategies through the programs and projects described throughout this report, and essential partnerships with internal and external partners.

School-Based Health Center Grant Program

Support of school-based health centers (SBHCs) is a key strategy we use to address several priorities, performance measures and objectives. SBHCs increase access to youth-friendly, age-appropriate services for young people in

places where they already spend a lot of time and have relationships with trusted adults. SBHCs in Washington – including those funded by DOH – provide a combination of integrated and comprehensive medical, behavioral, and sexual health care (and sometimes dental care) in or next to schools and are operational during school hours. The benefits of SBHCs are numerous and include increased access to youth-friendly health care services, improved graduation rates, positive youth development, and decreased rates of riskier behaviors (for more information, go to: Top 10 Benefits of School-Based Health Centers | California School-Based Health Alliance (schoolhealthcenters.org)). In addition, SBHCs in Washington are locally controlled and represent collaborative partnerships between the community, schools, and local health care providers. This ensures each unique community's needs are being met, making them an effective tool to addressing health equity at the mezzo level.

In July 2021, the Adolescent Health Team worked with partners to implement SHB 1225: Concerning School-Based Health Centers (codified at RCW 43.70.825). The law directs DOH to expand and sustain SBHCs throughout the state and prioritize students from communities or populations who are historically underserved. The legislation allocated $1.35 million for SBHC planning, startup, and operations grants. In the 2022 legislative session, DOH submitted an agency request for additional funding to expand and improve behavioral health services in SBHCs. The request was part of a larger Young Adult Behavioral Health Improvement (ESSB 5963) request, and was ultimately included in the 2022 operating budget and allocated an additional $720,000 for SBHC behavioral health improvement and expansion grants.

Over the reporting period, the Adolescent Health Team met significant milestones for the new SBHC program and implementation of both pieces of legislation. Activities included:

- We contracted with the Washington School-Based Health Alliance (WASBHA) to provide technical assistance, support, and training to SBHCs statewide and to assist us with development of grant funding criteria. WASBHA provided guidance on funding levels for grant types, the grant application and process, and ultimately helped us select final grantees.
- In winter and spring 2022, we recruited and hired two new staff to manage the new funding and grants. Both grant coordinators collaborated on the new SBHC program development, grant application materials, and now monitor and manage all four types of SBHC grants (formalized as contracts with DOH).
- In spring/summer 2022, we released two Requests for Applications (RFA) for the four SBHC grant types. Collectively, we received over forty grant applications. We convened a grant review committee to score each grant application. Then, based on overall grant projects and scores and findings of the review committee, we selected 17 SBHC grant sites to fund for the 2022-23 fiscal year. Grant projects kicked off in July and October 2022. Their first grant project deliverables consisted of formalizing workplans, meeting with WASBHA to outline technical assistance and support needs and attending Community of Practice meetings with us to share about projects, challenges, and solutions. For more information about grant types, amounts, and awards, go to: SBHC Planning, Start Up and Operations Grant Information | WaPortal.org and Behavioral Health SBHC Grant Information | WaPortal.org
- For more information about all grant sites, please see our SBHC Story Map at: School Based Health Center (arcgis.com)

Youth Advisory Council

We recognize the importance of getting input from young people on all our programs. As such, we have increased efforts to engage young people in more of our work. Engaging youth and ensuring their perspectives are reflected in our work has always been a priority, and over the reporting period, we formalized youth engagement in two new programs, including the new Youth Advisory Council (YAC). The YAC is a community engagement group comprised of 40 teens and young adults from all over Washington. We meet with this group every other month to discuss challenges, issues, and problems in health care, and youth-friendly solutions to address them. Our commitment to

this group is to take what we learn and integrate their perspective, feedback, and recommendations directly into our programs and projects. In addition, we have committed to exploring and implementing new projects and programs based on their recommendations and sharing their findings and recommendations with relevant partners throughout the state. Engaging with the youth advisory council will allow us to better represent the individuals we serve, and to expand our reach to more of the community.

Over the reporting period, we planned, recruited, and selected a new Youth Advisory Council, and had the honor of meeting with them three times. We have shared some details below. More will be shared in the upcoming report, scheduled to be released during the next reporting period.

- In December 2021, we released an application for young people ages 13-21 from all over Washington to apply to join the new YAC. Nearly 300 teens and young adults applied.
- In February 2022, we selected forty young people after application review by a small selection committee. Members were selected based on overall application score, their geographic location, and their identities and lived experiences to ensure a diverse group.
- In April 2022, we held our first kickoff meeting to discuss expectations of DOH and the YAC, the process, and get to know each other. We also asked them about their favorite activities to do online. In August, we also began meeting to plan the next generation of the YAC. Applications for that group were available in December 2022. The YAC Meeting was scheduled for October 2022.

Youth Voice Volunteers

The second youth engagement activity we implemented was to bring on two Youth Voice volunteers. Volunteers differ from the Youth Advisory Council in that they work with us directly on public health projects and create project plans and content that we use. Both volunteers were high school students and spent 12 months with us. Collectively, they helped us with three communications projects based on their interests and abilities. Here's what they did over the reporting period:

- One of our volunteers was interested in learning how to design webpages. She collaborated with the Teen Pregnancy Prevention Team and our agency communications team to update our WYSHIIN grant partners webpage. You can see that project here: WYSHIIN Interactive Map | WaPortal.org
- One of our volunteers was interested in social media and helped us make them relevant to young people. He had a lot of interest in health literacy for youth and devised a small social media campaign for October's Health Literacy Month. Social media posts were framed for teens and young adults and focused on personal health literacy. We created a social media toolkit to share with our partners so they can also promote this important topic. The interest in health literacy had an impact on the entire agency, and prompted DOH to create a personal health literacy webpage so everyone can learn more. You can see that here: Health Literacy | Washington State Department of Health

Adolescent and Young Adult Health Needs Assessment

Besides engaging directly with youth, we also wanted to hear from youth around the state. To do this, we collaborated with the Evaluation Team in our office to increase youth voice and representation in the MCHBG 5-Year Needs Assessment by developing a complementary Adolescent Health Needs Assessment (AYAH NA). We developed a multi-pronged approach that consisted of two surveys, one geared to adolescents and young adults, and one geared to youth-serving health care providers. We are also exploring the potential for listening sessions and key informant interviews with providers for the next reporting period.

During the reporting period, we submitted formal IRB exemption, and created the youth survey. We brought in a young adult intern to help us with the youth survey to make sure the questions made sense to young people, and to help us create communications materials that were youth friendly. The final survey for providers consists of open-

ended questions around the services they provide, including screening and risk assessments, well-visits, adolescent-friendly care, telehealth, general barriers/challenges, billing/reimbursement, and more. In the next reporting period, we will finalize and release the survey and develop communications materials to help us get the word out. For more information, go to: Adolescent Health Needs Assessment | WaPortal.org

Over the next reporting period, we will work on the provider portion of this activity. The provider survey will consist of open-ended questions on key topics that impact adolescent and young adult health care, including use of screenings for mental, behavioral, and sexual health, well visits and youth-friendly care, telehealth, and billing and reimbursement.

Teen Pregnancy Prevention aka WYSHIIN

The focus of our Teen Pregnancy Prevention grant - what we have called the Washington Youth Sexual Health Innovation and Impact Network (WYSHIIN) - is to build a multidisciplinary network committed to improving youth access to and experience with sexual health care. We are also focused on increasing youth engagement at the network coordination and implementation site levels, with an intentional focus on equity and priority populations. The Northwest Portland Area Indian Health Board (NPAIHB), a partner from the inception of the program, was involved in the planning and development of the application. Together, we intentionally co-coordinate a network inclusive of tribal and non-tribal entities.

The third and final grant year began July 1, 2022, and the grant's no-cost extension allows the continuation of project activities through December 31, 2023. We have 11 implementation sites, both tribal and nontribal, to develop and test innovations for youth. Ultimately, our goal is that adolescents see an increase in capacity to make their own appointments, receive a sexual wellness visit, and increase their likelihood of having a positive experience while accessing services. Partners include Planned Parenthood of the Northwest and Hawaii, Sea Mar Community Health Clinics, Public Health – Seattle and King County, and a first-time partner to federal and state funding, Greater Destiny Church and Room One.

We are developing a system where large organizations and government entities connect and work with local community-based nonprofit agencies with equity at the center of our vision. We want as much cross-collaboration as possible, by sharing resources and learning across all levels of agencies. Our key priority is to increase access and experience with sexual health for youth. Goals of the network are to:

- Increase youth engagement at the network coordination and implementation site levels to inform the work.
- Ensure that implementation sites work directly with historically underserved populations to conduct community needs assessments and implement interventions that are designed and tested with youth input.
- Ensure that clinics and providers are engaging in youth-serving community partnerships, trainings for staff, youth-friendly policy changes, and referrals for youth.

WA PREP

The Adolescent Health Team supports schools, systems-involved youth, and other youth-serving organizations in Washington through training and support to implement Comprehensive Sexual Health Education (CSHE) in accordance with new state requirements. The Washington State Personal Responsibility Education Program (WA PREP) is a federally funded program awarded to states to prevent the spread of sexually transmitted infections (STIs) and unintended pregnancy among youth. DOH, in partnership with the Office of Superintendent of Public Instruction (OSPI) and Cardea Services, does this through professional learning and capacity development. Intervention Partners (IPs) are selected based on readiness, and services can include needs assessments, curriculum selection and adoption assistance, and other support needed to deliver CSHE. WA PREP prepares teachers and youth development professionals to implement CSHE. All services are provided at no cost for WA

PREP partners. In addition to training to deliver CSHE, WA PREP provides training on select adult preparation subjects.

WA PREP continues to partner with school districts and work with OSPI to provide extra support to school districts with implementation of new legislation that requires schools to implement comprehensive sexual health education. WA PREP is also currently partnering with the Washington State Department of Children, Youth and Families, Juvenile Rehabilitation, to assess and implement comprehensive sexual health education in juvenile correctional facilities.

WA PREP is funded through the 2010 Affordable Care Act. The program's goal is to prevent teen pregnancy and STIs among youth 10 to 19 years old, using evidence-informed and evidence-based curricula. WA PREP recruitment prioritizes schools in counties with the highest rates of teen pregnancy, STIs, and poverty, with a focus on equity and inclusion. In FFY 2020, WAPREP served 1,914 youth; 824 youth in FFY 2021; and 2,236 youth in FFY 2022.

An interactive map of Washington with information on STIs and teen pregnancy rates is located on the WA PREP website. WA PREP prioritizes 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). 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 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. Training is provided on a variety of evidence-based/informed interventions.

Priorities, performance measures, and strategies

To clearly describe how programs in Adolescent Health work together to implement strategies and objectives to meet MCHBG priorities, as well as state and national performance measures, we've organized details of programs, projects, and activities relative to priorities and performance measures below. For more information on all the programs in Adolescent Health, go to: Adolescent Health | WaPortal.org

Additional Work Supporting Adolescent Health at the Local Level

The COVID-19 pandemic had many impacts on both local health jurisdictions (LHJs) and on adolescents. Adolescents were impacted significantly and lastingly by the isolation that was related to pandemic response measures including school closures, suspension of extracurricular activities, and family economic impacts. Many LHJ staff members worked on pandemic response. Staff have experienced high rates of burnout and many LHJs have had substantial staff turnover. The LHJs, despite these challenges, continued to make adolescent health a priority through the following activities.

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

Two of the LHJs chose to do work in support of this strategy. Garfield and Kittitas selected a variety of activities including providing references and resources for general health and well-being information to school counselors, school libraries, and local clinics for use by adolescents and young adults to help increase their understanding of navigating health systems. Kittitas chose to work with the Assessment Coordinator to conduct a literature review of best practices and evidence-based strategies for supporting/increasing youth and adolescent health literacy. They also chose to connect with other education, health care, and community-based organizations that work with youth to share findings on health literacy interventions and collect information on current practices/interventions. Finally, this LHJ is working to develop a regular communication plan as part of a work plan, and to create a work plan to implement selected interventions/practices. They will review this plan with DOH staff and work with the Health Equity

Committee during development.

Other Adolescent Strategies

Many of the LHJs support school-based health center work. For example, in Island County, the LHJ chose to explore potential community partners for School Based Health Clinic (SBHC) establishment. Although this LHJ was not selected by the state for SBHC funding, they are continuing to work on the project and seek other resources. Other LHJs chose to participate in local, regional, and statewide coalitions and task forces to promote the importance of maternal and child health.

Supporting youth mental and behavioral health

Priority:

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

SPM:

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.

Data:

Behavioral health is a priority issue for the Department of Health and the Adolescent Health Team. Like most of the nation, Washington data from 2019-2021 show us that behavioral health needs of young people in the state increased tremendously because of the COVID-19 pandemic. Teens and young adults continue to struggle with depression, anxiety, and for too many, thoughts of suicide. Substance use is still an issue impacting young people across the state. In addition, stigma and lack of behavioral health providers throughout the state have compounded the issue, making youth behavioral health a statewide initiative.

The data below highlight key findings from several sources that helped us decide where to focus efforts and funding to best support young people in the state, within our scope in Adolescent Health.

Healthy Youth Survey

The 2021 Washington Healthy Youth Survey indicates that 38% of 8th, 10th, and 12th graders reported depressive feelings. Among female students, it was 50%. White students were more likely to report depressive feelings than their Asian classmates, but less likely than Hispanic, American Indian/Alaska Native and classmates who identified as more than one race. All females, no matter which race/ethnicity they identified as, reported higher rates of depressive feelings than males of any race/ethnic group. Approximately twice as many respondents who identified as not heterosexual reported having depressive feelings as did those identifying as heterosexual, 62% and 30%, respectively. Sixty-five percent of students reported they did have an adult in the community they could talk to if they felt sad or depressed.

The Healthy Youth Survey from 2021 shows that most of the youth did not engage in drinking within the past 30 days and was related to grade level. Consumption of alcohol was related to grade, with 20 percent of 12th graders and 8% of 10th graders reporting drinking. Consumption of alcohol was down from 2018 when 28% of 12 graders and 18% of 10th graders reported drinking. The most common source of alcohol was from friends, while the second most common source was from parents with their permission. The attitudes of parents and peers does seem to influence adolescent drinking, with those who report more disapproval by either group less likely to report drinking. As the degree of disapproval increases, the likelihood of drinking decreases in a “dose-response” model.

Cannabis use in the prior 30 days was, like alcohol, engaged in by a minority of respondents and inversely related to grade level with 16% of 12th graders, 7% of 10th graders, 3% of 8th graders and 1% of 6th graders reporting use. There was a very strong inverse relationship between use and perception of acceptability of use from both peers and

the general community in which students lived. Fourteen percent of 10th graders and 27% of 12 graders reported that it would be very easy to obtain cannabis if the wanted to.

COVID Student Survey

In 2022, responses to the COVID Student Survey showed that 39.4% of high school students experienced extended periods of sadness and hopelessness and almost 20% reported having seriously considered suicide during the past year. LGBTQIA2S+ youth, disabled youth, and those reporting financial distress reported higher levels of prolonged sadness, suicidal ideation, and lower levels of hope.

Conversely, over two-thirds (67.9%) of all high school students reported having at least "moderate" hope. More than half (55.2%) of students reported that their stress was manageable.

Only 4.7% of high school students reported past year cigarette use compared to 13.6% who reported past year electronic cigarette use, 19.3% who reported past year alcohol use, and 15.2% who reported past year marijuana use. Overall, past year substance use was more common among students who identified as LGBTQIA2S+, those identifying as having a disability, and those identified as financially distressed.

MCHBG Needs Assessment

Respondents to the maternal and child health needs assessment reinforced findings of the youth behavioral health crisis impacting teens and young adults across the nation. Respondents consistently identified clear barriers and needs around youth mental and behavioral health care and support. For example, many shared how young people have difficulty finding medical and behavioral health providers because of the lack of providers (especially in rural areas), but also because the health care system is hard to navigate and needs better coordination, linkages, and referrals. Respondents also demonstrated there is still a need for providers to provide more and improved screening for mental health and substance use risk when seeing young patients and clients. The MCH needs assessment highlights, combined with data from a number of sources, clearly demonstrates the need for systems-level improvements so that adolescents can access and experience patient-centered medical and mental health care.

Other data

Recent data from the Washington State Healthy Youth Adverse Childhood Experiences Score (2021) found that while youth tended to most frequently report 0-1 adverse childhood experiences (ACEs), many young people are reporting 4 or more: 15% of 12th graders, 11% of 10th graders, and 12% of 8th graders reported four or more ACEs. For all grades, students who reported more ACEs reported feeling sad or hopeless more often and/or contemplated suicide more often than their peers who had fewer ACEs. Conversely those students with fewer ACEs reported they had more hope than those with more Aces. In addition, trauma-related events impact young people at different rates depending on their socioeconomic and racial/ethnic backgrounds.

Objectives and Strategies:

- By September 30, 2025, increase the number of school-based health centers with licensed mental health services by 5%.
- 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.
- 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.

Relevant Programs and Activities

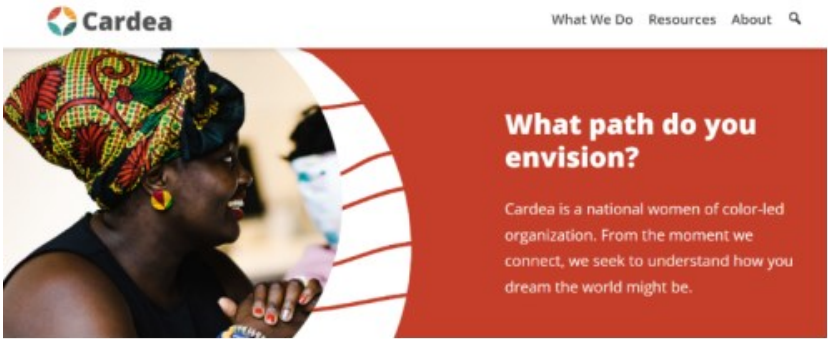
The discussion below highlights elements of Adolescent Health Programming and other activities that contribute to implementation of these strategies and objectives. For details on each program, please refer to the introduction at the beginning of this domain section.

School-Based Health Centers: A key activity used to address the behavioral health needs of young people is the expanded work at DOH around school-based health centers, including standing up the new school-based health center program as outlined in RCW 40.73.840, as well as leveraging the new grant program to increase access to behavioral health services in SBHCs through additional funding.

- In summer 2021, our agency request for additional funds to strengthen behavioral health services in school-based health centers was successful. The package was funded and provided DOH with almost $900,000 in additional funding for behavioral health improvement grants in new and operational SBHCs. Of this, the SBHC grant program received an additional $720,000 in grant funding for the SBHC program.
- In summer 2022, we released a request for applications to the community to apply for this funding. We anticipated funding grants of $90,000 each. We ended up funding five grant sites to focus specifically on behavioral health. This included one new SBHC in Grant County, a place with very few health care providers, and a high need for behavioral health care. We also funded four existing SBHCs to enhance behavioral staff wages, to help retain existing staff, and increase competitive wages to bring in new staff. Grant projects will start October 1, 2022.
- The decision package also allocated additional funding for the Washington School-Based Health Alliance to provide technical assistance and support for the new behavioral health improvement grants, and to support SBHCs to carry out health promotion activities in and with the schools they serve.

Trauma-informed and healing-centered training for providers: Statewide efforts, feedback from partners, and key data indicate a continued need for trauma-informed and healing-centered training for adolescent health care providers. We contracted with Cardea Services to create a training course called *Youth at the Center.* The training is comprised of eight micro-modules divided into three sections: Trauma Informed, Healing-Centered Care, What Are Youth Friendly Services, and Sexual Healthcare and Education. The modules cover a range of topics directly related to trauma-informed (healing-centered) care, adolescent-friendly care, gender, and sexuality-affirming care. The course supports our goal of expanding and sustaining SBHCs across the state and supporting youth-serving providers in a way that promotes equity, access, and inclusion. The training is available online, and providers can receive continuing education credits through summer 2024. We initially released the training in June 2022, but after feedback from partners, we worked with Cardea to modify it to better meet adolescent health providers' needs. We released the updated training in January 2023. To learn more, go to Youth at the Center: Effective and Equitable Support at Adolescent Healthcare Clinics Across Washington State - Cardea Training Center (matrixlms.com)

For more information on Cardea Services, click on the linked photo, below.



Youth Advisory Council: We convened the new Youth Advisory Council (YAC) to learn more about young people's thoughts on behavioral health and suicide prevention. In June 2022, we met with the YAC to discuss youth behavioral health care, including needs, challenges, barriers young people experience, and potential youth-friendly solutions. Overall, members reported ongoing challenges related to accessing and utilizing behavioral health care, including traditional barriers to care like cost and transportation, not knowing when and how to seek care, and once care is found, what to do if it doesn't go well. They also shared about more nuanced challenges, like lack of trust among providers and high rates of stigma among parents, caregivers, and their community. Despite the rise in needs for behavioral health care, 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. Stigma impedes recognition of behavioral health needs and increases the likelihood youth will not seek or utilize services. Stigma among young people, their peer groups, and supportive adults is compounded by the fact that people with mental health conditions report experiencing discrimination and prejudice, and stigma is a primary reason people do not seek the care they need when they need it.

Some of the solutions the YAC discussed included having concrete tools and how-to guides on how to find trustworthy and inclusive behavioral health providers, free or low-cost coverage of behavioral health care for youth, more use of social media, apps and other online resources for information, scheduling and finding providers, increased use of both telehealth and in-person behavioral health services that can be accessed in areas where young people are, easy ways to know whether a behavioral health provider is safe and inclusive of people from all types of backgrounds/identities, training and education for young people so they can support each other and know what to look for in their friends, and more stigma reduction efforts to ensure parents, caregivers, school staff, and the community can recognize, support, and intervene to address behavioral health needs.

The sentiments of the YAC were supported by several of our partners, including the Washington Chapter of the American Academy of Pediatrics, the University of Washington's Leadership in Education for Adolescent Health, and the Washington School-Based Health Alliance, which shared stories about parents who do not want mental health screenings for their children out of a belief that they will result in "false positives" and that some families do not want mental health care or services for their young people at all.

Figure 1 Thoughts, ideas and recommendations from the YAC on mental and behavioral health for young people, June 2022.

Youth Voice Volunteers: We recruited two new Youth Voice volunteers to collaborate on several projects with us, including to help create and carry out communications campaigns using social media to increase knowledge of mental and behavioral health conditions, information, and support. We anticipate this campaign to be released during the next reporting period.

AYA Needs Assessment: To learn more about how to support youth and providers around mental and behavioral health care, we collaborated with several partners and youth to develop a needs assessment. For more details on the needs assessment, go to: Adolescent Health Needs Assessment | WaPortal.org.

The youth survey of the needs assessment includes open-ended questions that young people can use to tell us about how mental and behavioral health visits are going, and how they have been accessed. Similarly, the provider engagement survey will include open-ended questions to tell us more about their practice and use of mental and behavioral health screenings, what screenings they are using, any success and challenges they've experienced, and what kind of support they need to continue to use and even improve use of appropriate screenings for young people.

Health disparities continue to be evident in rates of youth and young adult behavioral health needs, including substance use. To better understand how youth are impacted by substance use, and the inequities that exist, we continued to assess data to identify gaps in services and underlying socioeconomic factors playing into substance use, including structural issues through a lens that acknowledges systemic racism, sexism, and homophobia/transphobia, and their effects on health inequities. This, combined with what we learn from the needs assessment, will help us better understand gaps, so we can work with partners to address them.

Support of partnering programs: In Adolescent Health, we address mental and behavioral health needs among youth through existing programming and by supporting and promoting the work of our colleagues, including suicide and substance use prevention, which is a priority for DOH. Some of their work that we've supported, promoted, aligned with, and/or collaborated on includes:

- The Children and Youth Behavioral Health Work Group (CYBHWG) | Washington State Health Care Authority.
- The suicide prevention team's Native and Strong Campaign, a sister campaign to HCA's WA Tribal Opioid Solutions: www.nativeandstrong.org.
- The suicide prevention team's Sources of Strength, a peer-based youth suicide prevention program to reduce bullying and sexual violence in high schools.

- The Marijuana and Commercial Tobacco Prevention Team's five-year cessation grant. Learn more at Home | Washington Department of Health (youcanwa.org).

Supporting the work of the newly formed Opioid Prevention Team at DOH (in Injury and Violence Prevention) to address opioid use among young people, including the "Laced and Lethal" project in Seattle/King County to spread awareness about substances laced with fentanyl.

Improve access to and the quality of youth-friendly and age-appropriate health care services for youth

Priority:

Identify and reduce barriers to quality health care.

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

NPM:

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

Data:

Qualitative and quantitative data illustrate that young people face a lot of barriers and challenges with accessing and utilizing health care services.

Healthy Youth Survey

In 2021, 68% of 10th grade students reported seeing a health care provider for a checkup in the past year. This was down from 2018 when 77% reported seeing a health care provider in the prior year. Non-Hispanic White and non-Hispanic Asian students were more likely to have seen a provider than were students of other races or ethnicities. Hispanic students, non-Hispanic Black/African American students, and students identifying as more than one race all reported as less likely to have a checkup as non-Hispanic White or non-Hispanic Asian students. Students identifying as gay, bisexual, or any sexual orientation other than straight were as likely to report having a checkup in the prior 12 months as those identifying as heterosexual.

By 2021, 54% of all adolescents in Washington had completed the full 1:1:1 immunization series (Washington Immunization Information System IIS). The same year, 27% of 13--year-olds were up to date with the appropriate number of HPV shots. (HEDIS)

Rates of chlamydia infection in 2020 were highest among female 15- to 24-year-olds (2,010 cases per 100,000 population) and male 15- to 24-year-olds (773 cases per 100,000 population), with 59% of all cases occurring among those under 24 years of age. According to these data rates are down significantly in the past year. 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.

Objectives and Strategies:

- 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% of services delivered.
- By September 30, 2022, form youth advisory council and hold at least one initial meeting.
- Conduct needs assessment to identify top barriers for adolescents and young adults in seeking health care services.
- Ensure all adolescents and young adults, regardless of race, ethnicity, sexual orientation, and gender identity,

have a full range of education, access, and ability to utilize health services that meet their individual needs.
- Through partnerships, understand and mitigate issues related to financial eligibility for health care and other support services for adolescents and young adults.
- Support and enhance efforts to increase health literacy among adolescents and young adults.
- Promote the use of evidence-based practice guidelines, like Bright Futures, among adolescent health providers.
- Promote preventive care screening and wellness visits for adolescents and young adults.
- Increase the proportion of Washington adolescents who receive age-appropriate, evidence-based clinical preventive services.
- 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.

Relevant Programs and Projects:
Health care access and improvement for young people requires a multi-pronged approach. We leverage existing programs and partnerships to continue efforts to make youth-friendly and age-appropriate health care accessible and utilized by all young people in Washington.

School-Based Health Centers: Expanding and sustaining SBHCs is a key strategy we implement to increase access to health care services for adolescents in the state. For details on that work go to School-Based Health Center Program | WaPortal.org. Unfortunately, SBHCs experience a number of barriers, including (and primarily) sustainable funding, as well as unique barriers depending on each SBHC's sociopolitical and geographic context. In addition to our grant program to fund more SBHCs, over the reporting period, we collaborated with WASBHA to identify and address barriers that impede expansion and sustainability of SBHCs, and engaged directly with SBHC communities and partners to learn more about what they need and want in the DOH SBHC grant program. You can learn more about our community engagement findings in our new report 2022 SBHC Community Engagement Survey Report (waportal.org). Some highlights are included below:

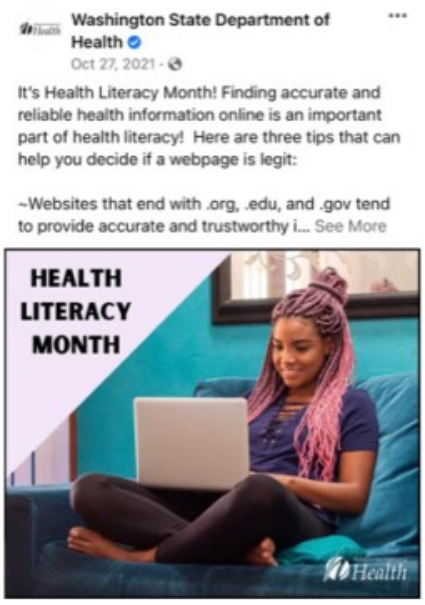
- There are misunderstandings among insurers about SBHCs and how they differ from the school-based health service program managed by the Health Care Authority.
- The SBHC model is too different from traditional primary care settings, warranting a completely new approach to billing and funding to truly make them sustainable.
- SBHCs need a flexible and reliable income to mold to fit their unique communities. One-size-fits-all funding sources are not equitable, reliable, sustainable, or feasible in all areas of the state.
- Some SBHCs are still encountering billing issues – but it's not clear what the source of the issue is, and where accountability lies. More work is needed to tease out the source of problems.
- Tribal health and education structures and needs are very different from non-Tribal health and education structures. This would make it difficult for tribal and Indigenous communities to apply for DOH SBHC grants to implement the traditional school-based health center model. In addition, current SBHC staff at DOH and WASBHA do not have enough knowledge about Tribal health and education systems, and how to start an SBHC (traditional model) in a Tribal community to properly support a Tribal SBHC.
- There isn't a clear picture of SBHCs in Washington state, this includes data on SBHCs and SBHC frameworks and structures, so more work is needed for statewide data collection.

Over the reporting period, we also began work to address many of these challenges, including:

- We worked with new DOH SBHC grant sites to be as flexible as possible within the limits of the SBHC law for their SBHC projects. This included funding grants that will work on meeting the full SBHC definition defined in the law during the grant period, allowing time for them to meet our goal, and providing support to them to be successful.
- We facilitated quarterly Communities of Practice to DOH SBHC grant sites to learn about their SBHC challenges and issues in real time. Learning from each other has been an invaluable activity for all grantees.
- DOH and the WASBHA delivered a presentation to the Medicaid Managed Care Organizations (MCO) Performance Improvement Project teams (managed by DOH's Health Systems Transformation Team) on the fundamentals of SBHCs and some of the funding challenges they face to increase awareness of SBHCs in Washington and build more support networks for SBHCs in the state, and to contribute to efforts to increase well-visits among teens and young adults.
- We participated in and contributed to plans to bring vendors to establish a statewide SBHC data platform. This work is being led by Public Health –Seattle and King County and WASBHA. We hope to support this work both logistically and fiscally as the project moves forward.
- We explored a new partnership with the Northwest Portland Area Indian Health Board to assist DOH with training about tribal healthcare and education systems and facilitating support and learning for tribal youth.

The Adolescent Health Team continues to participate in the Healthy Students, Promising Futures (HSPF) Learning Collaborative and regular meetings hosted by the National School-Based Health Alliance. Washington is one of 15 states participating in HSPF, and has cross-agency representation, including Washington State Health Care Authority (HCA), Office of the Superintendent of Public Instruction (OSPI), and Washington State Department of Children, Youth and Families (DCYF). The HSPF focuses on federal, and state polices that impact school-based health services for children with Medicaid coverage, models for delivering school-based health services and SBHCs, and cross-state collaboration. The purpose of this collaboration is to increase access to school-based health services through Medicaid reimbursement. The HCA recently released a draft resource guide to help schools understand Medicaid reimbursement for school-based health services, how to contract with managed care organizations, and how to bill for qualifying services. DOH's role on this workgroup is to provide insight and feedback from the Department's perspective and ensure activities contribute to increased access to health care services for students.

AYAH Needs Assessment: Over the reporting period, we began working on the Adolescent and Young Adult Health Needs Assessment to learn more about the experiences of young people with adolescent and young adult health care services. More details about this project can be found at Adolescent and Young Adult Health Needs Assessment | WaPortal.org . We specifically want to learn more about how key aspects of adolescent health care are being experienced by young people and their health care providers – including adolescent well-visits, youth-friendly care, use of key screenings, and use of best practices like Bright Futures. The needs assessment will help us address these priorities and is a key activity for a number of strategies. It will help us learn more about health care coverage and cost barriers young people are experiencing.



Youth Voice Volunteers: Over the reporting period, we released several social media campaigns. We also collaborated with the Youth Voice volunteers to develop health literacy and adolescent well-visit promotional campaigns for social media for the next reporting period. We developed content based on existing campaign materials from the CDC, HRSA, and other federal sources. The youth volunteers created the content, ensured it was youth-friendly, and helped us develop a dissemination plan to release the materials on social media to reach young people. We hope to continue this activity into the next reporting period.

We also approached OSPI and the Health Care Authority about partnering to promote health literacy in schools and in health care documents. However, competing activities delayed this partnership. Over the next reporting period, we hope to revisit this partnership and promote the inclusion of health literacy education in school curriculum (including comprehensive sexual health education) using strategies like those proposed in this Youth Health Literacy Toolkit, and with entities like HCA and managed care organizations, to make sure that health statements and documents are user-friendly and available in multiple languages to increase accessibility.

Inspired by the social media creation of our Youth Voice volunteers, over the reporting period, we collaborated with the social media team at DOH to increase youth-focused social media presence on all platforms. This included promoting the Office of Population Affairs' Adolescent Health Month in May 2022 and Well-Child Wednesdays in August 2022.

Youth Advisory Council: We also learned more about health care access issues from the Youth Advisory Council. The Youth Advisory Council continues to report that traditional barriers to health care services are still impacting youth – including transportation to and from appointments, the cost of health care services and health insurance, gaps in understanding health care information and health insurance, and the challenges in finding adequate and trusted health care providers.

In August, we met with the YAC to discuss youth-friendly health care. Teens and young adults may not access much needed preventive and acute services – like STI testing, family planning, behavioral health screenings, vaccines, and

more - if they are not youth-friendly for many reasons, including fear of judgment, negative interactions with providers and staff, hours and locations that don't work for them, cost and transportation, and concerns with confidentiality (learn more at: youth-friendly-services-starter-guide.pdf (umhs-adolescenthealth.org). During the meeting, we asked questions about what youth-friendly health care looks like and means to young people today. Members shared thoughts and ideas about youth-friendly environments, provider interactions, and services. Some of their feedback included ensuring providers create welcoming spaces in waiting rooms and exam rooms to help young people feel safe and secure, encouragement to providers to listen and trust their young patients, to explain upcoming appointments and exams so youth know what to expect, and to explain what information young people can consent to and what information will be kept confidential – and what information won't be kept confidential. YAC members highlighted a need for providers to use non-judgmental and matter-of-fact language to explain procedures, diagnoses, etc.

Provider Trainings: Another strategy we have been working on is to provide more learning resources for adolescent providers in the state to cover key topics like youth-friendly care on how to discuss sensitive topics with young people. As mentioned before, we partnered with Cardea Services to develop online trainings on key topics. For convenience and ease of access, the trainings will be available online and will include a podcast-like component. In addition, SBHC providers will be able to apply to receive continuing medical education (CME) or continuing education unit (CEU) credit for them. In the future, we hope to expand these trainings (funding dependent) so they are available to adolescent health providers statewide. For details, go to: Youth at the Center: Effective and Equitable Support at Adolescent Healthcare Clinics Across Washington State - Cardea Training Center (matrixlms.com).

Data and analyses: Over the reporting period, we partnered with the Surveillance and Evaluation Section to plan for a new Adolescent Health Data Dashboard and resource tool. The Dashboard will be a one-stop place for DOH staff (and ultimately, the public) to go to for key adolescent health data for Washington state – including data from our programs, survey activities, and data that are publicly available, as well as links and resources to more comprehensive and granular data. This will ultimately help us learn more about what data gaps exist so we can prepare to fill those gaps. During the reporting period, we began to outline the plan for the dashboard, including what key data we want to include, how we want to visualize the data, where it will be housed, and what resources we want to include. For the rest of the reporting period and into the next, we will finalize our plans and create the content. We will also work with our internal communications teams to make sure the content is ready for the public and identify the best platform for publication. We hope the dashboard is live by the time we report out next year and will be a useful tool for the Adolescent Health Team and other DOH and partners' programs whose work impacts young people.

Sexual health education and access: 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). For young people, this includes access to comprehensive sexual and reproductive health care, services, and education so they can take charge of their own health and sexuality and make healthy decisions for their own bodies.

The Adolescent Health Team supports robust sexual health programs that increase access to and improve the quality of sexual health education, information, and access. This includes:

Teen Pregnancy Prevention/WYSHIIN: The Adolescent Health Unit continues to lead the implementation of the Office of Population Affairs' (OPA) Teen Pregnancy Prevention (TPP) grant, the Washington Youth Sexual Health Innovation and Impact Network (WYSHIIN) in partnership with the Northwest Portland Area Indian Health Board (NPAIHB). The third and final grant year began July 1, 2022, and the grant's no-cost extension allows the continuation of project activities through December 31, 2023.

The Adolescent Health Unit onboarded a new Performance Coordinator in July 2022 to lead community-responsive evaluation efforts in collaboration with the project Epidemiologist. The Network expanded from seven implementation partners to 11 during this reporting period, and all are developing, implementing, testing, refining, and evaluating a total of 26 innovations to improve youth access to and experience with sexual health care. We also contracted with three partners to provide expert training, e-learning modules, and individualized technical assistance: Healthy Teen Network, Luna Consulting, and Cardea Services. The three tribal sites in the network are the Nisqually Health Department, The Tulalip Tribes of Washington, and the Quinault Indian Nation. Non-tribal sites include Domestic Violence and Sexual Assault Services (DVSAS) of Whatcom County, Greater Destiny Church, Public Health – Seattle and King County, Planned Parenthood of the Great Northwest, Hawai'i, Alaska, Indiana, and Kentucky (PPGNHAIK), Room One, Sea Mar Community Health Centers, and the Washington State University College of Nursing. Latino Leadership Northwest was also an implementation partner during this reporting period but left the Network in September 2022 due to constraints with organizational capacity. There are 10 standing Network partners as of September 2022.

Evaluators at DOH worked with partners to create evaluation plans that align with program logic models, collect TPP performance measures monthly, and collect qualitative process measures to understand each innovation, how youth and community feedback is being continuously applied, how programs continue to evolve in response to community feedback, and what lessons learned can inform dissemination activities and sustainability efforts. We also conducted key informant interviews with all Network partners to better understand progress toward the WYSHIIN Learning Agenda and continuously improve partners' experience in the Network. An insights report based on these interviews can be found online, here. Network activities also include individual partner check-ins, quarterly newsletters, maintenance of our WAPortal page, hosting Open Network Hours to discuss timely sexual health topics, and quarterly all-Network meetings. OSPI continues to partner with the Network by disseminating the WYSH survey and collecting responses, providing resources as needed on implementing sexual health education curricula, and sharing information about their sexual violence prevention efforts.

WYSHIIN partners presented at seven national meetings, six state-level meetings, and nine local meetings during the reporting period, and dissemination and sustainability continue to be central to project progress in Year 3. Sustainability efforts include building capacity for ongoing efforts to improve teen-friendliness, implementing an ongoing sexual and reproductive health subcommittee on the DOH Youth Advisory Council, building capacity among community-based and historically excluded organizations to administer state and federal funds, packaging innovation materials for continued refinement and dissemination, and pursuing additional funding opportunities.

To date, WYSHIIN programs have reached over 7,760 youth, 932 caregivers, and 2,583 community stakeholders.

WA PREP works with schools, juvenile rehabilitation facilities, and youth-serving agencies statewide to implement sexual health education effective in reducing adolescent pregnancy, sexually transmitted diseases, and HIV. Programs teach abstinence, contraception, and condom use, as well as adult preparation topics, including parent/child communication, healthy relationships, and healthy life skills. WA PREP teaches youth ages 11-21 with age-appropriate and culturally relevant curricula for the groups and communities where they are implemented. For more information on the state's comprehensive sexual health education law, see RCW 28A.300.475: Comprehensive sexual health education (wa.gov).

The Family Planning program has been renamed **Sexual and Reproductive Health** program. They 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 WA PREP program.

Proviso for STI Prevention: Over the reporting period, the Washington State Legislature passed ESSB 5092 which includes a proviso that directs DOH to provide recommendations for funding and policy initiatives to address the spread of sexually transmitted illnesses (STIs). The Adolescent Health Team, along with several programs at DOH, submitted recommendations, including the inclusion of youth in all activities related to STI prevention at DOH, and additional funding from the legislature to ensure young people are involved in STI prevention work in all state agencies.

Support safe communities and environments for young people

Priority:

Improve the safety, health, and supportiveness of communities

SPM:

Adolescents reporting at least one adult mentor

Data:

In 2021, bullying in the previous 30 days was reported by 21% of students in the Healthy Youth Survey across all surveyed grades. Reports of bullying varied by grade, with 3% of 6th graders reporting, 23% of 9th graders, and 13% of both 10th and 12th graders. Thirty-four percent of 10th graders who were bullied reported low grades compared with 25% of those who hadn't. Among 10th graders, individuals who identified as either gay or lesbian or as bisexual were much more likely to have reported as having been bullied, 24% and 23% vs. 10% respectively.

Data show interpersonal violence, including bullying, is an issue for young people in Washington. Interpersonal violence in the past 12 months among dating couples was reported at about 7% across 8th, 10th and 12th grades. Individuals not identifying as heterosexual were twice as likely to have experienced partner violence in the preceding year, 10% vs. 5%.

Objectives and Strategies:

- By September 30, 2025, reduce the percentage of 10th grade students receiving our interventions who reported that someone they were dating limited their activities, threatened them, or made them feel unsafe by 10% (from 9.5 to 8.5%).
- Support violence prevention efforts and promote healthy relationships among adolescents and young adults.

Relevant Programs and Projects:

The Adolescent Health Team continues to support and promote the work of the Injury and Violence Prevention (IVP) Team to help reduce violence and injury among young people. Among the many programs, IVP has been implementing several projects to reduce violence among school-aged youth, specifically among middle and high schoolers. The first is through the Sources of Strength program. This is a peer-based program, geared to high-school aged young people, that focuses on youth suicide prevention and reducing bullying and sexual violence. For middle schoolers, the IVP Team has introduced the "It's About Respect" campaign in middle schools around the state. Over the reporting period, they increased the number of schools the campaign reaches.

We will continue working with key partners to support efforts to promote healthy relationships among youth in our state, including providing resources, training, and support to adolescent health providers to recognize signs of dating and abuse. To do this, we purchased "In Her Shoes" trainings from the Washington State Coalition Against Domestic Violence (WSCADV) for all 60 School-Based Health Centers in the state. The curriculum can be found at In Their Shoes: Teens and Dating Violence (CLASSROOM EDITION) | WA State Coalition Against Domestic Violence – WSCADV. Over the rest of the reporting period, we will promote those to the SBHCs in hopes of having them utilize

the tools in those locations.
Our PREP will continue to provide education on adult preparation topics such as healthy relationships, including positive self-esteem, relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions; parent-child communication; and healthy life skills, such as goal setting, decision making, negotiation, communication, and interpersonal skills and stress management.

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

Adolescent Health Domain Application Year

Overview of Priority MCHBG Projects and Activities As the population of adolescents in Washington increases, our vision is to serve as a statewide leader in optimizing the health, well-being, and development of all adolescents and young adults (AYA), and our mission is to provide programs that promote the health and well-being of adolescents where they live, learn, work, and play.

Adolescent Health Programs

Our state action plan for adolescent health focuses on the following priorities: supporting youth behavioral health care, improving access to and the quality of adolescent and young adult health care, supporting sexual and reproductive health and education and access to appropriate services, and providing improving youth access to and experience with sexual health care. We selected MCHBG performance measures, priorities, and strategies that reflect the activities and programs we plan to continue. These measures, priorities, and strategies were selected for their impact on improving health care services and access for young people and will also contribute to our efforts to health equity for all. Over the next reporting year, we will expand and strengthen several programs and ramp up two new ones. We will also explore ways to better support young people's health care journey, and the providers that care for them.

School-Based Health Center (SBHC) Grant Program provides grants for planning, startup, operations, and behavioral health improvement for SBHCs in Washington, support and technical assistance to advance SBHC sustainability and operations, and training for SBHC health care providers. Among the many strengths of SBHCs is that the medical and behavioral health providers are embedded in the schools, allowing them to develop different kinds of relationships with their young patients compared with in traditional clinical settings. SBHC staff and providers collaborate with schools to coordinate care, services, and referrals, and emphasize health promotion. They also develop relationships with other community providers to ensure holistic care for their students. For more about our SBHC grant program, see our narrative in the report, or go to the webpage linked here.

The **Youth Advisory Council (YAC)** is a community engagement group of about 40 teens and young adults from around Washington state. YAC members meet with DOH staff regularly to discuss key topics in adolescent health care that overlap with Title V focuses, including youth mental and behavioral health, youth-friendly care, well-visits and primary care, teen dating, youth with special health care needs and disabilities, and sexual and reproductive health. Youth engagement is an integral part of mental and behavioral health program planning for Adolescent Health. Talking to young people about the issues they see in schools and their communities, and the solutions that they think will work to get young people the care they need is the only way for public health programming to truly be youth-friendly and responsive.

The YAC and other youth engagement opportunities at DOH are grounded in the theory of positive youth development. We are intentionally creating opportunities for teens and young adults to learn about and participate in public health planning and government activities as one more way we can make a positive change in our community. Creating a positive space for young people to develop and build positive relationships with caring and trusted adults is in itself a strategy to support youth and stave off negative outcomes from behavioral health conditions (see The Knowledge Institute 2019 and Positive Youth Development at CDC 2023). In addition, the CDC reports that positive youth development programming has the potential to prevent riskier behaviors, like substance use and riskier sexual behaviors that contribute to preventable pregnancy, as well as preventable illnesses and diseases, like STIs and HIV.

The **Youth Voice Program** is a volunteer/internship opportunity for teens and young adults to collaborate with DOH to develop youth-friendly communications materials that are geared to youth. Volunteers are recruited through DOH's Workforce Development Team in Human Resources, and notices go out to high schools and colleges throughout the state. Previous projects include making websites more youth-friendly, creating social media campaigns, and collaborating on other communications materials.

The new **Adolescent Health Data Dashboard** is a one-stop-shop for relevant and state-level adolescent health data. The Dashboard is housed on DOH's Washington Tracking Network page and contains interactive dashboards on key data about Washington youth ages 10-19, including demographics, teen pregnancy, STIs, mental and behavioral health. The Dashboard also includes links to other relevant data resources, including other state and federal resources.

The Washington State Personal Responsibility Education Program (WA PREP) is a federally funded program awarded to states to prevent the spread of STIs and unintended pregnancy among youth. DOH, in partnership with the Office of Superintendent of Public Instruction (OSPI) and Cardea Services, does this through professional learning and capacity development. Intervention Partners (IPs) are selected based on readiness, and services can include needs assessments, curriculum selection and adoption assistance, and other support needed to deliver comprehensive sexual health education (CSHE). WA PREP prepares teachers and youth development professionals to implement CSHE. All services are provided at no cost for WA PREP partners.

We are excited to share that we will be rolling out 2-3 new programs in the next reporting period:

- The **Adolescent and Young Adult Health Resource Hub and Information Center** will be a new DOH website geared to adolescents and young adults in the state. The Hub will include a curated list of youth-friendly health resources, and how-to guides and other guidance on health topics requested by youth. During discussions with the Youth Advisory Council in 2022, we learned that young people want easy and online access to quality and accurate information on specific health topics, including sexual and reproductive health, and mental and behavioral health. YAC members report that online tools like social media, websites, and apps can be a powerful tool to sharing health information with youth – and, because there is a lot of misinformation on the internet, having information that comes directly from a reputable source (like the government) is essential to support young people's health literacy and agency. Research supports this recommendation. Studies show that the number of people using the internet for health information is increasing, and that people go to the internet for many of their health care needs, including disease information, how to find providers, and how to get health insurance (see Zhao and Zhang, 2017). Internet use for health information has jumped to social media over the last few years. The American Academy of Pediatrics reports that in 2016, 76% of teens were using at least one social media site, and social media use by youth impacts behaviors, including substance use and sexual activity (see Hill et al, 2016). The use of social media to spread health information (and misinformation) was never more apparent than during the COVID-19 pandemic, where social media both benefited and harmed the public with non-stop access to virus information (see Rosenburg et al, 2020).

- Consumption of online content by teens and young adults provides DOH an opportunity to get important health information directly to young people, and in return, be responsive to young people by getting them the health information they want and need. In addition, the YAC reported that young people want to be able to access online health information in a youth-friendly, confidential way that is visually appealing and easy to navigate and understand. In response to this feedback and the YAC members' recommendations to promote and provide quality and accurate health information, over the next reporting period, we hope to release a new

adolescent health website. The website will cover four topic areas: primary care/well-visits, sexual and reproductive health, teen dating and healthy relationships, and mental and behavioral health. For each topic area, the website will provide two types of content: a curated health resources hub consisting of existing online resources and managed by trusted sources; the second type of content will consist of several how-to guides developed around topics and questions recommended by the YAC and made in youth-friendly and visual styles that resonate with young people. We will collaborate with the Youth Advisory Council and internal partners to plan content, create a brand identity, and contract with local vendors to enhance tools and promote the resource. Over the next reporting period, we hope to release the new adolescent health website in two phases. The first phase (January 2024) will include the release of the curated resources hub. The second phase (June 2024) will include the release of some of our how-to guides and other resources.

- The **DOH Youth-Friendly Certification** will benefit adolescents and young adults and the providers that care for them. During the last reporting period, the YAC identified a need for providers to demonstrate that they are youth-friendly, so teens and young adults know where to go to seek health care services from trustworthy providers. The YAC describes youth-friendly care as providing a welcoming and safe environment and creating positive interactions between providers and young patients that are compassionate, non-judgmental, inclusive, factual, truthful, and confidential. Over the next reporting period, DOH will collaborate with internal and external partners, including the YAC, the Children and Youth with Special Health Care Needs program, and the Washington State Health Care Authority, to outline criteria for youth-friendly health care clinics and practices, outline technical assistance and training to support health care provider and practice participation, and develop communications materials that include a logo that providers will be able to display to visually represent certification so they can be found by young people. Youth-friendly self-assessments and certification projects are not new, and other organizations and agencies have been successful in implementing them. National Adolescent and Young Adult Health Center's toolkit, National Health Mission Adolescent Friendly Health Clinics, and Minnesota's Hennepin County MySelf,MyHealth.

The New WYSHIIN and TPP

In 2019, the Washington Youth Sexual Health Survey findings highlighted issues for AYA regarding access to and experience with health care visits. Seventy-five percent of respondents reported they have a health care provider that they have seen more than once, yet only 18 percent reported having had a sexual health wellness exam. Respondents also reported barriers associated with going to see a health care provider, such as the hours of the clinic do not work with their schedule (37%), not understanding how insurance works (38%), feeling judged (39%), and being afraid that their parent or caregiver will find out (48%).

In 2020, the Adolescent Health team, in collaboration with the Surveillance and Evaluation unit, was awarded one new grant for the next round of Teen Pregnancy Prevention funding from the Office of Population Affairs (OPA). We are the only state agency awarded this funding, and one of only 13 grantees total. We will continue our partnership with the Office of Superintendent of Public Instruction and the Northwest Portland Area Indian Health Board to coordinate the Washington Youth Sexual Health Innovation and Impact Network (WYSHIIN) to understand and improve youth access to and experience with sexual health services holistically, and to learn about what works, how, for whom, and why. The interventions range from the clinic setting to social media campaigns, and the partners are from all sectors who have bidirectional impact on youth sexual health care. As described in the report, we are working with 11 implementation partners and to date have served over 3,500 youth, 372 caregivers, and 753 community members. More information can be found here: Washington Youth Sexual Health Innovation and Impact Network | WaPortal.org.

Pivots and program expansion into Year 3 of the project include the utilization of a youth advisory committee to provide feedback on program impact and youth-led presentation opportunities of their recommendations, culminating in a report of recommendations to share with implementation partners, lead agencies, OPA, and the communication of results to the youth.

Sustainability planning will be an integral part of year 3 activities among implementation partners. In the second half of year 2, we reported on the development of collaborative alliances among cohort 1 and 2 implementation partners. We will expand these opportunities in year 3 through:

- Promotion of the communications plan activities, providing additional activities and opportunities for cohort 1 and 2 to connect and collaborate.
- Key informant interviews with partners to ask about project goals, process measures for each organization, and evaluation themes.

MCHBG Plan for 2023-2024

Over the next reporting period, the Adolescent Health Team will continue ongoing programming and roll out new programs to advance efforts to strengthen adolescent and young adult health care and services, engage young people in adolescent public health, and support youth-serving health care providers in the state. This report provides a summary of ongoing and new programming, as well as discussions of specific projects and activities as they relate to specific priorities, performance measures and strategies, below. For more information, go to: Adolescent Health | WaPortal.org.

Topic areas of focus, priorities, performance measures, and strategies have been selected based on the data available at the time of this plan, feedback and recommendations from community engagement activities (including with the Youth Advisory Council), guidance from DOH leadership, and alignment with internal and external partners. The following is an outline of current and upcoming programming and its relevance to priorities, performance measures, and strategies for Adolescent Health's MCHBG/Title V deliverables.

Priority:

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

Data:

Behavioral health is a priority issue for the Department of Health and the Adolescent Health Team. Like most of the nation, Washington data from 2019-2021 show us that behavioral health needs of young people in the state increased tremendously because of the COVID-19 pandemic. Teens and young adults continue to struggle with depression, anxiety, and for too many, thoughts of suicide. Substance use is still an issue impacting young people across the state. In addition, stigma, and lack of behavioral health providers throughout the state have compounded the issue, making youth behavioral health a statewide initiative.

The data below highlight key findings from several sources that helped us decide where to focus efforts and funding to best support young people in the state, within our scope in Adolescent Health.

Healthy Youth Survey

The 2021 Washington Healthy Youth Survey indicates that 38% of 8th, 10th, and 12th graders reported depressive feelings. Among female students, it was 50%. White students were more likely to report depressive feelings than their Asian classmates, but less likely than Hispanic, American Indian/Alaska Native, and classmates who identified as more than one race. All females, no matter which race/ethnicity they identified as, reported higher rates of depressive feelings than males of any race/ethnic group. Approximately twice as many respondents who identified

as not heterosexual reported having depressive feelings as did those identifying as heterosexual, 62% and 30%, respectively. Sixty-five percent of students reported they did have an adult in the community they could talk to if they felt sad or depressed (HYS 2021).

Responses to the 2021 Washington Healthy Youth Survey showed that 20.5% of 10th grade students considered attempting suicide in the past year. 8% of 10th grade students reported making a suicide attempt in the 12 months prior to the survey.

The Healthy Youth Survey from 2021 shows that drinking within the past 30 days was related to grade level. It was also down considerably from 2018. In 2021, 20 percent 12th graders and 8% of 10th graders reported drinking. In comparison in 2018, 28% of 12 graders and 18% of 10th graders reported drinking. The most common source of alcohol was from friends, while the second most common source was from parents with their permission. The attitudes of parents and peers does seem to influence adolescent drinking, with those who report more disapproval by either group less likely to report drinking. As the degree of disapproval increases, the likelihood of drinking decreases in a “dose-response” model.

Cannabis use in the prior 30 days was, like alcohol, inversely related to grade level with 16% of 12th graders, 7% of 10th graders, 3% of 8th graders and 1% of 6th graders reporting use. There was a very strong inverse relationship between use and perception of acceptability of use from both peers and the general community in which students lived. Fourteen percent of 10th graders and 27% of 12 graders reported that it would be very easy to obtain cannabis if the wanted to.

COVID Student Survey

In 2022, responses to the COVID Student Survey showed that 39.4% of high school students experienced extended periods of sadness and hopelessness and almost 20% reported having seriously considered suicide during the past year. LGBTQIA2S+ youth, disabled youth, and those reporting financial distress reported higher levels of prolonged sadness, suicidal ideation, and lower levels of hope.

Conversely, over two-thirds (67.9%) of all high school students reported having at least “moderate” hope. More than half (55.2%) of students reported that their stress was manageable.

Only 4.7% of high school students reported past year cigarette use compared to 13.6% who reported past year electronic cigarette use, 19.3% who reported past year alcohol use and 15.2% who reported past year marijuana use. Overall, past year substance use was more common among students who identified as LGBTQIA2S+, those identifying as having a disability, and those identified as financially distressed.

MCHBG Needs Assessment

Respondents to the maternal and child health needs assessment reinforced findings of the youth behavioral health crisis impacting teens and young adults across the nation. Respondents consistently identified clear barriers and needs around youth mental and behavioral health care and support. For example, many shared how young people have difficulty finding medical and behavioral health providers because of the lack of providers (especially in rural areas), but also because the health care system is hard to navigate and needs better coordination, linkages, and referrals. Respondents also demonstrated there is still a need for providers to provide more and improved screening for mental health and substance use risk when seeing young patients and clients. The MCH needs assessment, combined with data from a number of sources, clearly demonstrates the need for systems-level improvements so that adolescents can access and experience patient-centered medical and mental health care.

Other data

Unfortunately, many young people have experienced trauma in their lives. This was true before the pandemic and is even truer now, as we move into after the pandemic. Recent data from the Washington State Healthy Youth Adverse Childhood Experiences Score (2021) found that while youth tended to most frequently report 0-1 adverse childhood experiences (ACEs), many young people are reporting 4 or more: 14.6% of 12th graders, 11.4% of 10th graders, and 12.4% of 8th graders reported four or more ACEs. In addition, trauma-related events impact young people at different rates depending on their socioeconomic and racial/ethnic backgrounds. For example, the same survey shows that lesbian, gay, and bisexual 10th graders were three times more likely to report 4+ ACEs than heterosexual youth, and transgender 10th graders were seven times more likely to report 4+ ACEs than boys. The data varied across race and ethnicity, with Asian/Asian American and white youth reporting the lowest WAH-ACEs scores compared to their peers. Additionally, 10th graders who moved with their families for seasonal, temporary, or agricultural work were more likely (15.0%) than those who didn't (10.7%) to have WAH-ACEs scores of 4+ or more.

State Performance Measure:

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.

Strategies:

- Improve the knowledge and ability of health care professionals to deliver youth-friendly and responsive mental and behavioral health care, screenings, and interventions.
- Promote standardized depression, anxiety, and substance use screening that are youth-friendly and responsive.
- Take action to reduce stigma surrounding adolescent and young adult behavioral health conditions, treatment, and related challenges, and implement trauma-informed services specific to adolescents and young adults in community services and health care systems.
- Expand access to and the quality of behavioral health services in SBHCs.
- Support efforts to address and mitigate individual and community effects of substance use among adolescents and young adults.
- Build on efforts to identify the scope of impacts of substance use, including inequities among adolescents and young adults from priority populations.
- Support interventions to address suicide ideation among youth, especially among those marginalized by mainstream society.

Objectives:

- By September 30, 2025, provide accessible training for adolescent and family health care providers on trauma-informed care, adolescent-friendly services, and discussing sensitive topics.
- By September 30, 2023, conduct an Adolescent Health Provider needs assessment to learn more about provider experiences with behavioral health screenings and risk assessments; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.
- By September 30, 2023, conduct an Adolescent Health needs assessment among youth to learn more about adolescent experiences with medical and behavioral health care; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.
- By September 30, 2023, partner with youth volunteers to develop and implement an adolescent behavioral health awareness campaign using social media.
- Through September 2025, implement efforts to expand trainings to additional adolescent and young adult friendly providers.

- Through September 30, 2025, identify/develop behavioral health interventions for young people based on the ideas and recommendations of the Youth Advisory Council.
- By September 30, 2025, increase the number of school-based health centers with licensed mental health services by 5%.

Relevant Activities and Projects:

School-based health centers (SBHCs) will continue to be a key strategy we use to address mental and behavioral health needs of young people. SBHCs provide comprehensive and integrated medical and behavioral health care in settings where young people already spend their time, and where they already have developed relationships with trusted adults. They increase access for all students, including those from low-income backgrounds, as well as improve health outcomes, and as a result, lower health care costs (see McNall et al 2010). Most SBHCs have advanced practice medical providers and mental and behavioral health providers on staff and see students both in person and in telehealth settings.

Supporting mental and behavioral health in school settings is an important part of our SBHC Grant Program. Research has shown that SBHCs are an effective tool and strategy to address youth behavioral health needs with trusted providers (see Guo et al, 2010). It is also a consistent recommendation of the Youth Advisory Council. Young people want and need the support of school-based physical and behavioral health professionals who can spend more time to build relationships, answer their young patient's questions, complete developmental, emotional, behavioral, and sexual health screenings, and provide culturally responsive and age-appropriate care and treatment.

Over the next reporting period, we will continue supporting our five behavioral health improvement SBHC grant sites to improve and expand behavioral health access in their school community. We anticipate that SBHC grants sites who are currently in the startup phase at the time of this plan will move into the operations phase, and along with other grant sites, will shift focus of their grant project towards long-term sustainability.

The DOH SBHC team plans to collect information and gather resources, trainings, and support for SBHCs, particularly around behavioral health, reimbursement for services, long-term sustainability, and other school-based health service delivery models. The team also plans to continue convening a Community Advisory Board to inform program priorities and goals.

We will also continue to provide training, information, and support on trauma-informed/healing-centered care for SBHC providers and staff, as well as school staff. We will also continue to promote and provide support on behavioral health screening in SBHCs and school settings.

YAC: The next reporting period will be the second service year for the second-generation YAC. During that year, we intend to dig into youth mental and behavioral health, including having topic-specific discussions around youth suicide prevention and youth substance use. Mental and behavioral health is one of the most important topics to YAC members. It's also a topic shared by a large proportion of YAC applicants as a key issue impacting their community they want to address. We intend to discuss issues, barriers, and challenges young people experience around behavioral health, as well as youth-friendly solutions. We will continue to collaborate with our partner programs at the agency, including Suicide and Substance Use Prevention in the Injury and Violence Prevention Unit, and Children and Youth with Special Health Care Needs, to plan and facilitate these important discussions with the YAC.

Like last year, the findings and recommendations of these discussions will be analyzed and summarized in a final report after the YAC service period has completed (2025). In addition, we will identify activities and actions that we can take in Adolescent Health or in other programs here at DOH. We will continue to expand the YAC's exposure to

the DOH, other state agencies, and youth-serving leaders, policymakers, and organizations in the state.

Youth Voice Volunteers: Over the next reporting period we will bring on two new youth voice volunteers to continue helping us with our social media campaigns, including creating a new youth mental and behavioral health campaign to increase awareness and reduce stigma. The goals of these campaigns will be to enhance the knowledge of mental and behavioral health signs and symptoms, resources, and knowledge among young people and their families, to help remove the more ephemeral barriers stigma can create. The Youth Advisory Council has shared that young people want to know specifics about behavioral health, including how to recognize when behaviors are normal and when they aren't, how to help their friends, where to find support, and how to get support and buy in from parents and the community. In response to the YAC's feedback, the Youth Volunteers will help us create communications content that addresses some of these topics and requests and provides information to young people and their families to connect them to the many behavioral health resources in the state.

New! Adolescent Health Website: The new Adolescent Health Info and Resource Hub website will include a section on youth mental and behavioral health resources and information, as well as how-to guides. This section of the website will be developed with members of the YAC as well as subject matter experts at DOH in Suicide Prevention and Substance Use Prevention, located in the Injury and Violence Prevention Unit. We expect this to be released in 2024.

Provider Training and Support: Over the next reporting period, we will plan provider training, support, and technical assistance based on what we learn during the previous reporting period's engagement and needs assessment activities. We anticipate funding and coordinating training on topics to support adolescent health care providers' knowledge and practice around behavioral health topics, including behavioral health screening, and trauma-informed and compassionate provider-patient interactions. We will leverage existing external and internal resources to identify and/or develop new training, and when needed, will contract with trusted vendors to develop new training as well. We will collaborate with partners, including providers, to learn more about how providers want training delivered and what they hope to get out of the training. We will also provide continuing education for training whenever possible.

Support of DOH Programs: We value the work of our internal colleagues and external partners that furthers collective efforts to create better health care and support systems for young people in the state. We will continue to learn about and align with programming at DOH and other agencies that impacts youth, so we can support the work that is successful, align our work with others, and find new and promising opportunities for relevant collaboration.

We will continue to learn from the Washington State Children and Youth Behavioral Health Workgroup. DOH contributed to the development of recommendations on this workgroup, and moved recommendations to action, at our own agency. Recommendations we've implemented included trauma-informed care training and education for health care providers (as described above), expanding the behavioral health workforce through the SBHC BH Grant, and supporting and promoting population-level screening for students and strengthening regional response teams.

We will continue to support and promote the suicide prevention work carried out by our partners in DOH's Injury and Violence Prevention unit. Their work includes contracting with middle schools throughout the state for Sources of Strength; launching the Native and Strong Campaign in partnership with the Health Care Authority; and working with tribal communities to launch the Washington State Indian Behavioral Health Hub. Future work will include reviewing suicide prevention data for adolescents to begin work to tease apart culturally relevant interventions.

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

Identify and reduce barriers to quality health care.

Performance Measures:

- **National Performance Measure:** Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- **ESM 10.1**: Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year.

Data:

The Washington State Health Care Authority (Medicaid agency) reports that rates of adolescent well-visits among Medicaid clients are down for 2021, and are especially low for people ages 18-20, at only 20%, while those for 12- to 17- year -olds were at 47%. (HCA Medicaid Maternal and Child Health Data Dashboard).

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.
- 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.
- Promote school-based health strategies to serve adolescent populations where they are.
- Promote preventive care screening and wellness visits for adolescents and young adults.
- Promote the use of evidence-based practice guidelines, like Bright Futures, among adolescent health providers.
- Conduct needs assessment to identify existing strengths and gaps in data, as well as top barriers for adolescents and young adults in seeking health care services.
- Identify and develop methods to monitor systems and data gaps and improvements needed in adolescent health.
- Through partnerships, understand and mitigate issues related to financial eligibility for health care and other support services for adolescents and young adults.

Objectives:

- By September 30, 2024, discuss key MCHBG topics with the Youth Advisory Council, including challenges, barriers, and youth-friendly solutions on health care access and utilization, youth-friendly services, patient-provider interactions, and well-visits.
- By September 30, 2024, have a sustainable comprehensive sexual health network focused on youth from historically underserved communities.
- By September 30, 2023, partner with youth volunteers to develop and implement social media campaigns on key adolescent health topics.
- By September 30, 2024, award grants to plan, start, and improve school-based health centers throughout Washington, primarily in communities that have been historically underserved.
- 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% of services delivered.
- By September 30, 2024, create a mechanism to share promising sexual health innovations and begin dissemination. Plan and begin implementation of sustained efforts to improve access to holistic, youth-friendly

sexual health care, particularly for youth from historically underserved communities.

Relevant Activities and Projects:

SBHCs: Ongoing support of SBHCs through grants, training, and technical assistance is a primary activity we use to address key objectives and strategies to improve equitable and inclusive access to and the quality of adolescent health care. The SBHC Grant Program works to expand and sustain SBHCs throughout the state with funding and activities prioritized in communities historically underserved. As outlined in the law, we continue to support and promote comprehensive and integrated medical and behavioral health care that is age-appropriate, youth-friendly, follows evidence-based recommendations, is community responsive, and is grounded in healing-centered care.

During the next reporting period, we expect to continue funding our current 12 SBHC grant sites. We hope planning grant sites will move into startup, resulting in up to five new SBHCs in Washington. We also hope to see startup grants move into more stable operations and shift grant projects to focus on long-term sustainability, community engagement, and the ever-present work of equitable health care. We hope to begin to analyze data collected from previous grant cycles to learn more about the impact of SBHCs and the DOH SBHC grant program.

We will support SBHC providers by funding/coordinating training on relevant topics, like youth-friendly care, behavioral health screening, and other topics identified as a need, facilitating Communities of Practice with SBHC Grant sites, and promoting educational webinars and training provided by WASBHA and the National SBHA.

In addition, we will participate in workgroups and partnerships to learn more about how to support SBHCs and adolescent and young adult health providers. We will partner with WASBHA to leverage partnerships with the HCA, the Office of the Insurance Commissioner, and the Medicaid Managed Care Organizations to identify barriers and solutions to long-term sustainability for SBHCs. We will continue to support WASBHA and Public Health – Seattle & King County (PHSKC) to bring a data platform vendor for the SBHCs to access and use to collect and report data. We will determine funding needs for the platform to allow all DOH SBHC grantees to also access the system and to report data to DOH.

YAC: We will continue work with the new Youth Advisory Council to learn about the challenges and barriers young people face when trying to access and use health care services, including adolescent well-visits, youth-friendly services, teen dating/violence support, and health care for youth with special health care needs and disabilities. We will organize the information we learn and share with relevant internal and external partners. In addition, we will integrate their ideas and recommendations into our MCHBG strategies to reduce barriers to care for young people. We also hope to finish writing a white paper outlining our YAC process and activities so we can contribute to building the evidence base for youth engagement in public health.

Youth Voice Volunteers: During the next reporting period, we will recruit two new volunteers to support our social media and communications work in Adolescent Health. We hope to continue work to expand social media campaigns we've already started (including our Well Visit campaign and our Health Literacy Campaign) and help us create new campaigns. In addition, we hope to collaborate with our youth voice volunteers on other communications projects, including the upcoming website and new visual communications materials.

***New!* Adolescent Health Website:** We expect to collaborate with both the YAC members and our youth volunteers to steer the website, the resources we include, and the how-to guides we create, as well as devise the name of the website and the overall design and visual style. We will leverage internal partnerships with DOH's communications and design team, and existing contracts for graphic design and branding based on guidance from our youth partners.

Youth-Friendly Certification: Over the next reporting period, we hope to develop and finalize criteria for youth-friendly certification in collaboration with internal and external partners and young people. We also hope to open the certification up to practices and clinics that serve teens and young adults and begin support of providers who want to be more youth-friendly and better serve their young clients. Following the successful kickoff, we will begin looking at impactful incentives to make participation in the program by youth-serving providers easier and more cost-effective. Ultimately the goal of this work is to support adolescent health providers so they can support teens and young adults in the state.

As recommended by the YAC, we will continue other efforts to **ensure health care is youth-friendly** for teens and young adults. This will include collaborating with the Sexual and Reproductive Health Team at DOH and the Health Care Authority and the Office of the Insurance Commissioner to create better mechanisms to protect confidential services and ensure teens and young adults understand their rights related to consent and confidentiality. We will also collaborate with the HCA and identify innovative ways to address ongoing barriers around transportation to and from health care visits for teens and young adults.

Adolescent Health Data: Over the next reporting period, we will evaluate the effectiveness and reach of the new Adolescent Health Data Dashboard housed on our Washington Tracking Network (scheduled for release in spring 2023). We hope to learn more about who is accessing the data, identifying new data sources to add and expand the dashboard, and increasing knowledge and awareness of the dashboard as a resource for people in the state. In addition, we hope to continue to learn from data collected through other programs.

Teen Pregnancy Prevention (aka WYSHIIN): The WYSHIIN implementation partners will continue refining, evaluating, and disseminating their innovations through December 2023. Partners are participating in four national conferences and will continue strategic dissemination initiatives throughout the final project year. We will continue to collect monthly quantitative performance measures and qualitative process data, in addition to conducting another round of key informant interviews with partners and a sample of youth they have served. These interviews will encourage partners to reflect on their progress toward the key priority area of improving youth experience with and access to sexual health care and collect testimony from youth who can speak to program impact and distal outcomes. By October 2023, we will begin work on our Innovation Network Promotion Package, a final report showcasing all WYSHIIN-developed innovations, to be completed by March 2024. We will create this Promotion Package using StoryMaps, a web-based application that allows users to share maps in the context of narrative text and other multimedia content. This platform will enable our team to use digital storytelling and present WYSHIIN products in a way that feels most relevant to our partners while meeting all grant requirements. The Promotion Package will be disseminated publicly via WAPortal and to all key partners to promote promising WYSHIIN innovations.

The 2022 Washington Youth Sexual Health (WYSH) Survey remains open to obtain as large a sample size as possible. WYSH Survey findings, partners' monthly and semi-annual reports, key informant interview data, and recommendations from our Youth Advisory Council will all be synthesized to inform next steps for sustainability of the Network, as well as the Adolescent Health Unit's overall strategy to improve sexual and reproductive health among WA youth, and especially historically marginalized youth.

WA PREP works with schools, juvenile rehabilitation facilities, and youth-serving agencies statewide to implement sexual health education effective in reducing adolescent pregnancy, sexually transmitted diseases, and HIV. Programs teach abstinence, contraception, and condom use, as well as adult preparation topics, including parent/child communication, healthy relationships, and healthy life skills. WA PREP teaches youth ages 10 - 21 with

age-appropriate and culturally relevant curricula for the groups and communities where they are implemented. WA PREP will continue to provide education on adult preparation topics such as healthy relationships, including positive self-esteem, relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions; parent-child communication; and healthy life skills, such as goal setting, decision making, negotiation, communication, and interpersonal skills and stress management. For more information on the state's comprehensive sexual health education law, see RCW 28A.300.475: Comprehensive sexual health education (wa.gov).

Family Planning/Sexual and Reproductive Health: Over the next reporting period, we will strengthen our partnership with the Sexual and Reproductive Health Team through collaboration and partnership on several projects. This includes collaborating on sexual and reproductive health discussions with the YAC, partnering with other state agencies to strengthen confidentiality for minors' health care services, and developing content for the sexual and reproductive health section of the new adolescent health website.

Priority:
Improve the safety, health, and supportiveness of communities.

SPM:
Adolescents reporting at least one adult mentor.

Data:
HYS data on bullying, violence, sexual assault.

HYS data show interpersonal violence, including bullying, is an issue for young people in Washington. In 2021, occurrences of bullying in the previous 30 days were reported by 21% of students in the Healthy Youth Survey across all surveyed grades. Among 10th graders, individuals who identified as either gay or lesbian or as bisexual were much more likely to have reported as having been bullied, 24% and 23% vs. 10% respectively.

Interpersonal violence in the past 12 months among dating couples was reported at about 7% across 8th, 10th, and 12th grades. Individuals not identifying as heterosexual were twice as likely to have experienced partner violence in the preceding year, 10% vs. 5%.

Strategies:
- Support violence prevention efforts and promote healthy relationships among adolescents and young adults.
- Build networks and resources in communities to enable and enhance community and peer support.
- Align violence prevention efforts with partners, including DOH Injury and Violence Prevention and the Office of the Superintendent of Public Instruction (OSPI)

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% (from 9.5% to 8.5%).
- By September 30, 2025, discuss teen dating and violence with the Youth Advisory Council to learn more about their thoughts on how to improve support for young people to engage in healthy relationships.
- By September 30, 2025, continue to promote resources and information about, and support projects that promote healthy relationships for young people.
- By September 30, 2025, continue to work to align and support violence prevention efforts with partners, including DOH Injury and Violence Prevention and the Office of the Superintendent of Public Instruction (OSPI).

- By September 30, 2025, continue to participate in and contribute to relevant internal and external workgroups that support the safety of young people to align efforts with agency partners.

Relevant Activities and Projects:
We will continue working with partners to support efforts to promote healthy relationships among youth in our state, especially those led by our partners in Injury and Violence Prevention.

Support of providers: We will continue to support providers to support their young patients to engage in healthy and appropriate sexual relationships. This includes providing access to training to SBHCs like "In Their Shoes", a teen dating violence experience training developed by the Washington Coalition Against Domestic Violence, and to develop new trainings to better support providers in identifying and intervening in teen dating violence.

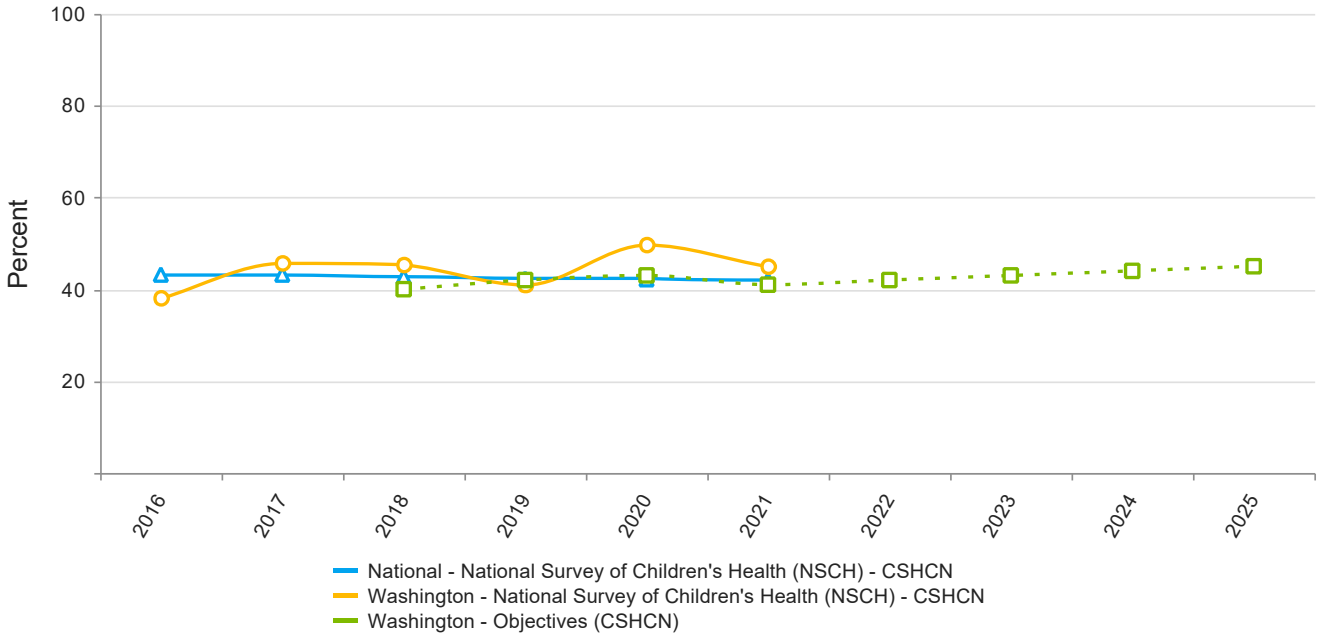
Support and promotion of partner programs: We will continue to support our colleagues in Injury and Violence Prevention to support young people's access to information, programming, and support to engage in healthy and appropriate sexual relationships. This includes supporting projects like the Rape Prevention Education (RPE) collaboration between OSPI and DOH. This project is a peer-based education that focuses on consent. We will also continue to partner with the Sexual Health Education Team at OSPI to ensure medically accurate and age-appropriate Comprehensive Sexual Health Education is delivered to teens in public schools and contribute to other violence prevention activities.

Children with Special Health Care Needs

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	40	42	43	42	42
Annual Indicator	45.7	45.3	40.8	45.0	45.0
Numerator	138,232	141,032	131,960	151,120	151,120
Denominator	302,213	311,138	323,785	336,052	336,052
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	43.0	44.0	45.0

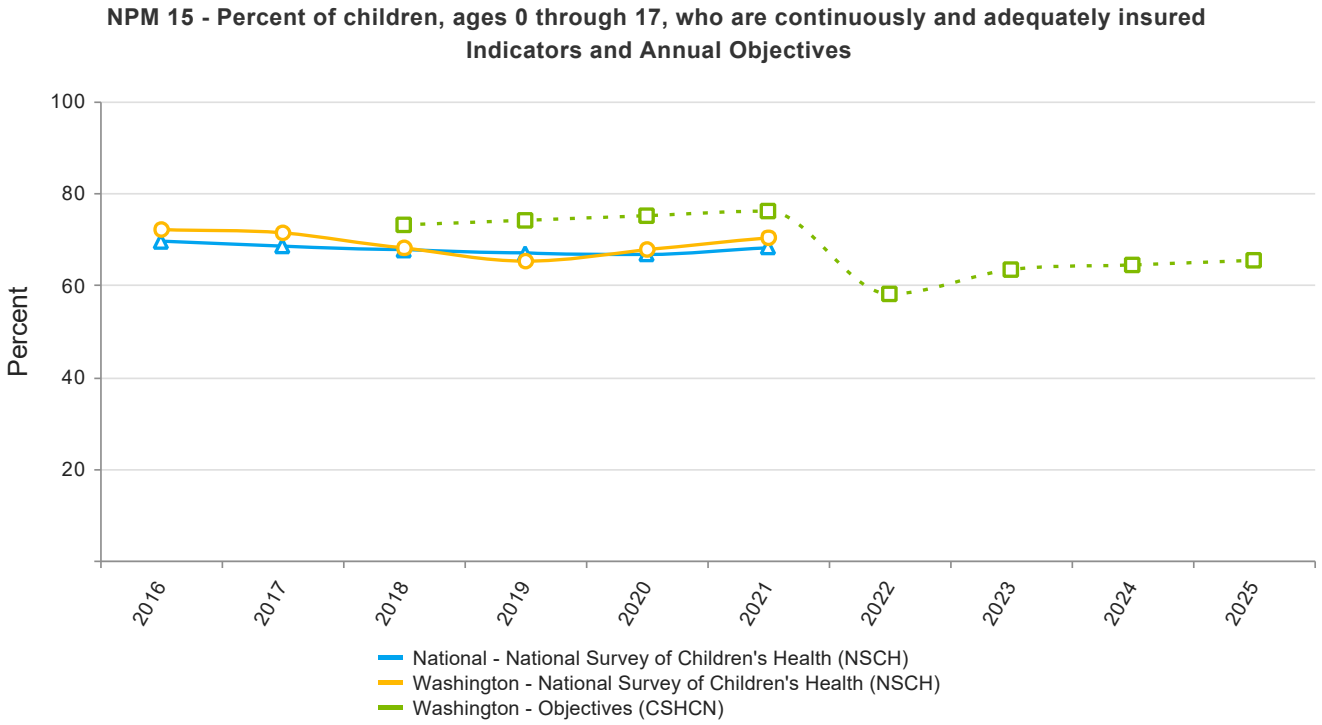
Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			80	90
Annual Indicator		87.5	88.6	100
Numerator		14	39	9
Denominator		16	44	9
Data Source		University of Washington LEND ECHO-Autism Program	University of Washington LEND ECHO-Autism Program	University of Washington LEND ECHO-Autism Program
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	91.0	92.0	93.0



NPM 15 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	73	74	75	58	58
Annual Indicator	71.2	67.9	65.1	70.3	70.3
Numerator	1,148,124	1,107,284	1,068,524	1,163,760	1,163,760
Denominator	1,613,555	1,630,587	1,642,095	1,654,315	1,654,315
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2020_2021	2020_2021

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	73	74	75	76	58
Annual Indicator				55.4	62.3
Numerator				180,522	208,824
Denominator				325,851	335,191
Data Source				NSCH	NSCH
Data Source Year				2019-2020	2020-2021
Provisional or Final ?				Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	63.3	64.3	65.3

Evidence-Based or –Informed Strategy Measures

ESM 15.1 - 15.1 Increase the percentage of CYSHCN who report having insurance when receiving services

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			99.3
Annual Indicator	99.2	99.2	98.4
Numerator	19,268	19,268	12,937
Denominator	19,424	19,424	13,154
Data Source	WA State Child Health Intake Form	WA State Child Health Intake Form	WA State Child Health Intake Form
Data Source Year	2020	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	99.4	99.5	99.6

State Performance Measures

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

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			38
Annual Indicator	40	38.2	38.2
Numerator	9,642	8,650	8,650
Denominator	24,105	22,643	22,643
Data Source	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2021	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	37.5	37.0	36.0

State Action Plan Table

State Action Plan Table (Washington) - Children with Special Health Care Needs - Entry 1

Priority Need

Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

Through September 2025 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. This objective has been completed.

By September 30, 2025, increase the number of dietitian members of the Nutrition Network with CYSHCN training and the number of community-based feeding teams working with CYSHCN. Prioritize training and support given to those in counties with limited resources and those with ability to provide services via telehealth.

By September 30, 2025, increase the percentage of CYSHCN ages 0-17 who receive care in a well-functioning system by 5 percent.

By December 2023, support access to clinical genetic services, and clinical genetic travel clinics to rural and underserved areas.

Strategies
Improve overall awareness of the complex needs of the children and youth with special health care needs (CYSHCN) population as a demographic identity, with distinctive cultural needs for access to communities and systems of care.
Partner with the Medical Home Partnerships Project to provide state-level subject matter expertise and technical assistance, and coordinate with the UW LEND program and Seattle Children's Hospital to support communities in workforce development, resource development, and ongoing training on family-centered, comprehensive systems of care for CYSHCN.
Provide targeted subject matter expertise to contractors and providers, including CYSHCN Coordinators, on areas of expertise such as complex nutrition for CYSHCN, children and youth with clinical and behavioral complexity, including autism, navigating state systems and policy, care coordination, family navigation, and community referral systems and clinical linkages.
Identify and develop methods to establish baseline data on CYSHCN, systems of care, gaps, and barriers to equitable, quality care. Make data accessible via a CYSHCN dashboard and other dissemination efforts. Utilize data to identify referral opportunities and strategies, and community needs for local health care resources and equitable service delivery.
Provide services to CYSHCN and family members of CYSHCN so they can be trained, engaged, supported, and involved at all levels of program planning and implementation of services for CYSHCN. Implement and promote inclusion opportunities and support resources for fatherhood, foster parents, grandparents, kinship care.
Partner with the Washington Statewide Leadership Initiative collaborative and community-based organizations to elevate family voices and provide connections so family voices can effectively influence the development of systems and services for CYSHCN.
Promote and facilitate successful transitions including transition from hospital to home, from Birth to 3 into school and community-based services, and from pediatric to adult specialty services.
Through partnerships, address the need for improved access to affordable services, and increased availability of CYSHCN service providers, quality healthcare, access to insurance, and adequate health care financing, particularly in rural communities and remote areas regardless of language spoken, gender identity, race and ethnicity, immigration status, or insurance status of families.
Through partnerships, facilitate innovative programming and technology solutions such as telehealth and remote services to address gaps in rural and remote areas and other barriers to access to care.
Enhance and maintain health systems and improve financing options to improve care coordination and family navigation.
Support access to clinical genetic services.

ESMs	Status
ESM 11.1 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Washington) - Children with Special Health Care Needs - Entry 2

Priority Need

Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

NPM

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

Objectives

By September 30, 2025, increase the percentage of CYSHCN ages 0-17 who receive care in a well-functioning system by 5 percent.

Strategies

Provide services to CYSHCN and family members of CYSHCN so they can be trained, engaged, supported, and involved at all levels of program planning and implementation of services for CYSHCN. Implement and promote inclusion opportunities and support resources for fatherhood, foster parents, grandparents, kinship care.

Partner with the Washington State Leadership Initiative collaborative and community-based organizations to elevate family voices and provide connections so family voices can effectively influence the development of systems and services for CYSHCN.

Promote and facilitate successful transitions including transition from hospital to home, from Birth to 3 into school and community-based services, and from pediatric to adult specialty services.

Through partnerships, address the need for improved access to affordable services, and increased availability of CYSHCN service providers, quality healthcare, access to insurance, and adequate health care financing, particularly in rural communities and remote areas regardless of language spoken, gender identity, race and ethnicity, immigration status, or insurance status of families.

Through partnerships, facilitate innovative programming and technology solutions such as telehealth and remote services to address gaps in rural and remote areas and other barriers to access to care.

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

ESMs	Status
ESM 15.1 - 15.1 Increase the percentage of CYSHCN who report having insurance when receiving services	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

State Action Plan Table (Washington) - Children with Special Health Care Needs - Entry 3

Priority Need

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

SPM

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

Objectives

By September 30, 2025, decrease the percentage of 10th grade CYSHCN who report they have considered attempting suicide by 5 percent.

By September 30, 2025, create and disseminate health education publications specific to autism and other developmental disabilities that are adopted by the suicide prevention program as part of their health education resources and curricula for the state-level suicide prevention plan.

Strategies

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

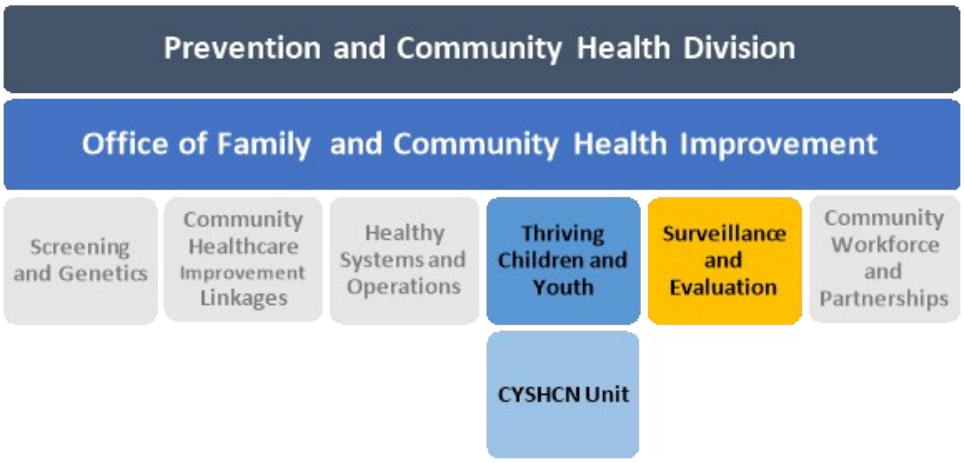
Support interventions to address suicide ideation among CYSHCN.

Identify opportunities to infuse trauma-informed care into working with CYSHCN.

Collaborate with surveillance and epidemiology Healthy Youth Survey leads to advocate for including questions about special health care needs in all Healthy Youth Surveys.

Identify and disseminate data for analysis on risk of suicide ideation for CYSHCN, including focus on youth with autism and other developmental disabilities. In the evidence base, increase representation of youth with disabilities as a complex disparate group with a high intersectionality between other known populations vulnerable to high risk factors.

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



Children and Youth with Special Health Care Needs Domain Annual Report

Overview

The Children and Youth with Special Health Care Needs (CYSHCN) unit at the DOH resides in the Thriving Children and Youth section of the Office of Family and Community Health Improvement in the Division of Prevention and Community Health. The CYSHCN program promotes a family-centered, integrated, collaborative, coordinated system of care that is equitably accessible to all children and youth with special health care needs (CYSHCN) and their families.

The Washington state CYSHCN program endeavors to serve the broad population of CYSHCN in our state and adopts the federal definition of CYSHCN in determining eligibility for services.
In 2021, an estimated 350,000 CYSHCN aged 17 and younger lived in Washington state. This is an estimated 21% of the population of this age group. This percentage is not statistically significantly different from the national rate of 19%. (NSCH) The Washington CYSHCN program serves this population through:

- Grants to local health jurisdictions for local CYSHCN coordinators that work on systems improvement for CYSHCN in their local communities as well as offering enabling and direct services to children and their families.
- Technical assistance to providers via the CYSHCN Communication Network meetings and other trainings and contracts with the University of Washington Center for Human Development and Disability's Medical Homes Partnership Project and Nutrition Network.
- Support for family engagement and leadership through the Washington State Leadership Initiative (WSLI) and contracts with family-led and family-serving organizations.
- Collaboration with other state agencies and providers on statewide systems enhancements to improve the system of care and care coordination for CYSHCN.
- Utilizing state funding to support a network of Neurodevelopmental Centers of Excellence (NDCs) and Maxillofacial Review Boards (MFRBs).
- Supporting education and outreach on Medicaid services for CYSHCN through an interagency agreement with our state Medicaid agency, the Health Care Authority (HCA).
- Utilizing a HRSA Pediatric Mental Health Care Access grant to expand resources for youth and families in crisis.

The Child Health Intake Form (CHIF) system, which tracks CYSHCN receiving direct services through MCHBG and NDC funding, captures an increase from 10,961 children served in 2016 to 14,268 children in 2021, a 32% increase. A small percentage of CYSHCNs receive direct services tied to MCHBG funding with most of the population benefitting from systems level improvements.

The 2020 needs assessment identified 2 priority needs:

- Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.
- Promote mental wellness and resilience through increased access to behavioral health and other support services.

The state action plan for the CYSHCN population domain was designed to address these needs and is aligned with the evidence-based and -informed Standards for Systems of Care for CYSHCN. The CYSHCN program also engaged in a strategic planning process with families and partners in 2021. We developed goals aligned with the national Blueprint for Change's 4 key areas: access to services, financing of services, health equity, and quality of life and well-being. Our first 4 goals address the first priority need: improving the overall system of care, providing equitable access, developing sustainable funding strategies, and enhancing family navigation and care coordination. Our final goal addresses the second priority need: providing concrete supports for the well-being of CYSHCN and their families.

Training and support on medical homes and community-based supports are needed for primary care practices and other providers, especially 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 required among state agencies and organizations, local community agencies and organizations, families, and other stakeholders to assure quality and increase access to needed services. The financing strategies of the health care system need to carve out a pediatric model that provides CYSHCN and their families enhanced care coordination services, such as those offered to adults with chronic diseases, with providers incentivized for successful outcomes.

The following sections describe progress made and programmatic highlights during FFY22 for our identified priority need **to Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.** National Performance Measures associated with this need are Medical Home and Adequate Insurance.

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.

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 FY22, we concentrated much of our work on the medical home national performance measure (NPMs) for CYSHCN.

In the 2020-2021 NCHS, 45% of CYSHCN in Washington state had a medical home. This percentage has remained relatively stable for the last five years. The percentage is not statistically significantly different from the % of children without a special health care need, 55%.

Medical Home

ACRONYM	MEANING
COE	Center of Excellence
ECHO	Extension for Community Healthcare Outcomes (Project ECHO model)
HCA	Health Care Authority
LHJS	Local Health Jurisdictions
LEND	Leadership Education in Neurodevelopmental and Related Disabilities
MHPP	Washington State Medical Home Partnerships Project
NPM	National Performance Measure
SMART TEAMS	School Medical Autism Review Team

The CYSHCN program contracts with the Washington State Medical Home Partnerships Project (MHPP) for CYSHCN to support the medical home NPM. The MHPP is a Washington state Title V-funded technical assistance center for medical homes for CYSHCN and for promotion and replication of comprehensive coordinated systems of care in communities for CYSHCN with autism and their families. The MHPP is co-located and works closely with the University of Washington Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program. 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."

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, developmental behavioral pediatric, and family 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 maintains a website, MedicalHome.org for medical home resources to support providers, families, and CYSHCN partners statewide.

The CYSHCN program, through the partnership with MHPP has long supported technical assistance on Community Asset Mapping (CAM) to local communities to build capacity for early childhood systems. This work has identified a common community need around the state to improve the continuum of supports and services related to the screening, identification, diagnosis, and intervention of autism spectrum disorders and other developmental disabilities (ASD/DD). Therefore, much of our medical homework has focused on improving medical home for children with autism. This work enhances the understanding of local services and statewide resources for CYSHCN and additional staffing that can support the needs of additional subpopulations of CYSHCN beyond those with autism. It also brings historically siloed systems that serve CYSCHN (e.g., health care, schools, public health, and social services) together to collaborate on a more coordinated and integrated system of care.

The CYSHCN program continues investigate with UW MHPP and UW LEND 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 autism-related initiatives outlined in the following section.

Autism Identification, Diagnosis, and Connection to Services System Development

With support from Title V funding, MHPP has led the state in enhancing communities' ability to diagnose and refer CYSHCN for autism through CAM, supporting the School Medical Autism Review Team (SMART) model, facilitating the Autism Centers of Excellence work, and leading the Project ECHO (Extension for Community Healthcare Outcomes) Autism initiative.

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 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. The SMART model was developed in one CAM county and has been replicated in 15 additional counties. Three other counties have been developing teams, and an additional five counties have expressed interest in the model.

MHPP hosts SMART networking zoom calls monthly. Here communities with SMART teams or coalitions, or partners such as Yakima Children's Village, share ideas and tips about what's working and what they need help with. In addition to MHPP attending, we usually have experts from the Seattle Children's Autism center there, DOH representation, and HCA partners from the ABA program.

FY 2022 has been a dynamic year for the SMART network. Teams in rural communities Okanogan and San Juan have started up. Jefferson and Kitsap coordinators and clinicians have actively recruited colleagues to join the September and December Autism Center of Excellence (COE) trainings and will have enough COEs to begin in 2023. MHPP staff attend the Pacific/Grays Harbor and San Juan SMART team monthly meetings and have been helping Jefferson and Kitsap get off the ground. Clallam County is reforming and expanding with a new COE and 2 new Speech Language Pathologists from the Port Angeles school district who are now attending the SMART networking calls. 15 teams/coalitions received a total of $11,000 in support for their work.

Autism Centers of Excellence (COE) and Project ECHO

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.

With Title V support, MHPP oversees the organization of the COE trainings, recruits speakers and manages the

logistics. 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 report hesitancy to diagnose because of lack of confidence in their skills.

To address this, Seattle Children's Autism Center used Autism Cares funds from the CYSHCN program through the MHPP to host a training with Dr. Kristin Sohl, the Project ECHO (Extension for Community Healthcare Outcomes) Autism in Missouri in August 2018. The training focused on helping partners figure out how to provide ongoing, deeper assistance to providers willing to evaluate and diagnose children if they had more resources and support. In partnership with community leaders statewide, Seattle Children's and UW LEND leaders, successfully received 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 is a key workforce development effort in response to the lack of diagnostic services available in many communities. The COE and ECHO trainings are integrated with the SMART model, with many SMART teams participating in COE and ECHO training. These efforts form the new INCLUDE collaborative - Interdisciplinary Network of Community Leaders focusing on Underserved and Disability Education. 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.

During FY22, the program continued to grow and increase integration. There are now 2 cohorts of the Autism ECHO – one focused on younger children and the other on the lifespan. The MHPP lead is part of the Hub team for Project ECHO as the public health Community Connector. Project ECHO meets twice a month for 90 minutes. The Hub team includes 10 interdisciplinary faculty (including a self-advocate and 2 parent advocates/resource navigators) and 85 community primary care providers/psychologist "spokes." MHPP staff participate as Community Connectors in the 2 ECHO cohorts. At each meeting, they discuss a patient case presented by a spoke and listen to a short didactic lecture. Many spokes are also currently part of SMART teams, others have been part 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.

There is a lot of connection between SMART teams and ECHO participants. Most SMART teams have one or more COEs involved in ECHO. MHPP involvement with both activities strengthens this synergy. We have also been able to bring learnings from the Diversity, Equity, Inclusion, Justice Team to ECHO work. This includes explicitly naming the diversity, equity, and inclusion barriers and challenges families and communities face as part of the case presentation and discussion.

The ECHO Intellectual/Developmental Disabilities (I/DD) Resources Navigation project started in March 2022. MHPP staff joined the Hub team to provide systems, parent/family support expertise, and to help with recruitment. The UW also supports other parent/self-advocate Hub team members. The Resources ECHO meets once a month. We have grown to over 240 registered participants and usually have 85-100 people at each meeting. Most SMART teams have one or more members participating in the Resources Hub, including the local CYSHCN coordinators. There is great potential to collaborate and leverage the learnings from the care coordination work described below.

The Project ECHO Autism Washington team surveys all identified COEs about their confidence levels about various topics, including serving as a medical home for children with autism. This survey is repeated annually with COEs going through Project ECHO and all other COEs. The MHPP secured an agreement from the UW LEND program, where Project ECHO is based, and the COE training leads at Seattle Children's to share the data about the medical home question over the next 5 years. These data are the basis of our ESM: **Percent of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients.**

The University of Washington's LEND program encountered some changes in the administration of their ECHO Autism program resulting in delays in providing the pre- and post-intervention surveys this past year. As a result, there were data from only 9 primary care provider trainees who completed the survey in the same manner as prior cohorts. All 9 individuals rated themselves as either "confident" or "highly confident" in their ability to provide a medical home for their patients with an autism spectrum diagnosis. At the time of submission, the program is preparing to send another round of surveys to program participants. We expect to have results in the next few months.

Nutrition Support, Workforce Development, and Systems Improvements

CYSCHN Nutrition and Feeding Networks

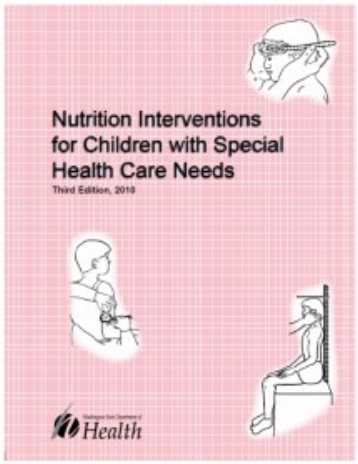
A key element of our Title V CYSHCN work is to improve nutrition services and supports for CYSCHN through the development and ongoing support, training, and technical assistance for the statewide CYSHCN Nutrition Network and Feeding Teams. We partner with the UW Center on Human Development and Disability Nutrition program and provide MCHBG funding to support this work. We partner with the UW Center on Human Development and Disability Nutrition program and provide MCHBG funding to support this work.

The figure below is a state map showing where Nutrition Network RDNs and feeding teams serve CYSHCN in Washington. In the CYSHCN Feeding Team network, there are currently 29 interdisciplinary feeding teams with an RDN participating, with 17 counties having at least one feeding team.

The UW Nutrition program provides technical assistance to these teams, identifies areas of need, and helps support the development of new feeding teams.

- Some examples are:
  The UW Nutrition contract holders hosted a discussion with Jefferson County Public Health on their CYSHCN work plan on increasing referral resources for children needing nutrition-related services. They also held an interview feeding team in Spokane to determine eligibility to be supported by contract activities and introduced Clallam County feeding therapists to Nutrition Network dietitian in Spokane to form feeding team through telehealth.
- TA was provided to Island and San Juan Counties' Feeding Team Development with 6 attendees to discuss and identify an RD to serve on community feeding team serving these counties.
- In October 2021, the contract holder provided a presentation to WA state programs serving CYSHCN on new pediatric feeding disorders ICD-10 code and nutrition and feeding resources in WA state.
- Finally, WA PAVE asked for reliable resources to share with families affected by the infant formula shortage on their website and a handout with talking points for concerning infant feeding practices including informal milk sharing, illegally imported European formulas, toddler formula, and homemade infant formulas was created to share with feeding teams and nutrition network.

Work in this area also includes development of new resources related to CYSHCN nutrition. Our Nutrition Consultant, in partnership with our UW Nutrition contractors, is updating our "Nutrition Interventions for CSHCN" publication (also referred to as the pink book). This is a textbook for CYSHCN dietitians on the nutritional needs of children with different health conditions. Work in FFY 2021-22 involved making author assignments, getting updated chapters from authors, and editing completed chapters. There was a delay in work as one of the nutrition contractors was out on extended maternity leave with her newborn twins. We anticipate finalizing this publication during FFY 2023-24.



Supporting Nutrition Workforce Training

Training for registered dietician nutritionists (RDN) and others within the Nutrition Network related to the care and management of CYSCHN nutrition issues is a significant component of our work. Typically, we hold a 2-day virtual training each year (on pause in 2021). In May 2022, the Nutrition Network training totaled 62 attendees. The Spring Nutrition Network series covered the **diagnosis topics** of '**Allergies and Gut Microbiome**' by a dietitian from Carolina Allergy and Asthma Center as well as 'Short Bowel Syndrome' and '**Down Syndrome**' presented by 2 dietitians in the clinical field. This space provided ongoing refinement of specialized nutrition skills and resources, and an opportunity to network and collaborate on relevant projects.

The Feeding Teams May 2022 training was attended by 24 WA State feeding teams, totaling 120 attendees including RDNs, feeding therapists, family resource coordinators, and infant mental health specialists. The topics covered '**Supporting Fragile Infant & Parent with Feeding at the Breast/Chest**' by a Speech Pathologist (SLP) at the UWMC NICU, '**Nutrition and Feeding Supports for the Child with a Tracheostomy'** by an RDN and SLP from Seattle Children's Hospital as well as '**Weaning from Tube to Food**' from a feeding team called Growing Independent Feeders.

Two virtual journal club options, which included Nutrition Network RDNs, were offered by nutrition trainees. The 2 articles discussed were '**Nutritional Deficiency Disease Secondary to ARFID Symptoms Associated with Autism and the Broad Autism Phenotype: A Qualitative Systematic Review of Case Reports and Case Series**' and '**Characterization of Information Hospitals Provide Parents on Tube Feeding, Including Tube Weaning**'.

Enhancing Diversity, Equity, and Inclusion in the Nutrition Workforce

Diversity, Equity, and Inclusion (DEI) within the national nutrition groups were previously not at the top of the priority list. This has changed in the past several years. The Washington State Academy of Nutrition and Dietetics (WSAND) was awarded the 2022 Inclusion, Diversity, Equity, and Access (IDEA) Mini-Grant. As a result, the grant was able support free webinars and hire a Diversity Liaison. In May of 2022, the speaker, Angel Planells, MS, RDN, CD, FAND, presented on the topic: 'Dealing with Our Differences to Come Together'. The WSAND website also has a Diversity Equity and Inclusion Resources page: Diversity - Washington State Academy of Nutrition and Dietetics (eatrightwashington.org) and Future Dietitian Diversity Guide – All Access Dietetics for members of WSAND. The clinical nutrition consultant has attended all webinars and has been a member of WSAND since 2021 and the State MCH Nutrition Council Liaison to the Association of State Public Health Nutrition (ASPHN) MCH Nutrition Council. The MCH Nutrition Council provides leadership to achieve optimal well-being through healthy eating and active living

among the maternal and child health population, including those served by Title V/MCH Block Grant. They have an MCH Nutrition Council DEI Workgroup. This workgroup has worked on 'Land Acknowledgment statements' training and reimagined the "Integrating Health Equity into Learning Sessions" document as an educational resource for ASPHN members, committees, and Council work. ASPHN Prioritizes Diversity, Equity and Inclusion - ASPHN.

The local Olympia Area Dietetics Association (OADA) has also focused on diversity. They had speakers present on specific populations like LGBTQIA2S+ individuals who face disordered eating and held a panel discussion on diversity and inclusion in our practice and our profession with dietitians in the field.

Lastly, the Clinical Nutrition Consultant assisted in the interview process for the new WIC RDN Access Coordinator. The goal of this position is to establish long-range plans to reduce barriers and increase opportunities for Washington State's local agency WIC staff to become Registered Dietitian Nutritionists (RDNs). The WIC RDN Access Coordinator will seek equitable pathways to strengthen the voice and representation of RDNs working in the Supplemental Nutrition Program for Women, Infants, and Children (WIC). The nutrition consultant will work with the WIC RDN Access Coordinator to help train the dietetic interns within WIC. Many bilingual non-RDNs who are WIC staff are integrated into their local community. This integration will help increase diversity within our state.

Addressing CYSHCN Nutrition Needs through WIC Partnership

The Assessment of Nutrition Services for CYSHCN completed in the fall of 2019 and published online in early 2020 recognized that families and health care providers value pediatric dietitians as an important part of the interdisciplinary care of CYSHCN. It also identified that Washington's well-established CYSHCN Nutrition Network of dietitians is an advantage as we work to improve nutrition services for the CYSHCN population.

Four recommendations to address gap areas emerged from the needs assessment:

- Expand hospital and community nutrition coordination systems and referral processes.
- Address nutrition workforce shortages and development needs.
- Create methods for quantifying and tracking the statewide population of CYSHCN with nutritional needs.
- Facilitate innovative solutions for nutrition access (telehealth and medical home models).

A key finding of the report was that based on existing data on nutrition risk factors, up to 26% (46,574 of 180,689) of infants and children participating in Washington's WIC program in 2018 have a special health care need. This finding 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. To better connect community nutrition and clinical nutrition for improved patient outcomes, the nutrition consultant has begun sharing dietitian contacts bi-annually as of 2022. The clinical contacts primarily come from Seattle Children's and Mary Bridge, with a continued focus on reaching Eastern Washington. They are shared through Nutrition Network, and WIC dietitians and the list of providers. The contact sharing has received positive feedback, and Seattle Children's reports, "It has long been a dream of mine to have a reference such as this," and Mary Bridge, "I find myself calling and talking with WIC offices all around the region every week, but sometimes finding the correct contact info is challenging. Thank you for helping us be collaborative with each other Khim, what a great way to help our patients and each other."

In the fall of 2021, the Clinical Nutrition Consultant began brainstorming ideas with WIC staff on strategies to meet this need and implemented 'CYSHCN-WIC Office Hours' in early 2022. These monthly meetings are open to all 88 WIC dietitians and are led and supported by the nutrition consultant. Case studies that WIC dietitians are seeing in their community are discussed and are an opportunity to learn about resources, and recommendations are shared. The CYSHCN-WIC office hours have gained popularity, and in early 2023, nutrition education topics have been incorporated. In April of 2021, we began to discuss better ways of tracking CYSHCN nutrition diagnoses in the WIC

Cascades data system but without our CYSHCN epidemiologist and the formula shortage occupying WIC state staff, this has been placed on hold in 2022.

Supporting Adolescent CYSHCN Nutrition

In the spring of 2022, the Clinical Nutrition Consultant completed the LEND program through as a public health trainee. She participated in 300+ hours of LEND Leadership and didactic training in academic, clinical, leadership, and community opportunities.

As part of her LEND training, the Nutrition Consultant learned more about adolescent health transition care gaps and services available to youth with special needs. In response to this need and interviews with community centers and dietitians teaching cooking classes, the nutrition consultant began to adapt Ram Chef Program, a culinary program that promotes health and independence for persons with disabilities and incorporates service learning for dietitians. In 2022, the DOH CYSHCN Nutrition Consultant began creating a new educator cooking module for adolescents with disabilities. The module is anticipated to be completed by the fall of 2023.

Improving Management of Complex Nutritional Needs of NICU Babies

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 CMC CoIIN grant focuses on families who have a medically complex infant with a nutrition need, such as a nasogastric (NG) tube or gastrostomy tube (G-tube). 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 the ongoing work of the CYSHCN program and our community partners.

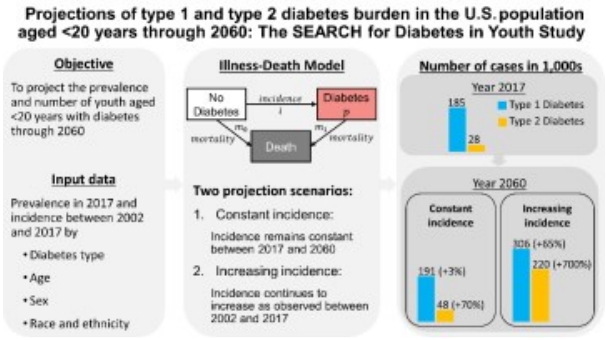
The CoIIN grant has worked to address major care coordination gaps identified by Title V between NICU discharge and establishing primary care, early intervention, and community supports. Through ongoing communication with the CYSHCN coordinators in each local health jurisdiction (LHJ), we hope to build on their initial findings and solutions. The CMC CoIIN focuses on a clinical pilot, so the HRSA CoIIN funds were awarded directly to Seattle Children's Hospital as the principal investigator. During the 2021-22 extension year, PAVE (our F2F) has taken over the contract to work on dissemination and sustainability. The CYSHCN program provides in-kind staff support. In addition, most partners outside of the hospital receive Title V CYSHCN funding, such as UW MHPP and the UW LEND Nutrition. 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 ended this year. We have also been researching with the HCA on potential options for Medicaid funding to continue and expand this project's critical care coordination and family navigation components. We are leveraging our Project ACCELERATE partnership to continue this work. More information about Project ACCELERATE is available in the section below under National Performance Measure 15-Adequate Insurance.

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 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.

Improving Type 1 Diabetes Support

In spring 2022, the Type 1 Diabetes (T1D) workgroup formed after a CYSHCN Coordinator noted an increase in

diagnoses, diabetic ketoacidosis hospital admissions, near fatalities, and Child Protective Services (CPS) involvement with this population and, in turn, requested additional support for working with these families. In year 1, the group has grown to 45 members who share passion, ideas, and knowledge around T1D. The statewide workgroup members include: Seattle Children's Hospital Pediatric Endocrinologists, Endocrinology social workers from SCH, Sacred Heart, & Mary Bridge, Diabetes Educators, Department of Social and Health Services (DSHS), Health Care Authority (Medicaid), representatives from Managed Care Organizations, PAVE, Caregivers of children with T1D, School Health Services RN Consultant from OSPI, Executive Director Type 1 United, STIX Diabetes Program President & STIX Community Outreach, multiple CYSHCN Coordinators, Dietitians, and clinicians from Valley View Health Center.



CDC predicts rising cases of diabetes among teens

The number of people in the US younger than 20 with Type 2 diabetes could rise almost eightfold by 2060. The number with Type 1 diabetes could rise by up to 65%, according to a CDC study published in **Diabetes Care**.

In the first year of this project, the main goals have been to create and distribute a provider survey to identify gaps and use responses to inform the work of the group moving forward. The project developed a resource page: Diabetes - Family to Family Health Information Center (familyvoicesofwashington.org) and an MCO guidance document. Two main themes identified in the provider survey are the urgent need for more support around the psychosocial complexity among youth and a need for community-based peer support groups. The Clinical Nutrition Consultant, the Behavioral & Adolescent Health Consultant and the CYSHCN epidemiologist have met with multiple other states to hear what they are doing to support T1D on a public health level. In year 2, the projects and workgroup continue.

National Performance Measure 15 – Adequate Insurance

Percent of children, ages 0 through 17, who are continuously and adequately insured.

When we created the new 5-year state action plan in 2020, we had not included NPM 15 – Adequate Insurance for 2021-2025. However, last year we decided to re-include NPM 15. There is much overlap between our and our partners' work on medical home and our work to improve coverage and families' use of available coverage for services.

The NSCH 2020-2021 shows the percentage of children with adequate insurance in Washington state was 72%. However, the insurance coverage rate among CYSHCN is only 62%, indicating the existing disparities.

Washington is a Medicaid expansion state, which allows many families the opportunity to access insurance coverage. However, for many CYSHCN, high out-of-pocket expenses continue to make their insurance inadequate for their needs. 24% of parents of CYSHCN reported that obtaining specialist care was “somewhat difficult”. Parents often describe barriers to access skilled providers. The most recent Washington Five Year Needs Assessment, reported that services for complex medical or behavioral health needs were limited or nonexistent in certain locations, making access for families difficult. Necessary travel to a distant provider location can result in additional expense and is sometimes impractical for families. This often creates bottlenecks in clinics serving 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. Nineteen percent of Washington families raising CYSHCN reported in the 2020-2021 NSCH survey that they stopped working or reduced working hours to provide care, compared with 3% who did not have a child/youth with special health care needs. This represents an apparent improvement over 2018-19 where 25% of Washington families reported stopping or reducing work hours. However, there is still a significant gap between families raising CYSHCN and those who do not have a child with special health care needs. The complexities of health care financing create an added barrier for families and providers. The work in the CYSHCN program to support adequate insurance has shifted from an enrollment to a focus on health care financing to adequately meet the needs of CYSHCN and their families without unreasonable out-of-pocket expenses or financial barriers to access services.

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 from community providers 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 year, CYSHCN program team members assisted families with access to and coverage for metabolic formulas. The most typical outcome is a referral to the DOH Newborn Screening Program and the Biomedical Genetics Clinic for individual assistance since this clinic has stockpiled formulas.

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 are inefficient and somewhat arbitrary. These products meet the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria for medical necessity and should 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 permitted to continue exploring 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 instead of liquid formulas, which 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 of 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 implementation of the new five-year plan for the DDC.

CYSHCN program team members have helped multiple provider types understand Medicaid EPSDT rules and how these impact client access to Developmental Disabilities Administration (DDA) waiver services. The CYSHCN program provided technical assistance to neurodevelopmental centers.

This year, most of the CYSHCN program's assistance to providers was about helping them with billing questions, licensing, and credentialing with Medicaid-managed care organizations. Offering 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, seem to be the most helpful to providers.

A barrier for providers is understanding the different rules and procedures of the 5 MCOs and the roles played in licensing, credentialing, and billing by DOH, HCA, and the MCOs. It is helpful for them to understand the criteria for reducing the billing error rate. Over the years, the CYSHCN program has assisted in solving billing problems, but providers still have challenges in this area. The CYSHCN program has been strategizing with HCA on a more systems-based approach 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 issue. The MHPP program has created a billing guide for autism screening, evaluation, and diagnosis to support providers to support providers to accurately bill so they can continue to offer this important service throughout the state. This need further reinforces our program goal to address health care financing as a key barrier to CYSHCN and their families – as it often prevents them from accessing skilled providers.

There is an increasing awareness by state agencies, medical providers, and families of EPSDT efforts in Washington. However, families of CYSHCN don't understand 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.

Care Coordination and Identification of CYSHCN

DOH's Title V staff continued to work closely with HCA, 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 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 incorporating value-based care and alternative payment models, there is an increasing awareness of cost-based risk models shifting more focus on adult care needs and chronic disease. While care coordination of CYSHCN increases the optimization of developmental outcomes, there are little data to show the long-term impact on overall cost savings within the already overburdened health care system. Due to the design characteristics of the current PRISM system, CYSHCN are largely under-identified, as their overall claims are significantly lower than adults with chronic disease due to their young age and therefore short time receiving services.

DOH has partnered with the DSHS and HCA to add a "flag" (indicator) in PRISM that identifies any child receiving services through our Title V CYSHCN program, indicated in our CYSHCN CHIF 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. We continue to work to refine our CHIF system so more CYSHCN can be flagged and to work with HCA and MCOs on utilization of the CYSHCN flag.

During FFY22, we partnered with HCA and PAVE to participate in Project ACCELERATE (Advancing Care Coordination through Evidence; Leveraging Existing Relationships Around Transforming PracticE). This national project brings together Medicaid Medical Directors, MCH/Title V Directors, and patient advocates in state teams to distill the latest PCORI-supported findings related to enhanced care coordination for CYSHCN and identify strategies best suited for their state-specific landscapes for dissemination. This project has helped forge stronger partnerships with HCA and family leaders and receive technical assistance from other states and national leaders on care coordination. We have also brought in partners from our Developmental Disabilities Administration (DDA) to participate in this work.

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 services for CYSHCN. We have educated and provided support for coverage of care coordination for children through efforts supporting 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 DOH's licensing division to ensure that licenses are processed on time so children can access services and initiate continuous quality improvement activities to improve the ABA licensing process.

State Performance Measure 10 – Suicidal Ideation

This section details work to address the second priority need identified in our 2020 needs assessment: *Promote mental wellness and resilience through increased access to behavioral health and other support services.* The

state performance measure associated with this work is
SPM 10: Suicide ideation among youth with special health care needs.

In 2021, 38% of 10th grade students with special health care needs reported engaging in suicidal ideation in the prior year. (Healthy Youth Survey)

Historically, CYSHCN with primarily behavioral health needs have not been a strong focus of Washington's program. HCA and other offices at DOH focused on injury and violence prevention primarily work in youth behavioral health. Our work this year has been to increase our capacity in this area and develop connections with others working to improve behavioral health for children and youth in Washington.

Increasing Data about CYSHCN Mental Health Needs

The first step in this endeavor was to establish better baseline data on the behavioral health needs and suicidal ideation of CYSHCN. Data for this measure come from our state's Healthy Youth Survey (HYS). The CYSHCN epidemiologist and CYSHCN director worked closely with the HYS team and a coalition of disability organizations to improve the disability screener within the HYS. The new screener will allow us to better identify CYSHCN within the survey and differentiate the responses and needs of CYSHCN with different types of disabilities. The updated screener will be implemented in the 2024 administration of the HYS.

Improving Access to Pediatric Mental Health Care

The CYSHCN team also partnered with DOH's COVID Behavioral Health Strike Team and Seattle Children's Partnership Access Line (PAL) to secure a HRSA Pediatric Mental Health Care Access grant in the fall of 2021. This grant is focused on expanding crisis care services to youth and families in eastern Washington (a rural and frontier area of the state with significant gaps in behavioral health care) through an enhancement of PAL and collaboration between the Seattle Children's Crisis Care Consultation Clinic and Frontier Behavioral Health in Spokane. We have leveraged this funding by braiding it with MCHBG, state funding, and Medicaid funds to support adding a new staff member to our CYSHCN team focused exclusively on behavioral health and adolescent transition. The new staffing addition and the new partnerships created through this grant have greatly increased our capacity to address this priority need. We participate in the Children and Youth Behavioral Health Workgroup and subcommittees and have forged connections with state and regional Family, Youth, and System Partner Round Tables (FYSPRT) and regional crisis care collaboratives. We are working more closely with our HCA colleagues on Behavioral Health issues and have improved our connections with other DOH teams working on child and youth behavioral health.

Additional Work Supporting CYSHCN at the Local Level

System Coordination and Collaboration

The need for coordination and collaboration across systems of care for CYSHCN is diverse and varied. The CYSHCN program hosted quarterly Communication Network meetings in FFY22. More than 45 people attended each meeting, representing geographically diverse CYSHCN partners from each Medicaid-contracted MCOs, medical and community groups and providers, multiple state and local agencies, and family-led organizations.

The meeting topics, chosen with stakeholder input, included mental health and wellness supports for CYSHCN and their families, family navigation, peer supports, school-based services and supports, equity, and strategic planning. These meetings are opportunities to meet with partners and solve problems people experience in addressing their families' needs. They are opportunities to hear updates about the work happening on behalf of CYSHCN around the state, receive training and information on changes and emerging issues, and network to partner and replicate successful practices across the state. These meetings were typically full-day, in-person meetings. They were transitioned to a shorter, virtual format in 2020 due to COVID-19 and have continued virtually during FFY22.

Family Professional Partnerships and Family Engagement

The Family Engagement Consultant (FEC) provides leadership to include family and community perspectives in policy and program development, oversees caregiver and lived-experience inclusion and outreach, and serves as a statewide subject matter expert in family engagement across Title V programs at DOH, local health jurisdictions, and contracted partners. The FEC provides navigation and connection to services to families who call or email the CYSHCN program seeking support or assistance.

The CYSHCN program created listening sessions with families as part of our ongoing needs assessment process during this reporting period. Local CYSHCN Coordinators also engage with families to assess local needs. For example, Clark County in Southwest Washington engaged in an extensive information-gathering effort with families. They collected feedback from a parent survey distributed to CYSHCN families receiving care coordination services and a broader sampling of families with children ages birth-5 currently living in Clark County to inform the development and maintenance of resource materials. They also conducted listening sessions to identify key themes with families of children with special needs. By early 2023, they plan to publish topical briefs on several key issues that families shared, and many briefs will have a call-out section about how that issue impacts CYSHCN, in addition to a report entirely about CYSHCN and their families. Each brief will include data from our survey and contextual secondary data, information about the importance of the issue, along with promising and innovative approaches to address the needs of CYSHCN and their families in the community.

The FEC continues to support the Washington Statewide Leadership Initiative (WSLI) for family leaders with PAVE. Together they serve as the backbone support for WSLI, providing funding and staff time to coordinate, facilitate, and follow-up on meetings and decisions made. PAVE provides technology support for the WSLI website and social media presence. The FEC creates a weekly newsletter of family leadership training events, advocacy opportunities, and educational resources. WSLI is a collaborative of family-led organizations and their community- and state-level partners.

For more information on Family Engagement efforts, see the Family Partnership section.

Maxillofacial Review Boards

Three of the 4 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 3 MRFB teams that operate outside a pediatric regional medical center. Our CYSHCN Clinical Nutrition Consultant supports these contracts and provides technical assistance to the MFRBs. Technical assistance included onboarding new staff, discussions of resources from the Pediatric Nutrition Care Manual (PNCM) – specific nutrition education for cleft lip/palate, guidance on interpreting growth charts and reviewing growth parameters specifically for cleft lip/palate population, a meeting with RN Consultants from Montana's Maxillofacial program to compare processes and funding ideas, a review of 2 articles focused on bullying, discussion of learnings from the American Cleft Palate Craniofacial Association (ACPA) Team Coordinator Retreat, and 3 special guests from the Dental Program Manager with the Health Care Authority, the Program Manager & Access to Baby and Child Dentistry (ABCD) State Managing Director as well as the Outreach Specialist for the DentistLink program at Arcora Foundation. Each team serves children from 9 - 10 counties in Washington's eastern, central, and southwestern portions. Their caseload of around 200 children is 80% or more Medicaid-insured.

The maxillofacial team coordinator supported by these funds is an allied health professional coordinating 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 with maxillofacial expertise and often volunteer their time and

services on these review boards. Data for each child served by the 3 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 to help identify service gaps.

All 3 MRFBs were given additional funding to accommodate the many psycho-social challenges that can accompany a diagnosis of a facial anomaly. The amendments included $3000 for each contract to go towards the use of an MSW Social Worker. The Tacoma MFRB team quickly put the money to use: “This quarter has been our biggest accomplishment. This program has never had a social worker to help provide psycho-social support. Our program was able to hire Lisa Loveland MSW in May of 2022 who has already made such a big impact. We couldn’t be more pleased with her helping families get services within Mary Bridge but also through the community. She has many years of experience in the Emergency room and has a wealth of knowledge that she brings to our team that no one else can provide. She observed the flow as well as shadowed me to see what family’s needs looked like from a clinical case manager approach. In June, she was able to call families prior to their appointments. She spent at least 30 minutes with some families hearing their stories, their struggles and helping them connect with services in their area. Many families need counseling, several of which are out by the ocean where even basic medical care is scarce. Pre- screening had a huge impact on our clinic! While many of the providers know the past medical history of the patients through a collection of information this RN provides, they are unaware of the barriers to care. Lisa was able to help share family dynamics prior to the family being seen.”

Neurodevelopmental Centers

The CYSHCN Team also supports grants to 19 Neurodevelopmental Centers of Excellence (NDCs) with state funding. NDCs are a group of community non-profit and hospital-based agencies who 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. NDCs provide speech, occupational and physical therapies. They also offer consultation referrals based on a primary care provider's recommendation. Other services may include nursing, nutrition, social work, educational services, adaptive equipment, computer-assisted communication therapy, and hydrotherapy. NDC service coordinators work with families to help identify and meet their needs. They also teach families to find their way through the health care system and help coordinate care. Many NDCs are also Part C providers for early intervention services. Several partner with primary care Autism Centers of Excellence to support autism assessments in communities across the state as part of SMART teams.

Local Health Jurisdictions

All LHJ partners are required to do CYSHCN work. Most of the work by our LHJ partners in this area continues to be care coordination, resource, referral activities, systematic change efforts, managing systems-level partnerships, and activities to improve local and regional systems of care for CYSHCN and their families. The focus for most LHJ partners is increasing the number of families connected to a medical home to provide them with holistic and individualized care. Additionally, our LHJ partners work to increase access to health insurance and provide services that may not be covered by insurance, specifically access to respite services for family caregivers. The LHJ CYSCHN Coordinators serve as the connecting point for families in their county to available resources and assist in navigating complex systems of care. Many LHJ CYSHCN 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. Along with this continued work, our LHJ partners have also undertaken the task of understanding the impact of the pandemic on children with special health care needs and their families to better assist them in their recovery. Some pandemic impacts have emphasized the existing flaws in our systems of care and their ability to weather changing health environments.

During this reporting year, the CYSHCN Process Improvement Specialist worked to develop a Care Coordination Toolkit for CYSHCN Coordinators in response to feedback from coordinators about their training needs. This document provides a comprehensive training manual and reference guide for care coordinators on the system of care for CYSHCN in Washington State. The toolkit was launched in the fall of 2022.

Overall Effectiveness of Program Strategies and Approaches

Many strategies and activities used to increase access to the medical home model of care and adequate insurance for Washington's CYSHCN seem to be effective (e.g., family leadership training, resource and information sharing, and UW MHPP technical assistance contract activities for medical home and autism systems of care). We are still working to increase and strengthen our capacity to evaluate the impact of some state program activities, including projects led by CYSHCN program staff and 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 convener to create connections between communities, 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 continue expanding our meaningful partnerships and manage our resources.

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

Children and Youth with Special Health Care Needs Application Year

Priority:
Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

National Performance Measures 11 and 15:
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:
Through September 2025, explore opportunities to work with the Community Health Worker (CHW) program to increase CHW knowledge of developmental screening and milestones. Implement the Autism and Developmental Disabilities module as part of broader training curriculum for CHWs. Develop strategies for linking trained CHWs to autism diagnostic network.

Strategy:
- Improve overall awareness of the complex needs of the CYSHCN population as a demographic identity, with distinctive cultural needs for access to communities and systems of care.

General Status on this Objective to Date:
Community health workers are increasingly seen as essential workers in our state for effective outreach to families with young children, even more so in the mid- and post-pandemic environment. A 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 to create a 2-part module, “Understanding Autism Spectrum Disorder.” The initial pilot of this experimental module, conducted in the summer of 2020, generated extremely positive feedback from CHWs. From 2021, the module was incorporated into the regular training schedule and is offered to CHWs at least once a year.

This legislative session (FY23-25) allocated ongoing funding to provide statewide leadership, training, and integration of community health workers with insurers, health care providers, and public health systems. We plan to work closely with early childhood services to support education and outreach to partners facilitating developmental screenings, including patient navigators, home visiting programs, and CHWs. We also work with the MHPP to increase access to CHWs through the medical home as part of our autism systems work. The CYSHCN team has been collaborating with HCA on enhancing Medicaid funding options for care coordination for CYSHCN, including options for funding CHWs. Legislative funding was allocated to support CHWs in pediatric practices, and the CYSHCN program promoted this opportunity to our SMART Teams and other networks. The team continues to partner with HCA to support CHWs to provide services to CYSHCN and their families as part of the medical home.

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:
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 the development potential for these CYSHCN and their families. But the 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, Autism Center of Excellence (COE), and ECHO trainings for providers around the state. 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 for the nutrition needs and common feeding difficulties of preterm birth or very low-weight CYSHCN, has been identified as a need. WIC office hours have been implemented to address this issue. These monthly meetings are open to all 88 WIC dietitians and are led and supported by the nutrition consultant. Case studies that WIC dietitians are seeing in their community are discussed and are an opportunity to learn about resources and recommendations. The CYSHCN-WIC office hours have gained popularity, and in early 2023, nutrition education topics have been incorporated.

We also developed a Care Coordination Toolkit for care coordinators serving CYSHCN based on feedback from CYSHCN coordinators and other care coordination providers. We plan to continue refining this toolkit and make it available on our website as a reference guide and training manual. We also plan to offer additional trainings on our care coordination toolkit during FFY24.

Strategy:
- Partner with the Medical Home Partnerships Project to provide state-level subject matter expertise and technical assistance, and coordinate with the UW LEND program and Seattle Children's Hospital to support communities in workforce development, resource development, and ongoing training on family-centered, comprehensive systems of care for CYSHCN.

We plan to continue our contract with MHPP and include this work as a deliverable. The CYSHCN Annual Report section provides details about this contract and work.

Objective:
By September 30, 2025, increase the number of dietitian members of the Nutrition Network with CYSHCN training and the number of community-based feeding teams working with CYSHCN. Prioritize training and support given to those in counties with limited resources and those with ability to provide services via telehealth.

Strategies:
- Provide targeted subject matter expertise to contractors and providers, including CYSHCN Coordinators, on areas of expertise such as complex nutrition for CYSHCN, children and youth with clinical and behavioral complexity, including autism, navigating state systems and policy, care coordination, family navigation, and community referral systems and clinical linkages.

- Identify and develop methods to establish baseline data on CYSHCN, systems of care, gaps, and barriers to equitable, quality care. Make data accessible via a CYSHCN dashboard and other dissemination efforts. Utilize data to identify referral opportunities and strategies, and community needs for local health care resources and equitable service delivery.

General Status on this Objective to Date:
The report on our nutrition needs assessment, Assessment of Nutrition Services for CYSHCN was published in early 2020. In FFY24, we will continue to address the gaps it identified and listed in the "CYSHCN Annual Report". 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 Nutrition Consultant is engaging with the Nutrition Network to increase membership and technical assistance for members. Outreach and intentional recruitment to increase Nutrition Network involvement to address the gaps in the current network (geographic, ability to take referrals, language/cultural diversity, etc.) are also underway.

We will continue our contract with UW Center on Human Development and Disability Nutrition program to support an interdisciplinary workgroup of providers, hospitals, families, and early intervention specialists to address ways to provide feeding supports for fragile infants transitioning from hospital to home. We will continue discussions to develop a training curriculum for community feeding teams on fragile infant feeding and support community based RDN skill development. We will work with the UW Nutrition program and LEND to implement recommendations from the nutrition needs assessment.

Through the quarterly CYSHCN Coordinators and CYSHCN Communication Network meetings, we will continue to include nutrition topics as education and discussion items. The Nutrition Consultant and the CYSCHN Coordinator of Pierce Co worked together to establish a workgroup to address the gap in care for newly diagnosed type 1 diabetic youth. Next year, trainings for parent peer support and school nurses are 2 focus areas for this group and a virtual teen support group.

The Nutrition Consultant is creating modules on teaching cooking classes to youth with disabilities for WA state. These modules will be disseminated in FFY24.

Objectives:
By September 30, 2025, increase the percentage of CYSHCN ages 0-17 who receive care in a well-functioning system by 5 percent.

Strategies:
- Provide services to CYSHCN and family members of CYSHCN so they can be trained, engaged, supported, and involved at all levels of program planning and implementation of services for CYSHCN. Implement and promote inclusion opportunities and support resources for fatherhood, foster parents, grandparents, kinship care.

- Partner with the Washington State Leadership Initiative collaborative and community-based organizations to elevate family voices and provide connections so family voices can effectively influence the development of systems and services for CYSHCN.

- Promote and facilitate successful transitions including transition from hospital to home, from Birth to 3 into school and community-based services, and from pediatric to adult specialty services.

- Through partnerships, address the need for improved access to affordable services, and increased availability of CYSHCN service providers, quality healthcare, access to insurance, and adequate health care financing, particularly in rural communities and remote areas regardless of language spoken, gender identity,

race and ethnicity, immigration status, or insurance status of families.

- Through partnerships, facilitate innovative programming and technology solutions such as telehealth and remote services to address gaps in rural and remote areas and other barriers to access to care.

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

General Status on These Objectives to Date:
The CYSHCN program supports and promotes the federal CYSHCN blueprint for change and the Standards for Systems of Care for CYSHCN, which emphasize integrated, coordinated, family-centered, and culturally and linguistically competent systems of care.

ACRONYM	MEANING
COE	Center of Excellence
ECHO	Extension for Community Healthcare Outcomes (Project ECHO model)
HCA	Health Care Authority
LHJS	Local Health Jurisdictions
LEND	Leadership Education in Neurodevelopmental and Related Disabilities
SMART TEAMS	School Medical Autism Review Team

Our continuing work with the Medical Home Partnerships Project directly addresses access to medical home and other aspects of the system of care, including provider training and technical assistance to support access. Their work includes:

- Providing a technical assistance center to support community providers in building more effective local systems of care and connecting to statewide resources. This includes:
    - Supporting the development of integrated networks of providers in communities across the state for diagnosis and treatment of autism. (e.g., SMART Teams, COE, ECHO).
    - Enhancing the availability of care coordination for CYSHCN through family navigation CHW training and participation in Project ACCELERATE.
    - Dissemination of information about mental/behavioral health services and social-emotional supports for CYSHCN and their families.
- Creating connections between systems and communities to support integrated, coordinated, and collaborative systems of care.
- Collaborating with DOH, HCA, LHJs, SMART Teams, ECHO, and COEs around addressing financing and billing issues for CYSHCN
- Supporting HMG and ECCS work in partnership with DOH as key elements of a robust system of care for CYSHCN in WA.
- Applying an equity lens to program activities and work to address gaps in the system of care for underserved CYSHCN populations through:

    - Developing networks with multicultural providers.
    - Elevating the voice of lived experience in training and program development.
    - Providing technical assistance to local and statewide partners
    - collecting data on system gaps.
    - Outreach to rural and frontier communities and historically underserved populations.
- Collaborating with LEND to develop strategies to increase the number and diversity of providers serving CYSHCN across the state. Foster partnerships between LEND (including LEND trainees), the CYSHCN Program, and community-based providers in workforce development, training, and interdisciplinary partnerships.
- Working with the DOH Family Engagement Coordinator, family organizations for CYSHCN, Youth with Special Health Care Needs and families with lived experience to support engagement in systems development work to improve family-centered, trauma-informed, and culturally humble systems of care.
- Provide community team payment for the development of annual medical home or autism activity plans as funding allows.

We continue to refine our CHIF data system and have recently developed a CHIF dashboard to share our CHIF data more effectively. We intend to work with stakeholders, including LHJs, to identify ways to improve CHIF and our use of the data to provide better overall surveillance and care coordination. For example, can we better identify children needing care coordination or identify children being served but whose data have not been collected?

We will continue to assist families with CYSHCN with clinical medical and behavioral complexity to access needed services, at the state and local levels. The CYSHCN program will also work with the licensing division in DOH to address licensing issues and scope of practice for services provided to CYSHCN and their families, such as Applied Behavior Analysis (ABA), therapies, nutrition services, facility, and respite provider licensing. We also have been working closely with HCA to support providers 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 through Project ACCELERATE. We will work with community-based providers exploring alternative payment models for the 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 experiences and identify opportunities to inform pediatric interventions based on these lived experiences. We are participating in the Developmental Disabilities Council (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 a successful and intentional transition to adulthood services for youth with special health care needs. It will include transition support activities in our work with local CYSHCN coordinators, our provider training and technical assistance contractors at UW, and our family engagement contractors. We have hired a new staff person focused on adolescent transition and behavioral health work for CYSHCN.

We recognize that many CYSHCN are also part of other underserved groups facing health disparities. By increasing surveillance methods, 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 needing more focused work or 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, community access, and self-determination.

Objective:
By December 31st, 2023, support access to clinical genetic services.

By December 2023, collect and analyze service utilization data on patients utilizing clinical genetics services, and disseminate the information to our stakeholders.

- **Strategy:**
  In collaboration with our clinical partners, assure access to clinical genetic services in rural and/or underserved communities through the provision of clinical genetics travel clinics to underserved areas statewide.

- Disseminate data and trends on service utilization of clinical genetic services to stakeholders.

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.

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

- Support interventions to address suicide ideation among CYSHCN.

- Identify opportunities to infuse trauma-informed care into working with CYSHCN.

- Collaborate with surveillance and epidemiology Healthy Youth Survey leads to advocate for including questions about special health care needs in all Healthy Youth Surveys.

- Identify and disseminate data for analysis on risk of suicide ideation for CYSHCN, including focus on youth with autism and other developmental disabilities. In the evidence base, increase representation of youth with disabilities as a complex disparate group with a high intersectionality between other known populations vulnerable to high risk factors.

General Status on These Objectives to Date:
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. Mental health and suicidal ideation are assessed biennially through the HYS, administered to middle and high school youth across the state. 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 consistently collecting this information is vital to measure risk for behaviors and risk factors for suicide and other behavioral health concerns and developing appropriate interventions. We have worked with the HYS team to change the HYS disability screener enabling us to better differentiate the responses of individuals with different types of disabilities. This screener will be included in next year's HYS survey. We will analyze the responses for disparities in mental health for those with disabilities.

The CYSHCN program has initiated conversations with the DOH suicide prevention program about providing appropriate educational material to address this disproportion. The CYSHCN adolescent and behavioral health consultant supports this work and our work on the adolescent transition. We continue to expand our network in the behavioral health space through our Pediatric Mental Health Care Access award, focused on providing mental health consultation to primary care providers and mental health services to families experiencing crises in rural areas of our state. We received expansion funding for this grant. And we are using it to increase consultation to EDs on complex youth with behavioral health issues boarding in EDs and autism assessment tools trainings for providers.

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 for suicide prevention in ASD/DD populations. These will 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).

The CYSHCN program will partner with the Injury and Violence Prevention unit to provide subject matter expertise on reducing bullying for 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 promote social connection and access to community, to address barriers to resilience.

Our program will work with autistic self-advocates 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.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

III.F Public Input

The Washington Title V program seeks ongoing input on priorities and programs from partners and stakeholders, including the public who fund and benefit from our work. We do this through advisory groups, workgroups, direct meetings with partners, working with parent and advocacy organizations, and surveying parents, providers, community organizations and the general public.

The Department of Health (DOH) maintains a website with pages that include maternal and child health information, reports, and publications. Most of our web pages include staff contact links to provide the ability to reach us for program-related questions or discussion. We make regular use of social media to connect and engage with the public, including Facebook, Twitter, YouTube, Instagram, and Medium, a blogging platform.

Input on the Maternal and Child Health Block Grant Application and Report

To inform people about the MCHBG application and report, we prepared an MCHBG Overview document based on the grant application's executive summary overview. We used the DOH Facebook and Twitter social media and email messages to groups such as representatives of local health jurisdictions to broadcast the availability of this material and to encourage comments and discussion.

The link in the social media messages took viewers to our MCHBG web page, which included a brief program description, links to the overview document and a full print version of the draft application, and a contact email and phone number for comments. The public comment period was announced as July 10-24, 2023.

We received 5 substantive comments on the MCHBG annual report and application this year. All these comments were received via email to the dedicated email address established for this purpose. Comments received on the DOH Facebook page were not substantive. The comments received addressed topics such as a request for DOH to provide additional supports for LGBTQIA2S+ youth, providing youth with unsafe home lives with access to safe, private, affordable and equitable health care, providing new mothers with more post-partum support since not all mothers have supportive family or community to help them, and expanding universal vaccine access to pregnant individuals. All these comments were provided to the appropriate DOH staff for review.

DOH has been working to improve accessibility to our written material by increasing the availability of our documents and communications in languages other than English. Spanish versions of our MCHBG web page and MCHBG Overview were created in summer 2023.

We had the MCHBG Overview translated into additional languages as well. The Overview document was translated into multiple languages including Russian, Vietnamese, Somali, Korean, Tagalog, Arabic, Punjabi, and Cantonese. These will be available on our website for public comment and will remain after the grant submission and shared with community partners as an educational piece about the program and Washington's use of the grant funding.

Tribal Engagement

This year we also held a Tribal Listening Session to gather input on the report and application from Tribes and Tribal serving organizations. The Tribal Listening Session was held on July 6, 2023. Approximately 21 individuals from various Tribes, Tribal Organizations, and State Agencies participated in the listening session. We were able to gather substantive feedback from this session on topics like the need for services for those impacted by a lack of birthing facilities in rural areas, the growing issue of food insecurity facing children and families, and a recommendation for improving collaborative funding across agencies that are focused on improving the lives of

children and their families to maximize the impact of those efforts in Tribal communities. We intend to continue to gather feedback from Tribes and Tribal serving organizations as we move through the five-year Needs Assessment process.

Advisory Groups

Throughout this application and report, we mention several advisory groups and committees that inform our work and priorities. These include the Washington Statewide Leadership Initiative collaborative, the statewide “Children with Special Health Care Needs Communication Network”, the Youth Advisory Council, the Birth Equity Advisory Council, the Community Health Worker Leadership Committee, the Washington State Perinatal Collaborative, and meetings of the local health jurisdictions’ maternal and child health and CYSHCN specialists.

Our efforts to get input on the Title V program, priorities, and activities are a continuous process as we engage with partners and stakeholders, including the public, throughout the year. During this next year we want to improve our efforts to engage with a broader range of community voices to ensure our programs serve all populations well.

III.G. Technical Assistance

III.G. Technical Assistance

The MCH Bureau and AMCHP have created several rich opportunities for engagement and learning to strengthen our Title V work. Region X calls held every month are an excellent resource for Title V staff and designed to provide policy and programmatic updates as well as peer learning and expert subject-matter presentations. In the Fall of each year, Region X Title V staff identify their priority learning interests and how they want these meetings designed. Many of the topics of interest coincide with technical assistance desires listed below. Staff also seek out learning and support through TVIS trainings, annual AMCHP conferences, sub-population focused national meetings, AMCHP's innovation station, communities of practice, additional trainings and workgroups, to name a few resources.

Looking at this next year, we would welcome the opportunity to explore technical assistance around a few pertinent areas. Some of these are areas of ongoing technical assistance needs:

- Continued shared learning about using the block grant wisely within a decentralized public health system. What are best practices? What are learnings from states who have tried varied models of fund distribution over time?
- Discussion on models that other states use to fund and support structures for on-going work for the 5-year Needs Assessment. For example, understanding leadership and community advisory group structures, ongoing data collection, data products, and staffing.
- Partnership in exploring child health outcome measures. What are other states using as state performance measures? How could we do a better job capturing work around primary prevention?
- Continued guidance and additional learning opportunities related to identifying appropriate state performance measures, state outcome measures, and selection and use of evidence-based strategy measures that are directly connected with our work.
- Amidst changes in access to the full spectrum of reproductive health, what are implications for populations with access barriers? How are cascading changes to the rural health landscape being addressed? Are there promising practices we should explore?
- How are Title V programs addressing gun violence?
- How can we be more gender inclusive in our work? Are any States pursuing legislation, policy or systems changes focused on gender inclusive services?
- Guidance on better framing and formatting our State Action Plan and connecting Objectives with Strategies; Guidance on improving reporting narrative and application narrative to be more cohesive to the reader

Staff have also indicated interests in training around the following topics:

- Leadership coaching and mentorship, for navigating challenging workloads and team dynamics. Foundational Public Health Services orientation and technical assistance, for internal and external partners, including local public health MCH leaders
- Continued training around telehealth and teleintervention, particularly for our EHDDI program and partners

and our Sexual and Reproductive Health program and partners.

- Federal and state policy training on rulemaking and the role of federal decisions on state level legislation.
- Equity and social justice training, including how to center community expertise in program planning and funding distribution, as well as diversity in staffing.
- Resiliency framing for maternal, child, adolescent health work. How to implement a shift in focus from deficit models to strength and hope-based approaches
- Growing staff morale amidst staff burnout, challenging partnership relationships, navigating the increasingly complex public health landscape, and continued agency-level changes
- Results-based accountability and systems-thinking training—how to apply these approaches to complex initiatives
- Training on implementation of the Blueprint for CYSHCN
- Implementing and maintaining quality improvement efforts in clinical and non-clinical settings
- Coordinating and leveraging HRSA funded initiatives such as MCHBG, ECCS and now ECDHS
- Trainings on Adolescent Health Well Visits

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - WA DOH Title V Medicaid MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - WA DOH Appendix A AbbreviationsAndAcronyms.pdf

Supporting Document #02 - WA DOH Appendix B LHJ Bodies of Work Overview.pdf

Supporting Document #03 - WA DOH Appendix C State Action Plan Table.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - WA DOH Organizational Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Washington

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 9,305,490	
A. Preventive and Primary Care for Children	$ 3,216,534	(34.5%)
B. Children with Special Health Care Needs	$ 3,250,985	(34.9%)
C. Title V Administrative Costs	$ 751,241	(8.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 7,218,760	
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)	$ 16,879,116	
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)	$ 15,402,961	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 32,282,077	

OTHER FEDERAL FUNDS	FY 24 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) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 5,000,000
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) > 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	$ 4,550,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Zero to Three Early Childhood Health Data Systems	$ 450,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Perinatal Quality Collaborative	$ 275,000

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 8,900,000 (FY 22 Federal Award: $ 8,973,317)		$ 6,630,809	
A. Preventive and Primary Care for Children	$ 2,948,035	(33.1%)	$ 2,192,652	(33%)
B. Children with Special Health Care Needs	$ 3,041,002	(34.2%)	$ 2,376,828	(35.8%)
C. Title V Administrative Costs	$ 771,615	(8.7%)	$ 639,905	(9.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,760,652		$ 5,209,385	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 7,573,626		$ 7,573,626	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 7,573,626		$ 7,573,626	
A. Your State's FY 1989 Maintenance of Effort Amount $ 7,573,626				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 16,473,626		$ 14,204,435	
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		$ 17,698,731	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 34,172,357		$ 31,903,166	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,120,893	$ 1,120,893
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Colorectal Cancer Control Program (CRCCP)	$ 779,403	$ 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	$ 160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Essentials for Childhood	$ 311,000	$ 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	$ 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	$ 354,234
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020	$ 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	$ 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	$ 1,577,811
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 700,000	$ 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	$ 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	$ 245,000

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 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) > Office of Population Affairs (OPA) > Title X Family Planning	$ 4,000,000	$ 4,000,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > TPP Innovation and Impact	$ 1,859,770	$ 1,859,770

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: These are expenditures through July 1, 2023. We anticipate an increase in grant expenditures by the end of the grant budget period 9/30/2023.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: These are expenditures through July 1, 2023. We anticipate an increase in grant expenditures by the end of the grant budget period 9/30/2023.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: These are expenditures through July 1, 2023. We anticipate an increase in grant expenditures by the end of the grant budget period 9/30/2023.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: These are expenditures through July 1, 2023. We anticipate an increase in grant expenditures by the end of the grant budget period 9/30/2023.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Washington

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 954,351	$ 672,878
2. Infants < 1 year	$ 954,351	$ 672,878
3. Children 1 through 21 Years	$ 3,216,534	$ 2,192,652
4. CSHCN	$ 3,250,985	$ 2,376,828
5. All Others	$ 178,028	$ 75,668
Federal Total of Individuals Served	$ 8,554,249	$ 5,990,904

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 0	$ 0
2. Infants < 1 year	$ 2,524,542	$ 2,524,542
3. Children 1 through 21 Years	$ 2,524,542	$ 2,524,542
4. CSHCN	$ 2,524,542	$ 2,524,542
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 7,573,626	$ 7,573,626
Federal State MCH Block Grant Partnership Total	$ 16,127,875	$ 13,564,530

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

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 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 116,847	$ 20,120
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 77,204	$ 10,060
B. Preventive and Primary Care Services for Children	$ 3,679	$ 2,012
C. Services for CSHCN	$ 35,964	$ 8,048
2. Enabling Services	$ 533,750	$ 325,255
3. Public Health Services and Systems	$ 8,654,893	$ 6,285,434
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		$ 19,996
Laboratory Services		$ 124
Direct Services Line 4 Expended Total		$ 20,120
Federal Total	$ 9,305,490	$ 6,630,809

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 7,573,626	$ 753,626
3. Public Health Services and Systems	$ 0	$ 0
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 7,573,626	$ 753,626

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: 82,908 **Data Source Year: 2022**

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	82,461 (99.5%)	217	216	216 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect	Citrullinemia, Type I
Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Cystic Fibrosis	Glutaric Acidemia Type I
Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency
Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Mucopolysaccharidosis Type I (MPS I)	Primary Congenital Hypothyroidism
S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy			

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Early Hearing Detection, Diagnosis, and Intervention (EHDDI)	81,810 (98.7%)	1,080	168	162 (96.4%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Washington State does not have the resources for long-term follow-up of all conditions. For conditions on which we have the ability to follow up, the information and duration of the monitoring depends on the condition under consideration.

Form Notes for Form 4:

In 2022, 108 infants born in WA State were diagnosed with and received surgical intervention for Critical Congenital Heart Disease (CCHD) after being identified in one of 3 ways: prenatal screening, pulse oximetry newborn screening, or symptomatic for CCHD.

Field Level Notes for Form 4:

1.	**Field Name:**	**Early Hearing Detection, Diagnosis, and Intervention (EHDDI) - Total Number Referred For Treatment**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**
	Field Note: A small number of confirmed cases may not have been screened for a variety of reasons, including; parental decline. medical fragility, or ineligibility for receipt of services.	

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 2022

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	252	84.3	0.0	14.8	0.6	0.3
2. Infants < 1 Year of Age	81,486	44.6	1.8	50.3	3.1	0.2
3. Children 1 through 21 Years of Age	541,803	42.0	3.2	45.1	3.1	6.6
3a. Children with Special Health Care Needs 0 through 21 years of age^	4,184	80.8	1.1	11.0	3.5	3.6
4. Others	65	56.5	0.8	12.0	5.3	25.4
Total	623,606					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	83,911	No	82,654	100.0	82,654	252
2. Infants < 1 Year of Age	83,493	No	81,486	100.0	81,486	81,486
3. Children 1 through 21 Years of Age	1,953,783	No	1,982,065	80.0	1,585,652	541,803
3a. Children with Special Health Care Needs 0 through 21 years of age^	411,038	Yes	411,038	100.0	411,038	4,184
4. Others	5,703,849	Yes	5,703,849	0.1	5,704	65

^Represents a subset of all infants and children.

Form Notes for Form 5:

Data used to complete Forms 5a and 5b

Form 5a:
Data on counts of pregnant women, CSHCN and “Other” are obtained from local health jurisdiction annual reports on numbers of clients served.

Data counts of infants comes from the First Steps program, housed in Health Care Authority.

Data on counts of children served come from a combination of local health jurisdiction report data and health promotion mailings conducted by the Watch Me Grow Washington (formerly Child Profile) program housed in DOH.

Data on primary sources of coverage were obtained from various sources including local health jurisdiction annual reports, the WA State Health Care Authority, the American Community Survey and the Medicaid Management Information System.

Form 5b:

The count of pregnant resident WA State women comes from the WA State Birth Certificate for the year 2001. 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 WA State's Office of Financial Management official estimates of population for 2021.

The count of CSHCN come from the estimated population derived from the 2021 NSCH.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2022**
	Field Note: This is the total number of pregnant people local health reported as having served. DOH does not provide direct nor enabling services to pregnant people with Title V funds.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**
	Field Note: This total includes all infants who received a Watch Me Grow Washington (formerly Child Profile) mailing from DOH.. The percent of infants with no insurance comes from the American Community Survey and is the rate for the population 0-17 years of age.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: This total includes all children 1-6 years of age who received a Watch Me Grow Washington (formerly Child Profile) mailing from DOH 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 Health Care Authority's medicaid dashboard.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: This is the number of CYSHCN for local health reports having provided a direct or enabling service.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**
	Field Note: This is the total number reported as having been served by local health jurisdictions.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**

	Field Note: Through educational and health promotional work including information on healthy pregnancies, as well as quality improvement initiatives with birthing hospitals, WA State reaches close to 100% of pregnant people with programs or campaigns funded in part by Title V funds.	
2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2022**
	Field Note: Data come from the WA State Birth File, 2021 births.	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	Field Note: Through WA State's Universal Vaccine coverage initiative al children 0-18 years of age in WA State have access to vaccines regardless of ability to pay. This initiative is paid for by state matching funds for Title V funds.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**
	Field Note: Data come from the First Steps Database.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Through WA State's Universal Vaccine coverage initiative al children 0-18 years of age have access to vaccines regardless of ability to pay. This initiative is paid for by state matching funds for Title V funds. The remaining 20% of individuals were over 18 years of age.	
6.	**Field Name:**	**Children 1 through 21 Years of Age Denominator**
	Fiscal Year:	**2022**
	Field Note: The count of children 1-21 comes from WA State's Office of Financial Management official estimates of population for 2021.	
7.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**

	Field Note: Through WA State's Universal Vaccine coverage initiative al children 0-18 years of age have access to vaccines regardless of ability to pay. This initiative is paid for by state matching funds for Title V funds. WA State has a very high percentage of CYSHCN enrolled Medicaid. These two factors combine to contribute to virtually all CYSHCN in WA State having access to services which Title V has contributed to.	
8.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**
	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 WA State. It is effectively zero percent of the this population. A value of 0.1 percent was added to allow the completion of the form.	

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 2022

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	81,482	44,559	3,751	15,984	949	8,838	1,213	2,624	3,564
Title V Served	252	138	12	49	3	27	4	8	11
Eligible for Title XIX	36,316	15,642	2,541	11,528	690	1,681	953	1,449	1,832
2. Total Infants in State	82,697	45,306	3,823	16,147	966	8,957	1,228	2,667	3,603
Title V Served	82,461	45,179	3,812	16,100	963	8,931	1,224	2,659	3,593
Eligible for Title XIX	36,833	15,883	2,588	11,665	703	1,708	966	1,470	1,850

Form Notes for Form 6:

Data on Title XIX eligibility comes from the First Steps program housed in Health Care Authority (HCA) a sister state agency. The data are from CY 2021.

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Data provided by First Steps.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Data come from local health jurisdictions and is the same total as reported in From 5a.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Data provided by First Steps.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Data provided by First Steps.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Total reported in form 4 received one screen.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Data provided by First Steps.	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Washington

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 322-2588	(800) 322-2588
2. State MCH Toll-Free "Hotline" Name	Help Me Grow Washington Hotline	Help Me Grow Washington Hotline
3. Name of Contact Person for State MCH "Hotline"	Mary Myhre	Mary Myhre
4. Contact Person's Telephone Number	(360) 236-4626	(360) 236-4626
5. Number of Calls Received on the State MCH "Hotline"		13,169

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names	N/A	N/A
2. Number of Calls on Other Toll-Free "Hotlines"		0
3. State Title V Program Website Address	https://doh.wa.gov/public-health-healthcare-providers/public-health-system-resources-and-services/local-health-resources-and-tools/maternal-and-child-health-block-grant	https://doh.wa.gov/public-health-healthcare-providers/public-health-system-resources-and-services/local-health-resources-and-tools/maternal-and-child-health-block-grant
4. Number of Hits to the State Title V Program Website		611
5. State Title V Social Media Websites	N/A	N/A
6. Number of Hits to the State Title V Program Social Media Websites		0

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Washington

1. Title V Maternal and Child Health (MCH) Director	
Name	Katie Eilers
Title	Director, Office of Family and Community Health Improvement
Address 1	P.O. Box 47855
Address 2	
City/State/Zip	Olympia / WA / 98504
Telephone	(360) 236-3687
Extension	
Email	katie.eilers@doh.wa.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Monica Burke
Title	Children and Youth with Special Health Care Needs Director
Address 1	P.O. Box 47855
Address 2	
City/State/Zip	Olympia / WA / 98504
Telephone	(360) 236-3504
Extension	
Email	monica.burke@doh.wa.gov

3. State Family Leader (Optional)	
Name	Nikki Dyer
Title	Family Engagement Coordinator
Address 1	P.O. Box 47855
Address 2	
City/State/Zip	Olympia / WA / 98504
Telephone	(360) 236-9353
Extension	
Email	nikki.dyer@doh.wa.gov

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Washington

Application Year 2024

No.	Priority Need
1.	Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course.
2.	Identify and reduce barriers to quality health care.
3.	Improve the safety, health, and supportiveness of communities.
4.	Promote mental wellness and resilience through increased access to behavioral health and other support services.
5.	Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.
6.	Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.
7.	Optimize the health and well-being of children and adolescents, using holistic approaches.
8.	Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Increase capacity of the local public health workforce to strategically identify, plan for, and address the needs of women and children throughout the state.	New
2.	Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course.	Revised
3.	Identify and reduce barriers to quality health care.	New
4.	Improve the safety, health, and supportiveness of communities.	Revised
5.	Promote mental wellness and resilience through increased access to behavioral health and other support services.	New
6.	Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.	New
7.	Improve infant health outcomes and reduce inequities that result in infant morbidity and mortality.	New
8.	Optimize the health and well-being of children and adolescents, using holistic approaches.	New
9.	Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.	New
10.	Identify and respond to emerging priority needs associated with public health emergencies and their effects on the maternal and child populations.	New

Form 10
National Outcome Measures (NOMs)

State: Washington

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

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
2021	78.2 %	0.2 %	58,426	74,721
2020	78.8 %	0.2 %	59,426	75,417
2019	78.5 %	0.2 %	61,029	77,738
2018	78.5 %	0.2 %	62,327	79,394
2017	78.5 %	0.1 %	64,698	82,452
2016	77.5 %	0.1 %	66,763	86,123
2015	77.5 %	0.1 %	65,652	84,691
2014	76.7 %	0.2 %	64,163	83,705
2013	74.1 %	0.2 %	60,342	81,406
2012	73.5 %	0.2 %	60,755	82,625
2011	72.5 %	0.2 %	59,485	82,030
2010	72.4 %	0.2 %	59,216	81,838
2009	69.8 %	0.2 %	59,133	84,682

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	77.9	3.2	589	75,576
2019	68.2	3.0	525	76,938
2018	66.8	2.9	519	77,695
2017	60.6	2.8	486	80,220
2016	58.7	2.7	482	82,103
2015	56.6	3.1	341	60,270
2014	56.8	2.7	449	79,074
2013	55.9	2.7	427	76,367
2012	51.5	2.6	394	76,573
2011	48.2	2.5	376	77,968
2010	49.8	2.5	389	78,132
2009	46.7	2.4	376	80,570
2008	41.8	2.3	344	82,254

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2021	20.4	2.2	87	425,539
2016_2020	17.6	2.0	76	432,133
2015_2019	15.8	1.9	69	438,037
2014_2018	14.7	1.8	65	441,727

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	7.0 %	0.1 %	5,830	83,801
2020	6.7 %	0.1 %	5,558	82,984
2019	6.4 %	0.1 %	5,456	84,778
2018	6.6 %	0.1 %	5,690	85,986
2017	6.6 %	0.1 %	5,776	87,479
2016	6.4 %	0.1 %	5,792	90,427
2015	6.4 %	0.1 %	5,730	88,909
2014	6.4 %	0.1 %	5,705	88,511
2013	6.4 %	0.1 %	5,547	86,483
2012	6.1 %	0.1 %	5,347	87,288
2011	6.1 %	0.1 %	5,340	86,831
2010	6.3 %	0.1 %	5,464	86,388
2009	6.3 %	0.1 %	5,580	89,111

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	8.9 %	0.1 %	7,422	83,738
2020	8.6 %	0.1 %	7,167	82,946
2019	8.5 %	0.1 %	7,172	84,719
2018	8.3 %	0.1 %	7,147	85,959
2017	8.4 %	0.1 %	7,334	87,454
2016	8.1 %	0.1 %	7,364	90,430
2015	8.1 %	0.1 %	7,216	88,923
2014	8.1 %	0.1 %	7,125	88,490
2013	8.1 %	0.1 %	7,023	86,321
2012	8.3 %	0.1 %	7,262	87,164
2011	8.2 %	0.1 %	7,107	86,602
2010	8.5 %	0.1 %	7,304	86,286
2009	8.5 %	0.1 %	7,553	89,026

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	26.1 %	0.2 %	21,885	83,738
2020	25.3 %	0.2 %	20,971	82,946
2019	25.3 %	0.2 %	21,419	84,719
2018	24.0 %	0.2 %	20,669	85,959
2017	23.8 %	0.1 %	20,837	87,454
2016	22.9 %	0.1 %	20,681	90,430
2015	22.5 %	0.1 %	19,987	88,923
2014	22.5 %	0.1 %	19,870	88,490
2013	22.2 %	0.1 %	19,196	86,321
2012	22.5 %	0.1 %	19,600	87,164
2011	22.3 %	0.1 %	19,339	86,602
2010	23.8 %	0.1 %	20,512	86,286
2009	24.4 %	0.1 %	21,689	89,026

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	2.0 %			
2020/Q3-2021/Q1	2.0 %			
2019/Q4-2020/Q3	2.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	1.0 %			
2014/Q3-2015/Q2	2.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
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
2020	4.5	0.2	378	83,275
2019	4.6	0.2	390	85,104
2018	4.6	0.2	397	86,276
2017	4.4	0.2	390	87,783
2016	4.6	0.2	418	90,718
2015	4.8	0.2	432	89,190
2014	4.8	0.2	428	88,799
2013	5.2	0.3	451	86,813
2012	5.2	0.2	452	87,662
2011	5.5	0.3	478	87,256
2010	5.3	0.3	463	86,794
2009	4.8	0.2	434	89,544

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	4.5	0.2	375	83,086
2019	4.3	0.2	362	84,895
2018	4.7	0.2	404	86,085
2017	3.9	0.2	340	87,562
2016	4.3	0.2	391	90,505
2015	4.9	0.2	434	88,990
2014	4.5	0.2	397	88,585
2013	4.5	0.2	392	86,577
2012	5.3	0.3	460	87,463
2011	4.6	0.2	396	86,976
2010	4.5	0.2	388	86,539
2009	4.9	0.2	439	89,313

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	3.0	0.2	246	83,086
2019	2.9	0.2	248	84,895
2018	3.1	0.2	271	86,085
2017	2.4	0.2	209	87,562
2016	2.8	0.2	251	90,505
2015	3.3	0.2	291	88,990
2014	3.0	0.2	263	88,585
2013	3.0	0.2	264	86,577
2012	3.6	0.2	311	87,463
2011	2.9	0.2	248	86,976
2010	3.1	0.2	265	86,539
2009	2.9	0.2	256	89,313

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	1.6	0.1	129	83,086
2019	1.3	0.1	114	84,895
2018	1.5	0.1	133	86,085
2017	1.5	0.1	131	87,562
2016	1.5	0.1	140	90,505
2015	1.6	0.1	143	88,990
2014	1.5	0.1	134	88,585
2013	1.5	0.1	128	86,577
2012	1.7	0.1	149	87,463
2011	1.7	0.1	148	86,976
2010	1.4	0.1	123	86,539
2009	2.0	0.2	183	89,313

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	120.4	12.0	100	83,086
2019	126.0	12.2	107	84,895
2018	145.2	13.0	125	86,085
2017	116.5	11.5	102	87,562
2016	118.2	11.4	107	90,505
2015	155.1	13.2	138	88,990
2014	160.3	13.5	142	88,585
2013	157.1	13.5	136	86,577
2012	173.8	14.1	152	87,463
2011	119.6	11.7	104	86,976
2010	135.2	12.5	117	86,539
2009	138.8	12.5	124	89,313

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	75.8	9.6	63	83,086
2019	70.7	9.1	60	84,895
2018	67.4	8.9	58	86,085
2017	76.5	9.4	67	87,562
2016	72.9	9.0	66	90,505
2015	75.3	9.2	67	88,990
2014	68.9	8.8	61	88,585
2013	79.7	9.6	69	86,577
2012	78.9	9.5	69	87,463
2011	83.9	9.8	73	86,976
2010	76.3	9.4	66	86,539
2009	95.2	10.3	85	89,313

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	6.5 %	0.9 %	5,229	80,668
2020	7.7 %	1.0 %	6,213	80,228
2019	7.4 %	0.9 %	6,065	81,797
2018	8.0 %	1.0 %	6,645	82,837
2017	7.9 %	1.0 %	6,581	83,373
2016	9.7 %	1.1 %	8,433	86,552
2015	14.0 %	1.2 %	11,851	84,870
2014	11.4 %	1.2 %	9,706	84,823
2013	9.8 %	1.2 %	8,149	82,814
2012	12.1 %	1.4 %	10,022	82,842
2011	9.3 %	1.1 %	7,740	83,644
2010	7.6 %	0.9 %	6,286	83,234
2009	7.3 %	0.9 %	6,253	85,862
2008	9.8 %	1.1 %	8,440	86,426
2007	11.0 %	1.1 %	9,293	84,446

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	9.2	0.4	695	75,828
2019	8.2	0.3	636	77,628
2018	9.7	0.4	754	77,963
2017	9.6	0.4	772	80,331
2016	8.9	0.3	737	82,820
2015	9.4	0.4	569	60,830
2014	9.5	0.4	752	79,405
2013	8.1	0.3	603	74,505
2012	7.0	0.3	543	77,768
2011	6.8	0.3	534	79,002
2010	5.8	0.3	460	78,933
2009	4.5	0.2	365	81,829
2008	3.7	0.2	307	83,450

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

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

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	8.7 %	1.0 %	138,166	1,585,546
2019_2020	9.5 %	1.2 %	150,732	1,586,520
2018_2019	11.0 %	1.5 %	173,321	1,576,641
2017_2018	10.4 %	1.5 %	161,216	1,555,296
2016_2017	11.1 %	1.3 %	169,068	1,529,985
2016	12.0 %	1.4 %	181,386	1,517,733

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	14.1	1.3	116	824,768
2020	11.7	1.2	98	835,231
2019	12.2	1.2	102	837,158
2018	12.8	1.2	107	838,955
2017	11.9	1.2	99	831,015
2016	13.0	1.3	107	823,889
2015	15.2	1.4	124	813,509
2014	13.0	1.3	105	807,568
2013	14.2	1.3	114	802,857
2012	14.7	1.4	117	794,091
2011	13.8	1.3	109	787,588
2010	15.6	1.4	122	782,518
2009	13.1	1.3	101	772,537

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	37.7	2.0	357	946,253
2020	34.5	1.9	317	918,183
2019	28.6	1.8	262	915,053
2018	32.5	1.9	296	909,851
2017	29.5	1.8	265	897,967
2016	27.9	1.8	248	887,344
2015	29.0	1.8	255	880,358
2014	25.4	1.7	223	878,349
2013	26.3	1.7	231	877,199
2012	28.8	1.8	253	879,611
2011	26.4	1.7	234	887,880
2010	25.9	1.7	233	900,361
2009	31.6	1.9	285	901,564

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	8.9	0.8	121	1,355,170
2018_2020	8.3	0.8	111	1,342,603
2017_2019	8.4	0.8	112	1,339,754
2016_2018	9.7	0.9	129	1,335,278
2015_2017	9.3	0.8	124	1,328,930
2014_2016	9.4	0.8	124	1,324,549
2013_2015	9.6	0.9	127	1,320,457
2012_2014	9.1	0.8	120	1,321,272
2011_2013	8.6	0.8	114	1,329,906
2010_2012	8.2	0.8	111	1,352,543
2009_2011	9.9	0.9	136	1,376,712
2008_2010	10.5	0.9	147	1,393,455
2007_2009	13.3	1.0	185	1,392,780

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	13.1	1.0	178	1,355,170
2018_2020	13.9	1.0	187	1,342,603
2017_2019	15.7	1.1	210	1,339,754
2016_2018	15.7	1.1	210	1,335,278
2015_2017	15.0	1.1	199	1,328,930
2014_2016	12.5	1.0	165	1,324,549
2013_2015	12.4	1.0	164	1,320,457
2012_2014	11.4	0.9	150	1,321,272
2011_2013	11.8	0.9	157	1,329,906
2010_2012	10.2	0.9	138	1,352,543
2009_2011	9.8	0.8	135	1,376,712
2008_2010	8.7	0.8	121	1,393,455
2007_2009	8.8	0.8	123	1,392,780

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	20.2 %	1.4 %	336,052	1,660,813
2019_2020	19.7 %	1.4 %	327,035	1,657,953
2018_2019	19.6 %	1.6 %	323,785	1,648,387
2017_2018	19.0 %	1.6 %	311,138	1,633,551
2016_2017	18.7 %	1.4 %	302,213	1,616,285
2016	18.6 %	1.6 %	299,109	1,606,451

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	13.9 %	2.3 %	46,701	336,052
2019_2020	12.4 %	1.9 %	40,660	327,035
2018_2019	14.1 %	3.2 %	45,552	323,785
2017_2018	21.3 %	4.5 %	66,378	311,138
2016_2017	21.2 %	3.9 %	63,925	302,213
2016	14.6 %	2.7 %	43,780	299,109

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	2.9 %	0.6 %	40,496	1,381,125
2019_2020	2.4 %	0.5 %	34,345	1,417,362
2018_2019	2.6 %	0.6 %	36,105	1,399,350
2017_2018	1.8 %	0.6 %	24,131	1,366,434
2016_2017	1.4 %	0.4 %	19,240	1,358,071
2016	1.5 %	0.4 %	20,417	1,351,429

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	9.6 %	1.1 %	131,870	1,371,735
2019_2020	6.3 %	0.8 %	88,246	1,410,242
2018_2019	7.2 %	1.0 %	99,775	1,383,262
2017_2018	7.2 %	1.1 %	96,700	1,350,305
2016_2017	6.9 %	0.9 %	93,781	1,349,694
2016	7.9 %	1.1 %	105,766	1,346,100

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	49.1 %	4.6 %	119,722	243,929
2019_2020	56.9 %	4.8 %	136,633	240,131
2018_2019	59.1 %	5.2 %	127,835	216,155
2017_2018	52.4 %	6.2 %	94,622	180,665
2016_2017	49.6 %	5.4 %	86,561	174,353
2016	47.0 %	5.6 %	90,026	191,685

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	91.7 %	1.0 %	1,519,145	1,656,401
2019_2020	91.3 %	1.2 %	1,513,153	1,657,131
2018_2019	91.5 %	1.3 %	1,505,380	1,645,610
2017_2018	90.0 %	1.5 %	1,469,085	1,631,596
2016_2017	89.7 %	1.4 %	1,446,187	1,612,130
2016	90.6 %	1.4 %	1,448,487	1,598,140

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	14.8 %	0.2 %	6,472	43,618
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 <20 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**
2020_2021	13.3 %	1.8 %	95,115	714,575
2019_2020	13.2 %	2.2 %	89,177	676,908
2018_2019	11.9 %	2.2 %	74,617	628,629
2017_2018	11.0 %	2.2 %	71,025	644,485
2016_2017	10.1 %	1.9 %	66,886	664,149
2016	8.7 %	1.7 %	55,307	637,589

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	3.1 %	0.2 %	52,316	1,673,480
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
2018	73.7 %	2.9 %	65,000	89,000
2017	72.7 %	2.8 %	66,000	90,000
2016	65.1 %	4.2 %	60,000	92,000
2015	61.3 %	4.4 %	57,000	92,000
2014	71.7 %	3.5 %	66,000	92,000
2013	70.3 %	3.5 %	63,000	90,000
2012	69.8 %	4.0 %	62,000	89,000
2011	69.1 %	4.2 %	62,000	90,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	62.8 %	1.6 %	980,011	1,559,365
2020_2021	65.4 %	1.8 %	1,014,780	1,551,652
2019_2020	66.9 %	1.6 %	1,045,249	1,562,405
2018_2019	63.8 %	1.7 %	981,394	1,538,476
2017_2018	61.3 %	1.8 %	923,632	1,505,667
2016_2017	56.7 %	1.8 %	854,661	1,507,339
2015_2016	60.9 %	1.8 %	907,341	1,489,887
2014_2015	57.2 %	2.0 %	850,483	1,485,820
2013_2014	57.3 %	2.1 %	853,456	1,489,875
2012_2013	58.4 %	2.7 %	860,850	1,475,399
2011_2012	46.9 %	2.5 %	685,858	1,461,885
2010_2011	48.4 %	3.4 %	697,849	1,441,836
2009_2010	40.1 %	2.1 %	566,535	1,412,806

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	79.0 %	2.9 %	368,074	465,832
2020	74.6 %	3.1 %	345,022	462,798
2019	72.0 %	3.4 %	328,726	456,290
2018	71.3 %	3.4 %	322,524	452,137
2017	71.9 %	2.9 %	322,727	448,849
2016	64.8 %	3.1 %	288,296	444,994
2015	56.1 %	3.0 %	248,735	443,688

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	87.4 %	2.5 %	407,077	465,832
2020	91.1 %	2.0 %	421,594	462,798
2019	89.8 %	2.0 %	409,584	456,290
2018	82.0 %	3.1 %	370,936	452,137
2017	88.6 %	2.1 %	397,478	448,849
2016	86.8 %	2.3 %	386,222	444,994
2015	85.3 %	2.3 %	378,574	443,688
2014	88.5 %	2.1 %	392,380	443,358
2013	86.2 %	2.5 %	381,483	442,689
2012	86.0 %	2.6 %	380,318	442,300
2011	75.0 %	3.2 %	334,615	446,367
2010	70.6 %	2.7 %	309,347	438,428
2009	60.2 %	3.2 %	264,685	440,072

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	85.4 %	2.5 %	397,594	465,832
2020	88.1 %	2.3 %	407,668	462,798
2019	83.3 %	2.8 %	380,007	456,290
2018	83.7 %	2.8 %	378,547	452,137
2017	82.6 %	2.5 %	370,830	448,849
2016	75.1 %	3.0 %	334,269	444,994
2015	75.4 %	2.6 %	334,333	443,688
2014	82.1 %	2.5 %	364,126	443,358
2013	79.0 %	2.9 %	349,775	442,689
2012	71.2 %	3.4 %	314,934	442,300
2011	69.4 %	3.3 %	309,700	446,367
2010	67.6 %	2.8 %	296,176	438,428
2009	55.8 %	3.2 %	245,424	440,072

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	10.1	0.2	2,276	224,472
2020	11.3	0.2	2,478	219,345
2019	12.7	0.2	2,788	219,326
2018	12.7	0.2	2,762	218,148
2017	14.8	0.3	3,191	216,216
2016	16.6	0.3	3,584	215,482
2015	17.7	0.3	3,773	213,738
2014	19.2	0.3	4,092	213,071
2013	20.5	0.3	4,386	213,860
2012	23.3	0.3	5,017	214,894
2011	25.4	0.3	5,530	217,942
2010	26.9	0.4	6,002	223,140
2009	30.4	0.4	6,866	225,775

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	11.6 %	1.2 %	9,216	79,554
2020	12.2 %	1.2 %	9,582	78,301
2019	12.9 %	1.1 %	10,350	80,359
2018	11.4 %	1.1 %	9,250	81,403
2017	11.3 %	1.2 %	9,337	82,399
2016	11.8 %	1.1 %	9,850	83,605
2015	11.1 %	1.1 %	9,165	82,941
2014	12.5 %	1.2 %	10,408	83,168
2013	11.1 %	1.2 %	9,064	81,419
2012	10.2 %	1.2 %	8,332	81,983

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	3.5 %	0.6 %	57,416	1,655,658
2019_2020	2.5 %	0.5 %	40,903	1,657,385
2018_2019	2.7 %	0.5 %	44,975	1,648,387
2017_2018	3.2 %	0.7 %	51,978	1,633,551
2016_2017	2.5 %	0.6 %	40,219	1,611,889
2016	2.1 %	0.7 %	34,305	1,597,659

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Washington

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

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective			47	67.2	67.2
Annual Indicator		69.7	69.3	63.4	63.4
Numerator		919,438	939,935	885,803	885,803
Denominator		1,318,605	1,355,481	1,397,128	1,397,128
Data Source		BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year		2018	2019	2021	2021

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

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

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Discussions between program and epidemiology staff, taking into account recent trends in the data, set an annual target of a 1% per year increase through 2025. These targets will be revisited next year and subject to revision as more data comes available.

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	93	93	94	94	94
Annual Indicator	92.4	91.0	92.5	93.7	93.7
Numerator	80,672	71,525	75,591	74,617	74,617
Denominator	87,274	78,591	81,714	79,628	79,628
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2019	2019

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	93	93	94	94	94
Annual Indicator	94.2	94.1	94.1	94.4	93.8
Numerator	80,140	79,016	79,016	77,512	76,241
Denominator	85,113	83,941	83,941	82,148	81,299
Data Source	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate	WA Birth Certificate
Data Source Year	2018	2019	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	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.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data comes from the WA State Birth file and reports the number of individuals identified as having breastfed on the birth certificate.	

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	33.1	34.8	36.5	40.2	40.2
Annual Indicator	29.1	27.6	28.9	29.5	29.5
Numerator	24,761	20,413	23,021	22,749	22,749
Denominator	84,974	74,010	79,683	77,059	77,059
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2019	2019

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

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	36	29	17.1	25.5	25.5
Annual Indicator	27.7	25.6	36.2	46.4	46.4
Numerator	55,326	53,459	65,908	102,689	102,689
Denominator	199,961	209,028	182,179	221,286	221,286
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	48.0	49.0	51.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Discussions between program and epidemiology staff resulted in a targeted increase of 3% per year through 2025.

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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	79	82	82	75	75
Annual Indicator	81.3	81.3	74.0	68.9	68.9
Numerator	432,006	432,006	405,716	384,050	384,050
Denominator	531,119	531,119	548,292	557,597	557,597
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2016_2017	2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	67.8	68.8	69.8

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
The expected rebound following COVD-19 closures of medical facilities was not seen. New targets were developed in light of these new data. A target of one percentage point per year is forecast through 2025.

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					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	40	42	43	42	42
Annual Indicator	45.7	45.3	40.8	45.0	45.0
Numerator	138,232	141,032	131,960	151,120	151,120
Denominator	302,213	311,138	323,785	336,052	336,052
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	43.0	44.0	45.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Considering factors such as a return to more standard care practices following the COVID-19 pandemic as well as anticipated federal funds coupled with on-going work by the CYSHCN program and external partners, an anticipated increase of one percentage point per year in the measure is forecast through 2025,

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)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	73	74	75	58	58
Annual Indicator	71.2	67.9	65.1	70.3	70.3
Numerator	1,148,124	1,107,284	1,068,524	1,163,760	1,163,760
Denominator	1,613,555	1,630,587	1,642,095	1,654,315	1,654,315
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2020_2021	2020_2021

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	73	74	75	76	58
Annual Indicator				55.4	62.3
Numerator				180,522	208,824
Denominator				325,851	335,191
Data Source				NSCH	NSCH
Data Source Year				2019-2020	2020-2021
Provisional or Final ?				Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	63.3	64.3	65.3

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Discussions between program and epidemiology staff resulted in a decision to increase the target for this measure by a percentage point per year based on a commitment to make slow but sustained improvements in this measure to reduce the disparity between children with and without a special health care need. An increase in the number providers who have been trained to provide a medical home for their patients on the autism spectrum (ESM15.1) is counted among the measures being undertaken to realize this increase.

Form 10
State Performance Measures (SPMs)

State: Washington

SPM 1 - Substance use during pregnancy

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			15
Annual Indicator	16.1	14.9	15.7
Numerator	13,672	12,382	13,172
Denominator	84,918	83,101	83,899
Data Source	WA PRAMS	WA PRAMS	WA PRAMS
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	15.0	15.0	15.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 2019 data has been revised since last grant submission. The new percentage reflects improved data capture techniques and is more accurate.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data in the denominator are the total births to WA residents in the given year. The numerator is the estimate of how many individuals used substances, based on the percent from the survey who reported having used one or more of them.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Discussions between program and epidemiology staff resulted in a decision to keep the targets constant. Most work on this issue is being done post-partum, so interventions may not have a direct effect on use before/during pregnancy. However, it is felt that it is important to continue to monitor the issue, so the measure will be maintained.	

SPM 2 - Provider screening of pregnant women for depression

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			88.3
Annual Indicator	87.2	88.3	87.1
Numerator	74,048	73,378	73,076
Denominator	84,918	83,101	83,899
Data Source	WA PRAMS	WA PRAMS	WA PRAMS
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	88.3	88.3	88.3

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data in the denominator are the total births to WA residents in the given year. The numerator is the estimate of how many individuals used were screened, based on the percent from the survey who reported having been screened..	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Rates for this measure are high and significant improvement may be difficult to obtain. While the point estimate has fluctuated some in the past few years, the change has been within the 95% confidence intervals of the estimates. Discussions between program and epidemiology staff resulted in maintaining the current high rate of screening through 2025.	

SPM 3 - Universal developmental screening system participation

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			0
Annual Indicator			0
Numerator			
Denominator			
Data Source			DOH
Data Source Year			2023
Provisional or Final ?			Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	0.0	0.0	0.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Data from the system are not yet available. It is expected that data collection will begin when the system "goes live" this fall, 2021.

2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Data from the system are not yet available. Recently staff have been hired to guide the final stages of creation and the beginning of data on-boarding into the system. It is hoped that we will have screening data to report for next year's submission.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Washington State Department of Health is moving forward with the Universal Developmental Screening system officially known as Strong Start- Washington State’s Universal Developmental Screening System.

As of submission of this application, a series of four small "pilot project" test data sets have been entered into the system. These pilots are being used to test system operability and user interface ahead of the planned statewide roll-out Fall of 2023.

SPM 5 - Ease of receiving mental health treatment or counseling

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			55
Annual Indicator	53.9	53.4	43.2
Numerator	108,903	109,574	87,700
Denominator	202,046	205,382	203,009
Data Source	NSCH	NSCH	NSCH
Data Source Year	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	56.0	57.0	58.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator for this measure was taken from the population estimate derived from the percent of respondents to the survey who reported that they did not have difficulty in getting the mental health treatment or counseling they needed as reported by The Child and Adolescent Health Measurement Initiative (childhealthdata.org). The denominator was derived using the population estimate and the percent reported.	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Discussions between program and epidemiology staff resulted in a decrease in the baseline of the target following the reduction in the rate seen in the latest results from the survey. A target of one percentage point per year increase was maintained from the new baseline.	

SPM 6 - Social and emotional readiness among kindergarteners

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	74.4	77	77	78	78
Annual Indicator	76.7	76.7	79	77.4	78.8
Numerator	60,266	60,266	64,553	53,759	60,617
Denominator	78,574	78,574	81,713	69,456	76,940
Data Source	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids	OSPI WA Kids
Data Source Year	2017-2018	2017-2018	2019-2020	2020-2021	2022-2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	79.0	79.0	79.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Denominator comes from OSPI. Numerator was calculated using denominator and WA Kids indicator percentage.

SPM 7 - Percentage of tenth grade students who have an adult to talk to when they feel sad or hopeless

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			60.5
Annual Indicator	59.9	60.4	60.4
Numerator	49,792	51,027	51,027
Denominator	83,120	84,488	84,488
Data Source	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2021	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	60.6	60.7	60.8

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
This measure is connected to the overall body of work the Adolescent Health program is undertaking, rather than any specific intervention. In the coming year work on social support will be undertaken by the program including supporting behavioral health in school based health centers, suicide prevention work, including through youth advisory councils. A needs assessment is planned on the topic of social support. It is hoped these initiatives will increase the percent reported in this measure.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
This measure is connected to the overall body of work the Adolescent Health program is undertaking, rather than any specific intervention. In the coming year work on social support will be undertaken by the program including supporting behavioral health in school based health centers, suicide prevention work, including through youth advisory councils.

The Healthy Youth Survey is administered every other year. No new data are available this year.

Denominator comes from OSPI WA State Report Card and is the 10th grade enrollment for the school year. Numerator is calculated by multiplying the denominator by the indicator.

3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Discussions were held between program and epidemiology staff which resulted in the decision to maintain the current targets as previously set of a 0.1 percentage point increase per year through 2025. Future targets may be revised as more data, especially qualitative data, are collected. It is hoped these data will illuminate and suggest new approaches to improving the metric, subsequently resulting in a grater felt support by adolescents in their communities.

SPM 8 - Percentage of tenth grade students who report having used alcohol in the past 30 days

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			15.8	14.8
Annual Indicator		18.8	8.4	8.4
Numerator		15,627	7,097	7,097
Denominator		83,120	84,488	84,488
Data Source		Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year		2018	2021	2021
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	13.8	12.8	11.8

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Three year's data, 22.2% in 2014, 14.9% in 2016 and 18.8% in 2019 do not indicate a clear trend. Discussions between program and evaluation staff, taking into consideration work that will be undertaken on the issue, resulted in a decision to target a one percentage point decrease per year starting in with the data collected in 2018. The next collection of data is for Fall 2021, for which a target of 15.8% has been created, three years after 2018's collection. Each year after will decrease by one percentage point. As more data become available these targets may be revised.

2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Discussions between program and epidemiology staff acknowledged a large decrease in 2021 but felt the decrease was unique to conditions prevalent during the COVID-19 pandemic.While a short-term return to prior drinking percents is not unexpected in the near term, a decision was made to remain with preexisting targets as work being done is expected to decrease rates in a sustained manner over the longer term.

3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The Healthy Youth Survey is administered every other year. No new data are available this year.

Denominator comes from OSPI WA State Report Card and is the 10th grade enrollment for the school year. Numerator is calculated by multiplying the denominator by the indicator.

4.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
As no new data are available it is presently unknown if the previously observed steep decline in reported alcohol consumption has continued since the survey was last administered in 2021. Discussions between program and epidemiology staff concurred that the specific circumstances of the COVID-19 pandemic likely played a key role in the decrease and was a root cause of the dramatic change seen in the last administration of the survey. As a result it is expected that the overall trend will return to a higher level but continue to decrease in a manner consistent with the trend prior to the pandemic.Therefore the previous target of a percentage point per year decrease in the rate will be maintained pending further data.

SPM 9 - Adolescents reporting at least one adult mentor

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			74.4	66.5
Annual Indicator		69.8	65.3	65.3
Numerator		58,018	55,171	55,171
Denominator		83,120	84,488	84,488
Data Source		Healty Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year		2018	2021	2021
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	68.0	69.0	70.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Talks between program and epidemiology staff led to an acknowledgement that previous targets may have been too optimistic and that COVID-19 may have impacted social connectivity more profoundly than previously imagined. As such targets were decreased to be more in line with current data. From 2023 to 2025 an increase of one percentage point per year was chosen as achievable. As more data become available these targets may be revised.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The Healthy Youth Survey is administered every other year. No new data are available this year.

Denominator comes from OSPI WA State Report Card and is the 10th grade enrollment for the school year. Numerator is calculated by multiplying the denominator by the indicator.

3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Talks between program and epidemiology staff resulted in a decision to maintain the current targets of an increase of one percentage point per year through 2025.

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

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			38
Annual Indicator	40	38.2	38.2
Numerator	9,642	8,650	8,650
Denominator	24,105	22,643	22,643
Data Source	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2021	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	37.5	37.0	36.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Past survey results for this indicator are as follows:
2002 45.2%
2004 44.9%
2008 45.0%
2012 50.1%

Regression modeling indicates an historical annual 1.2% increase in the rate since 2002.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Denominator comes from OSPI WA State Report Card and is the 10th grade enrollment of students identified with a special need in the Healthy Youth Survey, for the school year. Numerator is calculated by multiplying the denominator by the indicator.

3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Recent data have suggested a possible decrease in the rate. Work on this topic is expected to pick up over the next few years, specifically with youth on the autism spectrum. The work is anticipated to result in further reductions in the rate in this population. Therefore from the baseline of 38 percent, a decrease of 0.5 of a percentage point is set for 2023 and for 2024 resulting in a target of 37 percent in 2024. From 2024 to 2025 a further full percentage point reduction is targeted.

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

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	86.1	86
Numerator	1,387,536	1,372,316
Denominator	1,611,540	1,595,716
Data Source	NSCH	NSCH
Data Source Year	2019-2020	2020-2021
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	86.5	87.0	87.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Numerator for this measure was taken from the population estimate derived from the percent of respondents to the survey who reported that they did not have difficulty in getting the mental health treatment or counseling they needed as reported by The Child and Adolescent Health Measurement Initiative (childhealthdata.org). The denominator was derived using the population estimate and the percent reported.	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Discussions between program and epidemiology staff resulted in a slight decrease in the anticipated rise in the target due to the established stability of the measure. The measure is targeted to increase at a more modest 0.5 percentage point rate per year through 2025.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Washington

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

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			43	67.9
Annual Indicator	67.3	66.4	67.2	66.4
Numerator	57,910	56,386	55,844	55,702
Denominator	86,047	84,918	83,101	83,889
Data Source	WA PRAMS	WA PRAMS	WA PRAMS	WA PRAMS
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	68.6	69.3	70.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data in the denominator are the total births to WA residents in the given year. The numerator is the estimate of how many individuals reported having a preventive medical visit in the prior year, based on the percent from the survey who reported that they had one..	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Discussion between program and epidemiology staff resulted in a 1 percent per year increase through 2025, mirroring the similar increase set for NPM 1 to which this ESM is linked.	

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

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator		20.3
Numerator		12
Denominator		59
Data Source		DOH
Data Source Year		2022
Provisional or Final ?		Final

Annual Objectives			
	2023	2024	2025
Annual Objective	34.0	44.0	54.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
ESM 4.3 is a new measure covering a new accreditation program. In the first year of the adoption of the program data were not fully collected. With next year's Block Grant submission a full set of data will be collected and reported and associated targets will be set.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Work undertaken to recruit and enroll eligible facilities resulted in 12 of 59 obtaining their certification as LIFE program compliant. In addition to these 12 facilities 8 more were in the process of applying for certification.

These included
Nine hospitals certified with four in the process of applying of a total of 37 eligible.
Four clinics currently in the process of applying for certification of a total of 14 eligible.
Three stand-alone birth centers certified of a total of 8 eligible.

3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Targets were set assuming an increase of 6 eligible facilities per year through 2025. The total number of eligible facilities was assumed to be constant. As new data become available these targets may be revised.

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

Measure Status:	Active

State Provided Data		
	2021	2022
Annual Objective		
Annual Indicator	643	498
Numerator		
Denominator		
Data Source	Washington State Help Me Grow	Washington State Help Me Grow
Data Source Year	2020-2021	2022
Provisional or Final ?	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	550.0	605.0	665.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data were collected from July to June. These data are from July 2020 to June 2021 and comprise more than one calendar year.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data were collected CY2022; January 2022 to December 2022.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: This measure is new. A proposed increase of 10% per year has been decided on by program and epidemiology staff.	

ESM 10.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			50	69.9
Annual Indicator	68.4	68.4	69.2	69.2
Numerator	56,854	56,854	58,466	58,466
Denominator	83,120	83,120	84,488	84,488
Data Source	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey	Healthy Youth Survey
Data Source Year	2018	2018	2021	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	70.6	71.3	72.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
After missing a year in 2020, the Healthy Youth Survey was implemented in 2021. No large drop-off in medical check ups was noted due to COVID-19 as was expected. Given the nature of the measure and the indirect effects work by the Adolescent health program would have a modest one percent per year increase was targeted. As more data become available these targets may be revised.

2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The Healthy Youth Survey is administered every other year. No new data are available this year.

Denominator comes from OSPI WA State Report Card and is the 10th grade enrollment for the school year. Numerator is calculated by multiplying the denominator by the indicator.

3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**

Field Note:
Work on increasing the role of School Based Health Centers with their more youth-friendly approaches is hoped to have an impact on the receipt of care in this population. As a result an increase in the rate by one percent per year is targeted through 2025.

ESM 11.1 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			80	90
Annual Indicator		87.5	88.6	100
Numerator		14	39	9
Denominator		16	44	9
Data Source		University of Washington LEND ECHO-Autism Program	University of Washington LEND ECHO-Autism Program	University of Washington LEND ECHO-Autism Program
Data Source Year		2020	2021	2022
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	91.0	92.0	93.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The University of Washington's LEND program encountered some changes in the administration of their ECHO Autism program resulting in delays in providing the pre- and post-intervention surveys this past year. As a result, there were data from only 9 primary care provider trainees who completed the survey in the same manner as prior cohorts. All 9 individuals rated themselves as either "confident" or "highly confident" in their ability to provide a medical home for their patients with an autism spectrum diagnosis. At the time of submission, the program is preparing to send another round of surveys to program participants.	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Talks between program, LEND and epidemiology staff agreed that maintaining the current targets would be the most advisable approach. An increase of one percentage point per year through 2025 will remain the target.	

ESM 15.1 - 15.1 Increase the percentage of CYSHCN who report having insurance when receiving services

Measure Status:	Active

State Provided Data			
	2020	2021	2022
Annual Objective			99.3
Annual Indicator	99.2	99.2	98.4
Numerator	19,268	19,268	12,937
Denominator	19,424	19,424	13,154
Data Source	WA State Child Health Intake Form	WA State Child Health Intake Form	WA State Child Health Intake Form
Data Source Year	2020	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	99.4	99.5	99.6

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data for 2021 not available by the time of submission.	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Increases in the target for this measure reflect aspirational increases. It is acknowledged that real increases may not be possible. The main goal is to maintain the very high current rates through 2025.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Washington

SPM 1 - Substance use during pregnancy
Population Domain(s) – Women/Maternal Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Reduce the percentage of pregnant women who use drugs during pregnancy</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 pregnant women answering the PRAMS survey who reported illegal substance use during their most recent pregnancy.</td></tr>
<tr><td>Denominator:</td><td>The total number of women answering PRAMS.</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>Related to HP2030 MICH-11 Increase abstinence from illicit drugs among pregnant women.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>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.</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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 5 - Ease of receiving mental health treatment or counseling
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of children who needed mental health care and did not have difficulty in getting it.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of respondents to WA NSCH who indicate that they did not have difficulty getting care. **Denominator:** The total number of respondents to WA NSCH.
Healthy People 2030 Objective:	Related to HP2030 AHS-6.2 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care.
Data Sources and Data Issues:	The data will come from question K4Q22_R on the National Survey of Children's Health. The National Survey of Children's Health (NSCH), funded and directed by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), is designed to provide annual national and state-level information on the health and well-being of children ages 0-17 years in the United States. Selection is random, and participation is voluntary. Data issues: This survey makes use of self-reported data. The NSCH makes use of a small sample size making sub-population analyses difficult or impossible.
Significance:	Access to mental/behavioral healthcare is a known barrier to preventative health, with known disparities among specific populations. This measure gives a state-level estimate of the percentage of Washington youth who are receiving all necessary medical services.

SPM 6 - Social and emotional readiness among kindergarteners
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of Washington children who arrive in kindergarten demonstrating the appropriate social and emotional characteristics of children of their age.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of entering kindergarteners who demonstrate appropriate characteristics in the social and emotional domain WaKIDS assessment. **Denominator:** Total number of entering kindergarteners who were administered the WaKIDS assessment.
Data Sources and Data Issues:	The data for this measure will come from the Washington Kindergarten Inventory of Developing Skills (WaKIDS) assessment. The assessment is a collaboration of the Office of the Superintendent of Public Instruction, the Washington State Department of Early Learning and Thrive Washington. It is administered to incoming kindergarteners in the fall of the year they start school.
Significance:	Being socially and emotionally ready for kindergarten is an indicator of appropriate preparation for success in school and other settings. Young children who fall behind and encounter achievement gaps and disparities are also more likely to encounter other social and health disadvantages which tend to stay with them throughout their lifetimes if appropriate interventions are not undertaken. This measure will indicate how successfully Washington is preparing its children for success and where disparities in that preparation exist so that interventions can be devised to address these disparities.

SPM 7 - Percentage of tenth grade students who have an adult to talk to when they feel sad or hopeless
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Increase the percentage of children in the sixth grade reporting they have and adult they can turn to for help when feeling sad or hopeless.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of tenth grade respondents to the Healthy Youth Survey who report having an adult to talk to when feeling sad or hopeless. **Denominator:** The total number of 10th grade respondents to the Healthy Youth Survey.
Healthy People 2030 Objective:	Does not relate to any Objectives.
Data Sources and Data Issues:	The data will come from the Healthy Youth Survey (HYS), administered by DOH in cooperation with other State Agencies. The survey is administered every other year to youth enrolled in public school, grades 6,8.10, and 12. Participation in the survey is voluntary on both the school and individual child level; however, a high percentage of schools participate. Data issues: This survey makes use of self-reported data.
Significance:	Behavioral health services were identified as a gap in large parts of Washington and among most populations, including children/youth, in the most recent Needs Assessment. This measure will provide an estimate of the percent of children in tenth grade who have an adult they can talk with.

SPM 8 - Percentage of tenth grade students who report having used alcohol in the past 30 days
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Decrease the percent of Washington youth reporting alcohol consumption.
Definition:	<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 tenth grade respondents to the Healthy Youth Survey indicating alcohol use in the past 30 days.,</td></tr><tr><td>**Denominator:**</td><td>The total number of grade 10 respondents to HYS.</td></tr></table>
Healthy People 2030 Objective:	Related to HP 2030 SU-04 Reduce the proportion of adolescents who drank alcohol in the past month.
Data Sources and Data Issues:	The data come from the Health Youth Survey, administered by DOH in cooperation with the Washington State Health Care Authority Division of Behavioral Health and Recovery, the Office of the Superintendent of Public Instruction, and the Liquor and Cannabis Board. The survey is administered every other year to youth enrolled in public school, grades 6, 8, 10, and 12. Participation in the survey is voluntary on both the school and the individual child level; however, a high percentage of schools participate. Data issues: The survey makes use of self-reported data.
Significance:	In addition to health outcomes associated with alcohol consumption, this is associated with overall substance abuse and behavioral health among youth and adolescents.

SPM 9 - Adolescents reporting at least one adult mentor
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Increase the percentage of youth in Washington who report having at least one adult mentor.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of students in grade 10 reporting that they have at least one adult mentor. **Denominator:** The total number of grade 10 respondents to HYS.
Data Sources and Data Issues:	The data come from the Health Youth Survey, administered by DOH in cooperation with the Washington State Health Care Authority Division of Behavioral Health and Recovery, the Office of the Superintendent of Public Instruction, and the Liquor and Cannabis Board. The survey is administered every other year to youth enrolled in public school, grades 6, 8, 10, and 12. Participation in the survey is voluntary on both the school and the individual child level; however, a high percentage of school participate. Data issues: The survey makes use of self-reported data.
Significance:	Having an adult mentor is a known protective factor, and is associated with hope, resilience, and positive school and health outcomes later in life.

SPM 10 - Suicide ideation among youth with special health care needs
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Reduce the percentage of 10th grade students with special health care needs who report having suicidal ideation.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Related to HP2030 MHMD-02 Reduce suicide attempts by adolescents. **Denominator:** The total number of 10th grade students who are identified as having a special need in the Healthy Youth Survey.
Healthy People 2030 Objective:	Related to HP2030 MHMD-02 Reduce suicide attempts by adolescents.
Data Sources and Data Issues:	The data will come from the Healthy Youth Survey (HYS), administered by DOH in cooperation with other State Agencies. The survey is administered every other year to youth enrolled in public school, grades 6,8.10, and 12. Participation in the survey is voluntary on both the school and individual child level; however, a high percentage of schools participate. Data issues: This survey makes use of self-reported data.
Significance:	Behavioral health was identified as a gap in large parts of Washington and among most populations, including children/youth with special needs, in the most recent Needs Assessment. This measure will provide an estimate of the percent of children in 10th grade who have suicidal ideation, a significant risk factor for making a suicide attempt.

SPM 12 - Percent of families showing 4 or more factors indicating high resilience to challenges.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	The goal is to determine the resilience of Washington State families.
Definition:	<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 total number of respondents who indicated "yes" to four or more of the resilience measures used in the question's composition.</td></tr><tr><td>**Denominator:**</td><td>Total responses to these questions in the Washington State NSCH.</td></tr></table>
Healthy People 2030 Objective:	None
Data Sources and Data Issues:	Data will come from the National Survey of Children's Health Family Resilience measure as calculated and reported by the Child Health Data webpage. Data Issues: This survey makes use of self-reported data. The NSCH has a small sample size making sub-population analyses and year over year changes in trends, difficult to interpret.
Significance:	Having a strong family structure and communication can play important roles in a family's ability to successfully navigate difficult situations and challenges.This measure will help the Title V program assess the ability of Washington families to resist and overcome the stressors and challanges they encounter.

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 4.3 - Percentage of births taking place in facilities certified as compliant with LIFE by Washington State Department of Health.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the percentage of births at LIFE participating facilities.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** The number of births to Washington resident mothers in facilities certified as LIFE program compliant. **Denominator:** Total number of resident births in Washington State.
Data Sources and Data Issues:	The birth data will come from Washington State Birth Certificate. LIFE compliant facilities will be identified and reported by Department of Health staff.
Evidence-based/informed strategy:	The LIFE program is based on the World Health Organization and Baby Friendly USA's "Ten Steps to Successful Breastfeeding". This program recognizes health care organizations that work to support, protect and promote lactation. The LIFE program teaches new mothers about the importance of breastfeeding, supports new moms in the initiation and maintenance of breastfeeding, teaches troubleshooting and problem solving skills to address common challenges to breastfeeding as well as coordinating with patients at discharge to facilitate timely access to ongoing support and care.
Significance:	This ESM will measure the percent of new mothers who are presented with evidence based information on the benefits of breastfeeding and given support in initiating and maintaining breastfeeding through the initial months of life. It is important to measure this as breastfeeding has been shown to be extremely beneficial for both the mother and infant. The initiation of breastfeeding and its maintenance for as long as possible has been one of the Department of Health's core recommended practices. As such, its practice is highly recommended. An increase in this measure will help to assure new mothers are introduced to and educated about the practice with the greatest amount of support to achieve the longest maintenance of the behavior. In the long run, this will lead to healthier mothers and healthier infants.

ESM 6.4 - Number of developmental screens completed through Help Me Grow Washington.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase access to developmental screening.
Definition:	<table><tr><td>**Unit Type:**</td><td>Count</td></tr><tr><td>**Unit Number:**</td><td>999</td></tr><tr><td>**Numerator:**</td><td>Unique number of children receiving a developmental screening in the past 12 months through Help Me Grow Washington</td></tr><tr><td>**Denominator:**</td><td></td></tr></table>
Data Sources and Data Issues:	Help Me Grow Washington (including sub-affiliate) program data.
Evidence-based/informed strategy:	Help Me Grow is a nationally recognized resource and referral linkage system. Help Me Grow is included in the “Sample Strategies and Evidence-based or -informed Strategy Measures” document complied by the Strengthen the Evidence for Maternal and Child Health Programs Initiative. This new ESM is one way our program supports increasing related NPM 6 in WA State.
Significance:	Supporting Help Me Grow Washington activities to make developmental screening accessible helps families monitor the health and development of children and connect to resources to support child health and well-being. Measuring this ESM will enable us to determine if our activities are increasing the number of developmental screens completed through Help Me Grow Washington.

ESM 10.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of adolescents in school districts with active DOH-supported interventions who have accessed health care in the past year.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of adolescent respondents to HYS in school districts with DOH coordinated funding for adolescent health programs who indicate that they did get health care in the previous 12 months</td></tr>
<tr><td>Denominator:</td><td>The number of adolescent respondents to HYS in school districts with DOH coordinated funding for adolescent health programs</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The data come from the Health Youth Survey, administered by DOH in cooperation with the Washington State Health Care Authority Division of Behavioral Health and Recovery, the Office of the Superintendent of Public Instruction, and the Liquor and Cannabis Board. The survey is administered every other year to youth enrolled in public school, grades 6, 8, 10, and 12. Participation in the survey is voluntary on both the school and the individual child level; however, a high percentage of schools participate.
Data issues: The survey makes use of self-reported data from the HYS. Funding years for these programs do not always coincide with the Block Grant year. Additionally, some programs are defunded from time to time, and we receive new funding sources. As an example, Pregnancy Assistance Fund programs will be ending in December 2020, while we will be adding funding and programs associated with our new teen pregnancy prevention grant.</td></tr>
<tr><td>Significance:</td><td>Lack of access to healthcare is a known barrier to preventative health, with known disparities among specific populations. This measure gives estimates at a school district level to determine whether adolescent access to care is increasing in communities that are actively working to address this issue. The work tracked in this measure includes programs which implement curricula that is evidence informed and evidence-based while being culturally relevant and locally informed. Delivery of these programs is often in partnership with the OSPI and local youth serving organizations in order to be as culturally appropriate as possible.</td></tr>
</table>

ESM 11.1 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of providers who indicate they provide a medical home to patients with autism in the ECHO Projects survey.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of providers who rate themselves confident or very confident that they are able to provide a medical home for their patients with autism.</td></tr>
<tr><td>Denominator:</td><td>The total number of respondents who complete the question on the survey</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The ECHO Project uses a redcap survey based on the survey developed by the University of Missouri’s Project ECHO Autism. All primary care providers who have taken the Center of Excellence training and signed up to be COEs, and those COEs engaged in Project ECHO Autism are asked each year to complete the survey. This survey is repeated yearly, starting March 2020, to gauge increase in provider confidence in implementing their skills in diagnosing, treating and referring children with autism in a family- centered Medical Home.
Data Issues: Survey is self-administered. Terms are not independently defined.</td></tr>
<tr><td>Significance:</td><td>As communities around Washington work to meet the need of families with CYSHCN with autism, there have been gaps identified in diagnostic and referral process—particularly around who is recognized by Medicaid to provide billable diagnosis and referral services to CYSHCN with ASD/DD.
This places the burden on primary care providers who may not have the expertise to diagnose autism, or who are not recognized by Washington’s Medicaid agency as having the necessary expertise to diagnose and refer to autism specialty services. Often the providers themselves lack confidence in providing a medical home to children with ASD/DD when they lack access to consultations with qualified professionals to meet the often challenging needs of this population.
The Health Care Authority (HCA) funds a 1.5 day Center of Excellence training with faculty from Seattle Children’s and UW LEND to increase the number of PCPs who are recognized by the HCA to diagnose autism and refer children for HCA-covered treatment. COE PCPs interested in further developing their autism diagnostic and management skills can apply to join a UW LEND led year-long Project ECHO Autism WA cohort with twice a month Zoom videoconferencing case-based learning, consultation and didactics. The DOH-funded UW Medical Home Partnerships Project for CYSHCN participates in both the COE training and Project ECHO Autism helping connect providers to community colleagues and resources.</td></tr>
</table>

ESM 15.1 - 15.1 Increase the percentage of CYSHCN who report having insurance when receiving services
NPM 15 – Percent of children, ages 0 through 17, who are continuously and adequately insured

Measure Status:	Active
Goal:	Increase the percent of CYSHCN who have access to third party paid insurance.
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>The number of CYSHCN who indicate they have insurance on their Child Health Intake Form.</td></tr><tr><td>**Denominator:**</td><td>The total number of CYSHCN who have a Child Health Intake Form filled out</td></tr></table>
Data Sources and Data Issues:	The data will come from the Child Health Intake Form (CHIF) a data collection instrument used in Washington State to track CYSHCN to assure they receive appropriate services. The form is filled out by county/local CYSHCN directors and/or neurodevelopmental centers.
Evidence-based/informed strategy:	The Child Health Intake Form (CHIF) is the standard reporting form used to ensure CYSHCN receive appropriate care.
Significance:	Adequate insurance is critical for CYSHCN to receive needed services that their families can afford. Tracking the percent of CYSHCN receiving services will help to ensure that this population continues to be able to access care.

Form 11
Other State Data

State: Washington

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Washington

Annual Report Year 2022

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Monthly	3		
2) Vital Records Death	Yes	Yes	Monthly	0	Yes	
3) Medicaid	Yes	No	Quarterly	3	No	
4) WIC	Yes	Yes	Annually	1	Yes	
5) Newborn Bloodspot Screening	Yes	Yes	Annually	3	Yes	
6) Newborn Hearing Screening	Yes	Yes	Monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	Monthly	2	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	10	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Appendix A - Abbreviations and Acronyms

AAFP .....American Academy of Family Physicians
AAP .....American Academy of Pediatrics
ABA.....Applied Behavior Analysis
ACA.....Affordable Care Act
ACEs.....adverse childhood experiences
ACH.....Accountable Community of Health
ACOG .....American College of Obstetricians and Gynecologists
ADHD.....attention deficit-hyperactivity disorder
AHI.....Adolescent Health Initiative (at University of Michigan)
AI/AN.....American Indian/Alaska Native
AIHC.....American Indian Health Commission
AIM.....Alliance for Innovation on Maternal Health
AMCHP .....Association of Maternal and Child Health Programs
AND .....Academy of Nutrition and Dietetics
APP……Adolescent Pregnancy Prevention
ARNP .....advanced registered nurse practitioner
ASD.....autism spectrum disorders
ASD/DD .....autism spectrum disorders and other developmental disabilities
ASQ.....Ages and Stages Questionnaire
ASQ:SE.....Ages and Stages Questionnaire: Social Emotional
ASTHO .....Association of State and Territorial Health Officials
AYA.....adolescents and young adults
AYAH .....Adolescent and Young Adult Health
AYAN NA…….Adolescent and Young Adult Health Needs Assessment
BC .....birth certificate
BDS .....Birth Defects Surveillance
BDSS .....Birth Defects Surveillance System
BEP……Birth Equity Project
BERD.....Birth Event Records Database
BFF……..Bezos Family Foundation
BIPOC .....Black, Indigenous and people of color
BMI .....body mass index
BRFSS.....Behavioral Risk Factor Surveillance System
CAH……Critical Access Hospitals
CAM.....Community Asset Mapping
CAPTA.....Child Abuse Prevention and Treatment Act
CARES Act.....Coronavirus Aid, Relief, and Economic Security Act *(also, see below)*
CARES .....Autism Collaboration, Accountability, Research, Education & Support Act of 2019
CCHD .....critical congenital heart disease
CCO.....coordinated care organization
CDC.....Centers for Disease Control and Prevention
CDR……Child Death Review

CEU .....continuing education unit
CHARS.....Comprehensive Hospital Abstract Reporting System
CHIF .....Child Health Intake Form
CHIP .....Children's Health Insurance Program
CHR.....Community Health Representative
CHS .....Center for Health Statistics
CHU……Child Health Unit
CHW .....community health worker
CIRS……Coordinated Intake and Referral Systems
CLAS.....culturally and linguistically appropriate services
CMC.....children with medical complexity
CME .....continuing medical education
CMMI.....Centers for Medicare and Medicaid Innovation
CMS .....Centers for Medicare and Medicaid Services
COE.....Center of Excellence
COFA.....Compact of Free Association Islander Health Care program
CoIIN.....Collaborative for Improvement and Innovation Network
CoP……Community of Practice
Core SIPP .....Core State Injury Prevention Program (CDC)
CORONA .....Community Recovery-Oriented Needs Assessment survey (COVID-19 related)
CPS .....Child Protective Service
CSHE .....Comprehensive Sexual Health Education
CSHCN .....Children with Special Health Care Needs
CSLC.....Child Safety Learning Collaborative
CSS.....COVID-19 Student Survey
CSTE……..Council of State and Territorial Epidemiologists
CYSHCN .....Children and Youth with Special Health Care Needs
DBHR .....Division of Behavioral Health and Recovery
DCYF .....Department of Children, Youth, and Families
DCR……Data Collection and Reporting section
DD.....developmental disabilities
DDA .....Developmental Disabilities Administration
DDC .....Developmental Disabilities Council
DKA.....Diabetic Ketoacidosis
DO .....Doctor of Osteopathic Medicine
DOH.....Department of Health
DOL.....Department of Licensing
DSHS.....Department of Social and Health Services
DTR.....dietetic technician, registered
ECCS……Early Childhood Comprehensive Systems
ECHO .....Extension for Community Healthcare Outcomes (Project ECHO model)
EfC .....Essentials for Childhood
EHDDI .....Early Hearing-loss Detection, Diagnosis and Intervention
EMR.....electronic medical record

Epi.....Epidemiology (or Epidemiologist)
EPSDT .....Early and Periodic Screening, Diagnostic and Treatment
EPTWFF .....Expectant and Parenting Teens, Women, Fathers and Family
ERASE MM.....Enhancing Reviews and Surveillance to Eliminate Maternal Mortality
ESC……..Eat/Sleep/Console
ESF.....emergency support function
ESIT.....Early Support for Infants and Toddlers
ESJ……equity and social justice
ESM .....evidence-based strategy measure
F2F.....Family-to-Family Health Information Center
FEC……Family Engagement Consultant
FESAT……Family Engagement in System Assessment Tool
FERPA .....Family Educational Rights and Privacy Act
FFPSA.....Families First Prevention Services Act
FFY.....federal fiscal year
FPHS .....Foundational Public Health Services
FPL.....federal poverty level
FTE.....full-time equivalent
FYSPRT.....Family, Youth, and System Partner Round Tables
G-tube .....gastrostomy tube
GDL.....Graduated Driver's License
GRADS .....Graduation, Reality and Dual-role Skills
Great MINDS ..Great Medical Homes Include Developmental Screening
HCA.....Health Care Authority
HCBS.....Home and Community Based Services
HCUP .....Healthcare Cost and Utilization Project State Inpatient Databases (SID)
HEAL .....Healthy Eating Active Living
HEDIS.....Healthcare Effectiveness Data and Information Set
HEPA.....Health Education Peer Advocates
HHS.....Health and Human Services
HIE .....Health Information Exchange
HIPAA .....Health Insurance Portability and Accountability Act
HITECH .....Health Information Technology for Economic and Clinical Health
HMG .....Help Me Grow
HMG-WA.....Help Me Grow Washington
HPV.....human papillomavirus
HRSA.....Health Resources and Services Administration
HSPF .....Healthy Students, Promising Futures
HYS .....Healthy Youth Survey
IAPD.....HITECH Implementation Advanced Planning Document
IDEA.....Individuals with Disabilities Education Act
IEP .....individualized education program
IP……Intervention Partners
IIS.....Immunization Information System

ITD .....Impact Teen Drivers program
IVP……..Injury and Violence Prevention
L&D……Labor and Delivery
LARC .....long-acting reversible contraception
LAUNCH.....Linking Actions for Unmet Needs in Children's Health (Project LAUNCH)
LEAH .....Leadership Education in Adolescent Health
LEND.....Leadership Education in Neurodevelopmental and Related Disabilities
LGBTQIA2S+ ...lesbian, gay, bisexual, transgender, queer/questioning, Two Spirit, and other sexual identities
LHJ .....Local Health Jurisdiction
LOCATe[SM] .....Levels of Care Assessment Tool[SM]
M-CHAT.....Modified Checklist for Autism in Toddlers
MACPAC.....Medicaid and CHIP Payment and Access Commission
MAT.....medication-assisted treatment
MAWS .....Midwives Association of Washington State
MCH .....Maternal and Child Health
MCHBG.....Maternal and Child Health Block Grant
MCO .....managed care organization
MD.....Medical Doctor
MFRB.....maxillofacial review board
MHPP .....Medical Home Partnerships Project (at University of Washington)
MIECHV .....Maternal, Infant, and Early Childhood Home Visiting
MISA.....Mutual Information Sharing Agreement
MMR.....maternal mortality review
MMRP .....Maternal Mortality Review Panel
MOD.....March of Dimes
MOUD……..Medication for Opioid Use Disorder
MSS .....Maternity Support Services
MTHFR.....methylenetetrahydrofolate reductase gene
NAS.....neonatal abstinence syndrome
NCQA.....National Committee for Quality Assurance
NDC .....neurodevelopmental center
NEAR .....neurobiology, epigenetics, adverse childhood experiences and resilience sciences
NG .....nasogastric (NG tube)
NHOPI……..Native Hawaiian Other Pacific Islander
NICU .....neonatal intensive-care unit
NOWS.....neonatal opioid withdrawal syndrome
NPM .....national performance measure
NPAIHB……Northwest Portland Area Indian Health Board
NSCH .....National Survey of Children's Health
NWCPHP.....University of Washington Northwest Center for Public Health Practice
OADA…….Olympia Area Dietetics Association
OFCHI .....Office of Family and Community Health Improvement (in Department of Health)
OFM.....Office of Financial Management

OPEA…….Office of Public Affairs and Equity
OSPI .....Office of Superintendent of Public Instruction
P2P .....Parent to Parent
PA .....physician assistant
PAF .....Pregnancy Assistance Fund
PAL .....Partnership Access Line (PAL) for Moms
PAVE .....Partnerships for Action, Voices for Empowerment
PCEs…….Positive Childhood Experiences
PCH .....Prevention and Community Health Division (in Department of Health)
PCP .....primary care provider
PCPC…….Pierce County Perinatal Collaborative
PCECN……..Pierce County Early Childhood Network
PHAB .....Public Health Accreditation Board
PHSKC……..Public Health Seattle-King County
PI .....principal investigator
PIP……..Practice Improvement Projects
PICU.....pediatric intensive care unit
PMP……Prescription Drug Monitoring System
PNC.....pre-natal care
PPE .....personal protective equipment
PPCF……..Pregnant, Parenting, Children, and Families
PQC……Perinatal Quality Collaborative
PRAMS.....Pregnancy Risk Assessment Monitoring System
PREP .....Personal Responsibility Education Program
PRISM .....Promoting Innovation in State Maternal and Child Health Policymaking learning community (in Women's Health domain)
PRISM database ...Medicaid's Predictive Risk Intelligence SysteM database (in CSHCN domain)
PRN.....Perinatal Regional Network
Project ECHO.....Project Extension for Community Healthcare Outcomes model
Project LAUNCH ...Project Linking Actions for Unmet Needs in Children's Health
P-TCPi .....Pediatric – Transforming Clinical Practice Initiative
QI.....quality improvement
RBA.....Results Based Accountability
RCW.....Revised Code of Washington
RD.....registered dietician
RDN .....registered dietitian nutritionist
RHNTC……..Reproductive Health National Training Center
RN.....registered nurse
SE.....Surveillance and Evaluation Section (in Department of Health)
SAFE……..Safe Environment for Every Kid
SAMHSA .....Substance Abuse and Mental Health Services Administration
SBHC.....School-Based Health Center
SEEK……Safe Environment for Every Kid
SHB .....Substitute House Bill

SID .....Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases
SMART.....School Medical Autism Review Team
SNAP-Ed .....Supplemental Nutrition Assistance Program Education
SPM .....state performance measure
SRHP .....Sexual and Reproductive Health Program (in Department of Health)
SRPF.....Shared Risk and Protective Factors
SSDI .....State Systems Development Initiative
STI.....sexually transmitted infection
SUD.....substance use disorder
SUID.....sudden unexpected infant death
SWYC…….Survey of Wellbeing of Young Children
TCY .....Thriving Children and Youth Section
TERIS…….Teratogen Information System Database
TF-CBT .....Trauma-Focused Cognitive Behavioral Therapy
THC.....tetrahydrocannabinol
TPCHD .....Tacoma-Pierce County Health Department
TPP .....Teen Pregnancy Prevention
TVPPCP.....Tobacco and Vapor Product Prevention and Control Program
UDS.....universal developmental screening
USPSTF .....United States Preventive Services Task Force
UW .....University of Washington
VBAC.....vaginal birth after cesarean
WA.....Washington
WA PREP…….Washington State Personal Responsibility Education Program
WAC.....Washington Administrative Code
WaKIDS.....Washington Kindergarten Inventory of Developing Skills
WAPREP .....Washington State Personal Responsibility Education Program
WASBHA…….Washington School Based Health Alliance
WCAAP .....Washington Chapter of the American Academy of Pediatrics
WDC .....National Maternal and Child Health Workforce Development Center
WIC.....Women, Infants and Children Nutrition Program
WPIPN .....Western Pacific Injury Prevention Network
WSCADV.....Washington State Coalition Against Domestic Violence
WSCC.....Washington State Community Connectors
WSELC .....Washington State EHDDI Learning Community
WSFN.....Washington State Fathers Network
WSHA .....Washington State Hospital Association
WSLI .....Washington Statewide Leadership Initiative Coalition
WTSC.....Washington Traffic Safety Commission
WYSH.....Washington Youth Sexual Health innovation network
WYSHIIN…….Washington Youth Sexual Health Innovation and Impact Network
YAC…….Youth Advisory Council

Table of Contents

CYSHCN LHJ Summaries 2021-2022

LHJs selected local strategies and body of work summaries are listed below.

MCHBG Combined LHJ Summaries 2021-22

This Combined Focus of Work covers all MCH domains except Children and Youth with Special Health Care Needs. The shaded sections below list the state-level priorities and strategies. LHJs selected local strategies and body of work summaries are listed below.

CYSHCN LHJ Summaries 2021-2022

Declaration of Purpose - WAC 246-710

The purpose of the Children and Youth with Special Health Care Needs (CYSHCN) program is to assure comprehensive, coordinated, integrated, family-centered, and culturally competent systems of care. The CYSHCN program focuses on developing, extending, and improving services and service systems for identifying, diagnosing, and treating infants, children, and youth up to eighteen years of age who have or are at risk of developing chronic physical, developmental, behavioral, or emotional conditions, or any combination thereof, and require health and related services of a type beyond what is required by children generally. The program works to ensure CYSHCN are able to achieve the healthiest lives possible and develop to their fullest potential by building the capacity of communities to support CYSHCN and their families while developing and enhancing the capacity of statewide systems of care that are comprehensive, coordinated, integrated, family-centered, community-based, and culturally appropriate with the purpose of supporting and promoting health equity.

Vision

All CYSHCN and their families **belong, participate,** and **thrive** in **communities** with **integrated, accessible** systems that **equitably support** their social, health, developmental, and emotional **well-being.**

Goals

We will promote:

- a **system of care** that is family-centered, integrated, collaborative, coordinated, and equitably accessible to all CYSHCN and their families.
- equitable **funding** strategies that improve access and flexibility for underserved families and their providers and align with best practice interventions for CYSHCN.
- **equitable access** to high-quality care and related services to optimize support, health, and well-being for underserved CYSHCN populations, especially those facing disadvantages due to systemic racism and other systemic factors.
- **concrete supports** that CYSHCN and their families need for **well-being** and quality of life including:
    - Social-emotional support & connectedness to other families
    - A sense of belonging and inclusion in their community
    - Access to mental health and behavioral supports that are developmentally appropriate
- **family navigation**, and other family-centered **care coordination** models, to meet the complex needs of CYSHCN and their families, including health, socioeconomic, and psychosocial needs.

Required Activities

All LHJs are required as part of CYSHCN work outlined in the MCHBG Statement of Work to complete the following:

- **Complete intake and renewal process into Child Health Intake Form (CHIF)** database on all infants and children receiving assistance and accessing services through the local CYSHCN Program, as well as children residing in the jurisdiction who are receiving services from maxillofacial review boards, and who are accessing Diagnostic and Treatment Funds. Submit data by the 15th of the month after the end of the quarter. CHIF data reporting deadlines are documented in your contract deliverables. Required fields include ProviderOne number (if a child is participating in Apple Health / Medicaid), county, client name, zip code, date of birth, gender, race, ethnicity, economic level, third-party payment sources, ICD 10 diagnosis code, and additional involvement.
- **Work with partners to share updated local CYSHCN resources with Within Reach / Help Me Grow (HMG).** Review resources for your local area on ParentHelp123.org annually for accuracy and submit any updates to Within Reach.
- **Administer Diagnostic and Treatment Funds** for infants and children as needed, and track and report status of obligations periodically, as requested. Complete a Health Services Authorization (HSA) form for purchased CYSHCN services as needed.
- **Dedicate at least 30% of your total MCHBG budget to CYSHCN**. This requirement will inform the completion of your 2021-22 MCHBG Budget Workbook.

- ***Select at least one Local Strategy to address CYSHCN (see below)***. Examples of optional activities are listed after each Local Strategy. LHJs were allowed to design alternative strategies and activities after consultation and approval.

Local Strategies

Strategy 1: System of Care

Increase the percentage of CYSHCN who receive family-centered, integrated, collaborative, coordinated, and equitably accessible care.

Related MCHBG Priority Need: Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.

Example Activities

- Promote networking and partnerships and provide targeted consultation to local health care, education, and social service providers on areas of expertise such as children and youth with clinical and behavioral complexity, Universal Developmental Screening (UDS) and referral, navigating systems, care coordination, family navigation, community referral systems, school-based services, and clinical linkages.

Asotin

- Activity: Become fluent with statewide resources, their benefits, and how to teach others to navigate the systems.
- Activity: Educate policy makers, community, school administration, staff, students, families and daycares about the unique needs of CYSHCN and teach them to link CYSHCN to services provided by other entities while informing them of the benefits and resources available through the program, to link CYSHCN to needed resources to affect positive outcomes. This will be done though community forums, school collaboration, peer education, daycare staff training, social media and other venues.
- Activity: Promote networking and partnerships with local pediatric hospital and clinics to build better systems between partners who serve CYSHCN.

Benton-Franklin

- Activity: Maintain Regional Roadmap to assure appropriate referrals to assure collaborative, coordinated and equitably accessible care for B-3. Review contacts quarterly and update roadmap.
- Activity: Maintain Regional Roadmap to assure appropriate referrals to assure collaborative, coordinated and equitably accessible care for B-3. Post to web and share with partners/providers.

Chelan-Douglas

- Activity: We will do this by convening members of managed care case management, case managers from Confluence Health and CVCH, and education service providers to identify duplication of services, share available services being offered and determine who can best meet the needs of clients and include this in plans of care.
- Activity: We will share information about and encourage use of the Strong Start data system among health care providers and parents.

- Activity: We will work with our local DDA case managers to increase the number of referrals to CYSHCN and help families understand how to request paid services from DDA.
- Activity: We will assess current blood lead screening activity among our providers and share information about risk factors, targeted screening, retesting and appropriate assessments/referrals with medical providers and families.

Clallam

- Activity: We will attend coalition meetings including Readiness To Learn with the Quilayute Valley School District, the Quileute Tribe and Hoh Tribe; and Birth to Three, which connects DDA and family resource coordinators for this vulnerable age group. Attend pre-approved workshops and trainings that will build knowledge about need and resources available to CSHCN clients and share information about best practices learned with partners at the coalition meetings listed.

Clark

- Activity: MCHBG CYSHCN staff will facilitate Clark County Interagency Coordinating Council meetings and attend SW Regional Care Coordination Networking meetings, outreach to local family birth centers/NICUs; pediatric providers; PEACE/Parent2Parent, PAVE, DDA, school districts, and ESD 112/ESIT, Hispanic Disability Support SWWA (Pasitos Gigantes) and pediatric providers to increase awareness of CYSHCN program and community resources that benefit CYSHCN.
- Activity: The CYSHCN nurse will explain their current role supporting CYSHCN families, provide available resource materials, and prioritize regular messaging to community partners in advance of CYSHCN public health's transitioning role to population-level health strategy work effective September 30, 2022.

Cowlitz

- Activity: We will do this by partnering with local parent support groups/organizations (such as Parent to Parent Programs, the local Arc, Young Child Wellness Council, Cowlitz Community Network, Youth & Family Link, etc.) to connect CYSHCN families within the community.

Grant

- Activity: Reengage with the healthcare system for focused collaboration on CYSHCN
- Activity: Active participation with local and regional workgroups such as CICC (Coordinated Interagency Council and Autism Collaborative
- Activity: Team meetings with either healthcare or school districts

Island

- Activity: Promote networking and partnerships and provide targeted consultation to local health care, education, and social service providers on areas of expertise.

Klickitat

- Activity: Identify partners in the community who serve CYSHCN. We will do this by networking with the medical groups and school districts in our community.

- Activity: Identify the resources/access to services in the community that exist currently and identify gaps/system improvements needed to ensure services. We will attend Interagency Meetings and research the resources in our community to gain understanding.
- Activity: Identify community training needs, through a gap analysis of collected data. We will develop a survey, implement the survey to community partners, analyze the data, and identify gaps in understanding.

Lincoln

- Activity: We will do this by meeting with local providers at their medical team meetings, will email or do phone consultation with counseling center and schools through special ed directors so they know about UDS through Child Find.
- Activity: We will use staff time to develop a brochure for families and a reference sheet for providers to promote the new Washington State UDS system Strong Start and local services such as CYSHCN, local school districts, and local healthcare and mental health providers to facilitate the knowledge base of available services and the coordination amongst providers in Lincoln County to benefit families

Mason

- Activity: Participate in the Mason County Early Learning Coalition.
- Activity: Participate in the Pediatric Provider Case Management Meetings that are also attended by education providers, school therapy staff (OT, PT, and SLP), pediatricians, B-3 Early Intervention staff, hospital pediatric therapy staff (Therapy manager, PT, OT and SLP), and developmental preschool staff.

Okanogan

- Activity: OCPH will attend local and county meetings related to CYSCHCN such as perinatal mental health task force, early childhood advisory groups (HSAC) and coalitions (Oroville/Okanogan) that promote a system of change, policy development and increasing equitable access to service.
- Activity: OCPH will review pertinent health data from local hospitals/DOH and share that information with local advisory groups and appropriate community health meetings to identify and reduce barriers.
- Activity: OCPH will participate in local/regional needs assessments and health care transformation efforts through to elevate the needs of CYSHCN and their families in this work.

Pacific

- Activity: We will serve as Chief Health Strategist in local birth to eight coalitions, Developmental Disability Advisory Committee and Pacific County Immigrant Support to identify needs of the community and ensure that there is representation of our English as a second language communities.
- Activity: We will assign staff who are culturally appropriate, and equity minded to represent the Health Department in these meetings
- Activity: We will keep group accountable to including English as a second language in an equitable way while planning community events and trainings.

- Activity: We will develop strategies to recruit to the various groups, individuals who represent the communities we serve, particularly in the Hispanic population.

San Juan

- Activity: We will serve on the Health Care Provider Outreach team as part of the Help Me Grow WA and disseminate information to Community partners via email, in person, and group meetings. Continue to work with local healthcare providers to promote and provide training for UDS implementation in the clinical setting. Ensure local resources are updated annually to ParentHelp123.org. Facilitate Child Find activities and ensure families and children are connected to services and supports.

Sea-King

- Activity: We will do this by outreach to local schools with IEP teams, local pediatricians, and other locals service agencies to provide services to pregnant individuals and infants.
- Activity: Build foundational public health systems that promote an environment that is suitable for community agencies and other service providers to expand CYSCHN services in King County.

Skagit

- Activity: Lead Help Me Grow-Skagit Health Care Provider Engagement action team in developing and carrying out work plan.
- Activity: Coordinate with state Help Me Grow Health Care Provider Engagement team efforts.
- Activity: Coordinate with DOH UDS program to encourage local provider participation. When Strong Start is launched, this could include sharing information about the new data system and encouraging healthcare providers and parents/legal guardians to enter and access screening information into the system.

Spokane

- Activity: We will Make connections with Spokane County partners, Early Intervention Network, and case managers with MCO's to enhance referral processes to local services.

Thurston

- Activity: We will attend Early Childhood Coalition, Mother-Baby Coalition. Will also outreach local providers (peds, family practice) to the promote/advocate special needs of CYSHCN via one-on-one contact and email outreach.

Wahkiakum

- Activity: As an LHJ we will coordinate quarterly networking meetings to allow for agency resource sharing and care coordination.

Yakima

- Activity: Child and Family Staffing- Host monthly meeting with Children's Village and community providers; begin tracking ethnicity of children staffed to support and inform continued health equity.

- Activity: Care Coordinator meetings- Host monthly meeting with local care coordinators to promote networking and information sharing**.** Identify and engage Care Coordinators from new areas, including the Yakama Nation. Secure various disability related speakers/trainers for these meetings.
- Activity: Yakima County Interagency Transition (to adulthood) Network- Co-host ITN- identify/recruit multicultural members and representation from agencies not active with disability networks, that serve primarily multicultural families.

Enhance medical homes in your local community through consultation to local primary care and other providers on medical home and the Standards for Systems of Care for Children with Special Health Care Needs.

Adams

- Activity: We will communicate with local pediatricians and family physicians within our county and coordinate a quarterly meeting, either in-person or virtually to ensure that current Systems of Care for CYSHCN clients are being met.
- Develop formal and informal agreements on roles and data sharing between health systems, Medicaid Managed Care Plans, and various agencies serving CYSHCN throughout the county.

Cowlitz

- Activity: We will do this by working with community providers such as Progress Center, Cowlitz Tribal Health, ARC, etc., to develop MOUs or informal agreements to share information.

Tacoma-Pierce

- Activity: We will collaborate with MCO care management teams to educate about the CYSHCN population and provide consultation on appropriate and available services to meet child and family needs.
- Activity: We will regularly be in contact with our MCHBG contract leads as we identify gaps in MCO coverage and support for CSYCHN families
- Partner with the Medical Home Partnerships Project in autism systems development through participation in School Medical Autism Review Teams (SMART) Teams and other local coalitions working on autism screening, diagnosis, and treatment. Assist in recruiting primary care and other local providers to participate in Autism Centers of Excellence and ECHO training opportunities.

Chelan-Douglas

- Activity: We will do this by attending our local SMART Team meetings, attending the SMART Team Networking Meetings hosted by the Medical Home Partnerships Project and sending emails to local pediatricians about COE and ECHO training opportunities.

Gray's Harbor

- Activity: We will be coordinating the SMART Team for our county and partnering with Pacific County. We will coordinate referrals and facilitate monthly SMART Team meetings for review and follow-up with families that will also be given the opportunity to enroll in the CYSHCN program for continued support connecting with and navigating resources.

- Activity: The department CYSCHN coordinator will be participating in monthly statewide SMART Team networking calls and ECHO training through the UW Medical Home Partnership Program.
- Activity: As part of other MCHBG system work, we will be conducting outreach and education to local medical providers. With this work we also hope to recruit at least 1 more provider to attend COE training in 2022.

Jefferson

- Activity: Attend SMART Team Network calls to gain knowledge for effective SMART team development.
- Activity: Complete AAP "Identifying and caring for Children with Autism Spectrum Disorder" course and COE training.
- Activity: Identify partners in the community who serve children who need autism assessment.
- Activity: Recruit interested providers for UW Center of Excellence training.
- Activity: Identify partners within the school districts, Early Intervention services, and community for development of SMART Team and recruit SMART Team members.
- Activity: Identify community and regional resources that exist currently and identify gaps for support and treatment of ASD related needs.
- Activity: Convene SMART teams.
- Activity: Other activities as identified in the process of developing a local SMART team. Communicate with partners about staffing transition and JCPH commitment to convening SMART team in Jefferson County.

Mason

- Activity: Participate in the Mason County School Medical Autism Review Team (SMART)

San Juan

- Activity: We will coordinate and meet monthly as part of the San Juan County Autism Collaborative (SJCAC) – SMART. Participate in Statewide SMART networking and ECHO calls. Develop a robust resource list to connect families and children with Autism to services and supports. Conduct outreach to healthcare providers and community partners to ensure families and children are connected to SJCAC if needing a diagnosis or resource navigation.

Skagit

- Activity: Attend local and statewide SMART network meetings, as available.
- Activity: Incorporate this into our Help Me Grow health care provider engagement work.

Snohomish

- Activity: We will participate in School Medical Autism review team (SMART) monthly video conference calls

- Activity: We will assist in recruiting local primary care physicians to participate in the Autism Centers of Excellence and ECHO training opportunities. Our goal will be to outreach support to at least 2 providers as soon as a UW training becomes available.

Partner with the state CYSHCN Nutrition Network, local providers, and feeding teams to increase the availability of referral options for children who need nutrition-related services

Benton-Franklin

- Activity: Participate in CYSHCN Nutrition Network trainings and share resources with partners

Jefferson

- Activity: Activities limited to: identify Registered Dietitians (RD) within the community and potentially those eligible via remote service options and connect these RDs with the Nutrition Network.
- Activity: Explore WA Academy of Nutrition and Dietetics WSAND – "Find a Nutrition Expert" website and assess RDs availability through the local healthcare system to locate contact information for local RDs who would potentially want to join the Nutrition Network.
- Connect identified eligible RDs with Nutrition Network contractors at the Center on Human Development and Disability University of Washington.

San Juan

- Activity: We will attend Nutrition Network meetings and trainings. Work with Toddler Learning Center to set up a new Feeding team to serve children in Island and San Juan Counties. Set up a referral system for families needing feeding support. Conduct outreach activities to share Feeding Team information and resources to Community stakeholders. Convene regular Feeding Team meetings to serve children and families.

Walla Walla

- Activity: We will determine if there is a need for a feeding team in Walla Walla County by collecting data from providers, CHYSCN families, referral agencies, and neighboring county Benton-Franklin's feeding team.
- Activity: We will partner with WIC to explore improved methods of estimating CYSHCN participation in the WIC program.
- Activity: We will identify any key agencies and professionals within the community to determine the need, educate those key agencies on client benefits and cost effectiveness of a feeding team, and if needed, identify and recruit team members for a feeding team.
- Activity: We will coordinate and support training needs as required to establish feeding team.

Engage youth with special health care needs and families of CYSHCN in systems planning, development, and improvement efforts. Provide opportunities to connect youth and family voices with community providers and existing planning efforts.

Adams

- Activity: We will conduct a survey of CYSHCN and their families on experiences with services provided by local providers to share feedback/input on services/access). We will develop a simple survey in both English and Spanish and mail the survey to CYSHCN families.

Walla Walla

- Activity: We will follow-up with families already established with the CYSHCN program to collect qualitative data on unmet community needs.
- Activity: We will provide surveys in English and Spanish to families enrolled in CYSHCN program aimed at collecting data on what community resources are utilized and what resources in the community families need or would like to see.
- Activity: We will communicate data obtained from family surveys to community providers via FST and CICC meetings.

Develop methods to establish baseline data on CYSHCN in your local community, monitor systems, identify training needs, detect gaps, and determine system improvements needed to ensure CYSHCN and their families have access to community-based services.

Adams

- Activity: We will work with healthcare providers, schools, and other entities offering developmental and medical services in our area to identify areas of need within our community and work to address those areas by collaborating with other members of Medical Home Team.

Clark

- Activity: We will engage our Information Services Coordinator and our Health Assessment and Evaluation team to analyze CHIF data and information from focus group discussions conducted under CDC Essentials for Childhood grant.
- Activity: We will assess data for strengths and gaps in services and evaluate increased demand for services currently provided in the community. This process will inform allocation and distribution of available funds and inform strategic application for future available grant opportunities.
- Activity: We will distribute aggregated draft report to our key community partners (E.I., School Districts, Behavioral Health Providers, Specialty Care Providers, etc.).

San Juan

- Activity: We will complete intake and renewals to update the CHIF database. Work with Toddler Learning Center to ensure seamless transition of children to CYSHCN after their third birthday if needing CYSHCN support. Partner with our School Districts, Early Learning Programs and Health Care Providers to provide timely referrals and CYSHCN resources. Participate in a Community Asset Mapping project to identify assets and gaps/ needs for community-based services.

Spokane

- Activity: We will run a report in January, make any edits/updates and share with local and state stakeholders to emphasize the needs in our county.

Whitman

- Activity: Identify CYSHCN services locally. Have they survived COVID?
- Activity: Survey active CYSCHN services to find out what their utilization rates have been like in the past 2 years and any issues that made it difficult to help the families they serve due to COVID.

Explore ways to enhance the comprehensiveness of CHIF data through data share agreements.

Klickitat

- Activity: We will do this by gaining understanding of the CHIF data and identifying the gaps in data sharing agreements. We will meet with Sarah Burdette, Process Improvement Specialist for CYSHCN in order to help with this work.

Participate in local and regional needs assessments and health care transformation efforts and elevate the needs of CYSHCN and their families in this work.

Adams

- Activity: We will increase CYSHCN program awareness and education through involvement in the assessments and transformation efforts.

Clallam

- Activity: We will provide input based on observations and data developed through CYSHCN services to Clallam County Health and Human Services for 2022 Community Health Assessment.

Gray's Harbor

- Activity: Partnering with local agencies (The Arc, Birth to Three/ESIT) to develop and distribute a parent survey with the purpose of better understanding the needs around support and gaps in services. Including an emphasis on connecting with the Hispanic/Latino community.

San Juan

- Activity: We will work on a Community Asset Mapping project with SJCAC, Early Learning, Health Care Partners, Parents of children with special health care needs and other Community stakeholders.

Snohomish

- Activity: We will participate in the Children's Commission and the Accountable Communities of Health in the MCH-specific committees.

Spokane

- Activity: We will attend local Equipment Sharing Network monthly meetings to facilitate sharing of needed equipment from local therapy centers to families of CYSHCN.

Walla Walla

- Activity: We will create and distribute surveys in English and Spanish to local providers, social workers, and families of CYSCHN to evaluate their needs and whether those needs are being met or not.

Whitman

- Activity: Identify our current list of CYSCHN families. Ensure that they are included in our community health needs assessment efforts, including focus groups.
- Activity: Utilize the CHNA to gather data points on infant health outcomes based on race and ethnicity (BIPOC)

Strategy 2: Financing

Increase the amount of local financing options available to families and providers that improve equitable access, flexibility, and alignment with best practice interventions for CYSHCN

Example Activities

- Identify gaps and barriers in adequate health care financing and communicate to DOH.
- Convene local funders and stakeholders to raise awareness of the needs of local CYSHCN and their families and develop funding and other strategies to meet those needs.
- Provide information and work with DOH staff to identify gaps in coverage of some items, services and supports for CYSHCN.
- Support local efforts to coordinate and assist families to enroll in health care coverage (including Medicaid as a secondary insurance) by providing technical assistance and consultation on options for coverage for CYSHCN and the importance of adequate insurance for this population. (Enabling services to enroll CYSHCN can be found under Strategy 5).

Okanogan

- Activity: OCPH will ensure that data collected during intake of CYSHCN and provide health navigation resources for those that are not enrolled.

Thurston

- Activity: We will do this by referring families to patient navigators at Providence, Choice Regional Health Network, and directly to Apple Health for enrollment assistance.

Strategy 3: Equity

Reduce and eliminate disparities in equitable access to high-quality health and related services for all CYSHCN populations.

Example Activities

- Improve overall awareness of the complex needs of CYSHCN and the inequities they face in access to communities and systems of care due to systemic ableism and other factors.

Grant

- Activity: Sharing resources with local home visiting programs on CYSHCN resources
- Activity: Connecting families with translation resources for both medical and developmental appointments for their child. We will provide our community partners with updated information as well as updating our local Community Resource Forum group.
- Activity: Share the best-practice with community providers about the importance of providing services within the migrant family schedules.

Jefferson

- Activity: We will attend local meetings to advocate for families with CYSHCN, engage families of CYSHCN who in local systems work.

San Juan

- Activity: We will attend regional equity work group meetings and share resources and materials to local community stakeholders. Work with Toddler Learning Center, School Districts SPED, Parent 2 Parent partners, and SJCAC SMART to connect with CYSHCN and families to address barriers and challenges in access to care.

Utilize CHIF data and other local data to identify inequities that affect health of CYSHCN and develop strategies to eliminate those disparities.

Sea-King

- Activity: We will work closely with our epidemiology team to analyze data from a variety of local sources, in particular, the Best Starts for Kids annual survey. This analysis will help us identify which communities we are missing. Once we know who we are missing, we can target outreach efforts to those communities.

Whitman

- Activity: Analyze local CHIF data for new trends or gaps in services as part of the CHNA. Looking specifically to answer questions about access to care and insurance coverage.

Engage families of CYSHCN that are Black, Indigenous, or People of Color (BIPOC) in systems planning, development, and improvement efforts.

Increase representation of youth with disabilities in system planning as a complex disparate group with a high intersectionality between other known populations vulnerable to risk factors.

Through partnerships, understand and mitigate the disparate impacts 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.

San Juan

- Activity: We will partner with community providers to address the barriers CYSHCN and families face with access to care and the gaps in resources and supports in our rural community and work on identifying and implementing strategies to better support CYSHCN and their families.

Whitman

- Activity: Survey local clinics for ability to care for CYSHCN patients based on insurance and capacity.

Strategy 4: Well-being

*Increase the percentage of CYSHCN and their families that have the **concrete supports** they need for **well-being** and quality of life.*

MCHBG Priority Need: Promote mental wellness and resilience through increased access to behavioral health and other support services.

Example Activities

- Identify and promote local resources that provide social-emotional support for families of CYSHCN and connectedness to other families.

Adams

- Activity: Initiate contact with providers in our county and assess social-emotional support resources and how our CYSHCN families can easily access the resources. Incorporate this into the welcome packet that is sent to families that are new referrals.

Chelan-Douglas

- Activity: We will do this by collaborating with the Brave Warrior Project and other service providers to increase access to family support services and improve the lives of CYSHCN in our area. We will share resources and opportunities for support and connectedness with the families we serve.

Garfield

- Activity: We will: share quality Behavioral Health Wise program with school counselors, with parents who have child on IEP, and through social media update.

Island

- Activity: Access a directory of local providers specializing in perinatal mental health through PSI-WA.
- Activity: Partner with Island County Human Services (ICHS) to explore local counseling practitioners.
- Activity: Work with the Parent to Parent (P2P) coordinator from Island County Human Services (ICHS) to provide information to her to share with children/families through her newsletter, Facebook page, etc.
- Activity: Connect with local groups (Mother Mentors, Birth – Three programs, local healthcare practitioners) to collect information about their services and primary focus.

Kitsap

- Activity: We Will: Work with Kitsap Connecting for Kids Coalition (a Help Me Grow sub affiliate group Family and Community Outreach team) and Northwest Family Medicine Residency Behavioral Health Coordinator along with other coalitions and community partners to identify and share new or existing local resources that can support CYSHCN families.

Kittitas

- Activity: Attend local coalitions and workgroups including Kittitas County Early Learning Coalition, Kittitas County Health Network Childcare Workgroup, Kittitas County Parent to Parent, Kittitas County Resilience and ACEs Workgroup/Task Force, Kittitas County Family of Resources Coalition, Kittitas County Health Network Behavioral Health Workgroup.
- Activity: Conduct outreach with and stay up to date on services of local primary care and behavioral health providers, Developmental Disabilities program, school district special education programs/developmental preschools/counseling staff, Yakima Children's Village (Early Support for Infants and Toddlers program provider), WIC, and Head Start and Early Head Start programs.
- Activity: KCPHD has begun to talk about how we will transition out of the sub-contract that KCPHD has with Community Health of Central Washington and how we will bring that work back into the Kittitas County Public Health Department.
- Activity: Work with 211 to keep resource lists of local services up to date and accessible in the community.

NE Tri

- Activity: Staff will attend monthly Ferry County Coalition meetings, Stevens County Round table meetings that occur once a quarter, and Pend Oreille County Health Coalition quarterly; in addition to the county coalition meetings staff will attend meetings when available by other community partners to collaborate on social-emotional needs of families with CYSHCN and promote available services.

Okanogan

- Activity: OCPH will work to connect CYSHCN and their families to mental wellness services through involvement with local community entities such as ESIT and school based mental health services such as WISE.

Skamania

- Activity: We will work with local Pathways Program providers to promote infant and perinatal mental health, elevating the needs of CYSHCN and their families.

Spokane

- Activity: We will send resources to CYSHCN families via email group and will promote and be involved with planning for newly formed Parents Empowering Parents support group

Yakima

- Activity: Coordinate with Parent to Parent to ensure supportive resources are shared with families attending parent groups, and through the newsletter (English/Spanish).
- Activity: Identify opportunities to share information about the value of parent support and the Parent-to-Parent program with Yakama Nation families.
- Activity: Coordinate with Parent to Parent to provide outreach to Yakama Nation families raising children with special needs.

Work with local recreation, education, and other community providers on developing inclusive and accessible programs that increase the sense of belonging in their community for CYSHCN and their families.

Kitsap

- Activity: We will attend Kitsap HEAL (Healthy Eating and Active Living) Coalition quarterly meetings and Early Childhood Education Workgroup to develop relationships with partners working to support healthy eating and movement activities. Discuss ways to address CYSHCN specific concerns and the feasibility of forming a group to address these needs.
- Activity: We will collaborate with KPHD Chronic Disease Prevention Team to collaborate on the Kitsap Moves campaign. Partner to write a newsletter to families regarding the Kitsap Moves campaign and pledge form to increase movement in the classroom and in the home in addition to exploring the possibility of “free day” at the YMCA to CYSHCN families or other engagement, healthy eating, and movement opportunities for CYSHCN families.

Kittitas

- Activity: Work with coalitions, workgroups, and partners identified above, in addition to municipal parks departments, Central Washington University, Kittitas County Chamber of Commerce, and local elected officials.

Raise awareness of disparities in ACES for CYSHCN, support work on Strengthening Families for CYSHCN, and identify opportunities to infuse trauma informed care into working with CYSHCN.

Adams

- Activity: We will arrange meetings and/or presentations for local providers to spread awareness and offer knowledge and resources on trauma informed care and how to incorporate it into practice and policies.

NE Tri

- Activity: Staff will attend trainings to strengthen knowledge and skills in TI care as well. This will increase awareness to respond to the needs of CYSHCN who experience trauma.

Okanogan

- Activity: We will achieve the above through active involvement in coalitions and attendance at local/regional meetings.

Participate in anti-bullying and suicide prevention efforts in your local community, elevating the unique needs of CYSHCN. Support interventions to address suicide ideation among CYSHCN.

Garfield

- Activity: We will: share latest information related to CYSHCN and bullying/suicide rates with school counselors, with parents who have child on IEP, and through social media update.

Island

- Activity: Work with ICHS staff for inclusion of strategies addressing needs of CYSHCN.
- Activity: Utilize resources from www.StopBullying.gov if appropriate.
- Activity: Establish potential relationships with the local school districts beginning with elementary schools to discuss anti-bullying strategies they currently use.
- Activity: Discuss with Fleet and Family Support staff their efforts to combat this in childcare.

NE Tri

- Activity: Staff will attend meetings and work with HFCC to promote the unique needs of CYSHCN.
- Activity: HFCC has several community partners, one of the community partners has received funding for increased mental health support to focus on suicide prevention and opioid addiction, CYSHCN coordinator will work to partner with this group to promote needs of CYSHCN.

Participate in local efforts to promote infant and perinatal mental health, elevating the unique needs of CYSHCN and their families.

Island

- Activity: Discuss with local obstetric and pediatric providers the needs women who may be experiencing a perinatal mood disorder and advocate for them screen and refer to local support groups.
- Activity: Discuss with obstetric, pediatric, and family practice providers in Island and Skagit counties the possibility of hosting a Perinatal Mood and Anxiety Disorders training and what that would look like. Chief Health Strategist role of bringing partners together and emphasize unique needs of CYSHCN families.

Okanogan

- Activity: We will connect families with local resources such as early childhood groups and perinatal support groups linked through local health providers and/or early childhood programs like OCCDA, Dad's Move, and other local/regional coalitions/supports such as local parenting education support groups.

Snohomish

- Activity: Will continue to host, provide backbone services and steer the NEAR Collaborative meetings in 2022 of which perinatal mental health is the main priority.
- Activity: We will attend at least one WA State Perinatal Collaborative meeting to learn more about the work and to build a relationship with them. Once we have learned more and built a relationship with the collaborative, we will be able to define our level of engagement as well as the goals and activities of the engagement.

Spokane

- Activity: We will co-facilitate Birth Outcomes Task Force in Spokane

Strategy 5: Family Navigation & Care Coordination

Increase the percentage of CYSHCN and their families that have access to family navigation or other family-centered care coordination, to meet their complex health, socioeconomic, and psychosocial needs.

Example Activities

- Provide consultation and technical assistance to community organizations on care coordination for CYSHCN to build capacity in the community to transition enabling services to community providers. You may also provide enabling services to CYSHCN and their families where other services are not available. **Note**: Enabling services are non-clinical services that enable individuals to access health care and improve health outcomes. Enabling services include, but are not limited to care coordination, referrals, translation/interpretation, transportation, eligibility assistance, connecting to a medical home, health education for individuals or families, health literacy, and outreach. We recognize that counties have differential access to resources

and that communities will tailor these services to the needs of their community. **Therefore, provision of enabling services can continue indefinitely**, with the intent that communities with pertinent resources will strategically leverage such resources to support health systems activities.

Benton-Franklin

- Activity: Coordinate monthly Feeding Team meetings to allow for agency resource sharing and care coordination among service and therapy providers in our community.
- Activity: Participate in regularly scheduled Neonatal Intensive Care Unit (NICU) discharge planning meetings with local Early Support for Infants and Toddlers (ESIT), The Women, Infants, and Children Nutrition Program (WIC), and local hospitals.
- Activity: Will provide care coordination for NICU families.

Chelan-Douglas

- Activity: We will do this by meeting with clients currently on our caseload to help access enabling services.
- Activity: We will develop transition plans for current clients to ensure their complex needs will be met by other systems in the community.
- Activity: We will meet with stakeholders to identify gaps/needs that exist in our communities that lead to barriers in care.

Clallam

- Activity: We will support families in working towards equitable access to health care services through initial assistance navigating and ultimately familiarizing them with transportation systems including Paratransit and remote care services such as telehealth.

Clark

- Activity: Our 1.0FTE CYSHCN Nurse will spend 28hrs/week (0.7FTE) providing care coordination services for currently enrolled families. The last day for new referrals into this existing/historical system of care is scheduled for July 15, 2022. Effective July 18, 2022, all referrals will use the new care coordination system (currently under development with community partners). The existing/historical system of care coordination will formally sunset (all remaining clients will be transitioned/closed) by September 30, 2022.

Columbia

- Activity: CYSHCN nurse will spend 3 hours a week providing care coordination services.
- Activity: We will conduct a community asset mapping exercise to identify accessible services that are available to the entire age range of CYSHCN.

Cowlitz

- Activity: We will do this by providing enabling services to family members of CYSHCN by increasing care coordination/navigation services for CYSHCN with other community agencies in service area.

- Activity: We will do this by providing care coordination services for CYSCHN families that includes but isn't limited to consulting with healthcare team.

Gray's Harbor

- Activity: LHJ staff will support CYSHCN families to access resources that may include medical service providers, transportation, case management and coordination with the purpose of helping empower families to advocate for their children.

Jefferson

- Activity: Provide care coordination for 38 CYSHCN.
- Activity: Promote Successful transition from our enabling services (care coordination) to other agencies/services that can meet family needs. Conduct community asset mapping to determine resources and agencies/ services that can meet family's needs

Kitsap

- Activity: Our CYSHCN Nurse will provide care coordination services for families to connect them to community resources. Additionally, we will show steps in our transition plan of these services in our updates.

NE Tri

- Activity: We will provide 1.0 FTE to provide care coordination.
- Activity: We will conduct a community asset mapping exercise to identify accessible services that are available to the entire age range of CYSHCN.

Pacific

- Activity: We will refer children from our WIC clinic to one of our partners: start with N. County ELC Intervention (Specialist 0-5 group) and then they would refer if appropriate to higher level of care including one of 3 autism assessors.
- Activity: We will stay active with prevention coalitions to have a voice in community trainings and promote information within our own groups (e.g. parenting classes, behavioral intervention specialists and other family support trainings.)

Sea-King

- Activity: We will do this by working directly with the families of our CSHCN clients, linking them with tools, resources, and training so they can best support their child with special health care needs.

Snohomish

- Activity: We will conduct a community asset mapping exercise to identify accessible services that are available to the entire age range of CYSHCN.
- Activity: Create and implement a communication plan for our community partners and residents who have come to depend on the CYSHCN enabling services we have provided for decades to

make them aware of the change. This will be done gradually throughout the transition process and will feed into the new population-level services of use of the CYSHCN repository we will be creating and maintaining. Eventually, as the community becomes more aware of the change and lack of enabling services from us, entities that refer clients will be contacted and directed to the resource repository. Residents who self-refer will also be directed to the resource repository and those without internet access or language barriers will be sent a resource packet by support staff. We will translate most frequently used resources into the top used non-English languages in the county to prepare for the new way of serving clients.

- Activity: We will define the different acuity levels in our CYSHCN enabling services with a goal of creating a protocol to manage transition of cases based on acuity. The new protocol will guide the transitioning of services to the community based on acuity level. Lower acuity clients will be transitioned out quicker.
- Activity: We will conduct outreach with Snohomish County FQHCs to learn about any care coordination activities that they may be doing for CYSHCN as part of our community asset planning activity. We will develop a relationship with them so as to create a platform for us to provide consultations and technical assistance on care coordination as needed. Once this foundation is in place, we will conduct monthly outreach to them.

Tacoma-Pierce

- Activity: Our 1.0FTE CYSHCN Nurse will spend 28hrs/week (0.7FTE) providing care coordination services for currently enrolled families. The last day for new referrals into this existing/historical system of care is scheduled for July 15, 2022. Effective July 18, 2022, all referrals will use the new care coordination system (currently under development with community partners). The existing/historical system of care coordination will formally sunset (all remaining clients will be transitioned/closed) by September 30, 2022.
- Activity: We will begin to gauge interest of a stakeholder group to identify gaps and community-based strategies to address the care coordination needs of the CYSCHN population as we transition out of the care coordination role in the next grant cycle. This can include partners from our hospital systems, HMG, PAVE, MCOs, schools, Family Support Centers, and DCYF.
- Activity: We will request consultation from DOH as we move toward the Chief Health Strategist role to ensure families are not left without support and care coordination.

Thurston

- Activity: Our CYSHCN Nurse will work with families to connect them to resources such as transportation, housing, medical homes, medical plans and other resources to help meet their psychosocial, physical health and socioeconomic needs.

Walla Walla

- Activity: Our 1.0FTE CYSHCN Nurse will spend 28hrs/week (0.7FTE) providing care coordination services for currently enrolled families.

Whitman

- Activity: Continue to provide care coordination to clients currently on our caseload

- Activity: Promote successful transition from our enabling services (care coordination) to other agencies/services that can meet family needs.

Work with Help Me Grow (HMG), health systems, family led organizations, and other providers to improve access to care coordination and family navigation.

Benton-Franklin

- Activity: Provide technical assistance and resources to system partners as requested or opportunities arise.

Cowlitz

- Activity: We will do this by partnering with local parent support groups/organizations (such as Parent to Parent Programs, the local Arc, Young Child Wellness Council Cowlitz Community Network, Youth and Family Link, etc.) to help improve access to care coordination services.

Grant

- Activity: We will make sure they are aware of the resources available in Grant County since they are referring families to various resources.
- Activity: We will continually update our resource list and make sure Help Me Grow has the most updated information.
- Activity: We will work with other organizations (MSS, the FRCs, school nurses/counselors) to make sure families are aware of the Help Me Grow resource or have access to it.
- Activity: New group forming in Moses Lake who will be working on assisting families with family navigation in schools. We will ask to be a part of this team

Gray's Harbor

- Activity: Participation in local and regional HMG action teams, as well as early learning coalitions to build support and referral systems for families and providers.

Jefferson

- Activity: We will serve as the Regional Family Voice (formerly Family and Community Outreach) co-lead for the Washington Communities for Children - Help Me Grow WA.
- Activity: Work with families to improve access to Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.
- Activity: Develop a transition plan to meet with community partners to pull to gather partners to determine identify to serving families Jan to September 2022.

Kitsap

- Activity: We will provide consultation and technical assistance to HMG PECC local affiliate for Family and Community Outreach, Family Resource Coordinators, Community Health Workers, patient navigators, care coordinators, case managers, family navigators, and other providers on

care coordination standards for CYSHCN. Share CYSHCN specific needs, concerns, and resources with these providers.

NE Tri

- Activity: Attend meetings and gatherings with local partners, promote CYSHCN care needs while enforcing their complex health, socioeconomic, and psychosocial needs.
- Activity: Do a media campaign through social media and website.

San Juan

- Activity: We will partner with providers to ensure access to care coordination for CYSHCN and parents/caregivers as well as transportation, interpretation, housing, durable medical equipment, and other basic needs.

Sea-King

- Activity: We will continue to participate as an active voice throughout HMG development and beyond

Skagit

- Activity: Coordinate with Help Me Grow-Skagit Physician Champion to develop and share referral processes and pathways.
- Activity: Work closely with Help Me Grow-Skagit Family Resource Navigator and other local resource navigators to function as a system.

Tacoma-Pierce

- Activity: We will participate in monthly Pierce County Interagency Coordinating Council (PCICC) meetings to build partnerships and linkages with community agencies that serve CYSHCN.
- Activity: We will participate in the local HMG activities (ex. HMG Health Provider Outreach Team monthly meetings) to ensure the needs of the CYSHCN population are being addressed.

Walla Walla

- Activity: We will facilitate monthly Family Support Team (FST) meetings for professionals working with CYSHCN enrolled in the early intervention program to provide a time for interagency coordination and referrals. Also, allowing a time for care coordination/resource connection for children age three-eighteen years old whom professionals are working with.
- Activity: We will chair County Interagency Coordination Council (CICC) meetings for the local Early Supports for Infants and Toddlers (ESIT) – Birth to Three Early Intervention Program.
- Activity: We will facilitate the Developmental Disabilities Administration (DDA) Birth to Three & Autism Support Services focus groups formed form the CICC and others as needed.
- Activity: We will partner with the Walla Walla Valley Early learning Collation (ELC) to facilitate joint ELC and CICC meeting as appropriate to assist with implementing a community process for resource and service coordination

Whatcom

- Activity: Support Whatcom Taking Action Leadership team to promote CYSHCN priorities into planning efforts and increase alignment.
- Activity: Support the Help Me Grow planning efforts to prioritize CYSHCN in expansion efforts.
- Activity: Support the Family Tools team to increase parent involvement and develop outreach efforts

Provide consultation and technical assistance to Family Resource Coordinators, HMG Navigators, Community Health Workers, patient navigators, care coordinators, case managers, family navigators, and other providers on care coordination standards for CYSHCN.

Grant

- Activity: This will be a part of the collaboration we conduct at our Interagency Coordinating Council. We will staff complex cases and working with our local team who serve CYSHCN

Lewis

- Activity: We will facilitate meetings with local service providers to promote networking and partnerships that will improve access to community-based services for CYSHCN and their families.
- Activity: We will work closely with Lewis County Special Education Cooperative to ensure students and families are aware of and able to access family centered and culturally competent care in our community.
- Activity: We will build relationships with community service providers who serve the Latinx community.
- Activity: Materials that are shared with providers, schools, and the community will be translated to make information more accessible.
- Activity: We will increase opportunities/access for Latinx families to participate and provide feedback in community coalitions and workgroups.
- Activity: We will share resources, educational opportunities, and tools that promote health equity related to service coordination for the CYSHCN population.

Mason

- Activity: Participate in the Mason County SMART Team and Pediatric Care Coordination Meetings.
- Activity: Work with Help Me Grow (HMG), health systems, family led organizations, and other providers to improve access to care coordination and family navigation.
- Activity: Work to build more resources and systems planning for CSHCN

San Juan

- Activity: We will attend Statewide CYSHCN meetings and trainings. Convene regular meetings with local care coordinating entities such as Toddler Learning Center, School Districts, Resource

Centers, Community Health Workers, etc. to share resources and materials. Collaborate with partners to host, organize, and promote trainings.

Sea-King

- Activity: We will do this through frequent outreach and regular meetings. Our existing consultation and technical assistance networks cover most of King County. As we identify underserved communities, we will outreach to agencies who serve those communities and develop consultation networks specific to those communities.

Spokane

- Activity: We will provide consultation to family resource coordinators and LHJ ESIT program staff as needed on appropriate resources, best practices, and health information.

Walla Walla

- Activity: We will provide a resource, detailing care coordination standards for CYSHCN, on Walla Walla County website.

Train, engage, and support families and youth with special health care needs to be involved as advocates at all levels of program planning and implementation of services for CYSHCN.

Spokane

- Activity: We will send information regarding available services to CYSHCN families via local CYSHCN email group.
- Activity: We will attend County Inter-agency Coordination Council meetings and executive council meetings.
- Activity: We will work with local "Silos and Gaps" workgroup comprised of community partners and parents of children with complex medical conditions to detect gaps in services for CYSHCN and discuss improvements to ensure CYSHCN and their families have access to needed community services.

Promote and facilitate successful transitions, including transitions from early intervention to school and community-based services, and from pediatric services to a meaningful adult life.

Adams

- Activity: We will communicate with CYSHCN families with children that are advancing into school age and with children that are readying to age out of the CYSHCN system and mail out newsletters and information on transitioning into adult life and what that may look like for them. We will send this information to all CYSHCN families we are currently serving so that we can also create awareness for those that may need it in the future.
- Activity: We will discuss these different transition periods with healthcare providers and partners that offer other supportive services to develop goals and plans to assist our CYSHCN clients with the transition.

Clallam

- Activity: We will work with schools to improve care coordination services by offering technical guidance and support to schools and outside agencies providing support to school age kids. Provide navigation services directly to families by advocating alongside them for development of care plans that support their complex needs, including IEPs and transition plans beyond the school setting.

Columbia

- Activity: Reach out to clinic partners to explore how this will fit into the planning process.

Garfield

- Activity: We will reach out to school partners to investigate how this role with fit in to the planning process.
- Activity: We will work with school counselors and special education leaders to help with transition plans.

Grant

- Activity: We will have group meetings with our FRC coordinators/B-3 teacher on the transition plan as kids graduate out of the B-3 program.

Lewis

- Activity: We will partner with local family Resource Coordinators to enhance connections to DDA waiver services for 3 year olds who are transitioning from Early Intervention to school-based services. We will share and/or develop materials that will increase provider and family knowledge and of resources and supports that are available during various transition points. These materials will be provided in both English and Spanish.
- Activity: We will provide technical assistance to Northwest Pediatric Center social worker, Parent to Parent and The Equity Institute to enhance resource coordination for youth and families who are navigating the transition from pediatric services to adult services, including medical care, social services, housing, and recreation.

Okanogan

- Activity: OCPH will participate in local early intervention/school based 504 plans/local DDA meetings to promote and facilitate successful transitions, including transitions from early intervention to school and community-based services and from pediatric services to a meaningful adult life including sharing online resources such as *Informing Families**.***
- Activity: OCPH will attend monthly community coalitions, health service advisory meetings, early intervention (ICC) meetings to identify new resources and share data resource information with Help Me Grow/Within Reach and other systems that support CYSHCN, families and providers.

Sea-King

- Activity: We will do this through warm handoffs, interacting directly with the schools and community-based services so that the family and child feel supported and welcomed post-transition.

Spokane

- Activity: We will engage with LHJ ESIT program staff and Early Intervention Network regarding transition processes to ensure all children transitioning from ESIT services transition successfully to community-based and school-based services.

Develop resource materials for your local area that can be utilized across systems to support CYSHCN, their families, and providers. This includes adapting state or regional resource materials for your local area. Share local resources with Within Reach / HMG for their database.

Adams

- Activity: We will work with our CYSHCN partners within our county to update our comprehensive resource list to include the most updated services and contact information.

Benton-Franklin

- Activity: Update the BFHD website monthly with resources for CYSHCN families
- Activity: Share resources via social media
- Activity: Assure CYSHCN metrics are included in community assessment efforts

Clallam

- Activity: We will maintain existing resource lists used internally by assuring that all contact information and services provided are up to date. Work with community to find ways to publish and disseminate resource lists.

Clark

- Activity: We will develop resource materials that will benefit both CYSHCN, their families, health care providers, ECE, school district staff, and allied support services partners to better identify the range of supports available in Clark County.
- Activity: We will use information and feedback collected from our focus group sessions with service providers (funded through the CDC Essentials for Childhood grant award, completed by our Health Assessment and Evaluation Team and Chronic Disease Prevention Team) to inform resource mapping/material development.
- Activity: We will collect feedback from a parent survey (currently in development in partnership with HMG and community partners) that will be distributed to CYSHCN families receiving care coordination services and broader sampling of families with children ages birth-five currently living in Clark County to inform the development and maintenance of resource materials.
- Activity: We will work with our Help Me Grow partners to populate their database in alignment with their closed-loop referral system development as the workplan goals and objectives are shaped in parallel to MCHBG CYSHCN resource material development.

Cowlitz

- Activity: We will do this by partnering with local parent support groups/organizations (such as Parent to Parent Programs, the local Arc, Young Child Wellness Council, Cowlitz Community Network, Youth & Family Link, etc.) to connect CYSHCN families within the community, share information via social media platforms, and with Within Reach/HMG for their database.
- Activity: We will do this by attending meetings with community partners that have a focus on addressing homelessness and food security.

Grant

- Activity: This will be part of our new client onboarding to include providing a resource list as well as care binders for families to track care of their child. We will ensure all families have the resources they need.

NE Tri

- Activity: Share local resources with Within Reach / HMG for their database. This may include adapting state or regional resource materials that can be shared through electronic format with other organizations, NETCD website and social media. If unable to adapt materials through research, will search out a funding source to purchase needed materials to promote access to family navigation.

Okanogan

- Activity: OCPH will work with local Help Me Grow (HMG) and local health systems, family led organizations such as Early Intervention, local early childhood groups, Dad's Move, Family Health Centers and Room 1 and other providers to improve access to care coordination and family navigation.
- Activity: OCPH will attend local and county meetings related to CYSCHCN families and share data around the barriers/difficulty of families accessing care and strategies to meet their needs.

Skamania

- Activity: We will develop resource materials for our local area that can be easily reached by families with limited access.
- Activity: We will provide printed materials to all local health providers, essential businesses and service providers in our community. We will update social media pages and County websites to also include information about these resources.

Snohomish

- Activity: We will adapt materials provided by Within Reach and other organizations to meet the local needs of Snohomish County families.
- Activity: We will create new materials as needed to assist Snohomish County families with connecting to care.

Walla Walla

- Activity: We will update County CYSHCN resource list in English and Spanish at least every 6 months and distribute via website and to partners and local health care networks, as well as families and members within the community. Share his local resource list with Within Reach/HMG for their databases.

MCHBG Combined LHJ Summaries 2021-22

This Combined Focus of Work covers all MCH domains except Children and Youth with Special Health Care Needs. The shaded sections below list the state-level priorities and strategies for your information. LHJs selected local strategies from those listed below.

Women-Maternal Health

State Priorities	Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.	Promote mental wellness and resilience through increased access to behavioral health and other support services.
State Strategies include	Behavioral health, Substance use, Trauma-informed services, Maternal mortality, Preventive medical visits	

Local Strategies:

1. Increase resources and coordination of services to improve the quality of well women visits. This could include prenatal nutrition, sexual and reproductive health, cultural competency, etc.

None Selected.

2. Collaborate with local community Maternal Child Health coalitions, hospitals, managed care organizations, and provider groups serving pregnant/postpartum women and infants to increase referrals and ensure eligible women have access to breastfeeding information, mental and behavioral health, and necessary counseling and referrals.

Benton-Franklin

Activity: Identify partners in the community who serve pregnant and postpartum people; gather interest in birth outcomes/perinatal workgroup development.

Activity: Participate in local, regional & State workgroups or meetings that promote the importance of perinatal and postpartum support services

Activity: Work with BFHD Performance Management Team to develop/utilize assessment tools, compile and analyze data, and share out with community partners

Activity: Identify the resources in the community that exist currently and identify gaps

Activity: Work with Performance Management & CYSHCN coordinator to identify the impacts and referral sources for postpartum people & infants diagnosed with Neonatal Abstinence Syndrome or Substance Exposed Newborns, unspecified.

Klickitat

Activity: We will attend local MCH coalitions to share the data related to the mental health needs of pregnant/postpartum women.

Okanogan

Activity: OCPH will attend and participate in Perinatal Task force meetings and work within that group to support maternal/infant health including access to mental and behavioral health counseling and referrals.

Activity: OCPH will attend and participate in local Health Services Advisory groups that include supporting breastfeeding information including local WIC.

Skagit

Activity: Participate in Skagit Breastfeeding Coalition.

Activity: Participate in Breastfeeding Coalition of Washington (BCW).

Activity: Support local perinatal health capacity-building efforts including breastfeeding equity efforts with local organizations and non-traditional partnerships.

Activity: Connect all of this to Help Me Grow-Skagit system

Tacoma-Pierce

We will staff and support the efforts of the Perinatal Collaborative of Pierce County (PCPC;501c3). The PCPC supports professional practice improvement and improvements in systems of perinatal health care. Services addressed include prenatal education, breastfeeding support, nutrition, safety, and behavioral health.

Activity: In collaboration with the PCPC Board of Directors, we will convene quarterly meetings of the PCPC to promote interagency communication and cooperation.

Activity: We will convene and facilitate Board of Directors meetings during which quarterly membership training is planned and the work of various collaborative partners and subcommittees is monitored and supported.

Activity: We will support the work of the PCPC through attendance at quarterly meetings and educational offerings by the PCPC, and through participation on subcommittees.

Whatcom

Build connection and coordination among the local, regional, and statewide partners supporting perinatal and infant mental health.

Activity: Develop a local community standard of care around perinatal and infant mental health.

Activity: Increase community awareness of perinatal mood and anxiety disorders and normalize seeking support and skill building during the transition to parenthood.

Activity: Expand and facilitate access to culturally responsive peer support for parents prenatal to five years postpartum.

Activity: Increase community capacity to therapeutically identify, refer, and treat families experiencing perinatal mood and anxiety disorders by providing training and consultation opportunities for a variety of providers, including for health care, mental health, early learning and home visiting providers.

Yakima

Activity: Identify resources in the community that exist currently and identify gaps in services and resources.

Activity: Work with partners in the community who serve pregnant and postpartum people and promote community resources and education.

Activity: Participate in local workgroup/meetings that promote the importance of perinatal and postpartum support services.

Activity: Develop a pathway for breastfeeding that assist the transition from hospital/home that assures all women can receive breastfeeding assistance if needed.

Activity: Participate in local monthly Yakima Breastfeeding Coalition Meetings and Quarterly Washington State Breastfeeding Coalition Meetings. Identify ways to support coalition and use their resources to create local resources so that breastfeeding assistance/education are equitable for all mothers.

Activity: Identify behavioral/mental health services available for all perinatal people and create a perinatal resource and referral handout.

Activity: Identify who and when providers are screening for PMADs and what tools are used.

3. Participate in local, regional and statewide coalitions and task forces to promote the importance of maternal and child health. (e.g., Develop/use success stories, data and other tools to promote the importance of maternal and child health).

None selected.

4. Monitor emerging needs and prepare for future public health emergencies. Increase emergency preparedness capacity of families including those that have children with special health care needs.

None selected

5. Identify strategies to improve access to affordable, quality health care, regardless of location, language spoken, gender identity, race, sexual orientation or insurance. (e.g., 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).

Mason

Activity: Connect with community providers to identify gaps and plan for serving the family planning and nutrition needs in our community after our loss of WIC and Planned Parenthood.

Activity: Identify and promote supports for Spanish and indigenous language (Mam and Q'anjob'al) speakers in this population.

Activity: Provide information and partner with DOH Staff to raise awareness and develop strategies to meet these needs (i.e. WIC and family planning, etc.).

6. Increase connection to 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.

Cowlitz

Activity: We will do this by gathering information about community resources for fathers, attend Cowlitz Café Fatherhood Council Meeting and share info about importance of providing info to fathers.

Snohomish

Activity: We will promote fatherhood inclusion opportunities with community partners

Activity: We will explore groups in the county that are already working with people in parenting roles (such as foster parents, grandparents) to identify ways we can partner with them on CYSHCNs issues.

Spokane

Activity: We will collaborate with Community Minded Enterprises (Help Me Grow lead) on an assessment of existing referral practices of medical providers into community-based programming. Identify strengths, challenges, and opportunities to develop an integrated health and social services system to meet the needs of parents/caregivers of young children (0-5). Disseminate findings and recommendations among community partners.

Activity: Promote the use of home visiting services and creating social connections to other parents and trusted adults by utilizing existing peer support groups and community cafes. Promote linkages to services that meet unique client or subpopulation gaps in care to address the impact of 'pair of ACEs' on equitable health outcomes. Implement and promote fatherhood inclusion opportunities and support resources.

Activity: Develop and provide information on community-based parenting enrichment activities to cross-sector health and social services providers to increase connectivity of parents/caregivers to services.

Promote inclusion of additional people taking parenting roles, such as foster parents, grandparents, kinship care.

Activity: Identify and engage representatives from local home visiting programs to assess and compile information about referral criteria to participate in each home visiting program. Develop an intra-agency referral process, centering the client's needs and utilizing a strengths-based approach to match them with the most appropriate program offerings.

Perinatal-Infant Health

State Priorities	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.	Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.
State Strategies include	Bi-directional referral, Preventive care, early screening, referral, Breastfeeding, Home visiting, Trauma-informed services, Substance use, Access to services	

Local Strategies:

1. Provide Nurse Family Partnership services. (7 counties selected).

Clark

Activity: We will support a 1.01 FTE of a nurse to enroll into NFP first time pregnant (primiparous) clients, and those who have had previous pregnancies (multiparous) who experience low-income. The program prioritizes serving teen parents, Black, Brown, Indigenous, and persons of color as well as families with English as a second language and cultural identities outside of white dominant or Christian belief systems.

Kitsap

Activity: We will fund .5 FTE NFP staff

Lewis

Activity: We will subcontract with Thurston County to fund .5 FTE to provide evidence-based home visiting services for qualifying pregnant women through Nurse Family Partnership (NFP) program. The NFP subcontract will include language that will require use of data to address disparities and increase outreach to target populations.

Skagit

Activity: Funding will support up to 0.1 FTE administrator time and up to 0.15 FTE promotora time to work as a "cultural interpreter" to support NFP nurses with serving Mixteco and other immigrant families who enroll in NFP.

Tacoma-Pierce

Activity: We will support 1.5 FTE of an NFP nurse home visitor using MCHBG

Thurston

Activity: We will fund a .9FTE Nurse Home Visitor

Yakima

Activity: Maternal Health Services receives referrals from all community agencies that request home visiting for a nurse and or a counselor for the Maternal Child Population. As the centralized referral site, a referral is triaged, with other community sites that provide services for Perinatal women, infants, or children, decreasing duplication of services. If Parents or families are not eligible for other services provided for in the community, Maternal Health services provide home visiting to identify at risk families, using the evidenced based Strengthening Families (SF) Framework to promote and build protective factors. We will fund 1.4 RN, .4 Support staff & .4 BHS

2. Promote practices and policies that support breastfeeding in worksites, schools, institutions, and health care settings. (7 counties selected)

Grant

Activity: Active participation with our local Moses Lake Breastfeeding Coalition of WA.

Activity: Provide data to the coalition on breastfeeding rates for our community i.e., initiation rates, continuation rates using WIC data as well as key informant interviews and focus groups

Activity: Provide sample workplace breastfeeding policies to agencies to incorporate into their companies.

Activity: Work with the coalition to conduct a community needs assessment as staffing permits

> Success/Barriers: We are re-establishing our breastfeeding coalition which stopped meeting in 2020 due to the pandemic. A barrier we face is a lack of provider support at our local birthing hospital to support breastfeeding.

Kitsap

Activity: We will attend Kitsap Breastfeeding Coalition and Washington State Breastfeeding Coalition meetings to promote networking and partnerships and identify gaps and training needs to ensure eligible families have access to chest feeding/ breastfeeding information and necessary counseling and referrals.

Kittitas

Activity: Facilitate the Kittitas County Breastfeeding Coalition (KCBC), serve as the Chief Health Strategist for the KCBC and work with KCPHD Assessment Coordinator and Quality Improvement Coordinator to make available data and resources from Public Health (data sources include vital records, WIC, local hospital data from Kittitas Valley Healthcare, local community health assessment), support KCBC identified priority activities as time allows.

Activity: Attend quarterly Breastfeeding Coalition of Washington meetings to identify resources.

Activity: Work with the Washington State Department of Health's breastfeeding content experts (i.e., Milo Nicholas).

Sea-King

Activity: Update and create new breastfeeding policies to support early learning providers who have children in care taking bottles with breastmilk.

Activity: Create best practice policy to provide a welcoming space for mothers to breastfeed at the childcare programs.

Activity: Disseminate information on the benefits of breastfeeding.

Activity: We will participate in the Mahogany Moms Coalition

Activity: We will continue our work promoting equity and antiracism work in King County by publicizing antiracism trainings and events with childcare workers and lactations consultants in King County

Skagit

Activity: We will work with the Breastfeeding Coalition and community partners to reach out/provide consultation to worksites and other community settings to promote baby-friendly spaces and policies, using strategies such as those outlined by the CDC https://www.cdc.gov/breastfeeding/pdf/strategy5-support-breastfeeding_workplace.pdf

Activity: Along with promoting breastfeeding, we will work with employers, business-related organizations and the Skagit-Islands Human Resource Management Association to help them connect employees to health, development, social and early learning services so that children have safe, stable, nurturing relationships and environments and parents can focus on work without worrying about their children.

Snohomish

Activity: We will provide educational materials to community groups, employers and schools from Breastfeeding Coalition of Washington and the Breastfeeding Coalition of Snohomish County

Activity: We will continue to be a participating member of the Breastfeeding Coalition of Snohomish County

Activity: We will continue to work on establishing a breastfeeding-friendly childcare program. Work currently includes DOH as DOH would like the program we establish to be a pilot for a state-wide program. We will partner with childcare providers in Snohomish County. As with all MCHBG programs, targeted intensive outreach will be conducted in MCH priority areas for equity purposes (see 'Health Equity Lens' section).

Tacoma-Pierce

Activity: We will collaborate with hospitals, managed care organizations, and provider groups serving pregnant and post-partum women and infants to increase capacity for, and access to, community lactation support.

Activity: We will support hospitals and clinics to pursue and obtain the highest level possible of Lactation and Infant Feeding-Friendly Environments (LIFE) hospital and clinic designation. through the Washington State Department of Health.

Activity: We will work with community groups to develop and sustain culturally competent Peer Breastfeeding Counselor (PBC) training and support, focusing on populations with lower breastfeeding rates to eliminate disparities.

Activity: We will continue partnering with Help Me Grow Family Connects Pierce County in conjunction with Pierce County Early Childhood Network in their creation of Baby Lounges throughout the county. Through our IBCLCs we will provide expertise in the development of BF focused Baby Lounges. Our IBCLCS will also help promote connecting clients to these Baby Lounges through outreach to perinatal medical and service providers in Pierce County. Additionally, we will provide expertise/tech assistance on developing culturally relevant leadership/facilitation of the Baby Lounges.

Activity: We will continue supporting the Pierce County Breastfeeding Alliance. The Alliance membership includes black birth workers, doulas, health equity advocates, and providers. The Alliance coordinates educational offerings to promote breastfeeding support and enabling practices and policies.

3. Take action to identify and address BIPOC infant health and health disparities (e.g. gather data, raise awareness with decision makers, develop, recommend, implement and/or evaluate community efforts).

None selected

4. Facilitate access to free or affordable and accessible prenatal care across the state, ensuring culturally competent care such as doula care.

None selected

5. Participate in local, regional and statewide coalitions and task forces to promote the importance of maternal and child health. (e.g., Develop/use success stories, data and other tools to promote the importance of maternal and child health).

Okanogan

Activity: We will attend community coalition meetings such as Oroville Cares, Okanogan Community Coalition, Health Services Advisory group, and Okanogan Community Health Improvement (CHI) meetings.

Skagit

Activity: Participate in local and regional early learning coalitions (Children's Council and Northwest Early Learning), including serving as regional rep to First5Fundamentals

Activity: Participate in local, regional and state Help Me Grow action teams and coordination efforts.

Activity: Participate in Population Health Trust (community health advisory board) to ensure that maternal and child health is well-represented in community health improvement plan.

Activity: Convene local Prenatal to Three Network on a quarterly or so basis.

Activity: Partner with North Sound ACH to elevate MCH efforts in our region.

Activity: Coordinate with neighboring LHJs whenever possible to create synergy and expand capacity to support MCH in our region.

Activity: Build new partnerships with business community/employers and others to support MCH.

6. Monitor emerging needs and prepare for future public health emergencies. Increase emergency preparedness capacity of families including those that have children with special health care needs.

None Selected

Child Health

State Priorities	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	Promote mental wellness and resilience through increased access to behavioral health and other support services.	Optimize the health and well-being of children and adolescents, using holistic approaches
State Strategies include	Well child visits; Universal Developmental Screening; ACEs prevention; Assessment of Parent/caregiver and child health capacity, access and service effectiveness; family support, protective social norms		

Local Strategies:

1. Universal Developmental Screening: Support statewide roll-out of developmental screening data system (Strong Start).

Chelan-Douglas

Approach: Gather information about current activities related to UDS screening tools, available resources and service gaps, referral mechanisms, and sources for referral.

Activity: We will do this by meeting with the area managers of pediatric/family practice offices and childcare directors and/or surveying medical and childcare staff to assess current UDS activities, screening tools utilized, referral mechanisms etc.

Activity: We will share information about and encourage use of Strong Start as it is rolled out statewide.

Columbia

Approach: Increase the number of early learning and healthcare providers trained on developmental screening tools and a community referral system.

Activity: We will do this by promoting use Within Reach Parent Help 123 and Strong Start, Coordinating with Region Birth-Three Resources, Distributing latest version of ASQ questionnaire to daycares and community

Garfield

Activity: We will participate in the training for the system and providing information about it to families and the local medical clinic.

Grant

Activity: Reengage with the healthcare system for focused collaboration on CYSHCN

Jefferson

Activity: This is a placeholder. Could include sharing information with your local healthcare providers and parent networks.

Lincoln

Activity: We will do this by meeting with local providers at their medical team meetings, will email or do phone consultation with counseling center and schools through special ed directors so they know about UDS through Child Find.

Activity: We will use staff time to develop a brochure for families and a reference sheet for providers to promote the new Washington State UDS system Strong Start and local services such as CYSHCN, local school districts, and local healthcare and mental health providers to facilitate the knowledge base of available services and the coordination amongst providers in Lincoln County to benefit families

Mason

Activity: Share information and provide support about UDS and Strong Start to local health care providers, local early childhood partners, and parents/legal guardians.

Sea-King

Activity: The CCHP (Child Care Health Program) staff will, upon discerning UDS concerns from childcare providers, connect childcare providers with the UDS systems and supports being rolled out in King County.

Activity: Support the statewide rollout of the Strong Start data system by following. When ready, we will follow direction from DOH and contribute to educating community agencies about the Strong Start system.

Activity: The CCHP will design or distribute tools and methods for enhanced understanding of UDS resource materials that parents, guardians, and providers can easily access (such as https://www.cdc.gov/ncbddd/actearly/milestones-app.html), allowing adults the means to access UDS materials to facilitate positive outcomes from the UDS process.

Activity: Promote ParentHelp123 (https://www.parenthelp123.org/) use and other resources that facilitate UDS and follow-up after screening. Refer to the WithinReach Family Health Hotline (https://withinreachwa.org/) and Parent Trust (https://www.parenttrust.org/for-families/developmental-screenings/), which can provide assistance with resources.

Activity: Provide education and technical assistance to providers to help them understand follow-up processes and how to communicate with families and access available community resources to ensure appropriate services and supports.

Skagit

Activity: Coordinate with DOH UDS program to encourage local provider participation. When Strong Start is launched, this could include sharing information about the new data system and encouraging healthcare providers and parents/legal guardians to enter and access screening information into the system.

Whatcom

Activity: Elevate family voice and experiences in accessing preventive care and the impacts on their children and families

Activity: Inform families about the safety and importance of preventive care and motivate them to make an appointment

Activity: Work with community groups and stakeholders to address systemic racism and inequitable access to preventative care services

Activity: Promote preventive care screening and behavioral and physical wellness visits

Activity: Share information about the Strong Start data system to track developmental screenings over time.

2. Complete an inventory of current local strategies by collecting community data to capture evidence-based, emerging, and innovative policies, processes/procedures, and programs being implemented locally to strengthen family resiliency and promote healthy child development. The focus is on strategies that benefit pregnancy, infancy, young childhood, middle childhood, and caregiving/parenting. The intent is to share a completed inventory with Angie Funaiole in the Child Health Unit (formerly the Essentials for Childhood Landscape Asset Inventory Pilot Project). If you select this strategy, Angie will provide you a template to report your findings due by the end of the contract year.

None Selected.

3. Support healthy nutrition and physical activity best practices in schools, before-and after-school programs (including Safe Routes to School), early learning programs, youth community centers, and community settings accessed by children.

Garfield

Activity: We will attend school wellness council/committee with the school district. We will find out what they (and families) are interested in changing; and bring expertise on best practices to the table. We will use the models from CDC. Comprehensive School Physical Activity Programs: A Guide for Schools (cdc.gov) and Comprehensive Framework for Addressing the School Nutrition Environment and Services (cdc.gov)

Sea-King

Activity: Review childcare and early learning program menus.

Activity: Disseminate best-practice information on healthy meals for children including those resources available on the Nourished and Active in Early Learning :: Washington State Department of Health website

Activity: Disseminate best-practice information on physical activity.

Spokane

Activity: We will support early learning programs to utilize National CACFP (Child and Adult Care Food Program) Sponsors Association tools and recipes, along with WA DOH resources: Nourish and Active in Early Learning; Child and Toddler Physical Activity and Active Environments resources.

Activity: Train Early Achiever's coaches in nutrition and physical activity best practices.

Wahkiakum

Activity: Meet quarterly with school and ECEAP staff to discuss approaches to ensure adequate healthy nutrition is able to be accessed by families in the communities that may be hindered by food insecurity.

Activity: Discuss options with local food banks/pantries to ensure that families with food insecurity can access healthy, nutrient dense foods as needed. Public Health will reach out to the local food banks to set up a meeting to discuss policy and potential policy, environmental and system changes that could assist in meeting goals.

Activity: Encourage and assist outreach with community/school gardens to help provide season appropriate fresh fruits and vegetables. Also discuss with school district their policy on ensuring healthy, nutrient dense foods are available to students as well as summer and weekend food programs. Discuss policy and potential policy, environmental and system changes that could assist in meeting goals to include setting up a system for potential plans of regularly providing food to families in need to include contacting local entities (store, food banks and restaurants to name a few) to provide excess healthy foods to be placed in food boxes for families to bridge the gap.

4. Support establishing new and/or enhancing existing Safe Kids Coalitions by serving as Chief Health Strategist on coalition. Potential approaches might include strategies to reduce preventable injuries, poison prevention, and/or substance use.

None selected

5. Trauma-informed services/Adverse Childhood Experiences: Serve as Chief Health Strategist to share education about the 10 Kaiser ACEs and other adverse experiences with community partners (e.g. schools, youth serving community coalitions, juvenile justice, providers) and encourage them to provide staff training and adopt TI practices/policies. Work with own LHJ to become a trauma-informed agency by providing education to staff and developing policy to become a TI Agency.

Adams

Approach: Work closely with providers locally and in surrounding areas to increase education on ACES program and policies and ways to implement them. Encourage providers and other healthcare staff members to increase awareness and education in an effort to recognize the need for ACES practices within our community.

Activity: We will discuss ways to incorporate ACES program and policies into daily practice with local providers.

Approach: Increase the education for employees in our own agency on Trauma-Informed practice, program, and policies. Encourage communication between staff members on methods to educate providers within community.

Activity: We will continue to attend regular educational classes to increase competency in Trauma-Informed practice.

Asotin

Activity: Learn current information and resources and share with community partners serving youth.

Benton-Franklin

Activity: Implement an internal Trauma-Informed agency policy

Activity: Educate staff on integrating TI approaches into existing work

Activity: Collaborate with schools and community partners to assess needs for staff and/or community trainings around ACEs/Resilience/Trauma-Informed Approaches

Activity: Plan and implement local resilience trainings for school staff and other adult influencers, in partnership with local partners

Columbia

Approach: Assessment: Develop and implement an assessment of existing programs, organizations and coalition in the larger community that aim to prevent ACEs and promote resilience.

Activity: We will develop an assessment tool with our Public Health staff, we will administer the assessment to at least 5 community organizations.

Approach: Education: Increase the number of opportunities for LHJ staff, community services providers, and/or community members to learn about ACEs, complex trauma, brain science and resilience.

Activity: We will share knowledge of available trainings on ACEs and resilience with community partners attending Southeast Washington Alliance for Health, Coalition for Youth and Families, as well as other organizations, and we will email training opportunities to local partners.

Approach: Partner Engagement: Increase resources and coordination of services and aim to prevent ACEs and promote resilience. This may include engaging new partners and/or sectors. Efforts may include sharing information about interventions, programs, and/or coalitions.

Activity: We will invite 4 new partners and will attend our Southeast Washington Alliance for Health, Coalition for Youth and Families coalition which addresses resiliency, quarterly.

Approach: Increase resources and coordination of services that aim to prevent ACEs, promote resilience, and increase staff awareness about the 10 Kaiser ACEs.

Cowlitz

Activity: We will do this by sharing information with partners about interventions, programs and/or sharing information about ACEs at coalition meetings. Will also work to engage new partners and/or sectors with TI work.

Grays Harbor

Activity: Activity: We will continue the work of our department Trauma Informed Committee and the 3-year action plan the committee implemented. One of the goals of the committee is to identify policy, knowledge and environment changes within our department each year to promote progress toward a

Trauma-Informed approach to service delivery. This plan also includes continued training opportunities offered to staff in team meetings or as part of their individual professional growth and development plan.

Activity: Partner with other internal department programs and/or local coalitions/boards to bring training opportunities to the community about ACEs and Trauma Informed Care.

Kittitas

Activity: Working externally with the Resilience and ACEs Task Force/workgroup though the Kittitas County Health Network by attending at least 10 monthly workgroup meetings and 8 monthly Kittitas County Health Network Leadership Council meetings. Provide access to relevant data, best practices, resources, and trainings.

Approach: Work with own LHJ to become a trauma-informed agency by providing education to staff and developing policy to become a TI Agency**.**

Activity: Work with our internal KCPHD Health Equity Committee to provide technical assistance and data around health equity and trauma-informed care and ensure internal application of these principles (data/best practice sources include state-wide Community of Practice, ACEInterface, Community Resilience Initiative, Kitsap Strong)

NE Tri

Activity: Through partnership with DCYF and Strengthening Families Locally (SFL) funding was received to provide TI trainings. NETCHD will assist with coordination, organization, and providing information on trauma informed trainings for child serving agencies and community partners for development of creating “Caring Communities”. This may include local caregivers, community partners and child serving agencies, community partners. To increase resource sharing between agencies and provide a way to identify additional needed resources for our communities.

Sea-King

Activity: Conduct “grand rounds” style meetings during which community providers (health care workers, childcare providers) come together to share, build community, and collaboratively problem-solve about ACEs and trauma and to connect providers with the growing body of resources for resilience associated with the traumas of the COVID-19 pandemic, which have amplified other ACEs’ factors.

Activity: The CCHP will engage in education and planning to become a more trauma-informed program that increases its skills in attending to the intersection of inequity and trauma as that plays out in human behavior-- internal to the team’s health-services functioning as we work toward becoming a trauma informed system.

Activity: Through dialogue, interaction, and support, the CCHP will help child care providers and families to understand the importance of how ACEs and complex trauma affect children.

Activity: The CCHP will also meet regularly with providers, who in turn support families, to understand the community’s resources that can help them build resilience, coping, and capacity to deter ACEs’ harms and prevent ACEs as well.

Activity: Through established meetings and collaboration, the CCHP will engage in planning, education, and systems change to become a more trauma-informed program that increases its skills in attending to the *intersection* of inequity and trauma as that plays out in human behavior.

Snohomish

Activity: We will conduct outreach to 10 community partners to engage them in exploring becoming trauma-informed or helping them understand ACES

Activity: We will continue to offer train Snohomish Health District staff and community partners through the ACES Quarterly trainings

Spokane

Activity: We will convene SRHD Beginnings Matter program to operate as Chief Health Strategist to provide data, information, and education about how addressing the "Pair of ACEs" and using HOPE (Healthy Outcomes from Positive Experiences) science can decrease the impact of ACEs, improve resilience and pursue health equity in Spokane County.

Activity: Provide education about "pair of ACEs" and HOPE science via presentations, targeted trainings, and listserv information sharing to cross-sector community partners working with pregnant people and families with young children (0-5).

Activity: Gather information about all current local collaboratives, alliances, and task forces with a main focus on ACEs prevention and family resilience development to determine areas of emphasis, populations of focus, areas of alignment and their needs. Determine gaps, barriers, and assets for greater collaboration on prevention of ACEs.

Activity: Assess interest and readiness of organizations that focus on women and children (0-5) to engage in a county-wide effort to examine and change current policies and practices to implement HOPE science in organizations.

Activity: Identify and engage key community partners across different systems who work with pregnant people and families with young children (0-5) in a county-wide collaborative work group to evaluate current policies and practices that promote HOPE and develop resilience in families with young children (0-5). Prioritize the inclusion of partners who are not represented in other current community collaboratives and task forces focused on ACEs prevention and development of resilience in families with young children (0-5).

Activity: Promote the mitigation and prevention of ACEs by providing education on HOPE and sharing resources from "Project Pinwheel", a webpage created in conjunction with the Our kids: Our business child abuse and neglect prevention coalition. The main messaging includes information about how the community can support parents, so children grow, play and learn in safe and nurturing environments. The promotion of this upstream approach to preventing ACEs and developing resilience in families with young children (0-5) will include providing education, information about available training and opportunities to implement HOPE framework in existing work. The team will provide technical assistance in implementing HOPE in the work of the local, regional, and statewide groups we are part of.

Activity: HOPE science and Project Pinwheel will be promoted during our participation in local, regional, and statewide coalitions, tasks forces and collaboratives such as: DCYF- Strengthening Families Locally,

Better Health Together Collaborative work team meetings, The Spokane Regional Domestic Violence Coalition, the Our kids: Our business coalition meetings, Spokane Regional Birth Outcomes Task Force, and Statewide Essentials for Childhood Steering Committee.

Activity: Continue to be a bridge between Our Kids: Our Business coalition and DV Prevention Coalition and maintain the focus on the needs of mothers and children, and how the 'pair of ACEs' are creating inequities in Spokane County communities.

Activity: Work with DCYF and early learning stakeholders to identify how self-regulation and social emotional well-being can meet the new Early Achievers quality rating criteria and support systems change.

Activity: Provide support and expertise to assist Child Care Aware of Eastern Washington (CCAEW) to identify ways to integrate social emotional well-being into early learning training and coaching to support the 2022 Early Achievers Quality Improvement program.

Activity: Assess interest and common priorities in developing resilience in families with young children (0-5) within SRHD programs that focus on women and children (e.g. WIC, NFP, CYSHCN, and Opioid Treatment Program) and provide information about infusing programmatic activities with HOPE science, using health equity lens.

Activity: Review and revise the SRHD 1-2-3 Care: A Trauma-Sensitive Toolkit for Caregivers of Children with updated research findings to include HOPE science, 'Pair of ACEs", and information about healthy nutrition and physical activity' roles in building resilience in families with young children (0-5).

6. Participate in local, regional and statewide coalitions and task forces to promote the importance of maternal and child health. (e.g., Develop/use success stories, data and other tools to promote the importance of maternal and child health).

Grays Harbor

Activity: CYSHCN Coordinator and program Manager will continue participation and attendance at monthly and quarterly early learning coalition meetings (local, regional and statewide.) Participation and engagement with these groups will continue to help inform services and need for resources for local MCH programs and work.

Activity: We will also use information and resources received when providing presentations about the state of MCH to local Board of County Commissioners (at least 2x per year) and other community partners (at least 2x per year.)

Skagit

Activity: Participate in local and regional early learning coalitions (Children's Council and Northwest Early Learning), including serving as regional rep to First5Fundamentals

Activity: Participate in local, regional and state Help Me Grow action teams and coordination efforts.

Activity: Participate in Population Health Trust (community health advisory board) to ensure that maternal and child health is well-represented in community health improvement plan.

Activity: Convene local Prenatal to Three Network on a quarterly or so basis.

Activity: Partner with North Sound ACH to elevate MCH efforts in our region.

Activity: Coordinate with neighboring LHJs whenever possible to create synergy and expand capacity to support MCH in our region.

Activity: Build new partnerships with business community/employers and others to support MCH.

Spokane

Activity: We will explore interest in "Lunch and Learns" regarding child development, domestic violence prevention (including child abuse and neglect) with additional area employers - including male dominated fields. Tailor messages as appropriate.

Activity: We will continue to be involved with Our kids: Our business, our local child abuse prevention coalition. We will assist with project planning and implementation to promote the importance of maternal child health

Wahkiakum

Activity: We will participate in quarterly ACH meetings as a health department quarterly

7. Monitor emerging needs and prepare for future public health emergencies. Increase emergency preparedness capacity of families including those that have children with special health care needs.

Cowlitz

Activity: We will do this by acting as surge capacity during public health emergencies; sharing resources with CYSHCN families that include planning for emergencies.

Okanogan

Activity: We will attend local/regional North Central Accountable Communities of Health (NCACH) meetings quarterly.

Activity: We will ensure families of children with special health care needs have information regarding emergency preparedness including having a physical address on file for EMS purposes.

Whitman

Activity: Use the CHNA to look specifically for COVID related gaps in service or barriers to care in the MCH and CYSHCN community.

Adolescent Health

State Priorities	Identify and reduce barriers to quality health care	Promote mental wellness and resilience through increased access to behavioral health and other support services.	Improve the safety, health, and supportiveness of communities
State Strategies include	Well child visits, ACEs prevention, Behavioral health, Substance use, Family support, Reduce barriers to access		

Local Strategies:

1. Use evidence-based strategies to support healthy nutrition and physical activity best practices in schools, before-and after-school programs, youth community centers, and community settings accessed by adolescents and teens.

None Selected

2. Support community efforts to increase holistic health among adolescents and young adults through direct support and/or referrals to community resources.

None Selected

3. Promote use of the Bright Futures guidelines for adolescents among providers.

None Selected

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

Garfield

Activity: We will provide references and resources for general health and well-being information to the school counselors, library and local clinic for use by adolescents and young adults to help increase their understanding of navigating health systems.

Kittitas

Activity: Work with Assessment Coordinator to conduct a literature review of best practices and evidence-based strategies for supporting/increasing youth and adolescent health literacy

Activity: Connect with other education, healthcare, and community-based organizations that work with youth to share findings on health literacy interventions, collect information on current practices/interventions in place and develop regular communication plan as part of work plan (below)

Activity: Create a work plan to implement selection intervention/practice and review with DOH, work with Health Equity Committee during development

5. Promote preventive care screening and behavioral and physical wellness visits for adolescents and young adults.

None Selected

6. Support local school-based health center work.

Island

Activity: Explore potential community partners for School Based Health Clinic (SBHC) establishment.

Activity: Develop an SBHC advisory group composed of parents, Human Services, DOH, WhidbeyHealth, SeaMar, school district staff, nonprofit groups, and other stakeholders.

Activity: Review feasibility of different models, such as Rural Health Clinic (RHC) designation and Federally Qualified Health Centers (FQHC).

Activity: Review alignment of SBHC with addressing needs outlined in CHIP 2020 and ongoing needs assessment conducted by Assessment & Health Communities.

Activity: Develop a sustainable SBHC framework document in partnership with community stakeholders, working with guidance from the Washington School Based Health Care Alliance.

7. Participate in local, regional and statewide coalitions and task forces to promote the importance of maternal and child health. (e.g., Develop/use success stories, data and other tools to promote the importance of maternal and child health).

Garfield

Activity: We will attend the Pomeroy Partners meetings, and the Accountable Communities of Health Coalition.

8. Monitor emerging needs and prepare for future public health emergencies. Increase emergency preparedness capacity of families including those that have children with special health care needs.

None Selected

Washington State Action Plan Table
2021-2025 Five-Year Plan for 2024 Application

Core Principles:

- All people deserve the opportunity to thrive and achieve their highest level of health and well-being. Improving systems that serve families and children to be more equitable is a core responsibility of public health practitioners. We embrace this responsibility in our maternal and child health work. We are committed to being anti-racist and to supporting gender equity in our programs and policies.
- We value evidence-based/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

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
Women/Maternal Health					
Promote mental wellness and resilience through increased access to behavioral	Build on efforts to identify scope of impacts of substance use, including inequities, at the local and state levels. Provide training for clinical staff providing care at birthing hospitals Improve the care of infants with neonatal abstinence syndrome (NAS)	By September 30th, 2024, and in partnership with the Child Welfare Division at the Department of Children, Youth, and Families, Within Reach and the	SPM 1: Substance use during pregnancy		NOM 10: The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
health and other support services.	and neonatal opioid withdrawal syndrome (NOWS). Support efforts to address and mitigate individual and community effects of substance use.	Washington State Hospital Association, implement the state's new portal and policy for infants who are born substance exposed, including promotion of supports for the substance-affected mother/infant dyad. (Modified)			
Promote mental wellness and resilience through increased access to behavioral health and other	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	Through September 30, 2025, building from the completion of the revised maternal mortality review panel report to the Washington State Legislature, DOH staff will share the findings widely with partners and community members around the state and	SPM 2: Provider screening of pregnant women for depression		NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
support services.	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.	participate in conversations about ways to involve community members in implementing recommendations. DOH will also include applying lessons learned from the AIHC listening sessions in our work to implement the report's recommendations. (Modified) By September 2025, we will continue to review cases of maternal mortality in Washington by facilitating meetings with the Maternal Mortality Review Panel. We will provide training			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		opportunities for the panel on health equity and align our work with the CDC.			
	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.	Through September 2025, ensure 80 percent of birthing hospitals in Washington state have established processes to universally screen everyone giving birth for substance use disorders and perinatal mood and anxiety disorders as part of the Alliance for Innovation on Maternal Health (AIM) patient safety maternal mental health protocols. (Modified)			
Optimize the health	Integrate MCH COVID communications into the DOH COVID team	By Sept 2023, maintain	NPM 1: Percent of women, ages	ESM 1.1: Percent of women reporting in PRAMS that they had a preventive medical visit in the prior year.	

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.	communications and maintain current guidance documents and communications. Support the “One Vax Two Lives” campaign to dispel misinformation, and address fears some expecting families may have about COVID vaccines. This campaign is a partnership with The University of Washington‘s Center for an Informed Public and the UW Medicine‘s Department of OB-GYN. Support access to and communication clarity around emerging guidance for COVID-19 vaccination during pregnancy and lactation.	communications and guidance documents for COVID and pregnancy/birth/post partum/children to reflect up to date COVID data and understanding, to include racial disparity considerations. The Objective has been discontinued. DOH materials were reviewed by the COVID in pregnancy community group and distributed to our partners for review and use.	18 through 44, with a preventive medical visit in the past year	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 23: Teen birth rate, ages 15 through 19, per 1,000 females	
	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.	By December 2022, distribute health promotion materials in relation to Senate Bill 6128 passed by			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	Promote standardized depression, anxiety, and substance use screening across the life course. Address the need for more services, support, providers, and insurance coverage, particularly in rural communities and remote areas.	the Washington State Legislature to expand Medicaid coverage to one year postpartum. This objective has been completed and is no longer in the narrative.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	Support active engagement by birthing hospitals, licensed birth centers, and perinatal providers in quality improvement efforts that reduce the leading causes of maternal mortality and morbidity. Support healthy pregnancies, births, and maternal recovery; address inequities and prevent maternal mortality and morbidity. Support women during the "fourth trimester"; enhance postpartum care to allow providers to check in with mothers about their mental health and other medical issues.	Through September 2025, 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. (Modified)			
	Support access to prenatal genetic services. Provide technical assistance by offering all prenatal genetic providers paid subscription access to the Teratogen Information System (TERIS) database.	By December 2023, support access to prenatal genetic services and technical assistance and disseminate data and trends on prenatal genetic			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		services to stakeholders.			
	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.	Through September 30, 2025, 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. (Modified)			
	Support interventions to address suicide ideation among pregnant and parenting people.	By December 2022, collaborate with tribal partners to hold a listening session that includes			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	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.	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. This objective has been completed Through September 2025, support implementation of community birth			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	Implement trauma-informed services into community services, health care systems, and the public sector.	worker projects that address racial disparities in birth outcomes. (Modified) Through September 2025, continue to collaborate with Tribal partners to meet the needs of Tribal communities impacted by maternal mortality through additional listening sessions and data quality improvement. (Modified)			
Perinatal/Infant Health					
Enhance and maintain health systems to	Support the "One Vax Two Lives" campaign to dispel misinformation, and address fears some expecting families may have about COVID vaccines. This campaign is a partnership with The	By September 30, 2023, support infant vaccinations as outlined by the CDC, and continue COVID-	SPM 3: Universal developmental screening system participation		

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course.	University of Washington's Center for an Informed Public and the UW Medicine's Department of OB-GYN. Support access to and communication clarity around emerging guidance for COVID-19 vaccination during pregnancy and lactation. Support and promote bidirectional referral and linkage systems at the local, regional, and statewide levels. Collaborate with Office of Immunization on infant vaccine promotional messaging to providers and families.	19 vaccination campaign efforts for pregnant people through providers, managed care organizations, pharmacies, and local health jurisdictions. This objective has been completed and is no longer in the narrative.			
	Support access to pediatric genetic services. Conduct data analyses and create summary reports for birth hospitals and midwifery clinics on Critical Congenital Heart Disease (CCHD) diagnoses data.	By December 2023, support access to pediatric genetic services and disseminate data and trends on clinical genetic services and CCHD hospital summary reports to stakeholders.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	Support and promote bidirectional referral and linkage systems at the local, regional, and statewide levels.	By June 30, 2023, secure funding through 2023 legislative session to fully support the EHDDI program's data system, referral services, and outreach activities to ensure quality, family-centered newborn hearing screening, diagnostic, and early support services are provided in Washington. This objective has been completed.			
	Identify and develop methods to monitor systems and data gaps and improvements needed in preventive care, early screening, and referral.	By December 31, 2025, complete a statewide gap analysis for perinatal substance use services, and align			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		this analysis with county-level maternal and infant data.			
	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.	By February 1, 2024, launch statewide roll-out of implementation phase of new developmental screening program, working with early childhood partners as part of a statewide effort to increase developmental screening rates and connection to responsive services. (Modified)			
Improve infant and perinatal health outcomes	Promote breastfeeding and lactation support programs and services. Promote home visiting to provide support to families where they are.	Annually, partner with at least eight local health jurisdictions to offer perinatal home	NPM 4: A. Percent of infants who are ever breastfed; B. Percent of		NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
and reduce inequities that result in infant morbidity and mortality.	Implement trauma-informed services into community services, health care systems, and the public sector. Implement and promote fatherhood inclusion opportunities and support resources.	visitation services to low-income women in local communities, supporting well-newborn visits, on-schedule vaccination, and breastfeeding initiation/sustenance	infants breastfed exclusively through 6 months		NOM 9.5: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births
	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	Continue to promote awareness and training opportunities to health care providers on provider bias and disparities on an ongoing basis.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	providers across Washington state and members of the Maternal Mortality Review Panel.				
	Provide training for birthing hospital clinical staff about the policy definitions for infants exposed to substances and the online referral process for notification and wrap around services. Integrate motivation interviewing and reflective listening training into hospital trainings to facilitate trauma-informed communication about notification and reporting requirements. Promote and facilitate education for health care professionals and systems regarding stigma, cultural sensitivity, and implicit bias in perinatal health care systems.	By September 20, 2025, in partnership with Child Protective Services at the Department of Children, Youth, and Families and Help Me Grow, pilot diagnostic definitions for neonatal abstinence syndrome in two counties, develop and launch training materials for statewide implementation. finalize piloting the diagnostic definition for neonatal abstinence syndrome as a central component to			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		improve care of substance-affected newborns in Yakima and Pierce counties.			
	Identify and develop methods to monitor systems and data gaps and improvements needed. Develop monitoring systems to identify leading causes of infant mortality/morbidity.	By December 31, 2023, complete the development of a new data system for the Birth Defects Surveillance System (BDSS), which will combine birth defects reporting data from providers and facilities with existing information from vital statistics, including birth, death, fetal death, and hospital discharge data.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
Child Health					
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.	Provide leadership, staffing, and funding support for the ongoing development and implementation of the statewide Help Me Grow WA system and related collaborative statewide initiatives that include explicit focus on connecting families to developmental screening and resources. Communicate developmental screening and developmental milestones information through a variety of social media and virtual/live modalities. Incorporate Vroom™ brain building tips and other child development resources in Watch Me Grow Washington mailings.	By September 30, 2025, increase the number and proportion of families with children (ages 0-3) who receive information about developmental screening, developmental milestones, and resources to support healthy child development.	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	ESM 6.4 # of unique children receiving developmental screening in the past 12 months through Help Me Grow WA	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 NOM 22.1: Percent of children, ages 19 through 35 months, who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) NOM XXX: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) NOM XXX: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
	Promote utilization of Strong Start Universal Developmental Screening data system with all health care	By September 30, 2023 and ongoing, increase the number of pediatric health			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	provider practices serving young children in WA State Promote Strong Start with state and local partners that work closely with families of children birth through age five, and provide training and technical assistance, as well as information about resources and supports related to early childhood development. Continue coordination between Strong Start and Help Me Grow WA to ensure alignment of developmental screening data systems and services. Encourage the coordination of pediatric screening efforts, results, and referrals among clinical care settings, medical homes, child-care settings, schools, and other organizations.	care practices who are using the Strong Start statewide universal developmental screening data system as part of their practice.			
	Explore options to improve availability and usability of Medicaid data provided	By September 30, 2024, identify			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	through HCA-DOH mutual data share agreement. Explore data agreements with other insurers or other sources to track developmental screening rates. Incorporate data from Strong Start UDS data system.	improved methods to track the proportion of children who are receiving timely developmental screenings			
	Promote routine well-child visits and recommended preventive care in early and middle childhood (birth to age 11). Activities include Patient/Parent education (communications campaign, social media posts, school flyers, public education ads, etc), and provider education (webinars, communications, clinic collaborations, etc.), Partner with pediatric and primary care clinic systems to engage over-due or unestablished members/children into the practice to receive well-child visits. Establish partnerships with early learning focused organizations and	Through September 2025, increase the proportion of children who receive timely well-child visits and are up-to-date on recommended vaccination			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	school-based health centers to identify and deploy collaborative activities to improve well-child visits.				
Promote mental wellness and resilience through increased access to behavioral health and other	Provide state leadership and coordination for development of an integrated and comprehensive early childhood system of services and supports through the Early Childhood Comprehensive System: Health Systems Integration project and other related state initiatives, such as Essentials for Childhood, State Early Learning Coordination Plan, and Pritzker's Prenatal-to-3 Children's Initiative.	Through September 2025, implement the early childhood comprehensive systems strategic plan in collaboration with state partners and families	SPM 6: Social and emotional readiness among kindergarteners		NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
support services.	Identify and implement effective, equity focused strategies to engage parents, caregivers and those with lived experiences in decisions about the development and improvement of the early childhood system of services and support. Collaborate with state partners to increase health care provider engagement in state coordinated access and referral network through state Help Me Grow and local efforts. Work with families and state partners to identify and address ongoing structural barriers within state systems that impact the ability of families to access supports for themselves and their children. Prioritize efforts to eliminate barriers for families who identify as Black, Indigenous, People of Color, immigrant, or LBGTQ+ members; families of children with special health care needs; families who live in rural or				

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	geographically isolated areas; and families who experience trauma of parental incarceration, child welfare system involvement, homelessness, substance use disorder and mental illness, and other adverse experience. Support the development and implementation of anti-racist, trauma-informed and healing-centered policies and practices within health care and other service settings serving children and families.				
	Partner with pediatric and family medicine organizations to promote focus on strengthening parent-child relational health in well-child visits. Support training for clinical and community health workforce on early relational health concepts, promotion of parent and child social-emotional skill development. Promote routine use of social determinants of health screening tools	Through September 2025, increase the number of health care providers who have received training and are incorporating focus on early relational health and screening for social and economic needs in routine care.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	such as evidence-based Safe Environment for Every Kid (SEEK) or Survey of Well-being of Young Children (SWYC) tool in pediatric health care settings, with referrals to resources through Help Me Grow WA or local coordinated access and referral programs.				
Promote mental wellness and resilience through increased access to behavioral health and other support services.	Participate in state efforts to expand access to infant, early childhood and child behavioral health services and supports, including the efforts of the state Child and Youth Behavioral Health Work Group. Promote standardized depression, anxiety, and substance use screening for children and their parents per the AAP Bright Futures, school-based health center models, and specific needs of communities. Support interventions to address suicide ideation among children, especially	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.	SPM 5: Ease of receiving mental health treatment or counseling		NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	among children who are involved in child welfare systems, LGBTQ+, BIPOC. Identify and support evidence-based practices to prevent and reduce the harmful impacts of bullying and social media on children, especially in the middle childhood period. Support efforts to address and mitigate effects of parental substance use on children and prevent early initiation in children. Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges. Increase knowledge, visibility of and access to parent and child behavioral health resources and services available locally. Promote linkages to services that meet unique client or subpopulation gaps in care. Work with HCA and other state partners to identify ways to increase diversity of child and family behavioral health service providers in order to better				

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	serve unique needs of BIPOC, immigrant, rural, and other populations Support the development and implementation of anti-racist, trauma-informed and healing-centered policies and practices within behavioral health, health care, and other service settings serving children and families. Build networks and resources in communities to enable and enhance community and peer support.				
	Participate in state efforts to expand access to infant, early childhood and child behavioral health services and supports, including the efforts of the state Child and Youth Behavioral Health Work Group. Promote standardized depression, anxiety, and substance use screening for children and their parents per the AAP Bright Futures, school-based health	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.	SPM 5: Ease of receiving mental health treatment or counseling		

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	center models, and specific needs of communities. Support interventions to address suicide ideation among children, especially among children who are involved in child welfare systems, LGBTQIAS+, Black, Indigenous, and People of Color. Identify and support evidence-based practices to prevent and reduce the harmful impacts of bullying and social media on children, especially in the middle childhood period. Support efforts to address and mitigate effects of parental substance use on children and prevent early initiation in children. Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges. Increase knowledge, visibility of and access to parent and child behavioral health resources and services available locally. Promote linkages to services				

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	that meet unique client or subpopulation gaps in care. Work with HCA and other state partners to identify ways to increase diversity of child and family behavioral health service providers in order to better serve unique needs of Black, Indigenous, People of Color, immigrant, rural, and other populations				
Optimize the health and well-being of children and adolescents, using holistic approaches.	Collaborate with Essentials for Childhood and other partners to promote state leadership, commitment, and investment in the vision of all children in WA State thriving in safe, stable, nurturing relationships and environments. Adopt and share concepts, tools, trainings, and practices aligned with the Healthy Outcomes from Positive Experiences (HOPE) Framework in state Essentials for Childhood initiative and other settings.	By September 2025, increase community-based primary prevention programs, practices, policies, and systems to reduce childhood adversity and promote child and family well-being	SPM 12 Family Resilience metrics (National Survey of Children's Health) (New measure)		NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	Promote evidence-informed programs and policies to prevent and reduce adverse childhood experiences (ACEs) and promote positive childhood experiences (PCEs) statewide through local health jurisdictions, community-based home visiting programs, schools and early learning settings, and other prevention programs sponsored by DOH, HCA and DCYF. Promote school- and community-based health strategies for early and middle childhood to increase accessibility of services for children where they are, informed by parents of diverse races/ethnicities. Support community-led resilience building initiatives in communities with higher rates of child maltreatment and other adversity. Connect with DOH Health Equity Zones and other related initiatives. Advocate for investment in prevention services for parents. Implement and				

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	promote fatherhood inclusion opportunities and support resources. Promote inclusion of additional people taking parenting roles, such as foster parents, grandparents, kinship care. Incorporate learnings from the Inventory of What Works (to reduce child maltreatment/increase family resilience) Project for state and local prevention planning				
	Work with EfC partners to identify ongoing priorities and resources, and the most appropriate structure to support ongoing collaboration.	By October 1, 2023 and ongoing, develop a sustainability plan to continue progress on strategies and actions identified in collaboration with Essentials for Childhood partners. (Modified)			
	Determine scope and scale of positive community norms campaign.	By March 31, 2024, develop a positive community norms campaign or			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	Develop and test messaging, identify message dissemination strategies to support related areas of interest (e.g., ACEs, trauma-informed/healing centered services). Coordinate campaign development and implementation strategies with EfC partners and parents representing diverse communities.	educational awareness campaign focused on community support for children and families. (Modified)			
	Collaborate with EfC partners and statewide initiatives (i.e., Governor's Dismantling Poverty Strategic Plan) to expand access to economic and concrete supports, through development and implementation of evidence-based policies, such as guaranteed basic income, and simplification of enrollment in state benefits programs. Use a racial equity lens to prioritize economic stability strategies that address economic inequities	By September 2025, advance program, policy, and system changes that increase the proportion of families with children who have sufficient household income plus concrete supports to meet basic needs.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	experienced by Black, Indigenous, and People of Color children and families. Participate in statewide efforts to expand access to affordable, high-quality child-care and evidence-based home visiting as strategies to support family financial well-being, reduce family stress, and promote healthy child development. Continue work with state and local partners to improve access to and navigation of family supports and services (including economic supports) through development of state and local coordinated access and referral networks (Help Me Grow WA and related local efforts)				
	Work with Surveillance and Evaluation section and other partners to identify valid and reliable measures for ACEs/PCEs incidence and promising strategies at the state and community levels.	By June 30, 2024, develop an approach to measure and monitor community contextual resilience/communit			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	Engage with academic partners to research potential community resilience questions, possible inclusion in existing survey tools, or other approaches to measurement. Pursue funding sources to implement recommended approach. Define future data needs to measure child and family health and well-being. Support current data collection activities in this population, such as the oral health basic screening survey. Advocate for additional resources to expand availability of child health and well-being data, such as through state roll-out of the Child Wellness Survey.	y factors that reduce or mitigate childhood adversity and support positive child and family well-being outcomes. (Modified)			
	Collaborate with other DOH sections, units, and state/local partners to identify existing data focused on middle childhood health. Develop and implement methods to assess current state and local assets and identify gaps and opportunities related to middle childhood health.	By September 30, 2024, launch a communications campaign focused on supporting middle childhood mental well-being (ages 6-11 years), including addressing impacts of			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	Identify and support evidence-based practices to prevent and reduce the harmful impacts of bullying and social media on children Conduct research on need for and feasibility of communications strategy related to social media and bullying in middle childhood	social media use and bullying. (Modified)			
	Facilitate coordination and shared learning among Local Health Jurisdiction Child Death Review programs Provide technical assistance to local Child Death Review (CDR) teams Develop and implement processes for reviewing local CDR findings and creating recommendations for addressing preventable factors contributing to child deaths.	Through September 2025 and beyond, establish a comprehensive state Child Fatality Review Program to identify preventable factors contributing to child deaths, develop recommendations for addressing these factors, and create state and local prevention plans. (New)	*Potential SPM: Preventable child deaths (TBD)*		

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
Adolescent Health					
Promote mental wellness and resilience through increased access to behavioral health and other support services.	Improve the knowledge and ability of health care professionals to deliver comprehensive evidence-based/informed services, including integrated mental health and chemical dependency screening and interventions for adolescents and young adults. Promote standardized depression, anxiety, and substance use screening that are adolescent and young adult-friendly.	By September 30, 2023, conduct an Adolescent Health Provider needs assessment to learn more about provider experiences with behavioral health screenings and risk assessments; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.	SPM 7: Percentage of 10th grade students who have an adult to talk to when they feel sad or hopeless		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

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	Take action to reduce stigma surrounding adolescent and young adult behavioral health conditions and implement trauma-informed services specific to adolescents and young adults in community services and health care systems.	By September 30, 2023, conduct an Adolescent Health needs assessment among youth to learn more about adolescent experiences with medical and behavioral health care; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.			
	Expand access to and the quality of behavioral health services in SBHCs.	By September 30, 2022, award nine or more grants to SBHCs for behavioral health services. This objective has been completed.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		By September 30, 2023, partner with youth volunteers to develop and implement an adolescent behavioral health awareness campaign using social media.			
		Through September 30, 2025, provide accessible trainings for SBHC providers on trauma informed care, adolescent friendly services, and discussing sensitive topics. This objective has been completed. Through September 2025, implement efforts to expand trainings to			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		additional adolescent and young adult friendly providers.			
	Support interventions to address suicide ideation among youth, especially among those marginalized by mainstream society.	Through September 30, 2022, discuss mental and behavioral health with the Youth Advisory Council to learn more about their thoughts, ideas and recommendations for behavioral health needs and gaps, including stigma around BH care and suicide prevention. This objective has been completed.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		Through September 30, 2025, identify/develop behavioral health interventions for young people based on the ideas and recommendations of the Youth Advisory Council.			
Promote mental wellness and resilience through increased access to behavioral health and other support services.	Support efforts to address and mitigate individual and community effects of substance use among adolescents and young adults.	By September 30, 2025, increase the number of school-based health centers with licensed mental health services by 5 percent. By September 30, 2023, hold at least 10 Youth Advisory Council meetings, where behavioral and mental health care – including substance	SPM 8: Percentage of 10th grade students who report having used alcohol in the past 30 days		

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		use among youth– are discussed.			
	Build on efforts to identify scope of impacts of substance use, including inequities among adolescents and young adults from priority populations.	By September 30, 2022, collaborate with internal and external partners (including OSPI and S/E) to identify strengths and gaps in data, and define strategies to address them. This objective has been completed. By September 30, 2023, provide funding to support health campaigns in SBHCs that promote awareness/reduce stigma around adolescent substance use.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
Identify and reduce barriers to quality health care.	In collaboration with payers and health coverage organizations, understand and mitigate issues related to financial eligibility for health care and other support services. Through partnerships, understand and mitigate issues related to financial eligibility for health care and other support services for adolescents and young adults.	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.			NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza 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 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
		By September 30, 2023, have a sustainable comprehensive sexual health network focused on youth from			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		historically underserved communities.			
	Conduct needs assessment to identify existing strengths and gaps in data, as well as top barriers for adolescents and young adults in seeking health care services.	By September 30, 2023, conduct an Adolescent Health needs assessment to learn more about adolescent experiences with health care; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.			
	Ensure all adolescents and young adults, regardless of race, ethnicity, sexual orientation, and gender identity, have a full range of education, access, and	By September 30, 2023, discuss key health topics with the Youth Advisory Council to learn more			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	ability to utilize health services that meet their individual needs.	about their thoughts, ideas and recommendations for health needs and gaps. By September 30, 2023, identify/develop strategies and interventions to increase access to healthcare services for young people that are based on the ideas and recommendations of the Youth Advisory Council.			
	Support and enhance efforts to increase health literacy among adolescents and young adults.	By September 30, 2025, partner with youth volunteers to develop and implement an adolescent health promotional			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		campaign using social media.			
Improve the safety, health, and supportive ness of communiti es.	Support violence prevention efforts and promote healthy relationships among adolescents and young adults. Align violence prevention efforts with partners, including DOH Injury and Violence Prevention and the Office of the Superintendent of Public Instruction (OSPI)	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).	SPM 9: Adolescents reporting at least one adult mentor		NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
		By September 30, 2025, continue to work to align violence prevention efforts with partners, including DOH Injury and Violence Prevention and the			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		Office of the Superintendent of Public Instruction (OSPI)			
		By September 30, 2025, continue to promote resources and information about, and support projects that promote healthy relationships for young people.			
	Build networks and resources in communities to enable and enhance community and peer support.	By September 30, 2025, continue to participate in OSPI's monthly School Safety and Student Wellbeing Workgroup to align efforts with agency partners.			
Optimize the health and well-	Include adolescents in this work through strategies such as building and supporting a youth advisory council and	By September 30, 2022, form youth advisory council and	NPM 10: Percent of adolescents, ages 12 through	ESM 10.1: Increase the percentage of	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
being of children and adolescents, using holistic approaches.	identify other meaningful ways to engage the population to be served.	hold at least one initial meeting and by September 30, 2023 discuss adolescent well visits and adolescent and young adult care and services.	17, with a preventive medical visit in the past year	10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year	NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
		By September 30, 2023, conduct an Adolescent Health needs assessment to learn more about adolescent experiences with adolescent and young adult well visits, and transition care; by September 30, 2024, follow up on the needs assessment with recommendations			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		and actions for improvement.			
	Collaborate with internal and external partners to identify and implement solutions that support accessible, affordable, and quality childcare, including care that meet the needs of families with CYSHCN.	By September 30, 2023, partner with the Washington School Based Health Alliance and the Health Systems Transformation Team to present information about School-Based Health Centers, and their importance in improving access to health care and well visits for adolescents.			
	Promote school-based health strategies to serve adolescent populations where they are.	By September 30, 2022, award grants to plan, start, and improve school-based health centers throughout			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
		Washington, primarily in communities that have been historically underserved. This objective has been completed			
Children and Youth with Special Health Care Needs					
	Support access to clinical genetic services.	By December 2023, support access to clinical genetic services, and clinical genetic travel clinics to rural and underserved areas.			
Identify and reduce barriers to needed services and supports for children and youth	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.	Through September 2025, explore opportunities to work with the Community Health Worker (CHW) program to increase CHW knowledge of developmental screening and	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	ESM 11.1: Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home	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

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
with special health care needs and their families.		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.	NPM 15: Percent of children, ages 0 through 17, who are continuously and adequately insured	to their patients ESM 15.1: Increase the percentage of CYSHCN who report having insurance when receiving services	NOM 25: Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year
	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.	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. This objective has been completed.			

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
	Provide targeted subject matter expertise to contractors and providers, including CYSHCN Coordinators, on areas of expertise such as complex nutrition for CYSHCN, children and youth with clinical and behavioral complexity, including autism, navigating state systems and policy, care coordination, family navigation, and community referral systems and clinical linkages. Identify and develop methods to establish baseline data on CYSHCN, systems of care, gaps, and barriers to equitable, quality care. Make data accessible via a CYSHCN dashboard and other dissemination efforts. Utilize data to identify referral opportunities and strategies, and community needs for local health care resources and equitable service delivery.	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.			

	Provide services to CYSHCN and family members of CYSHCN so they can be trained, engaged, supported, and involved at all levels of program planning and implementation of services for CYSHCN. Implement and promote inclusion opportunities and support resources for fatherhood, foster parents, grandparents, kinship care. Partner with the Washington State Leadership Initiative collaborative and community-based organizations to elevate family voices and provide connections so family voices can effectively influence the development of systems and services for CYSHCN. Promote and facilitate successful transitions including transition from hospital to home, from Birth to 3 into school and community-based services, and from pediatric to adult specialty services. Through partnerships, address the need for improved access to affordable services, and increased availability of CYSHCN service providers, quality healthcare, access to insurance, and	By September 30, 2025, increase the percentage of CYSHCN ages 0-17 who receive care in a well-functioning system by 5 percent.			

	adequate health care financing, particularly in rural communities and remote areas regardless of language spoken, gender identity, race and ethnicity, immigration status, or insurance status of families. Through partnerships, facilitate innovative programming and technology solutions such as telehealth and remote services to address gaps in rural and remote areas and other barriers to access to care. Enhance and maintain health systems and improve financing options to improve care coordination and family navigation.				

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or -Informed Strategy Measures	National Outcome Measures
Promote mental wellness and resilience through increased access to behavioral health and other support services.	Take action to reduce stigma surrounding behavioral health, treatment and related challenges. Support interventions to address suicide ideation among CYSHCN. Identify opportunities to infuse trauma-informed care into working with CYSHCN. Collaborate with surveillance and epidemiology Healthy Youth Survey leads to advocate for including questions about special health care needs in all Healthy Youth Surveys. Identify and disseminate data for analysis on risk of suicide ideation for CYSHCN, including focus on youth with autism and other developmental disabilities. In the evidence base, increase representation of youth with disabilities as a complex disparate group with a high intersectionality with other known populations that experience higher risk factors.	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.	SPM 10: Suicide ideation among youth with special health care needs		