



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Washington**

**Application for 2013
Annual Report for 2011**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

To obtain a copy of the Assurances and Certifications, contact:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

An attachment is included in this section. ID - Table of Contents

E. Public Input

*/2012/Please find attached to the Table of Contents the List of Acronyms (Appendix 2)//2012//
/2013/Please find attached to the Table of Contents the List of Acronyms. //2013//*

The Office of Maternal and Child Health (OMCH) has a policy of seeking ongoing input on priorities and programs from partners and stakeholders. We do this through advisory groups; workgroups; direct meetings with partners; surveying parents, providers and community organizations; program specific websites and email boxes; focus groups and working with parent organizations.

The Children with Special Health Care Needs (CSHCN) section convenes the CSHCN Communication Network of contractors, other state and local agencies, parent groups, and others. Network meetings are a statewide forum to inform partners and solicit stakeholder input on programs and policies and to collectively solve access issues.

The autism and epilepsy state implementation grants have advisory groups. The Epilepsy Partnership Committee is helping develop a plan to sustain work of the epilepsy project. The Combating Autism Advisory Council oversees a Community Asset Mapping Project to survey parents and others in several communities about local resources for children with developmental

delays like autism. The work helps communities ensure these children get appropriate resources and services in a coordinated, efficient, and timely manner. CSHCN partners are exploring internet avenues to get input from youth with autism and epilepsy.

/2013/The epilepsy grant ended in 2010, the autism grant ends August 2012. We continue to work with partners to sustain work that began through these grants. Gathering input from youth with autism and epilepsy is difficult. While we have not yet found a reliable way to do this, we continue to explore possibilities.//2013//

The CSHCN section surveyed CSHCN coordinators from the local health jurisdiction (LHJs) about data they collect with the Child Health Intake Form during the intake process for CSHCN. The section met with its contractors to gather input and to improve website utilization. Staff regularly monitor user comments in the input sections of the CSHCN Program, Autism, and Epilepsy websites.

The CSHCN section contracts with Parent to Parent (P2P) and Fathers Network (FN), non-profit support and information programs for families with children with special health care needs, to promote culturally competent family/professional partnerships and to increase parent involvement in planning and policy development. P2P and FN actively involve parents and families in decision making, improving systems of care, and leadership training.

/2013/CYSHCN also contracts with Family to Family for the same purpose.//2013//

The CSHCN section employs a parent of a child with special health care needs as a family involvement coordinator. This individual works with staff on all CSHCN issues and actively facilitates family consultation and participation with OMCH and at the local, regional, and state levels. More detail on this position is in Section III D, Other MCH Capacity. We take steps to reduce barriers like child care and travel expenses to parents' ability to provide input.

Early Childhood Comprehensive Systems periodically does a formal evaluation, surveying stakeholders at the local, regional and statewide levels. The program also gives and receives input through the state's Early Learning Plan website and in direct meetings with early learning stakeholders.

The Maternal, Infant, Child, and Adolescent Health (MICAH) section assists Medicaid in administering the First Steps Maternity Support Services program (MSS). MICAH gathers input from MSS providers through a provider advisory group, discipline specific clinical workgroups, and an email mailbox for providers and clients. MICAH, Medicaid, and MSS providers share this feedback.

To inform OMCH Mental Health activities, MICAH staff participates in a several partnership groups. One group, the Mental Health Transformation Workgroup, regularly gathers input from local governments, community agencies and other stakeholders.

MICAH's perinatal work is informed by a Perinatal Advisory Committee (PAC) which has a variety of perinatal health care providers, professional organizations, and consumer groups. PAC prioritizes statewide perinatal concerns and makes recommendations to its members and DOH. The Perinatal Regional Network (PRN) Coordinators on the PAC work regionally to coordinate statewide projects. MICAH exchanges input with the PRNs by regular meetings, email and telephone.

The Linking Actions for Unmet Needs in Children's Health project (LAUNCH) gathers community input from the Project LAUNCH Young Child Wellness Council, representing key child serving programs, and from service providers. The local LAUNCH program shares this input with MICAH so it can inform program direction.

MICAH uses statewide focus groups for input from youth and adults on teen pregnancy prevention efforts. The goal is to get input on a specific topic, such as developing media literacy

curricula or a media campaign.

//2013/We continue to use focus groups and stakeholders to gather input from youth and adults on teen pregnancy and teen parenting. Our Pregnant and Parenting Teens and Women (PPTW) project and PREP (Personal Responsibility Education Program) focus on supporting pregnant and parenting teens, and providing evidence-based comprehensive sexual health education. We also use surveys to gather input from youth.//2013//

In 2009, the state budget crisis led the Governor to disband the State Genetics Advisory Committee, which gave broad input on genetics services. OMCH's Genetics Services staff now uses the Western States Genetic Services Collaborative for input on its programs.

The CHILD Profile Advisory Group includes parents, state agencies, professional associations, LHJs, the state immunization coalition, and health plans. It gives DOH input for decision making on CHILD Profile policy and planning activities. OMCH uses input from a satisfaction survey of parents receiving health promotion mailings to improve the mailings.

The Vaccine Advisory Committee, mostly physicians from a wide range of specialties, makes recommendations to DOH on interventions to control preventable diseases.

Staff and managers from across MCH meet quarterly with the LHJ staff, managers and health directors to share information and conduct strategic planning.

OMCH posted the draft 2011 Block Grant application/2009 report and 2010 Needs Assessment to its website for public input in mid-July, 2010. We notified over 400 people from multiple stakeholder groups, including several parents of CSHCN, seeking their input. We incorporated some comments into the final documents. Others will be considered for future applications. We will post the final documents on our website after submission to HRSA in September 2010.

//2012/The draft copy of the 2012 Block Grant application/2010 Report was posted on the DOH website for public input from mid-June through September 12th. We notified multiple stakeholder groups via e-mail to let them know the application was posted. For most key partner agencies our e-mail invitation went to multiple key staff within the agency. We received feedback from two parents of special health care needs. One parent questioned why the family mentoring program she had participated in had not been included in the MCH block grant application, and the other parent wondered why she had not been included in the e-mail distribution list to whom the e-mail soliciting public input, had been sent. She is now included in the e-mail distribution list. Appendix 6 includes both the break down of the key stakeholders that were notified regarding the BG posting as well as a list of stakeholders who were directly notified about the reorganization. //2012//

//2013/The draft copy of sections of the 2013 Block Grant application/2011 Report was posted on the DOH website for public input from mid-June through September 10st. We notified multiple stakeholder groups via e-mail to let them know the application was posted, a total of 1,511 stakeholders were contacted. The organization types are included in the attachemnt to this section. Feedback has been received from several parents, their comments were disctributed to the OHC sections for follow up. For most key partner agencies our e-mail invitation went to multiple key staff within the agency. Further, the OHC state plan which is in process of being developed was distributed to all MCH stakeholders and input sought through a feedback form and follow-up was conducted by the OHC statewide HUB system. Additionally, input was sought from stakeholders throughout the year and examples are included.

The Washington State School Sealant Guidelines were updated in partnership with the Office of the Superintendent of Public Instruction (OSPI), University of Washington, Community College dental hygiene professors, local oral health programs and mobile dental providers, professional licensing staff, dental professionals, and various national oral health experts. The process allowed partners to provide input and raised their

awareness of the online guidelines. These guidelines provide local public health, schools and providers information on how to establish school sealant programs.

Healthy Eating Active Living (HEAL) program works with UW to maintain the Partners in Action newsletter and website. UW conducts an annual survey of partners to assess activities and needs.

The tobacco program has an opportunity for people to make online complaints about violations of the secondhand smoke law at <http://www.smokefreewashington.com/laws/registercomplaint.php>. The LHJ's were surveyed and their input is summarized in the SOW attachment. See attachment to this section.//2013//.

An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2013/ /Needs Assessment Update

A. Changes in population strengths and needs

The economy in Washington continues to struggle, with a depressed real estate market, housing foreclosures, rising fuel prices and unemployment strongly impacting families. As the state's minority populations continue to grow, Hispanics and Native Hawaiian/Pacific Islanders grow the fastest, and increases in health disparities and poor health outcomes may result. Also, access to higher education is limited due to tuition increases. On a positive note, adolescent birth and pregnancy rates continue to decline. We continue to have some of the best birth outcomes in the nation, though there are ethnic and racial disparities, especially among Native American/Alaska Natives and African Americans.

B. Changes in State MCH or system capacity

We continue to strengthen the organizational structure which in turn increases the capacity to address the needs of the MCH population. Since the last Block Grant application the Children with Special Health Care Needs Program (CSHCN) has transitioned from one section to another.

Additionally, the Maternal, Infant and Child Home Visiting (MIECHV) Program housed out of the Department of Early Learning (DEL), received a 3 year expansion grant this year and will expand evidence-based home visiting to 20 of the highest risk communities identified in the Washington State home visiting needs assessment. We continue to play a strong role in providing data and systems coordination. The Departments of Health, Early Learning, and Social and Health Services continue to serve as a governing council for the MIECHV program.

The Washington State Early Learning Plan continues to be a driving force for the development of a comprehensive, coordinated, effective, measureable, and accessible early learning system. There are thirty-six priorities in the ten year plan. Every year priorities are identified to focus on. Fourteen priorities from the plan have been identified as a focus through 2013. DEL, Office of Superintendent of Public Instruction and the public private partnership, Thrive by Five Washington are leading this work in collaboration with the DOH and Department of Social and Health Services. Washington State received a Race to the Top grant and the previously mentioned MIECHV expansion grant which will help to further our early learning systems work.

One of the fourteen priorities added this year in the Early Learning Plan is Universal Developmental Screening for infants and children. The Department of Health with the Developmental Screening Partnership Committee, including over 70 members, is taking the lead on advancing this priority. Washington is working to include both early learning and health systems in our developmental screening system. An accomplishment this year is the addition of developmental screening to the strategic priorities of the Early Learning Plan for 2012 -2013.

Through a grant from federal Office of Adolescent Health, we have collaborated with OSPI to develop a standardized curriculum framework for pregnant and parenting teens. The update meets state and national standards. The curriculum is taught in several schools within 13 high risk counties.

We are developing systems and improving services for teens, their families and community providers to improve support across systems for pregnant and parenting teens. We have launched a website tailored to pregnant and parenting teens. The website educates and provides information about resources for pregnant and parenting teens.

Through a grant from Maternal and Child Health Bureau, we developed an outreach campaign for low income pregnant women. The campaign directs women to the WithinReach toll free line or ParentHelp123 website for information, resources and referral. This grant also helped to publicize Text4Baby and we saw a significant increase in the number of women in our state taking part in that campaign. The same grant has allowed us to provide better support to victims of domestic violence, sexual assault, and stalking, resulting from a new collaboration with the state Attorney General's Office and two statewide coalitions. Through a federal capacity grant, five local communities with local Parent 2 Parent programs were funded to reach Hispanic parents of children with epilepsy. Supplemental federal autism grant funds are being used to augment the "Learn the Signs" campaign. A public private partnership called the Bree Collaborative was formed by the Legislature. The intent is to improve quality of care in several areas, including perinatal/obstetric care. The Bree subcommittee on obstetric care has turned to the work of the Washington State Perinatal Collaborative to guide improvements in this area.

The statewide Perinatal Advisory Committee consisting of representatives from Department of Health, Health Care Authority, DSHS(RDA), Washington State Hospital Association, Washington State Obstetrical Association, Washington State Medical Association, Washington State American College of Obstetricians and Gynecologists, Washington Association of Family Physicians, insurance companies, March of Dimes, Perinatal Regional Networks, American College of Nurse Midwives, Midwives Association of Washington State and others have formed the Washington State Perinatal Collaborative (WSPC). The WSPC has been collaborating on quality improvement initiatives for the past three years.

Over the past year WSPC has concentrated on reducing elective births before 39 weeks; there has been a 16% decrease in 3 quarters of reporting. That work will continue through this year. Recently, the WSPC agreed to address the rising C-section rate in Washington. These efforts must be responsive to issues that influence this rate, including provider liability concerns, lack of standardization in labor and delivery management, and logistics and staffing needed to safely offer VBAC and operative vaginal deliveries.

DOH is convening the WSPC to identify priority strategies to reduce all medically unnecessary C-sections. To evaluate these efforts, we are tracking C-sections among low risk women (NTSV). These deliveries are to first time mothers, carrying one infant, head down, who have reached term with a low risk delivery. These C-sections are more likely to have medical indications that are subjective and therefore, may be more subject to influence. For this reason, we expect to see an impact on NTSV C-section rates more readily. In 2010, the NTSV C-section rate in Washington among hospitalized births was 26.7%.

C. Ongoing needs assessment efforts to assess priority needs and capacity to meet those needs

Assessment and program staff continue to monitor and evaluate maternal and child

priority health needs and capacity on a continuous basis. We administer surveys, needs assessments, collect and analyze data. Reports continue to be shared with stakeholders to evaluate and improve programs and policies. In Sept 2011, we received the 2011 PRAMS survey dataset and used the data for a number of analyses. We have updated the following chapters of the MCH Data report: Low Birth Weight, Prenatal Care, Unintentional Injury, Infant Mortality and Immunizations/Vaccine Preventable Diseases. The Perinatal Indicator Report was updated which includes data from birth, death and fetal death certificates and PRAMS. The Infant Mortality Chapter of the health of Washington State was completed. Other chapters are scheduled for updating in the coming year. For details of ongoing needs assessment activities see the Needs Assessment Summary Update attachment to this section.

D. Activities undertaken to operationalize the 5 year Needs Assessment

In March 2012, the Office of Healthy Communities hired an MCH Consolidated Contracts Coordinator. Duties include coordination and development of new LHJ consolidated contracts and managing the administrative aspects of the new Consolidated Contracts with local health jurisdictions (LHJs). Administrative duties include networking with internal staff and LHJ staff to develop and implement accountability and transparency measures. 2012-2013 activities include: increasing partnership opportunities with LHJs, development of 2013-2014 Statement of Work Guidance and training/technical assistance calendar, implementing a web-based contract management system, and reviewing billing documentation prior to payment authorization.

The 2013 Maternal and Child Health Consolidated Contract Guidance will reflect the following NEW requirements from the 34 MCH Consolidated Contractors in Washington State: Conduct a comprehensive MCH Needs/Capacity Assessment, address NPM 5 and either WA State MCH Performance Measure (SPM) # 5 - ACES or # 3- Universal Developmental Screening. LHJs will also be required to address no more than one to three additional national or state performance or outcome measures. Additionally, LHJs will be developing SMART Objectives related to their selected performance/outcome measures. All LHJ statements of work will be reviewed by an internal team prior to activity implementation and entered into a web-based contracts management system to facilitate increased accountability and transparency.

The 2012-2013 Training/Technical Assistance plan will include topics that are relevant to sustaining past successes, addressing emerging challenges, and the diverse needs of Washington State's rural, semi-rural, and urban LHJs. The attachment to this section outlines the process undertaken with the LHJ's to implement the new 2013 Concon. Attachment -Needs Assessment Update and Concon Timeline//2013//

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

Washington State encompasses over 66,000 square miles of the northwest corner of the United States. It is bordered north and south by British Columbia and Oregon, east and west by Idaho and the Pacific Ocean. The Cascade Mountains divide the state into distinct climatic areas. A mild, humid climate predominates in the western part of the state. The climate is drier and has a wider temperature range east of the Cascade Range

Population Density

In 2009, the average population density in Washington was 100.3 persons per square mile. The national rate from the 2009 Population Estimates Program is reported at 82.6 persons per square mile (1). In 2009, about 75% of Washington's population was concentrated west of the Cascades. The three most populous counties, King, Pierce, and Snohomish are located on and prosper from Puget Sound. Another western county, Clark, gains economically from proximity to Portland, Oregon. The city of Spokane and Spokane County in Eastern Washington are near enough to benefit from Coeur d'Alene, Idaho.

/2012/The 2010 Census reports WA average population density to be 101.2 persons per square mile. (15) The national average population density is 87.4 persons per square mile(16). See 2010 Census Population Density Map --see Appendix 5//2012//

Geography, climate, and economic resources influence Washington's population distribution. (see attached map). Population density estimates for 2009 range from 906 persons per square mile in King County to less than 4 persons per square mile in Garfield and Ferry counties (1). Washington has 39 counties, each with its own local government. These counties form 35 independent local health jurisdictions (LHJs), funded with varying amounts of federal, state, and local dollars.

/2012/According to the 2010, Census King County's population density is 913 persons per square mile. Since the 2000 Census two counties, Pacific and Garfield, have experienced a decrease in their populations. The remainder have seen an increase, with Franklin county growing by the largest percentage, 58.4%.(15)//2012//

Population

Washington's population continues to grow. The 2000 Census indicated the state's population was 5,894,143, an increase of 21.1% since the 1990 Census (1). The Population Estimates Program intercensal population estimate for the state in 2009 was 6,664,195 (1).

/2012/The 2010 Census put WA State's population at 6,724,540. The population increased 14.1% since the 2000 Census(15).//2012//

According to the 2000 Census, Washington ranked seventh in the country in numerical population growth and tenth in percentage population growth since 1990 (1). The growth continues in Washington State's population. In 2009, the Washington State population grew by 1.5% (1). According to the Census Bureau, Washington's population grew by 12.7% between 2000 and 2009 compared to 8.8% for the nation. As a state, Washington ranked 13th in population growth during this time frame (1).

/2012/Washington's population grew by 14.1% from 2000 to 2010 (15), the USA as a whole grew by 9.7% over the same time period(16)./2012//

In 2009 the natural increase was 39,835 per year, an increase that has been observed since

2006, primarily due to a larger number of births. Net migration (people moving into the state versus people moving out) decreased from 42,720 in 2001 to an estimated 25,833 in 2003 (1). In 2009 the net migration into Washington State increased to 58,157 (1).

/2012/Between 2000 and 2010 the natural increase in WA population was 378,576 an increase of 6.4%. Net migration for the same period was 451,821, an increase of 7.7%.(15)//2012//

Race/Ethnicity

The majority of Washington's population identifies itself as White and non-Hispanic. In the 2000 Census, 81.8% of Washington's population reported its race as White, 5.5% Asian, 3.2% Black, 1.6% American Indian or Alaskan Native, 0.4% Native Hawaiian and other Pacific Islander, and 3.9% other. Individuals who reported two or more races accounted for 3.6%. Individuals who reported Hispanic or Latino ethnicity were 7.5% (1). Although the majority of Washington's population remains White and non-Hispanic, the state's other race and ethnic minority populations increased rapidly in the last decade. Together, non-Whites and Hispanics in Washington increased from 13.2% of the overall population in 1990 to 21% (1,241,631) of the population in 2000. The state population of Asian/Pacific Islanders increased by 78%; Blacks by 35%; and American Indians, Alaska Natives, and Aleuts by 29% (1).

/2012/According to the 2010 Census WA population is as follows: White 77.3%, Asian 7.2%, Black 3.6%, American Indian or Alaska Native 1.5%, Native Hawaiian and other Pacific Islander 0.6%, and other race 5.2%. Individuals who reported more than one race were 4.7%; Hispanic or Latino ethnicity, 11.2%. The total non-white and non-Hispanic population increased to 27.5% in 2010 (15).//2012//

The most recent population estimates produced by Washington State Office of Financial Management (OFM) in 2006 predict a general increasing trend among the population of non-White and Hispanic residents (2). Between 2000 and 2010, the estimated population increase is projected to vary widely by race and ethnicity. The estimated population increase was 12.4% for White, 23.6% for Black, 17.4% for Alaska Native and American Indian, 45.1% for Asian and Pacific Islander, and 38.4% for those of two or more races. In addition, the estimated population increase for those of Hispanic Origin is 47.5% between 2000 and 2010 (3).

/2012/According to the 2010 Census population has increased from the 2000 Census by the following; white 7.8%, Black 26.2%, American Indian and Alaska Native 11.3%, Asian 49.2%, Native Hawaiian and Pacific Islander 69.0%, more than one race 46.6%, other race 52.8% and 71.2% for those of Hispanic Origin.(15)//2012//

Washington is experiencing a significant growth in its Hispanic population. The Hispanic population in Washington State has more than doubled since the 1990 Census, from 214,570 in 1990, to 441,509 in 2000. The estimated Hispanic population in 2010 is 651,027. (3) Counties with large proportions of Hispanics tend to be located in rural areas of Eastern and Central Washington. In Adams County, the Hispanic population rose from 32.8% in 1990 to 47.1% in 2000, and to 54.1% in 2008; Franklin County saw an increase from 30.2% to 46.7%, and to 59.3% in 2008; and Yakima County saw an increase from 23.9% to 35.9%, and to 42.5% in 2008 (4). The 2000 Census data showed that while Hispanics make up a large proportion of the population in these Eastern and Central Washington counties, most Hispanics live in King, Pierce, and Snohomish counties. The majority (74.7%) of Hispanics in Washington are from Mexico, 20.6% are from other countries (Central and South America), 3.7% from Puerto Rico, and 1.0% from Cuba (1). In 2000, there were approximately 289,000 migrant and seasonal farm workers and dependents living in Washington, most of whom were Hispanic (5). Migrant and seasonal farm workers are more likely to face language barriers, and to have low family incomes and limited transportation options. Most rely on community and migrant health centers for their health care.

/2012/The Hispanic population is 755,790, surpassing the previously estimated 2010 population. Hispanics are the majority population in Franklin and Adams counties, making up, respectively, 59.3% and 51.2% of the population. Hispanics made up 45% of Yakima County. Grant County saw an increase in its Hispanic population from 30.1% in 2000 to 38.3% in 2010(15)//2012//

Blacks and Asian/Pacific Islanders are predominantly located in urban areas west of the Cascades. Approximately 54% of Asian/Pacific Islanders and 48% of Blacks resided in King County alone in 2008 (6).

There are also 29 federally recognized American Indian tribes throughout Washington with varying populations and land areas. There are seven additional tribes, some of which are seeking federal recognition.

/2012/Approximately 50% of African Americans and 57% of Asian/Pacific Islanders reside in King County in 2010 (15) The increase in Pacific Islanders statewide is very similar to that of the statewide increase in the Hispanic population. In many MCH indicators the Pacific Islander population lags behind the statewide indicators.//2012//

Languages

According to the 2006-2008 American Community Survey 3-year estimates, approximately 18.8%, or 209,276, of Washington's children age 5-17 years speak a language other than English at home (1). Of these children, 55.8% speak Spanish, 21.4% speak Asian and Pacific Islander languages, 17.9% speak other Indo-European languages, and 5.0% speak other languages (1). A similar figure of 17.1%, or 710,729, of the adult population age 18-64 years does not speak English at home (1). Of those who speak another language at home, 71.2% of the children and 50.6% of the adults speak English "very well" (1). Approximately 10% of the children and 26% of the adults, speak English "not well" or "not at all" (1). Approximately 83,484 (8%) students were enrolled in the Transitional Bilingual program in Washington State for the 2008-2009 school year (7).

Age

The 2000 Census population counts show that almost 22%, or 1.29 million of the estimated 5.9 million people in Washington in 2000, were women of reproductive age (age 15-44 years) (1). Nearly 29%, or 1.68 million, were children age 19 years and younger. There were over 125,000 women ages 15 to 17 years. A state forecast predicts that over the next 30 years, as the children of baby boomers reach adulthood, the number of women of reproductive age will increase substantially (8).

/2012/2010 Census counts show that almost 20.2%, which is 1.25 million of 6.72 million people, in Washington were women of reproductive age. Children 19 years and younger were 26.3% or 1.77 million of the population. There were 224,551 women between the ages 15-19 years of age in 2010.(15)//2012//

2009 population estimates show that 20%, or 1.35 million of the estimated 6.67 million people in Washington, were women of reproductive age (age 15-44 years) (9). Nearly 27%, or 1.78 million, were children age 19 years and younger. There were over 135,000 women ages 15 to 17 years (9).

In 2009, there were an estimated 1,142,329 children and adolescents aged 5 to 17 in Washington (9). The school age population (age 5 --17 years) is expected to remain stable through 2010 and then gradually increase.

In 2007, there were 88,921 births in Washington State (10). In 2008, there were 90,270 births in Washington State (10). Birth and pregnancy rates among women 15-24 years declined substantially from 1990-2003, but no clear pattern has emerged recently (10).

/2012/In 2009 there was a slight decrease in the number of births to women residing in WA, 89,242. That trend in fewer births to women residing in WA continued in 2010, with 86,480 births.(17)//2012//

Urban/Rural

91% of population growth between 2000 and 2009 occurred in the state's urban counties, where the majority of the population lives. While there are many rural areas in Western Washington, the most rural counties are located in Eastern Washington. Rural county residents tend to be older and to have lower median household incomes, higher poverty rates, and higher unemployment rates. Rural counties are less diverse than urban counties. Hispanics and American Indians account for a larger share of their minority populations. There is a higher percent of uninsured residents and residents enrolled in Medicaid in rural counties (11).

A recent review of hospital utilization rates and mortality rates showed poorer outcomes in rural areas. The overall rates of hospitalization and hospitalization rates for cancers and diabetes are significantly higher in rural areas of the state. Some mortality rates are also significantly higher, including the overall mortality rate and rates for the younger population (ages 1 -- 24) and for deaths from transportation accidents, suicides, and diabetes. Many factors may contribute to these poorer outcomes including geographic isolation and decreased access to care, the lower socio-economic status of residents and their older age (11).

/2012/ A recent Department of Health assessment found five indicators of maternal and child health for which Washington's rural areas are doing less well than the state as a whole (statistical significance $p < 0.05$). Rural areas are higher than the state average for the percentage of women who smoke during pregnancy, for the rate of teenage births and for the rate of children who are hospitalized due to unintentional injuries. Rural areas are lower than the state average for the percentage of children with health insurance coverage and for pregnant women who receive first trimester prenatal care. Differences in age structure, gender, race, income and education could explain some of the variation.(18)//2012//

Economy

Washington State faces the same challenges as many other states with large budget deficits, high unemployment, a depressed real estate market, housing foreclosures, and rising fuel prices and continues to suffer from an economic slowdown. According to the Bureau of Labor Statistics, Washington State's seasonally adjusted unemployment rate in May 2010 was 9.1, slightly lower than the 9.3% for April 2010. The US rate was 9.7% in May 2010 which is slightly lower than in previous months. There was no significant job growth in any major industry or sector. (12)

/2012/ Unemployment in WA remains high. In April 2011 WA seasonally adjusted unemployment rate was 9.1% slightly lower than the March 2011 rate of 9.2%. The US rate was 9.0% in April 2011. Private sector jobs grew by 49,400 since April 2010 but public sector jobs decreased by 7,900 over the same period.(19)//2012//

/2013/The unemployment rate has fallen from last year, but still remains high at 8.3%. As of April 2012 the maximum weeks of unemployment benefits in WA have reduced from 99 to 73 (22)//2013//

The budget for the 2009-2011 biennium was adopted after resolving a \$9.0 billion shortfall for the two year biennium (13). Several years of economic doldrums, combined with spending constraints and spending limits from voter-approved initiatives, have produced a continuing budget crisis for Washington. The legislature just adopted a supplemental budget for FY10 that decreased expenditures to meet another \$2.6 billion shortfall. In order to meet anticipated shortfalls, state agencies have been under a number of freeze directives from both the Governor

and the Legislature. Freezes have impacted hiring, contracts, equipment purchases and travel. The first freeze was enacted in August 2008 and continues through at least June 2010. The impact on the Department of Health's budget is noted in Section V.A and V.B.

In the past, state revenue surpluses have been available to backfill revenue shortfalls faced by local governments. Continuing budget problems greatly reduce the state's capacity to subsidize local government revenue shortfalls. The result is that many local programs are struggling financially. At the same time, economic hard times have increased the need for public health services at the local level, so the current decrease in funding is having a major impact on local public health. As the economic slowdown and state fiscal crisis continue, future reductions in local public health are expected. LHJs are currently being forced to reduce staff and programs. In 2009-2011, approximately \$10.7 million in MCHBG allocations will be distributed among the 35 local public health agencies in Washington, a 2.7% reduction from what they received in 2007-2009. Finally, in the second biennial year, LHJ's will receive a 10% reduction in State Oral Health funding in response to recent legislation. Termination of an interagency contract with the Department of Early Learning means that beginning in CY2011, LHJ's will no longer receive funding for activities related to child care issues.

As a result of the budget cuts, protracted fiscal constraints, and anticipating that they will continue into the future, local health jurisdiction leaders are meeting with Department of Health senior management to identify what activities are core and what can be dropped. This initiative, Reshaping Public Health, is looking at significantly changing the future direction and emphasis of public health in Washington State.

To date four core areas are protected:

1. Preventing and rapidly responding to community health threats
2. Safe food and water
3. Healthier Washingtonians with reduced health care costs
4. Access to safe, quality health care

/2012/ In November 2010, the state and local health departments formed an implementation work group for the Reshaping Public Health initiative. This workgroup has four sub-groups, each focusing on one of the four core public health areas needing protection. The overall workgroup will oversee and coordinate the identification of goals, strategies, measures, and action plans. The product of their work will become the Washington State Public Health Improvement Plan, the statewide public health system's long-term plan for improving the public's health. (For more detail see <http://www.doh.wa.gov/PHSD/reshape.htm> //2012//

Poverty and Health Insurance

According to the 2008 Washington State Population Survey, an estimated 26.2% of households had a family income below 200% of the federal poverty level (FPL) and an estimated 9.6% of households had an income below 100% FPL. Approximately 28.8% of households with children under 18 were below 200% FPL (9) . According to the 2006-2008 American Community Survey 3-year estimates, an estimated 12.4% of Washington families with related children under 18 years were below 100% FPL (1). Overall, an estimated 15.1% of children were living below 100% FPL and 6.5% were living below 50% FPL (1).

/2012/According to the 2010 WA Population Survey an estimated 28.95% of households had a family income below 200% of the FPL; 11.4% had an income below 100% of the FPL.(20)//2012//

The 2008 Washington State Population Survey indicated that the percent of Washington residents without health insurance has stayed the same since 2006 (9). Among the general population, 11% were uninsured in 2008, while 10.6% were uninsured in 2006. The percent of uninsured children decreased slightly from 5.0% in 2006 to 4.6% in 2008; however, this is not a statistically significant change.

/2012/ According to the 2010 WA Population Survey, 12.2% of the general population was uninsured. Among children under age 18 the percentage was 3.4. (20)//2012//

/2013/According to the 2010 American Community Survey, 6.4% of children in Washington State had no health insurance, compared with 8% who had no health insurance in 2008. This is a different data source, using different methodology, than the source used in 2012, because our previous source, the WA Population Survey, will no longer be conducted. Therefore, starting next year, we will use ACS as our source for insurance coverage. (23)//2013//

The Department of Social and Health Services Medicaid Purchasing Administration (MPA) funds health care services to low income people in Washington, primarily through the federal/state Medicaid partnership. In 2008, Medicaid covered pregnant women up to 185% FPL and paid for prenatal care and deliveries for approximately 48% of state births (14). The Take Charge program provided family planning for men and women with incomes at or below 200% FPL. The State Children's Health Insurance Program (SCHIP) provided health coverage for children of families with incomes between 200% and 250% FPL. In 2009 the SCHIP income limit was increased to 300% FPL.

/2012/The percent of Medicaid paid deliveries has not appreciably changed since 2008(21). The final 2011 state budget preserved most of the state Medicaid and SCHIP services (now called Apple Health). Children in households above 200% FPL pay a small premium of \$20.00 or \$30.00 a month per child. This is limited to two premiums per family a month. Undocumented children in families above 200% FPL will pay a higher premium in the next biennium to remain in the program.//2012//

Washington State has been a national leader in giving low-income families access to health insurance. For example, prior to SCHIP, Washington was one of only four states providing Medicaid coverage to children at or above poverty level. When SCHIP was adopted in Washington State in 2000 the Medicaid income limit for children was already up to 200% FPL. SCHIP expanded coverage to low income children up to 250% FPL. In 2006, Washington re-established the Children's Health Program to provide coverage to non-citizen children up to 100% FPL. Then in 2007, the state increased the income limit for the Children's Health program to 250% FPL to mirror the income limit for SCHIP. In 2008 the state consolidated Medicaid, Children's Health, and SCHIP programs under a single umbrella name "Apple Health for Kids". The benefit package under "Apple Health for Kids" is the full-scope of Medicaid benefits. The Apple Health for Kids Hotline does outreach to connect parents with Medicaid and SCHIP and to provide information about children's health services. Other legislation provides incentives to primary care providers to become medical homes for children and families.

OMCH works closely with MPA to sponsor outreach efforts designed to increase enrollment of children. Washington's statewide network of community, rural and migrant health centers, public hospital-affiliated clinics, and local public health jurisdictions serving low-income and/or special populations also supports access to health services.

***/2013/
Summary:***

Washington State benefits from a relatively well educated population and an employment situation which appears to be improving, albeit at a slow rate. Washington's economy is improving but, as with the nation as a whole, that improvement is slow and at times inconsistent. Washington's demographics continue to change with the influx of Hispanic residents, by birth and immigration, and increases in other racial and ethnic groups relative to the non-Hispanic white population. This increase is disproportional among younger Washingtonians and therefore is especially important to the work MCH programs

do statewide. Washington remains committed to providing access to health care for its youngest lower income residents through its Medicaid and SCHIP programs, and rates of child and youth health care coverage remain high, but recent budgets have resulted in a co-payment model in some publically funded insurance which may result in some rationing of needed care to these children. There continues to be a disparity between urban and rural Washington with rural areas experiencing more challenges to its MCH population. Finally, the budget cuts enacted over the past few years have made providing services to the WA MCH population more challenging.//2013//

- (1) US Census Bureau, American Factfinder. (<http://Factfinder.census.gov>)
- (2) Washington State Office of Financial Management (OFM), Population, <http://www.ofm.wa.gov/pop/default.asp>
- (3) Washington State Office of Financial Management (OFM), Projections of the State Population, <http://www.ofm.wa.gov/pop/race/projections/default.asp>
- (4) OMF <http://www.ofm.wa.gov/pop/race/minoritygraphics/hispanic08.pdf>
- (5) Larson A.C. Migrant and seasonal farm worker enumeration profiles study: Washington. Bethesda (MD): U.S. Department of Health and Human Services, Bureau of Primary Health Care; September, 2000)
- (6) OFM <http://www.ofm.wa.gov/pop/race/minoritygraphics/api08.pdf>
- (7) Washington State Office of Superintendent of Public Instruction School Report Card, 2009).
- (8) Office of Financial Management <http://www.ofm.wa.gov/pop>
- (9) Washington State Office of Financial Management, Research and Data, State Population Survey. <http://www.ofm.wa.gov/sps/default.asp>.
- (10) Washington State Vital Statistics, Center for Health Statistics, 2008.
- (11) Washington State Department of Health, What is different about rural Washington: a rural health snapshot, February, 2006. (<http://www.doh.wa.gov/hsqa/ocrh/WRHAP/WARuralSnapshot.pdf>)
- (12) Washington State Employment Security Department, Labor Market and Economic analysis, Washington State Employment Situation Report for March 2010
- (13) Washington State Economic and Revenue Forecast Council, <http://www.ercf.wa.gov/> .asp
- (14) First Steps Database. Personal communication from Laurie Cawthon, Washington Department of Social and Health Services, Research and Data Analysis, May, 2010.
- /2012/(15) OFM 2010 US Census data for WA State: <http://www.ofm.wa.gov/pop/census2010/data.asp>
- (16) US Census Bureau, 2010 Census Data: <http://2010.census.gov/2010census/data/>
- (17) Washington State Vital Statistics, Center for Health Statistics, 2009 and 2010.
- (18) Rural Washington: Closing Health Disparities (2010 Update) Department of Health

Publication # DOH 346-030. <http://www.doh.wa.gov/hsqa/ocrh/har/FactClosing2010.pdf>

(19) Washington State Employment Security Department, Labor Market and Economic analysis, Washington State Employment Situation Report for April 2011

(20) Washington State Office of Financial Management, Research and Data, State Population Survey, 2010

(21) First Steps Database. Personal communication from Laurie Cawthon, Washington Department of Social and Health Services, Research and Data Analysis, May, 2011.//2012//

/2013/

(22) Washington State Employment Security Department, Labor Market and Economic analysis, March Unemployment Report, 2012

(23) American Community Survey <http://www.census.gov/acs/www/> //2013//

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

The Office of Maternal and Child Health (OMCH) works to protect and improve the health of people in Washington State with a focus on women, infants, children, adolescents, and families. OMCH programs work in close partnership with state and local agencies and consumers to promote effective health policies and quality systems of care. Maternal and child health (MCH) data are collected, analyzed, and shared with other agencies and organizations to help ensure sound decision-making around health care policies and practices. OMCH program activities emphasize infrastructure-building and population-based activities through preventive health information and educational messages to the public and to health care providers about early identification of health issues, referral and linkage to services, and coordination of services.

OMCH is responsible for administering the Title V Block Grant, Washington State General Funds, Title XIX Medicaid Administrative Match, the Centers for Disease Control and Prevention (CDC) Immunization Grant, and a variety of other federal grants pertinent to MCH priorities and performance measures. OMCH contracts with 35 local health jurisdictions (LHJs) and several community-based organizations, universities and hospitals, direct service providers, family organizations, and others to address MCH priorities and state and national performance measures.

Capacity for better understanding cultural competence as an office and for staff has improved over the years due to continued participation in the division level Multicultural Workgroup and ongoing training. In addition, the Community and Family Health Division established a division wide Health Disparities Workgroup that OMCH staff serves on. This workgroup surveyed all the programs in the division for information about activities that aim to address health disparities. Statewide, the Legislature passed a bill creating the Governor's Interagency Council on Health Disparities. The Department of Health serves on the council. This Council adopted recommendations to eliminate health disparities through education, healthcare workforce diversity, health insurance coverage, obesity and diabetes. They are now charged with developing an action plan to implement these recommendations through 2012.

Each of the five specialized sections within OMCH supports programs to help create infrastructure and provide population based services, and enabling services. The Office generally does not fund direct services, but can support a "last-stop safety net" when there is a major gap in services for the maternal and child health (MCH) population. Each section has a specific focus. Two sections focus on distinct Title V populations: one on Maternal, Infant, Child and Adolescent

Health, and the other on Children with Special Health Care Needs. The other sections, Genetic Services, Immunization Program/CHILD Profile, and MCH Assessment, and the Oral Health program (which is part of the Administration section) focus on issues that encompass the entire MCH population. The Administration section is the sixth section in the office and supports all of the specialized sections. A brief description of the basic role of each OMCH section follows.

MCH Assessment (MCHA)

This section, with 12.4 full time equivalents (FTEs), provides data, analysis, research, surveillance, and consultative support and management of all assessment activities in OMCH. To ensure that OMCH activities are data driven, MCHA works collaboratively with its sister OMCH sections. MCHA assigns epidemiologists as liaisons and advisors to other OMCH sections. These epidemiologists routinely meet with their assigned section's staff and manager to discuss and interpret data related to a specific program. Together they review data on past performance and set future objectives and targets for the program. This assures that the program's objectives and targets are based on data trends across multiple years. It also helps focus the programs activities where they can have the most impact.

MCHA also has a lead epidemiologist for the MCH Block Grant application process. The MCHA grant lead regularly meets with program staff and managers to discuss and interpret performance and outcome data related to each program. In addition, the MCHA Block Grant epidemiologist lead consults and works in collaboration with staff from non-MCH programs and outside state agencies to solicit additional data needed to complete the grant application and report.

MCHA sees the consultation and collaboration described above as critical to OMCH's overarching goal of protecting and improving the health of the MCH population of Washington State.

Specific MCHA activities include leading the Five Year Needs Assessment process, reporting performance measures and health indicator data; administering ongoing surveys such as the Pregnancy Risk Assessment Monitoring System (PRAMS) and the Healthy Youth Survey (a biennial survey of 6th, 8th, 10th and 12th graders in public schools), conducting surveillance through a variety of mechanisms such as collecting and analyzing data from child death reviews, cluster investigations, and birth defects surveillance; and implementing State Systems Development Initiative activities. MCHA also designs and implements other surveys as needed and responds to data requests from OMCH, other areas of the Department of Health, local health jurisdictions, other state agencies and other external stakeholders. The OMCH Assessment unit participates in the HRSA Graduate Student Intern Program, mentors graduate practicum students, as well as other workforce development programs like the Council of State and Territorial Epidemiologists fellowships as part of its regular functioning.

Maternal, Infant, Child and Adolescent Health (MICAH)

In 2009, the Maternal and Infant Health section and the Child and Adolescent Health section merged to form the Maternal, Infant, Child and Adolescent Health (MICAH) section. MICAH is comprised of 23.8 FTEs. It is committed to two primary goals: 1) to identify and implement effective strategies to protect and improve the health of women, infants and families and 2) to promote, support, and provide public health leadership for state and community-based systems that assure the health and well-being of children, adolescents, and families in Washington State. Focusing on pregnant and post-partum women and their infants, MICAH works to improve birth outcomes by promoting quality health and support services for women of childbearing age. This includes supporting these women in making choices to adopt and maintain healthy behaviors and ensuring that women and infants, especially those in vulnerable populations, have equal access to quality health and support services that meet their needs. This work is accomplished through monitoring trends in data, maintaining a 1-800 hotline resource and referral number, and by working collaboratively with private and public healthcare partners and contractors to improve

access and quality of health services. MICAH also promotes the use of national guidelines for well child and adolescent screening and referral, family support and leadership, teen pregnancy prevention, youth development, promotion of social emotional wellbeing and mental health, and child care health consultation. In partnership with other agencies, MICAH promotes health in early learning and school readiness.

/2013/The Access, Systems and Coordination section was formed in July 2011. The section is comprised of the same MICAH (formerly MCH) staff and the Family Planning Program. In February 2012, the CYSHCN section also became part of ASC, Kathy Chapman is the section manager. ASC has 30 FTE. ASCs purpose is to develop and support coordinated state and local systems to improve access to health services and information, increase health equity and improve health of individuals and families. See Organizational Structure for more information.//2013//

Immunization Program/CHILD Profile (IPCP)

IPCP is comprised of 27 FTEs and committed to two primary goals: 1) preventing the occurrence and transmission of childhood, adolescent, and adult vaccine-preventable diseases; and 2) ensuring that parents, health care providers, and state and local health agencies are working together to promote healthy families and increase use of preventive health care for children from birth to age six years. The section has created partnerships with the Washington Chapter of the American Academy of Pediatrics, the Washington Academy of Family Physicians, a Vaccine Advisory Committee of expert physicians, a statewide immunization coalition, and all local health jurisdictions. IPCP maintains the state's Immunization Registry and coordinates the Child Profile Health Promotion System which regularly mails health promotion materials to households with children under six years of age. Seventeen mailings are sent to the households with young children, over the period from birth through age six.

/2012/In 2011, IPCP began reporting directly to the Assistant Secretary for Community and Family Health rather than being part of the structure.//2012//

Children with Special Health Care Needs (CSHCN)

The CSHCN section has a total of 10.9 FTEs. The program promotes integrated systems of care that ensure that children with special health care needs and their families have the opportunity to achieve the healthiest life possible and develop to their fullest potential. CSHCN staff provide leadership in addressing health system issues that affect this population; work with families and other leaders to influence priority setting, planning and policy development; and support community efforts in assessing the health and well-being of children with special health care needs and their families. This work is carried out through partnerships with other state-level agencies and contractual relationships with LHJs, private and non-profit agencies, the University of Washington, Seattle Children's, other tertiary care centers, and family organizations. These contracts and partnerships significantly extend CSHCN program capacity in the areas of policy development, assessment, provider education, and family leadership development. A small amount of funding is used for medically necessary services and equipment for children whose families are at or below the Federal Poverty Level for Medicaid not covered by any other source of payment.

/2013/In February 2012, the CSHCN section became part of ASC. The State CYSHCN Coordinator reports to Kathy Chapman, ASC section manager. The Great MINDS (Medical Homes Include Developmental Screening) that includes a partnership with the WCAAP stayed in Practice Improvement.//2013//

Genetic Services Section (GSS)

Genetic Services, with 8.1 FTEs, is focused on assuring high quality comprehensive genetic services and early hearing-loss detection, diagnosis, and intervention (EHDDI) throughout the state. The section serves as a resource for accurate, up-to-date information, promotes

educational opportunities for health and social service providers, and evaluates quality, trends, and access to services.

OMCH Administration

This section has a total of 6.5 FTEs and provides office management and administrative support to OMCH as a whole through policy and fiscal development and oversight. The Oral Health Program is located in the Administration section because it serves the entire MCH population and works with all of the sections within the office. Oral Health works through partnerships with other state-level agencies and contractual relationships with LHJs. This program has partnered with various programs internally within DOH and with external stakeholders like Washington State Oral Health Coalition, Washington State Dental Association, Washington State Dental Hygiene Association, Community Health Centers, and University of Washington School of Dentistry to improve oral health in the state.

/2012/ The final 2011-2013 budget cut funding to maternal and child health programs by \$1.6 million per year starting in July 2011. Cuts were made to several contracts and several positions were eliminated due to these state budget reductions. The budget cuts at the state and local levels have not only been multiple over the past two years but are also cumulative in the impact on maternal and child health programs and services. What follows reflects the impact of cuts made only this year and not the cumulative impact. Further, the budget forecast indicates more cuts will come. Impact on MCH program and services:

CSHCN:

1. A reduction in state funding for neurodevelopmental centers will impact the 15 centers across Washington State in different ways, considering their size and diversity of funding sources. Most will continue to serve similar numbers of children for specialized therapy (12,000 in 2010) for the time being, but the quality and comprehensiveness of those services may be impacted by reduced training opportunities for therapists, increased use of less expensive therapy assistants, reduced ability to do home-visits, and elimination of supplemental services often needed by the children and their families, like social work and nutrition services.
2. Reductions in CSHCN staff at the state level have resulted in delays in producing statewide data reports about children and youth with special health care needs. This impacts requests for data within the agency, by other state agencies and legislators and the ability to do state and local planning for services.
3. Reductions in CSHCN staff at the state level has creating delays in approving requests from public health nurses on behalf of parents of children and youth with special health care needs for medically necessary services or products not covered by any other funding sources, like batteries for hearing aids, nutrition products for tube feedings, corrective shoe inserts, and oral surgery.
4. Due to state funding reductions the CSHCN Program had to terminate the Adolescent Health Transition Project at the University of Washington, even though it was funded with stable MCH Block Grant funds. Another reduction had to be made to the contract with the Center for Children with Special Needs. That also resulted in a reduction in staff hours on adolescent transition activities. Both of these projects were tied to the specific CSHCN national performance measure on Adolescent Health Transition. It still needs to be determined how to retool these efforts and with what remaining funds.
5. Reductions in CSHCN FTE and transfers of staff due to the division modernization have left the CSHCN Program without a nursing consultant to provide medical consultation when needed and an interface with School Health and the School Nurse Corps. Also, an innovative project to collect nursing outcomes data based on public health nursing interventions with children with special health care needs and their families across the state has 2013//been stalled without a lead at the state level and is likely to be terminated.

/2013/Proposed cuts to Neurodevelopmental Centers were not implemented.//2013//

Genetics:

The Genetics Services Section experienced a \$300,000 federal cut in 2009 and an additional \$150,000 cut in 2010. As a result, contracts to Regional Genetic Clinics serving primarily pediatric and adult clients were reduced from 8 facilities to 3. These 3 sites are in Eastern Washington, the more rural part of the state. In addition, the contract with Seattle Children's Hospital to provide Medical Genetics coverage to outreach clinics statewide was reduced from \$110,000 to \$30,000. This resulted in a ~45% decrease in the number of outreach clinics held. There were 36 outreach clinics annually and this dropped to 16 clinics in 2010. This is the lowest level of outreach service since 1990. While the 2010 service utilization data are not yet available, we estimate that the number of families seen dropped from over 10,000 families to less than 5,000 families. Current budget reduction plans will eliminate all state funds for genetic services. This will mean no contracts even for rural facilities and an end to Medical Genetics coverage to all outreach clinics. Anticipated short term impacts include continued decline in access to services, fewer families seen, families waiting longer to be seen, delayed diagnoses. Long-term impacts include increased morbidity and mortality of individuals with genetic disorders primarily due to late or no diagnoses or genetic counseling.

Maternal, Infant and Adolescent:

MSS

First Steps Maternity Support Services (MSS) provides enhanced support services for pregnant and postpartum women who are receiving Medicaid. In Washington State that is almost 50% of births. Services include home visiting and case management by nurses, behavioral health Specialists, and registered dietitians. The program began in 1990. By the end of 2009, more than 475,000 pregnant women had received services. Gains in pre-natal care access, low birth weight, and infant mortality were clear by 1995. MSS is associated with decreased LBW for medically high-risk. In spring, 2010, the program was reduced 20%, including reduction of state administrative staff; other cuts are being considered due to budget shortfalls. Data on women served has not yet been evaluated for 2010. Impacts include:

- Decreased numbers of women served
- Provider attrition, resulting in some rural areas in the state with no services, and most areas with reduced access
- Clients served are receiving a reduced level of service.
- Decreased opportunities for Family Planning and tobacco cessation
- Women with acute medical issues or severe depression may be missed or may receive reduced service.

Impacts that may be expected due to MSS reductions include:

- Low-income pregnant women will have increasing difficulty accessing prenatal care.
- Increase in Low birth weight/prematurity.
- Increased child abuse/neglect cases, or missed referrals.
- Decreased support for providers from state staff resulting in loss of expertise in evolving evidence-based practices.

SBHC

Cuts to support for School-Based Health Centers have resulted in loss of expertise at the state level to assist start-up clinics, and loss of funds to assist with SBHC start up and maintenance. Funding for SBHC's is made up of local dollars, usually local taxes, and public private funds from billing and in some cases, state funds. In WA, one SBHC has closed due to local fund shortfalls (sorry no data). Many sites had been considering beginning clinics, but with local and state budget reductions, have not been able to follow through with planning.

Health Disparities

Cuts in funding have resulted in loss of expertise at the state level to focus on health disparities and health equity. Work will continue on these issues; however there are fewer resources to work

directly with impacted communities and populations.

Assessment

MCH Surveillance, Assessment and evaluation activities have been reduced significantly. With loss of discretionary funding (e.g. non-categorical federal grants), MCH Assessment staff have reduced activities in the following areas: analysis of PRAMS data, birth defects surveillance, reporting of publicly funded services to the MCH population and less frequent production of data and issue briefs that focus on specific MCH related issues. Staff need to spend an increasing proportion of their time reporting on specific categorical grant requirements and less on the MCH population's needs as a whole and the states capacity to meet those needs. Assessment staff capacity was cut by an additional FTE this past year. Delays in filling vacancies due to additional expenditure reviews have delayed or shortened time needed to conduct training of local staff, bias analyses on surveys, questionnaire development and other assessment infrastructure needs. (See Appendix 9).//2012//

/2013/An updated staff list since the OHC merger and current org charts are attached.//2013//

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

The Department of Health (DOH) is Washington's statewide public health agency. It is located in the Executive Branch of state government, with the Secretary of Health reporting directly to the Governor. DOH includes five major divisions: Office of the Secretary; Division of Community and Family Health (CFH); Division of Environmental Health; Epidemiology, Health Statistics and Public Health Laboratories Division; and Health Systems Quality Assurance. The Office of Maternal and Child Health (OMCH) is one of four offices in the Division of Community and Family Health. In Washington State, the Children with Special Health Care Needs Program is part of OMCH.

The Department of Health was created as a single state agency in 1989. The legislative intent was to focus "the need for a strong, clear focus on health issues in state government and among state health agencies to give expression to the needs of individual citizens and local communities as they seek to preserve the public health. It is the intent of the legislature to form such focus by creating a single department in state government with the primary responsibilities for the preservation of public health, monitoring health care costs, the maintenance of minimal standards for quality in health care delivery, and the general oversight and planning for all the state's activities as they relate to the health of its citizenry.

Further, it is the intent of the legislature to improve illness and injury prevention and health promotion, and restore the confidence of the citizenry in the efficient and accountable expenditure of public funds on health activities that further the mission of the agency via grants and contracts, and to ensure that this new health agency delivers quality health services in an efficient, effective, and economical manner that is faithful and responsive to policies established by the legislature."

As such, DOH, through the Office of the Assistant Secretary for Community and Family Health and OMCH, is responsible for the overall administration of programs focusing on the health of the MCH population.

On a program by program basis, OMCH staff collaborates extensively with staff in the other CFH offices and in the other DOH divisions. Some areas our internal collaborators address are health statistics; the state Public Health Laboratory, epidemiology; chronic, infectious and communicable disease; reproductive health; tobacco control and prevention; Women, Infants and Children (WIC); health promotion; environmental health; community health systems; and regulation and licensing of health facilities and professionals. They are described in detail in Section IIIE, the

State Agency Collaboration section of this application.

Organization charts for the Department of Health, the Division of Community and Family Health and the Office of Maternal and Child Health are attached. These organizational charts are also at the following internet links: 1) Department of Health organization chart at <http://www.doh.wa.gov/Org/org.htm> 2) Division of Community and Family Health chart at <http://www.doh.wa.gov/cfh/CFHOrgChart/CFHorg.htm>. 3) Office of Maternal and Child Health chart at <http://www.doh.wa.gov/cfh/mch/documents/MCHOrg.pdf>.

/2012/ The Prevention and Community Health Division (formerly Community and Family Health) underwent an extensive modernization as of July 1, 2011 (see Appendices 6 and 9). Many factors have contributed to this change.

What are some of the drivers for this change?

Continued budget reductions --federal, state and local

In the 2009-2011 governors' budget the child and maternal health division will achieve program savings through efficiencies gained by reorganizing division responsibilities.

In addition to funding becoming more competitive:

- Federal funders are encouraging integration
- Funding more targeted and outcome-focused
- Local health jurisdictions and their partners have asked us to integrate services, to improve services and streamline our interaction with them.
- Health reform will happen in some form or fashion
- Some people will still be uninsured
- Role of governmental public health is going to continue to evolve
- There will be a general election in Washington in 2012
- Difficult decisions are ahead
- These assumptions force us to relook at our strategies and effectiveness

Beginning in early 2009 conversations began with local health jurisdiction staff, Washington State Health Officer, Division of Community and Family Health Assistant Secretary (both the current Assistant Secretary and her predecessor), and public health nursing directors regarding their need to do MCH work in a different way.

In February 2010, in response to the changing environment, the Washington Department of Health Secretary put out a call to action to transform the current system, indicating the need to design a public health system that is based on the resources available and that is most effective. The Secretary appointed a workgroup to consider what this transformation means to the governmental public health system over the next five years. The charge to the work group, referred to as Reshaping Governmental Public Health in Washington State, was to:

- Draft a public health change agenda that will increase our emphasis and focus on key statewide/system issues that are responsive to our changing environment
- Draft a shared set of guiding principles and decision criteria to consider on policy, program, and funding decisions
- Draft a communication plan to engage others in the system and our partners in order to refine and reach agreement on the agenda and principles

The workgroup developed the Agenda for Change which is now considered to be a roadmap for the Agency. The outcome resulted in a What and How of doing our work.

Agenda for Change (see Appendix 6)

What:

Focus our communicable disease capacity on and enhance the most effective and important elements of

prevention, early detection, and swift responses to protect people from communicable diseases and other health threats

Focus on policy and system change efforts to foster communities and environments that promote healthy starts and ongoing wellness, prevent illness and injury, and better provide all of us the opportunity for long, healthy lives

With healthcare reform, it is time for public health to more effectively and strategically partner with the healthcare system to improve access to quality, affordable and integrated health care that incorporates routine clinical preventive services and is available in rural and urban communities alike.

How:

- Retrain the public health workforce to the skills and competencies needed for the new work
- Re-prioritize work and modify business practices
- Develop a long-term strategy for predictable and appropriate levels of financing

After a year-long process, a decision was made and implemented in July 2011, that reorganized the division. The name of the Community and Family Health Division changed to Prevention and Community Health.

The change emphasizes the importance of prevention and supportive community environments in health.

The division now consists of four offices:

- The Office of the Assistant Secretary
- Office of Infectious Disease- moved to Division of Epidemiology, Health Statistics and Public Health Laboratories
- Office of Nutrition Services -- WIC and Snap Ed
- Office of Immunizations and CHILD Profile
- The Office of Healthy Communities structure integrates the programs and functions of the former Office of Community Wellness and Prevention and the Office of Maternal and Child Health and Family Planning.

The Office of Healthy Communities, which has been organized on a functional basis and has five sections:

- **Access and Care Coordination:** includes federally funded statewide programs that focus on promoting and improving the health of Washington residents. Programs within the unit include and targeted federal grants Family Planning, Maternal and Child Health, Early Childhood Comprehensive Systems, Prevention of Teen Pregnancy, Domestic Violence against Women, Early Childhood Wellness and Mental Health, and First Time Mothers. The purpose of the Access and Care Coordination Section is to improve health and health equity of Washington State Citizens, particularly focusing on Women, Children, Youth, and families through working on improve access to health and preventive services. The purpose of the section is to develop and support access, outreach, linkages to services and case management including coordination with relevant entities. This section achieves this through working to achieve health equity through improving access, planning, developing and implementing population health programs, and fostering policy, environmental and systems changes.

//2013/ACC section became the Access, Systems and Coordination section (ASC). CYSHCN has also been moved to this section.//2013//

- **Practice Improvement:** includes federally funded statewide programs that focus on promoting and improving the health of Washington residents. Programs within the unit include Asthma, Breast Cervical and Colon Screening, Children with Special Health Care Needs, Diabetes Prevention and Control, Genetics, Heart Disease and Stroke Prevention Program, and the Medical Home Quality Improvement Project. The purpose of the section is to develop and support partnerships across health care delivery and purchasing systems to improve the quality, outcomes and affordability of health care. This section achieves this through participation on cross agency work groups, establishment and maintenance of key stakeholder relationships including health reform partners in the Health Care Authority and Department of Social and

Health Services, Aging and Disability Services, training health care providers to improve the quality and efficiency of clinical preventive services and care for people living with chronic conditions like diabetes and heart disease.

- **Community Based Prevention:** includes federally funded statewide programs for Adverse Childhood Events, Coordinated School Health, Healthy Communities, Nutrition Physical Activity and Obesity Prevention, Oral Health, and Tobacco Prevention and Control. The purpose of the Community Based Prevention Section is to develop and support policies, environments and systems to prevent disease, injuries, and adverse childhood experiences. The purpose of the section is to develop and support policies, environments and systems to prevent disease, injuries and adverse childhood events. The section achieves this through implementing neighborhood and population level programs and fostering policy, environments, and systems changes.
- **Partnerships, Planning and Policy and Operations:**

enhances the effectiveness of the Office programs through provision and coordination of statewide partnership and policy development, and administration services. The section coordinates performance management and accountability projects; develops and implements health systems projects such as Community Health Worker Training System, prevention based health reform, and Meaningful Use/Health Information Exchange; ensures integration of social determinants of health and health equity into all planning, policy, funding decisions and partnership work; coordinates OHC legislative process and requests for information; supports and aligns all OHC partnership efforts such as the Healthiest Communities Partnership, Washington Cares about Cancer Partnership, and others; coordinates OHC sustainability efforts through grant funding research, application coordination, and reporting; develops and disseminates OHC's policy, environment and systems change agenda with input from agency, partners and other stakeholders; researches, develops, and disseminates materials on policy, environmental and systems change issues, interventions, and best practices; and monitors policy, system and environmental change efforts statewide and tracks policy change progress and outcomes measures.

- **Surveillance and Evaluation:** provides surveillance, evaluation, assessment support to the Office, Division and Agency. Surveillance work includes the collection and reporting of notifiable condition information such as through the birth defects and cancer registries and through the administration of surveys such as the Healthy Youth Survey and Pregnancy Risk Assessment Monitoring System (PRAMS) as well as participation in other surveys such as Behavioral Risk Factor Surveillance System (BRFSS). Surveillance and Evaluation uses the data from the registries and surveys, as well as other sources of data, to inform state and community level program and policy decisions. Surveillance and Evaluation staff also provide program evaluation to assure programs are meeting expectations. The section is responsible to assure assessment, surveillance and evaluation systems are in place required for effective planning, monitoring, and action to improve health outcomes.//2012//

/2013/OHC is organized to integrate MCH BG activities to improve efficiencies and share best practices through a life course approach. OHC is developing a single statewide plan titled the Washington State Plan for Healthy Communities (WSPHC) to guide our work, communities and stakeholders to implement policy, environmental, and systems changes to improve the overall health of all Washingtonians. The goal of the integrated plan is to provide a unified platform for DOH's efforts to create healthier communities in collaboration with key partners and community leaders.

We are using 6 overarching strategies to achieve population-wide improvements: 1) Policy, environment, program, and infrastructure changes to support OHC priorities, 2) System change to improve delivery and use of high impact quality clinical preventive services to prevent and control chronic conditions; and 3) Clinical and community linkages to ensure that people at risk are referred to clinics for screening and treatment, and clinical providers connect patients to community prevention resources as a

framework for developing and implementing our WSPHC. 4) surveillance and evaluation 5) empower individuals and 6 partnerships. Additionally, we are applying a health-equity lens to prioritize culturally appropriate interventions for high-risk groups.

A multi-step process is used to develop this plan. The first step was assimilating state plans and grants such as the MCH Block Grant, Cancer Plan, Diabetes Prevention and Control Plan, to review related or mutually reinforcing activities and identify OHC priorities. Staff linked state and national public health improvement initiatives and public health accreditation requirements. This step has been completed.

The second step is stakeholder involvement. Stakeholder participation is occurring through state and regionally led efforts. Using the most recent county-level data profiles, local stakeholders are engaging community leaders and members. We are working with Washington's Healthy Communities Hubs which allows us to meet partners where they are geographically and enables us to use our partners pre-established communication channels. This step is currently in process.

An interview guide developed by the UW's Prevention Research Center is being modified and will be used in our last step, gaining consensus on the identified issues. Each state plan goal, objective, and strategy will be reviewed by relevant internal and external participants assigned to appropriate work groups. Recommendations for continued inclusion, exclusion, or changes to the WSPHC will be submitted and reviewed. Content experts will draft a final framework and list of recommendations. DOH will convene the recently formed Prevention Alliance (PA) to review these recommendations and provide final endorsement and guidance. Attachment-State Plan Overview, OHC Logic Model and Stakeholder Involvement Timeline//2013//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The Office of Maternal and Child Health (OMCH) has staff in a variety of specialty areas including: epidemiology, public health administration, public health nursing, social work, oral health, children with special health care needs, obstetrics, perinatal care, adolescents, early childhood, health education, nutrition, genetics, immunizations, and psychology.

The family perspective is an integral component of developing high quality, culturally competent programs and public policy. OMCH employs a parent of a child with special health care needs as a full-time family involvement coordinator for the CSHCN program. This individual works with staff on all CSHCN issues and plays an instrumental role in facilitating family consultation and participation within OMCH and at the local, regional, and state level. OMCH's Family Involvement Coordinator takes a leadership role in activities to increase family involvement in children with special health care needs policy and program development, including implementation of the family leadership strategic plan to increase integrated systems of care for CSHCN and their families. The Family Involvement Coordinator also develops and manages contracts, grants, and other program activities related to children with special health care needs and the broader maternal and child health population. The current Family Involvement Coordinator for OMCH is one of five delegates from Washington to the Association of Maternal and Child Health Programs (AMCHP).

The majority of staff are located in Olympia, Washington. The Genetic Services section is located in Kent, Washington, which is south of Seattle and Shoreline, Washington which is on the northern edge of Seattle.

/2012/Following are brief biographical sketches of Department of Health (DOH) senior management and OMCH managers: (Appendix 6-New Organizational Charts)//2012//

Mary Selecky has been the Secretary of Health since 1999. She is a political science and history

graduate of the University of Pennsylvania and past president of the Association of State and Territorial Health Officers (ASTHO). Prior to her appointment as Secretary of Health, Mary worked for 20 years as the Administrator of the North East Tri-County Health District in Eastern Washington.

Dr. Maxine Hayes serves as the Health Officer for DOH. Prior to this, she was the Assistant Secretary of Community and Family Health, the Title V Director, and president of the Association of Maternal and Child Health Programs. Dr. Hayes is Associate Professor of Pediatrics at the University of Washington, School of Medicine and is on the MCH faculty at the University's School of Public Health and Community Medicine. In October 2006, Dr. Maxine Hayes was elected to the Institute of Medicine of the National Academies. The Institute is the principal advisor to the federal government, health care organizations and research institutions on health policy.

Allene Mares became Assistant Secretary for the Division of Community and Family Health in July, 2010. She also directs DOH's Office of Public Health Systems and Development. Allene has over 30 years experience in public health. Prior to coming to DOH, she was the Health Officer/Executive Director for the Cascade City-County Health Department in Great Falls, Montana and the Health Commissioner for Public Health-Dayton & Montgomery County, Ohio. She has also worked in management positions at health departments in Seattle & King County, Seattle, WA, Monterey County, CA and Tacoma-Pierce County Health Department in Tacoma, WA. Allene has a Master's degree in Public Health from the University of Washington and a Bachelor of Science in Nursing from Montana State University.

Mary Wendt was the Assistant Secretary for the Division of Community and Family Health until June, 2010. Mary joined DOH in 2008 after nearly eight years with the Washington State Department of Social and Health Services (DSHS), most recently serving as the Chief Financial Officer for the Mental Health Division. Her prior roles with DSHS include serving as the Office Chief for the Office of Rates Development, where she oversaw professional-level analysts in charge of setting reimbursement rates and policies for the state's Medicaid program. She has also served as the Rural Health Clinic and Federally Qualified Health Center Program Manager for DSHS. Mary has a Master's in Public Administration: Health Administration from Portland State University and a Bachelor's Degree in Biology and Chemistry from the University of Utah. /2012/Ms.Wendt no longer works for the Department.//2012//

Jennifer McNamara is the Chief Administrator for Community and Family Health at the Washington State Department of Health. Jennifer is a certified Project Management Professional, past manager of the Department of Health Project Resource Center, and is a twenty five year veteran of state government, serving both Department of Information Services and Department of Transportation previously.

/2012/Sue Grinnell became Director of the Office of Healthy Communities in July, 2011 and serves as the MCH director and AMCHP delegate. Since December, 2006, she has been Office Director for Community Wellness and Prevention. Sue has over 30 years experience in public health. Prior to coming to DOH, she was the Director for the Cowlitz County Health Department in Longview, Washington and the Disabilities Services Supervisor for EOC of Clark County, Vancouver, Washington. Sue received her Master's degree in Public Health from the University of North Carolina and a Bachelor of Science, Community Health Education from Oregon State University.//2012//

Riley Peters, Ph.D. became the Director of the Office of Maternal and Child Health (OMCH) in June 2007. Dr. Peters has a PhD in epidemiology from the University of Washington. He also holds a Master's in Public Administration with an emphasis in health administration from the University of Southern California. He has worked in local and state public health for over 25 years and served as the manager of the MCH Assessment section for five years. /2012/Riley became the Section Manager, Surveillance and Evaluation in the Healthy Communities Office in July,

2011./2012//

Amira El-Bastawissi, MBCHB, Ph.D. became Senior Epidemiologist/Manager of the Maternal and Child Health Assessment section, in October, 2009. She has a medical degree from Alexandria University, Egypt and a PhD degree in perinatal epidemiology from University of Texas School of Public Health. Dr. El-Bastawissi worked at the Seattle-King County Department of Public Health before joining the Department of Health in 2002. Prior to her current position, she worked on the evaluation of the Diabetes Collaborative, part of a statewide medical home effort. Dr. El-Bastawissi has over 15 years experience conducting epidemiologic studies, program evaluation, surveillance and health services research with specific expertise in maternal and child health, diabetes, and cancer. /2012/Dr. El-Bastawissi work for the Department ended in April, 2011./2012//

Kathy Chapman, manager of the Maternal, Infant, Child and Adolescent Health section, has a Master's degree in maternal and child health nursing from the University of Washington. She was previously the manager of the Children with Special Health Care Needs Section and also supervised the MCH Assessment Section for several years. Kathy has worked for more than 20 years in state and local public health programs focusing on maternal and child health issues./2012/Kathy became the Section Manager, Access and Care Coordination in the Healthy Communities Office in July, 2011./2012//

/2013/Kathy manages the Access, Systems and Coordination section (previously named Access and Care Coordination), in the Office of Healthy Communities./2013//

Debra Lochner Doyle, manager of the Genetic Services section, has a Bachelor of Science degree in genetics from the University of Washington and a Master of Science degree in human genetics and genetic counseling from Sarah Lawrence College in New York. She is board certified by the American Board of Medical Genetics and the American Board of Genetic Counseling. She is also the past president of the National Society of Genetic Counselors, a founding member of the Coalition of State Genetic Coordinator, current Board member of the American Board of Genetic Counseling and an Affiliate Instructor with the University of Washington, School of Public Health, Institute for Public Health Genetics. /2012/Debra is currently the President of American Board of Genetic Counseling. In July, 2011, she joined the Practice Improvement section in the Healthy Communities Office./2012//

/2013/Deb Doyle is now also the Breast, Cervical, Colorectal Health Program manager./2013//

Maria Nardella is the manager of the Children with Special Health Care Needs section. Maria has more than 20 years experience in state CSHCN programs. She is a Registered Dietitian with a Bachelor of Science degree in nutrition from Cornell University and a Master of Arts in nutrition and mental retardation from the University of Washington, including clinical training at the university-affiliated program. /2012/She is currently on the Board for the Association of Maternal and Child Health Programs (AMCHP) and serves as the Region X director. She is also on the Advisory Board for the new CSHCN National Center for Community Based Services. In July, 2011, Maria joined the Practice Improvement section in the Healthy Communities Office./2012//

/2013/Maria is part of the Access, Systems and Coordination section in the Office of Healthy Communities, and continues as the CYSHCN director for Washington State./2013//

/2012/Anne Shields became manager of the Practice Improvement section in the Healthy Communities Office in July, 2011. From January to June, 2011, she was director of the Chronic Disease Health Improvement Unit in the Office of Community Wellness and Prevention. Anne has 25 years experience in public health and health administration. She was manager of Community and School-Based Partnerships at Public Health Seattle/King County; Chief Operations Officer at HealthPoint (a group of community health centers in King County); and manager of the Community Diabetes Initiative for the Community Health Council of Seattle & King County. She previously worked for the Washington State Department of Health in the area of HIV/AIDS. Anne has a Bachelor of Science in Nursing Degree from Seattle University and a

Master's degree in Health Services Administration from the University of Washington.//2012//

Janna Bardi, manager of the Immunization Program CHILD Profile section, has a Master's in Public Health in behavioral science and health education from the University of California, Los Angeles. She was previously the manager of the CHILD Profile section before it merged with the Immunization Program in 2005. She has experience in program analysis, policy development, systems development, inter-and intra-agency collaboration, and program evaluation. Janna is a 2003 scholar of the Northwest Public Health Leadership Institute. /2012/In 2011, Janna Bardi and IPCP left OMCH and began reporting directly to the Assistant Secretary for Community and Family Health. In July, 2011 she became the Director of the Office of Immunizations in the Prevention and Community Health Division.//2012//

Shumei Yun, MD, PhD was Senior Epidemiologist/Manager of the MCH Assessment section until September, 2009. Dr. Yun holds a MD and a Master's in Public Health from Beijing Medical University, and a PhD in nutritional epidemiology from the Cornell University. She joined the Washington State Department of Health in July 2008. Prior to moving to Washington, she worked as a state chronic disease epidemiologist in Missouri for five years. /2012/Dr. Yun vacated her position January, 2010.//2012//

/2012/ Pama Joyner, section manager of the PPPO section has 24 years of experience working in collaboration with state and local legislators, state health commissioners, legal/policy experts, and major health system organizations on behalf of the state's chronic disease programs.//2012//

/2012/Susan Ray, Family Involvement Coordinator, takes a leadership role in activities to increase family involvement in children with special health care needs, and policy and program development. CSHCN involves parents in the majority of our work. Many of the contractors we work with are parents of children with special needs or work directly with families of CSHCN. In addition, the CSHCN Family Involvement Coordinator provides input on the family perspective in all areas of the work we coordinate. The Family Involvement Coordinator also develops and manages contracts, grants, and other program activities related to children with special health care needs and the broader maternal and child health population. The current Family Involvement Coordinator is one of five delegates from Washington to the Association of Maternal and Child Health Programs.//2012//

/2013/Susan is now part of the Access, Systems and Coordination section in OHC.//2013//

/2013/Paj Nandi assumed his current role as the Community Based Prevention Section Manager in the Office of Healthy Communities in August 2011. He is responsible for supervising and overseeing a team of 19 staff working on policy, systems and environmental change strategies related to healthy eating, active living, tobacco prevention, oral health, school health, healthy communities and adverse childhood events and experiences. Prior to his current role, Paj managed the state's Heart Disease and Stroke Prevention Program and served as the Policy and Advocacy Chair of the National Cardiovascular Health Council in 2010-11. Paj has also worked in Maternal and Child Health; he was the state's teen pregnancy prevention coordinator and was instrumental in shaping policy around medically and scientifically accurate sexual health information for school-age youth. Paj holds a Bachelor of Science degree in Community Health from Western Washington University and a Master of Public Health degree from the George Washington University.

OHC has developed a business plan (attached) which includes all aspects of the office and program functions and serves as the yearly planning and review document.//2013//

An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

//2012/ The Community and Family Health Division (CHF) is now the Division of Prevention and Healthy Communities. The partnerships described here will continue; however, restructuring may realign the responsible units.//2012//

Working with other DOH federal grant programs:

OMCH collaborates with several DOH federal grant programs within the Community and Family Health Division: WIC, HIV/AIDS and Family Planning and Reproductive Health (FPRH).

OMCH, WIC, FPRH and over ten other DOH programs form the Women's Health Resource Network (WHRN)--a forum for DOH-wide input and response to women's health issues and service gaps. Its goal is to help build state and local capacity to address women's health needs. The focus includes data analysis, quality assurance, program services, and health systems changes.

To improve women's health and access to obstetric care, MICAH works with the Offices of Rural Health, Tobacco Control and Prevention, HIV Prevention and Education, and Injury Prevention Program (IPP) and WIC.

MICAH convenes the cross-division Preconception Workgroup of partners from WIC, Chronic Disease Prevention, FPRH, STD program, and others.

OMCH works with DOH's HIV/AIDS program to develop effective policies and programs for HIV/AIDS prevention and care in the MCH population and to increase HIV testing of pregnant women.

WIC and MICAH promote breastfeeding, exchange data, enhance referrals, and address access issues between WIC and Title XIX programs for pregnant women. They also collaborate on policies and practices to promote workplace breastfeeding.

//2012/ We work with DOH's Injury Prevention on Child Death Review. Block Grant funds support Safe Kids Coalitions and the State Injury and Violence Prevention Plan. The CSHCN Program works with the University of Washington (UW) and WIC to train WIC dietitians about nutritional needs of CSHCN.//2012//

CSHCN, WIC and Newborn Screening cross-train staff and coordinate coverage for special formulas for children on Medicaid. WIC and IPCP collaborate on nutrition materials for CHILD Profile mailings. IPCP works with WIC to enhance immunization rates. MCHA and WIC collaborate to evaluate issues like WIC's impact on adverse pregnancy outcomes.

MICAH trains WIC staff to identify and intervene in cases of domestic violence and child abuse. The Family Violence Prevention Workgroup, with members from OMCH, IPP, Emergency Medical Services, and FPRH plans and evaluates activities and seeks resources to decrease family violence.

The Oral Health program works with chronic disease programs in Community Wellness and Prevention as well as the Office of Rural Health.

//2013/Family Violence Prevention Workgroup is no longer active.//2013//

Working with other state agencies

OMCH collaborates with many state agencies including the Department of Health and Social Services (DSHS), Office of the Superintendent of Public Instruction (OSPI), Department of Early Learning (DEL), Council for Children and Families (CCF), University of Washington, Family Policy Council, Developmental Disabilities Council, Office of the Education Ombudsman, Office of the Insurance Commissioner, Health Care Authority, and Department of Commerce.

/2013/The Family Policy Council ends 6/2012.//2013//

1. Washington State Board of Health (SBOH) is an independent 10-member board appointed by the Governor. The Secretary of Health is a required member. OMCH works with SBOH on children's health issues and rulemaking activities. Topics addressed include newborn screening; prenatal screening, HIV testing of pregnant women, immunization requirements for school and child care attendance, genetics, and hearing, vision, and scoliosis screening in schools. The SBOH has a representative on the Medical Home Partnership Committee hosted by CSHCN. /2012/Oral Health works with the SBOH, WIC, licensing boards, HRSA Region X and others. //2012//

2. We frequently collaborate through interagency groups and public/private partnerships to ensure all stakeholders are at the table. A good example is Early Childhood Comprehensive Systems (ECCS) Grant which MICAH administers. The broad based, public-private ECCS partnership includes the DEL, its Head Start office, Thrive by Five Washington, OSPI, Foundation for Early Learning, Reach Out and Read, CCF, and many other stakeholders. ECCS has five critical components: health, social-emotional development and children's mental health, early care and education, parenting, and family support. Staff work with all OMCH sections to improve systems across these components and link with the state's SAMHSA Project, Linking Actions for Unmet Needs in Children's Health (LAUNCH) grant, as required by both grants. The ECCS partnership is creating an Early Learning Plan for Washington--a strategic plan to assure children are healthy and ready for school. ECCS also works to integrate medical home into health and early literacy activities; integrate Strengthening Families protective factors across early learning systems; develop a Birth to Three plan for the state, and assure mental health is included in services for child well-being. ECCS has convened a stakeholder workgroup to collaborate, examine, and expand our role in home visiting.

/2012/ Many of these same partners, state agencies, and professional organizations are working on the Developmental Screening Partnership Committee to create a system to support universal developmental screening.//2012//

/2013/Council for Children & Families ends 6/2012, and work is transitioning to DEL.

Medicaid moved to HCA

//2013//

3. The Mental Health Transformation Grant (MHT) ends in late 2010 after five years. An MHT Prevention Advisory Group, with members from DSHS, OMCH, OSPI, and SBOH, has been working to promote a public health approach to mental health. This group is now transition planning for the long term continuation of the cross agency, public-private, state-local partnerships established during the MHT. OMCH keeps public health and early learning stakeholders informed about how to coordinate with and influence this work. OMCH staff also promotes a public health approach to mental health on an advisory group to DSHS-Division of Behavioral Health and Recovery (DSHS-DBHR) on children's treatment and services.

/2013/MCH/OHC director co-chairs state policy enhancement consortium with DBHR//2013//

4. Healthy Child Care Washington (HCCW) is a MICAH program that works with the DEL, OSPI, the local health jurisdictions (LHJs), other OMCH sections and Division of Environmental Health (EH), to distribute information to Child Care Health Consultants at the LHJ's and child care providers on a variety of topics.

/2012/HCCW funding ended. We still collaborate with DEL and others on health and safety in early learning.//2012//

5. Many programs across OMCH collaborate with the Department of Social and Health Services (DSHS) Medicaid Purchasing Administration (MPA) to implement the state Medicaid plan. The CSHCN manager serves on the Title XIX Interagency Advisory Committee.

To improve women's health and access to obstetric care, MICAH collaborates with MPA, the Children's Administration (CA), other agencies; and contractors. First Steps Maternity Support Services (MSS) works to improve early access to prenatal care through its diverse base of providers.

MPA supports PRAMS since data is stratified by Medicaid recipient status and used by the First Steps program to evaluate services effectiveness. MCHA and DSHS collaborate to compare birth outcomes of Medicaid women to others.

MICAH assists DSHS in managing the MSS and childbirth education programs targeting pregnant women under 185% of the Federal Poverty Level. OMCH participates on an oversight committee for a treatment program for chemically dependent pregnant or parenting women and their children with DSHS-DBHR and the CA.

//2012/Budget reductions ended our role in First Steps. DOH still collaborates with DSHS and the Health Care Authority on birth outcomes for low income women.//2012//

OMCH works with DSHS to provide outreach for the Apple Health for Kids program, which consolidates outreach for Medicaid, SCHIP, and state children's coverage. CSHCN assists MPA with implementing recently expanded publicly funded health coverage for children. OMCH provides DSHS-DBHR with data to meet Medicaid 1915B waiver requirement to identify the number of children with special health care needs served by both Title V and Mental Health.

CSHCN partners with MPA and LHJs to work with Medicaid managed care plans to meet requirements of the CMS 1915B waiver which requires MPA to identify, track, and coordinate care for children in managed care who are also served by Title V. It also allows families to request an exemption from managed care if needed.

Through CSHCN Communication Network meetings, CSHCN, MPA and health plan representatives work to improve access to and quality of health services for children with special health care needs and to implement quality assurance measures and data sharing for Title V children in Medicaid managed care.

OMCH partners with DSHS-MPA and the Health Care Authority- the two largest purchasers of health care in Washington--to develop performance measures for providers and health plans caring for children . While the focus of this effort is children in publically funded health coverage, all children receiving care in Washington benefit when services meet performance measure targets. DSHS-MPA and IPCP work to maintain and expand partnerships with the state's health plans through a quarterly meeting with health plan quality staff.

CSHCN is also working with managed care plans to identify ways to provide medical homes for all children. Expansion of publicly funded health coverage includes provision of care within a medical home. New legislation in 2008 funded primary care pilots to implement medical home for all patients using a learning collaborative model currently used by CSHCN medical home teams.

CSHCN, Disability Determination Services (DDS) and the Social Security Administration have an agreement to provide information to families of children under 16 years who apply for Social Security Income (SSI). DDS provides data files of all SSI applicants up to age 16 years to the CSHCN program.

MPA and IPCP have data sharing agreements. They also develop and distribute health promotion materials for parents. MPA is on the CHILD Profile Advisory Group. IPCP works with MPA on the Vaccines for Children (VFC) Program to ensure VFC-qualified children get adequate immunizations. IPCP has an agreement with DSHS to distribute information about development and early intervention services to parents of infants ages 3 to 18 months.

OMCH works with the Division of Developmental Disabilities' Infant Toddler Early Intervention Program (ITEP) to implement Part C of the Individuals with Disabilities Education Act. An interagency agreement of DOH, DSHS, Department of Commerce, Department of Services for the Blind, and OSPI ensures a broad statewide system of early intervention services for eligible children birth to 3 years with disabilities and their families.

/2012/ITEP is now Early Support for Infants and Toddler (ESIT) at DEL.//2012//

OMCH provides state funding match for Medicaid prenatal genetic counseling services. OMCH oversees the program and works with MPA to ensure that up-to-date billing instructions are in place and that MPA has a current directory of qualified providers. Medicaid also covers genetic counseling services for parents of infants up to 90 days after birth. GSS has a data sharing agreement in place with DSHS-ITEP matching their early intervention data with our EHDDI data to evaluate the goal of infants with hearing loss entering early intervention services by six months of age. GSS works with the DSHS- Office of the Deaf and Hard of Hearing to link members of the deaf and hard of hearing community to families with infants diagnosed with hearing loss.

/2013/The MHT Prevention Advisory Group no longer meets. The DSHS-DBHR mental health advisory group is now Behavioral Health Advisory Group, DOH is a part.//2013//

6.Office of the Superintendent of Public Instruction (OSPI): IPCP works with OSPI to distribute child development and school readiness information and with OSPI Health Services on immunization requirements for school entry. OSPI is on the IPCP CHILD Profile Advisory Group. CSHCN participates in monthly OSPI School Nurse Corps (SNC) meetings. SNC supervisors attend MCH Regional meetings. SNC and OMCH participate in each other's regular meetings. Washington State received a Coordinated School Health (CSH) Grant from CDC. This is a partnership between DOH and OSPI. CSHCN and MICAHA are on the CSH Interagency Committee and work to align this effort with related adolescent health and mental health planning initiatives. The CSHCN section works with OSPI to identify appropriate health outcomes for CSHCN. OSPI is on the Combating Autism Advisory Council. MICAHA works with OSPI and local health jurisdictions to review sexual health education curricula for adherence to the state's Healthy Youth Act and to develop scientific accuracy trainings for school personnel.

/2012/We work with OSPI to support teen parents.//2012//

/2013/ School Health Interagency Workgroup, with state depts. of Health, Education, Early Learning, Employment, DSHS, and State Board of Health, meets monthly.//2013//

7.Department of Early Learning (DEL): DEL partners with MICAHA on the ECCS and the MH Transformation grants. It is also on the CHILD Profile Advisory Group and provides materials for CHILD Profile Health Promotion mailings on choosing quality child care.

/2012/The Transformation grant ended, other projects with DEL are the Early Learning Plan and Home Visiting grant.//2012//

8.University of Washington (UW): UW's Center on Human Development and Disability (CHDD) receives Leadership Education for Neurodevelopmental Disabilities grants. OMCH uses MCH block grant funds to extend and enhance MCH priorities in the areas of CHILD Profile, nutrition, high-risk infants and children, adolescent transition, medical home, and emotional behavior in very young children. MICAHA also works with the CHDD to develop and implement curricula on topics such as improving nutrition, and teen pregnancy prevention. GSS staff works with the UW Center for Health Policy, Center for Genomics Healthcare Equality and the Institute for Public Health Genomics on a variety of training and health systems research endeavors. /2012/ CSHCN and UW LEND Program created Combating Autism Advisory Council (CAAC). With autism funding ending, LEND has agreed to support CAAC for another year.//2012//

/2013/Adolescent Helath Transition Project ended 6/2011.//2013//

9.Washington State Developmental Disabilities Council and Office of the Education Ombudsman

are partners on the CSHCN Autism Project.

10. The Council for Children and Families (CCF) partners with IPCP to provide shaken baby and post partum depression brochures in the CHILD Profile Health Promotion mailings. The OMCH Director is on the boards of CCF and the Family Policy Council.

/2013/CCF and Family Policy Council both end 6/2013.//2013//

11. The Oral Health Program has a core advisory group that consists of representatives of the main organizations involved in dental health from the public and private sectors.

/2013/OHP works with Medicaid, DSHS/HCA, and OSPI to collect data on school sealant programs.//2013//

12. The Planning Committee for the Healthy Youth Survey, a Washington survey of adolescents, has staff from OMCH and other DOH programs, OSPI, Department of Commerce, DSHS, the Liquor Control Board, and the Governor's Family Policy Council. With other state and local agencies, they form the Washington State Partnership for Youth, whose purpose is to develop a plan for improving adolescent health in Washington State.

/2013/TP works with Reduce Underage Drinking (RUaD) coalition, AG office, DSHS, OSPI, LCB (Liquor Control Board) Dept. of Commerce and participates in WA Interagency Network (WIN) to coordinate efforts to prevent substance and tobacco use, with DSHS, LCB, OSPI, and Commerce and Dept. of Revenue.//2013//

Working with Local Health Jurisdictions (LHJs), Schools, and Counties:

1. OMCH contracts with 35 LHJs to address maternal and child health needs in local communities. OMCH works with LHJs to oversee contract activities and provide consultation and technical assistance. OMCH administrators and staff meet regularly with the Nursing Directors of LHJs and other local MCH staff through quarterly MCH Regional meetings. DOH works with Nursing Directors to develop key activities, outcomes, and indicators for local public health. MICAH provides technical assistance and data support for the local Child Death Review teams. Oral Health has a list serve for communication with and among LHJs. Until the end of FY2011, Oral Health will train and give technical assistance to the LHJ oral health coordinators. Some LHJ activities are described in the performance measure narratives. A report of LHJ activities is available by contacting OMCH at 360-236-3502 or mch.support@doh.wa.gov.

/2012/To increase needs assessment capacity, we will amend the LHJs' 2013 contract. Each LHJ will submit a) 5 yr. assessment on the needs and capacity of their MCH populations and b) plans to be accountable for performance measures. Oral Health will support local Healthy Communities initiatives.

We work with LHJ CSHCN Coordinators to collect outcome data on nursing interventions for CSHCN.

Eight LHJs participated in the Epilepsy Grant activities. The autism grant had eight LHJs doing Community Asset mapping on early screening for autism.//2012//

/2013/TP contracts with 35 LHJ's to educate retailers.//2013//

2. MICAH, the DOH Office of Health Promotion, OSPI, LHJs and other stakeholders collaborate to promote school-based health centers (SBHC). Through a School-Based Health Center Interagency Group they implement the Coordinated School Health Grant; provide technical assistance to existing SBHC and communities interested in starting SBHC. OMCH supports two SBHC's with ongoing funding, has funded others for short term projects, and is exploring ways to increase mental health access and address SBHC provider reimbursement issues.

/2012/We will only support one SBHC after June 2011.//2012//

3. MICAH is the state coordinator for the SAMHSA Project LAUNCH grant to promote young child (0 to 8) wellness at a local and a state systems level. Our local LAUNCH partner, Yakima County, is implementing evidence-based practices to strengthen family and caregiver skills to promote positive social emotional development. Washington State University is evaluating LAUNCH. ECCS and LAUNCH staff collaborate, benefitting both efforts. The Project LAUNCH Young Child Wellness Council has partners from public and private agencies. LAUNCH, with the Autism Grant, is co-convening a statewide stakeholder to develop a universal developmental screening vision and plan.

Working with Hospitals and Other Specialized Services:

1. GSS contracts with Seattle Children's to provide training and technical assistance to birthing hospitals on newborn hearing screening. Seattle Children's Center for Children with Special Needs provides information to families, providers, and policy makers on health issues for children with special health care needs and their families. IPCP works with Seattle Children's to develop and distribute materials for parents of children aged birth to six years on injury prevention and on preventing and treating childhood illnesses. Since Seattle Children's is a regional pediatric referral center, children and families from Alaska and Idaho also benefit from some of these collaborative efforts.

/2013/We work with Seattle Children's Protection Program on a shaken baby prevention task force and other child abuse and neglect prevention efforts.//2013//

2. Mary Bridge Children's Hospital and Health Center (MB) is the site of an OMCH supported neurodevelopmental center and the Maxillofacial Review Team for Southwest Washington.

3. OMCH contracts with Yakima Valley Memorial Hospital to provide services to MCH population.

4. CSHCN contracts with Sacred Heart Children's Hospital for nutrition services in the Spokane area. Madigan Army Medical Center partners on the CSHCN Autism Project.

/2012/ Naval Air Station Whidbey Island joined the Autism Project. Madigan left it. CSHCN worked with both epilepsy and autism centers at several hospitals to improve collaboration with local health and mental health providers. We also worked to identify system barriers to autism diagnosis and better ways to collaborate with schools.//2012//

5. Neurodevelopmental Centers (NDC): CSHCN provides funding to support the infrastructure of 15 NDCs across the state. NDCs provide evaluation, diagnosis, coordinated treatment planning, and specialized therapy to children with a variety of developmental or neurodevelopmental conditions. These non-profit centers depend on funding from the state and other sources to provide a structure for specialty services.

6. GSS helps fund six of Washington's 30 genetics clinics to provide clinical genetic services for the MCH population and educational outreach to communities. GSS uses annual utilization data from the clinics for program planning and policy development.

/2012/Due to budget cuts, contracts with 8 genetic clinics were reduced to 3.//2012//

7. Four Perinatal Regional Networks coordinate state and regional quality improvement projects to decrease poor pregnancy outcomes. MICAH coordinates and funds this work through contracts with four regional perinatal programs.

8. Perinatal Advisory Committee, staffed by MICAH, brings together representatives of the Perinatal Regional Network, tertiary care centers, professional associations, consumer groups, and state agencies to review and assess perinatal health issues and advise DOH and MPA about policies and practices to improve perinatal and neonatal outcomes.

9. Community Health Clinics (CHC) play a major role in providing access to direct health services as LHJs continue to move toward core public health functions. Most CHCs are First Steps providers and participate in First Steps education updates sponsored by OMCH and MPA.

/2012/This First Steps work has ended.//2012//

/2013/OHP provides CHCs, CMHCs and Free Clinic Assoc., Women's Prison system, oral health messages and referrals to Medicaid, low-income and/or uninsured patients. HEAL partners with WIC and ASC to fund the Maternity Care Practices in Hospitals breastfeeding project.//2013//

Working with Tribes

Areas of concern in American Indian Health Commission's (AIHC) 2010-2012 Health Care Delivery Plan are infant mortality, teen pregnancy, immunization rates, and oral health. MICAH, Oral Health, IPCP, the First Steps program, WIC, and tribal liaisons work on strategies to improve health outcomes in Native American mothers and children through AIHC workgroups. MCHA works closely with the Northwest Portland Area Indian Health Board and the Seattle Urban Indian Health Institute on maternal and infant assessment issues.

OMCH and DOH's tribal liaison have expanded and improved communication with tribes. With AIHC, we expanded use of the DOH Tribal Connections website.

/2013/OHP works with tribes to provide oral health messages, HEAL co-funds the Healthy Tribal Communities project, and provides TA to AIHC. TPC contracts with AIHC of Washington to implement a Healthy Communities model in tribes. Liaison with Indian Education at the state education agency to strengthen SBH strategies.//2013//

Working with Communities, Foundations, and Organizations

1. WithinReach, the state's Healthy Mothers, Healthy Babies organization, works with IPCP to provide information on child health and immunizations and immunization outreach activities through the Immunization Action Coalition of Washington. WithinReach also provides content on accessing health insurance for CHILd Profile Health Promotion mailings.

/2012/We work with WithinReach on projects related to pregnant women/teens and new parents. We partner with WithinReach on the Family Health Hotline and parenthelp123 website.//2012//

2. The Autism Society of Washington, Autism Speaks Washington, Family Voices of Washington, Washington PAVE, the Family to Family Health Information Center, and Easter Seals partner with CSHCN on its Autism Project.

/2012/Northwest Autism Center and a family group joined the Autism Project.//2012//

3. Epilepsy Foundation Northwest and CSHCN are collaborating on a 3 year grant to DOH to improve community-based system of services for children and youth with epilepsy. Activities focus on medically underserved and rural areas of central Washington, particularly areas with large Hispanic populations.

/2012/The epilepsy project ended in 2010.//2012//

4. GSS and Washington Sensory Disabilities Services train providers statewide to work with deaf or hard of hearing children and to conduct a birth-to-three educational program at the annual Deaf Family Weekend.

5. GSS contracts with Washington State Hands and Voices to support the "Guide By Your Side™ Program", a resource for parents of children with or at risk for hearing loss. Trained parent guides provide information and support for families about newborn hearing screening, diagnostic

evaluation, early intervention, and other services

6.Foundation for Early Learning (FEL) and IPCP revise and distribute the "Birth to 18 months" and "18 months to 3 years" development charts for parents. The charts address social, emotional, physical, language, motor, and cognitive development and give parents specific activities to support their child's development. FEL and CHILD Profile distribute a booklet on school readiness to parents of 4-year-olds.

7.Washington Dental Service Foundation and Washington State Dairy Council work with IPCP on materials in their areas of expertise for the CHILD Profile mailings.

8.IPCP, CSHCN and MICAH work with health care provider associations including the Washington Chapter of the American Academy of Pediatrics, Washington Association of Family Physicians, Washington State Obstetrics Association and the Washington Medical Association, to provide information on best practices for immunization, quality assurance activities around vaccine use, special projects to increase immunization rates, developmental screening and prenatal practices.

9.Oral Health works with the state dental and dental hygienists associations to reach private dental and dental hygiene providers and also with DOH's Office of Rural Health and the WA Association of Community and Migrant Centers to reach dental providers working in community health centers and other public clinics.

/2012/Federal funds support dental workforce development in underserved areas.//2012//
/2013 OHP works with state dental and dental hygienists associations, colleges, WA Dental Service Foundation, WA Oral Health Foundation, WithinReach, SHIBA, WACMHC, Free Clinic Association and WA State Oral Health Coalition to bring oral health messages to all WA residents. TPC participates with American Lung Association, American Cancer Society, and American Heart Association to promote tobacco free living.//2013//

10.OMCH sponsors HRSA Graduate Summer Interns, Council of State and Territorial Epidemiologists fellows and practicum students from the University of Washington.

11.MCHA staff actively participates on many work and advisory groups that impact policy both internal to DOH and statewide. Examples are the Preconception Workgroup, C-section Workgroup, Perinatal Advisory Committee, Child Death Review, Childhood Drowning Policy Task Force, and Coordinated School Health Workgroup.

/2013/WA is one of 3 states funded through Action for Healthy Kids project. Our PPPO section developed a database of all partner's activities statewide to reduce duplication, improve comm. and track policy.//2013//

An attachment is included in this section. III E - State Agency Coordination

F. Health Systems Capacity Indicators

/2013/Publically funded insurance and receipt of services

HSCI02	Medicaid enrollees with one screen
HSCI03	SCHIP enrollees with one screen
HSCI06a	Infant eligibility for Medicaid and SCHIP
HSCI06b	Children eligibility for Medicaid and SCHIP
HSCI07a	Medicaid eligible children who received a service
HSCI07b	EPSDT eligible children who received dental services
HSCI08 SSI	Beneficiaries who received services from CSHCN pgm

Publically Funded Insurance and Receipt of Services

Utilization by children of preventive medical services paid for by public funding in WA has been on the increase. According to HEDIS reports the percent of Medicaid enrollees less than one year of age who have received at least one screen has increased since 2000 from 87.0% to 99.4% in 2010. In every year since 2005 at least 99% of these infants have received at least one screen. SCHIP children are not examined as a separate group in the HEDIS scores but there is no indication that they are different from the non-SCHIP children in regards to having received a screening. In WA State infants (< 1 year) and children (1-18 yrs) up to 200% of the FPL and pregnant women up to 185% of FPL are eligible for Medicaid. Infants and children up to 300% of FPL are eligible for SCHIP. Pregnant women are not eligible at all for SCHIP in WA State. The percent of Medicaid eligible children, 1-21 years of age, who received a service in the previous year, has increased by almost ten percent since 2007 from 88.5% to 97.2%. Some of that increase may be due to the change to a new computerized system by the Medicaid program in WA. EPSDT eligible children between the ages of 6 and 9 who have received dental services have seen a moderate increase since 2006 from 57.0% to 62.8% in 2011. WA has only two years of data which track the percent of SSI beneficiaries in WA 16 years old and under that received services from the CSHCN program due to past restrictions on data from the Social Security Administration. In 2010 and 2011, the years for which we have data, 4.9% of SSI recipients received services.

Medicaid vs non-Medicaid access to care and outcomes

HSCI05a	LBW Medicaid vs non-Medicaid
HSCI05b	IMR Medicaid vs non-Medicaid
HSCI05c	1st Tri PNC Medicaid vs non-Medicaid
HSCI05d	Adequate PNC Med vs non-Med
HSCI04	Kotelchuck score = or > than 80
HSCI06c	Pregnant women eligibility for Med and SCHIP

Medicaid vs. non-Medicaid indicators

In Washington State there are clear and consistent disparities among pregnancy related risk factors and poor birth outcomes between women whose births are paid for by Medicaid and those whose births were non-Medicaid deliveries. Given that Medicaid pays for approximately 50% of deliveries in WA these disparities have real and have measurable negative impact on the whole of perinatal health in WA.

All of the main perinatal indicators remain worse for women on Medicaid compared to non-Medicaid women. Low birth weight (LBW) remains higher for Medicaid 6.8% vs. 5.7% for non-Medicaid. However, the rate of increase in LBW since 1998 has been higher in non-Medicaid women 5.0% in 1998 to 5.7% in 2010 vs. 6.6% in 1998 to 6.8% in 2010 for Medicaid women. Infant mortality remains higher in Medicaid women, 5.7/1,000 vs. 3.6/1,000 for non-Medicaid women. Infant mortality has been decreasing for both groups since 1998, however it has fallen farther for Medicaid women 7.8/1,000 to 5.7/1,000 than it has for non-Medicaid women 4.4/1,000 to 3.6/1,000. First trimester pre-natal care also shows a large disparity between Medicaid women and non-Medicaid women, 72.2% vs. 88.2% respectively in 2010. Both groups saw a drop-off in percent starting in around 2003/2004 with Medicaid women seeing a larger drop-off. Recently both groups have seen increases and are about back to where they were in 1999. In both Medicaid and non-Medicaid women the same general trend can be seen in the percent of women who rate an adequate Kotelchuck score with an approximate ten percentage point disparity, 65.5% for Medicaid women and 75.7% for non-Medicaid women. As with initiation of PNC in the first trimester this indicator shows a decline in the mid-2000s with a recent recovery to pre-decline percents. In WA women up to 185% of FPL are eligible for Medicaid, but are not eligible for SCHIP. Among Medicaid recipients those who tend to be poorer, those on TANF, tend to have worse outcomes than those who are eligible for Medicaid solely due to

their pregnancies, S-Women. However, undocumented women, who tend to be even less well-off than many TANF women, tend to fall somewhere in between S-Women and TANF women in many perinatal indicators. This may be due to stronger familial or social-cultural support systems among these women. In WA, undocumented women tend to be from Mexico, and other Latin American nations.

Since the Maternity Care Access Act in 1989, the MCH programs in the Department of Health have had a strong and productive partnership with the state's Medicaid Agency. That partnership has taken on several forms.

The State Medicaid Agency contracted with the Department of Health to manage the case management aspect of the First Steps program which was created with the law of 1989. DOH staff recruited, trained, and provided oversight to the providers enrolled in the program. Program policies were jointly developed and implemented by staff from both agencies.

Data sharing agreements were established to allow sharing of birth certificate, PRAMS and Medicaid enrollment data across the two agencies. Vital record, PRAMS and hospitalization data analysis were coordinated.

The desired outcome for this measure is to decrease disparities between Medicaid funded and non Medicaid funded perinatal outcomes.

The Perinatal Advisory Committee is staffed by the Department of Health and brings together representatives from the four regional perinatal networks, professional organizations, consumer groups, and state agencies to review and assess perinatal health issues. This group also assists in developing policies and practices to improve perinatal outcomes. The Washington State Perinatal Collaborative is the quality improvement arm of the Perinatal Advisory Committee. Together, the State Medicaid Agency and Department of health have worked with partner entities to improve perinatal outcomes.

The budget cutbacks and reorganizations in the previous few years have had significant impact on the infrastructure of both agencies. Resources are not as available to conduct joint data analysis and strategic planning.

For 2012-3, Washington continues to fund the First Steps program for the highest risk pregnant and post partum women and infants receiving Medicaid funding. The Department of Health convenes and staffs the Perinatal Collaborative in partnership with Health Care Authority, the state Medicaid agency. Our focus is on improving the perinatal care system for all women. Over the past year, we have worked collaboratively with HCA, the Washington State Hospital Association, Washington State Obstetrics Association, midwifery associations, and many other partners to reduce elective deliveries before 39 weeks. We have seen a 65% reduction. We believe that this reduction will contribute to better birth outcomes, decreased health care costs, and improved quality of care. We will continue this effort for the next year with a goal of no more than 5% elective deliveries before 39 weeks. In addition we will take on reducing variability in episiotomy rates. At the same time we are preparing to begin a 3 year quality improvement project to reduce Cesarean Section rates in Washington.

We have a multiyear project in partnership with the American Indian Health Commission (AIHC) of Washington State to develop and implement plan to improve maternal infant health in American Indian and Alaska Native women and infants. A high proportion of births to AI/AN women in our state are Medicaid funded. For 2012-3, we will continue that partnership with AIHC; they will work to engage tribes in implementing the MI plan.

African American, women have been shown to benefit from First Steps Services, but their participation in the services is lower than other women. We have a multiyear project with Tacoma Pierce County Health Department to provide outreach through churches to young pregnant African American women. The program has been successful in raising visibility of the program and imparting health messages.

Washington State home visiting program, lead by the Department of Early Learning has focused funding in the highest risk counties in the state, based on a needs assessment conducted by DOH. The needs assessment used low income as one of the major indicators of risk. With a recent expansion grant, we will have evidence-based home visiting programs in 20 of our highest risk communities in the state. Nurse Family Partnerships and Parents as Teachers are the main programs that we are funding. NFP in particular shows improvement of birth outcomes for clients.

HCA has recently awarded 5 health plans new contracts. Health plans now cover all of Washington State and almost all pregnant women on Medicaid are covered by managed care now. Over the past several years, we have analyzed PRAMS data to determine barriers to PNC access and have worked with HCA on several issues, including targeting some geographic locations with large disparities in first trimester access. Although PNC first trimester access remains a disparity, our overall good birth outcomes and poor economy have contributed to our focusing on other areas to improve birth outcomes. Washington is a state that has retained perinatal regions; we monitor births at different level hospitals and we are doing well at having high risk deliveries at the appropriate hospital. We will continue to support the Regional system and to monitor trends.

As we continue to weather the economic downturn, we are struggling to maintain the safety net services and systems we have developed over the years to close the gap in outcomes. We are increasingly partnering across state systems and public and private sectors to improve quality in our perinatal system. We are striving to agree on quality goals and using scarce resources to work toward those goals. Legislative and Executive policy makers have been supportive of these efforts.

Services Utilization

HSCI01 Asthma hospitalizations

Since 2000 there has been a sustained and significant decrease in the rate of hospitalizations due to asthma in children under 5 years of age in WA. The decrease has averaged around 5.5% per year since 2000 from a high of 36.9/1,000 in 2000 to 21.6/1,000 in 2010./2013//

An attachment is included in this section. IIF - Health Systems Capacity Indicators

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Office of Maternal and Child Health (OMCH) built the 2010 Needs Assessment (NA) process on the results of its 2005 Needs Assessment. In the early stages of the 2010 Needs Assessment, we reviewed the priorities identified in the 2005 process with OMCH leadership and with internal and external stakeholders. Their input affirmed that the priorities are still valid and provide a strong foundation for improving outcomes in maternal and child health. The priorities are:

1. Adequate nutrition and physical activity
2. Lifestyles free of substance use and addiction
3. Optimal mental health and healthy relationships
4. Health equity
5. Safe and healthy communities
6. Healthy physical growth and cognitive development
7. Sexually responsible and healthy adolescents and women
8. Access to preventive and treatment services for the maternal and child population
9. Quality screening, identification, intervention and care

Since the priorities are very broad, we initially asked stakeholders to define and choose among sub-priorities that drill down separately into each of OMCH's nine priorities. Our goal was to have more focused and concrete sub-priorities to help frame Office and program objectives. However, midway through the 2010 NA process, another significant state budget cut was proposed. This proposal continued a trend OMCH has experienced in both federal and state funding over the last few years. At the same time, there was a proposal from the Governor and legislators for the Department of Health (DOH) to reorganize OMCH services. We realized a mid-course shift in the 2010 NA process was prudent.

Given the budgetary and policy changes OMCH is experiencing and anticipates over the next several years, we refocused the Needs Assessment on identifying and enhancing core strategies that cross the nine priorities rather than defining sub-priorities that drill down into each of the nine priorities separately. These cross priority strategies will focus on the Infrastructure and Population-Based Services levels of the pyramid. For example, stakeholders consulted in the 2010 NA process valued the work that OMCH does in convening people to develop strategies and solve problems. Our work on a universal developmental screening process is a good example of OMCH's convening a range of stakeholders to work on a strategy that crosses priorities. We will seek other strategies and interventions that cross priority areas in their impact.

Concurrent with the 2010 Needs Assessment, the Division of Community and Family Health, which OMCH is part of, began a strategic planning process. The strategic planning is driven by similar budget and policy factors that impacted the 2010 Needs Assessment process. The strategic planning process is seeking new efficiencies across Offices and new ways to integrate work. For example, OMCH is looking at the life course approach as a better way to prioritize its work. At the same time, the Office Community and Wellness Prevention, which manages the chronic disease programs, is moving away from disease management toward more prevention efforts. These two changes provide an opportunity for the two offices to better integrate their work.

OMCH's efforts in the area of preconception are a good example of our using the life course approach. Preconception care aims to improve reproductive outcomes by promoting and improving the health of women prior to and in between pregnancies. We knew that focusing on preconception would be a challenge given Washington's unintended pregnancy rate. This rate has remained constant and close to 50% for many years. In 2006, we used focus groups of reproductive age women and of health care providers to get a better understanding of perspectives and behaviors regarding healthy living and the use of primary care services. The

results informed our strategies for addressing preconception issues. They lead us to develop health promotion messages that imbed factors promoting preconception health into overall healthy living messages for women of reproductive ages. These messages are now included in DOH birth control brochures, in health promotion material for WIC clients, and in a newly developed DOH women's health web page. In addition, WithinReach, the non-profit organization, operating the state's toll-free Family Health Hotline incorporated healthy living messages into telephone conversations with callers and its interactive website to connect families with children with essential services and resources, including health promotion information. We have also partnered with the state Department of Corrections, Medicaid, and other state agencies to provide appropriate health education messages and linkages to community resources to female inmates transitioning out of prison.

In most cases, the needs reflected in the 2010-2014 priorities are more pronounced than they were in previous years due to significant budget reductions and increased economic hardship statewide. In some cases, like Healthy Child Care Washington, program funding has been completely eliminated at the federal and state levels. MCH Block Grant reductions most significantly impact National Performance Measures 3 and 4 and State Performance Measures 5 and 6. Results of budget cuts are described in the performance measure narratives.

OMCH's work on national and state performance measures are described in the next two sections, C. National Performance Measures, and D. State Performance Measures. In the 2009 application and 2007 annual report, Washington introduced three new performance measures. They are process measures intended, over time, to lead to outcome measures aligned with the MCH priorities. We have been successful in using the process measures to develop three new state performance measures aligned with MCH priorities in the areas of optimal mental health and healthy relationships, health equity, quality screening, identification, intervention and care.

After the 2005 Needs Assessment, staff developed issue briefs that clearly describe our focus, objective, and expectations for each priority. We will update the issue briefs to reflect the life course approach and opportunities to work across the nine priorities. Our goal is to include updated issue briefs in the 2012 Block Grant Application and 2010 Report.

//2012//An issue brief was prepared for each of the nine priorities identified in the 2010 Five-Year Needs Assessment. Each issue brief is an overview of current data, activities supported through MCH funding, and expected outcomes. The issue briefs also compare the MCH priorities to Healthy People 2020 objectives and are located in Appendix 7 A-I. //2012//

//2013//The Office of Healthy Communities (OHC) underwent a review of the priorities of MCH, chronic diseases and family planning and merged them into eight OHC priorities. All MCH priorities were maintained from the 2010 state needs assessment and health disparities is now an overarching office wide value. An office wide planning process is currently underway to further develop cross cutting strategies to address these priorities. Attachment-OHC Priorities and definitions.//2013//

An attachment is included in this section. IVA - Background and Overview

B. State Priorities

2005 - 2009 OMCH Priorities

The following summarizes the relationship between Washington State Office of Maternal and Child Health's (OMCH) nine priority needs and the current state performance measures, national performance measures, outcome measures, health systems capacity indicators, and health status indicators for the 2005-2009 Priorities.

This crosswalk tool reflects current state performance measures as of July, 2010.

Adequate nutrition and physical activity

NPM 11, 15
OM 1-5
SPM 07
HSCI 5, 9a
HSI 1a-b, 2a-b

Lifestyles free of substance use and addiction

NPM 10, 15
OM 1-5
SPM 08
HSCI 1, 9b
HSI 1a-b, 2a-b, 3a-c, 4a-c

Optimal mental health and healthy relationships

NPM02, 6, 11, 16
OM 6
SPM 09
HSCI 4

Health Equity

OM 2
SPM 10

Safe and healthy communities

HSCI 1
NPM 10, 16
OM 6
SPM 08, 9
HSI 3a-c, 4a-c

Healthy physical growth and cognitive development

NPM 06, 11, 12
SPM 07, 8, 9

Sexually responsible and healthy adolescents and women

NPM 08, 18
SPM 01, 8, 9
HSCI 4
HSI 5a-b

Access to preventive and treatment services for the MCH population

NPM 03-7, 9, 12-14, 17-18
OM 1-5
SPM 01, 6, 7, 10
HSCI 3-8

Quality Screening, identification, intervention, and care coordination for the MCH population

NPM 1-3, 5-7, 9, 12, 17, 18
OM 1-5
SPM 06, 8, 10
HSCI 2-5, 7

2010 - 2014 OMCH Priorities

As part of the 2010 Five Year Needs Assessment, OMCH reaffirmed that the nine priority needs first identified in the 2005 Needs Assessment are still valid. The following summarizes the relationship between Washington State OMCH's nine priorities and the new state performance measures, the national performance measures, outcome measures, health systems capacity indicators and health status indicators for the 2010-2014 Priorities.

This crosswalk tool reflects new state performance measures that Washington will report on starting with the 2012 Block Grant Application/2010 Report.

Adequate nutrition and physical activity

NPM 11, 15
OM 1-5
New SPM 04
HSCI 5, 9a
HSI 1a-b, 2a-b

Lifestyles free of substance use and addiction

NPM 10, 15
OM 1-5
New SPM 07
HSCI 1, 9b
HSI 1a-b, 2a-b, 3a-c, 4a-c

Optimal mental health and healthy relationships

NPM02, 6, 11, 16
OM 6
New SPM 05
HSCI 4

Health Equity

OM 2
New SPM 06, 7

Safe and healthy communities

HSCI 1
NPM 10, 16
OM 6
New SPM 04, 5, 7
HSI 3a-c, 4a-c

Healthy physical growth and cognitive development

NPM 06, 11, 12
New SPM 04, 5

Sexually responsible and healthy adolescents and women

NPM 08, 18
New SPM 01
HSCI 4
HSI 5a-b

Access to preventive and treatment services for the MCH population

NPM 03-7, 9, 12-14, 17-18
OM 1-5
New SPM 02, 4, 7

HSCI 3-8

Quality Screening, identification, intervention, and care coordination for the MCH population
NPM 1-3, 5-7, 9, 12, 17, 18
OM 1-5
New SPM 02, 3, 4, 7
HSCI 2-5, 7

/2012/Washington State's 2010 - 2014 Maternal and Child Health Priorities

The relationship between the nine maternal and child health (MCH) priorities that Washington State identified in the 2010 Five Year Needs Assessment and the state and national performance measures, is summarized below.

Adequate nutrition and physical activity

NPM 5 Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.
NPM 11 The percent of mothers who breastfeed their infants at 6 months of age.
NPM 14 Percentage of children, ages 2 to 5 years, receiving WIC services that have a Body Mass Index (BMI) at or above the 85th percentile.

Lifestyles free of substance use and addiction

NPM 10 The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
NPM 15 Percentage of women who smoke in the last three months of pregnancy.
SPM 5 Percent of households with children (0 -- 18 years old) in which the reporting adult has an Adverse Childhood Experience (ACE) score of 3 or more.
SPM 7 Decrease the rate of infant mortality among the Native American population.

Optimal mental health and healthy relationships

NPM 2 The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. (CSHCN Survey)
NPM 6 The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey)
NPM 11 The percent of mothers who breastfeed their infants at 6 months of age.
NPM 16 The rate (per 100,000) of suicide deaths among youths 15-19.
SPM 5 Percent of households with children (0 -- 18 years old) in which the reporting adult has an Adverse Childhood Experience (ACE) score of 3 or more.

Health Equity

NPM 3 The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)
NPM 4 The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)
NPM 5 Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)
NPM 6 The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
SPM 6 Identify health disparities, develop and implement interventions to address disparities, and evaluate the effectiveness of interventions in achieving health equity.
SPM 7 Decrease the rate of infant mortality among the Native American population.

Safe and healthy communities

NPM 5 Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)
NPM 10 The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
NPM 16 The rate (per 100,000) of suicide deaths among youths 15-19.
SPM 4 The degree to which state has assisted in planning and implementing comprehensive, coordinated care in order to develop an integrated system of care for children, birth to eight.
SPM 5 Percent of households with children (0 -- 18 years old) in which the reporting adult has an Adverse Childhood Experience (ACE) score of 3 or more.
SPM 7 Decrease the rate of infant mortality among the Native American population.

Healthy physical growth and cognitive development

NPM 5 Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)
NPM 06 The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey)
NPM 11 The percent of mothers who breastfeed their infants at 6 months of age.
NPM 12 Percentage of newborns who have been screened for hearing before hospital discharge.
NPM 14 Percentage of children, ages 2 to 5 years, receiving WIC services that have a Body Mass Index (BMI) at or above the 85th percentile.
SPM 4 The degree to which state has assisted in planning and implementing comprehensive, coordinated care in order to develop an integrated system of care for children, birth to eight
SPM 5 Percent of households with children (0 -- 18 years old) in which the reporting adult has an Adverse Childhood Experience (ACE) score of 3 or more.

Sexually responsible and healthy adolescents and women

NPM 8 The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
SPM 1 Percent of pregnancies (live births, fetal deaths, abortions) that are intended.

Access to preventive and treatment services for the MCH population

NPM 3 The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)
NPM 4 The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)
NPM 5 The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily. (CSHCN Survey)
NPM 6 The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey)
NPM 7 Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.
NPM 9 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
NPM 12 Percentage of newborns who have been screened for hearing before hospital discharge.
NPM 13 Percent of children without health insurance.
NPM 14 Percentage of children, ages 2 to 5 years, receiving WIC services that have a Body Mass Index (BMI) at or above the 85th percentile.
NPM 15 Percentage of women who smoke in the last three months of pregnancy.
NPM 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
NPM 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

SPM 2 Percent of children 6 -- 8 years old with dental caries experience in primary and permanent teeth.

SPM 4 The degree to which state has assisted in planning and implementing comprehensive, coordinated care in order to develop an integrated system of care for children, birth to eight.

SPM 7 Decrease the rate of infant mortality among the Native American population.

Quality Screening, identification, intervention, and care coordination for the MCH population

NPM 1 The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

NPM 2 The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. (CSHCN Survey)

NPM 3 The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

NPM 5 The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily. (CSHCN Survey)

NPM 6 The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey)

NPM 7 Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

NPM 9 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

NPM 12 Percentage of newborns who have been screened for hearing before hospital discharge.

NPM 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

NPM 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

SPM 2 Percent of children 6 -- 8 years old with dental caries experience in primary and permanent teeth.

SPM 3 The percent of children who received a standardized developmental screening.

SPM 4 The degree to which state has assisted in planning and implementing comprehensive, coordinated care in order to develop an integrated system of care for children, birth to eight.

SPM 7 Decrease the rate of infant mortality among the Native American population.//2012//

//2013//The merged OHC priorities are listed below with the related MCH performance measures:

Healthy Starts: NPM 14,17,18; OM 1-5; SPM 01; HSCI 01,02,03,04,05A,05C,05D,06A,06C, HSI 01A,01B,02A,02B.

Healthy Eating and Active Living: NPM 11; HSCI 09A

Tobacco and Substance Free Living: NPM 15; HSCI 05B, 09B

Social and Emotional Wellness: NPM 2, 6, 16; SPM 5

Healthy and Safe Communities: NPM 10; HIS 03A-C; 04A-C

Reproductive and Sexual Health: NPM 08; SPM 01; HSI 06A, 06B

Access Quality Clinical, Preventive, and Treatment Services: NPM 3, 4, 5, 9, 13; SPM 2, 4; HSCI 06B, 07A, 07B, 08

Quality Screening, Identification, Intervention, and Care Coordination: NPM 1, 7, 12; SPM 3,6.

Please see the attachment to Background and Overview for a comparison of the Priorities pre and post merger, with definitions//2013//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	99.2	100.0	100.0	
Numerator	89	125	119	137	
Denominator	89	126	119	137	
Data Source		WA Newborn Screening Program	WA Newborn Screening Program	WA Newborn Screening Program	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

Data not available.

Notes - 2010

PERFORMANCE OBJECTIVES: The Newborn Screening program expects to maintain 100% of screen positive newborns receiving timely follow up. Therefore, through 2016, the future objectives will be 100%.

These data come from the WA Newborn Screening Program and are the same as reported in Form 6. The numerator is the number of live births in Washington that were reported by the Office of Newborn Screening as screened and were a confirmed case that received timely follow up. The denominator is the number that were screened and were a confirmed case. In 2010, 99.2% of newborns received a newborn screening (83,086 of 83,718). Excluded from the denominator were births in military hospitals (2,605), refusals (66), neo-natal deaths (113) and a

small number tested by the State of Oregon (8).

See Form 6 for details on screening for each condition.

Notes - 2009

PERFORMANCE OBJECTIVES: The Newborn Screening program expects to maintain 100% of screen positive newborns receiving timely follow up. Therefore, through 2015, the future objectives will be 100%.

These data come from the WA Newborn Screening Program and are the same as reported in Form 6. The numerator is the number of live births in Washington that were reported by the Office of Newborn Screening as screened and were a confirmed case that received timely follow up. The denominator is the number that were screened and were a confirmed case. In 2009, 98.6% of newborns received a newborn screening (84,871 of 86,058). Excluded from the denominator were births in military hospitals (3,551), refusals (65), neo-natal deaths (120) and a small number tested by the State of Oregon (16).

See Form 6 for details on screening for each condition.

a. Last Year's Accomplishments

Washington met its target for newborn screening; 100% of infants who had presumptive positive screens received timely follow-up. The Newborn Screening (NBS) Program continued to ensure that all screen positive infants received prompt and appropriate follow-up. In 2010, 99.1% of all eligible infants received a screen. Of 83,086 infants screened in calendar year 2010, 140 infants were found to be true positive for a disorder on Washington's newborn screening panel (overall prevalence of 1 in 593 infants). Seventy-six infants screened positive for congenital hypothyroidism; 23 with cystic fibrosis; 18 with hemoglobinopathies; 17 with metabolic disorders; 3 with galactosemia; and 3 with congenital adrenal hyperplasia. All of these infants received timely diagnostic testing and treatment and were referred to the appropriate pediatric specialist or clinic for long-term clinical management. We also identified and referred for diagnostic testing two infants with other metabolic disorders detected even though they were not on our screening panel. Finally, we identified 1,199 infants with hemoglobin patterns that, while not clinically significant, are worth the parents and providers knowing given future reproductive implications for the parents, other family members, and the child later in life. Examples are sickle cell trait which was found in 447 infants, alpha thalassemia in 229 infants, and hemoglobin E in 235 infants.

For the Lysosomal Storage Disease research project (an ongoing IRB approved study with the University of Washington Biochemical Genetics Clinic supported by a National Institutes of Health grant), over 70,000 samples were tested. Anonymous specimens that were residual to required screening were evaluated with enzyme assays for Fabry, Pompe, and MPS-I. A simpler triplex assay was developed that has been shown to be very easy to execute in the Newborn Screening (NBS) Laboratory. Improvements in the assays were continually made throughout the year to increase sensitivity and specificity, as well as turnaround time.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensured that all screen positive infants receive timely diagnosis and, if needed, are enrolled in long-term clinical management.				X
2. Performed screening tests for all mandated conditions on approximately 170,000 specimens.			X	
3. Followed-up to assure that appropriate diagnostic and clinical services are provided in response to screening test results.			X	

4. Contracted with pediatric specialists and comprehensive care clinics to provide expert diagnostic and treatment services for infants with abnormal screening results.				X
5. Updated and developed new professional and lay educational information for distribution: websites, provider manuals, on-site hospital visits, disorder-specific fact sheets and pamphlets, etc.				X
6. Determined family eligibility for financial and support services and coordinate through state and county Children with Special Health Care Needs programs (CSHCN) and medical homes.		X		
7. Purchased and distributed medically necessary formulas and low-protein foods for individuals with PKU and other metabolic disorders.		X		
8. Collected long-term outcome data to evaluate the benefit of various components of treatment, compliance, and intervention.				X
9. Continued to work with researchers to evaluate potential screening tests for other treatable childhood disorders; currently lysosomal storage diseases.				X
10. Processed 859 PKU diet monitoring and 153 adult hemoglobin dried blood specimens as an adjunct to newborn screening and genetics services.	X			

b. Current Activities

The NBS Program ensures all screen positive infants receive prompt and appropriate follow-up. In 2011, 99.2% of all eligible infants (87,374) were screened. Of them, 183 were true positive for a disorder on our NBS panel (overall prevalence of 1 in 477 infants); 106 congenital hypothyroidism, 17 cystic fibrosis, 17 clinically significant hemoglobinopathies, 19 amino acid, organic acid, and fatty acid oxidation disorders, 2 biotinidase deficiency, 11 galactosemia, 11 congenital adrenal hyperplasia. These infants receive timely diagnostic testing, treatment, and referrals to pediatric specialists for long-term clinical management. Eight infants were identified, and referred, with metabolic disorders not on our NBS panel but shared biochemical markers as the mandated conditions.

We did not receive the CDC grant for new lab capacity for blood spot screening of severe combined immunodeficiency (SCID). We convened an Advisory Committee to review SCID against the Board of Health's criteria for inclusion. The Board was briefed on March 14, 2012, with a presentation on June 13, 2012, recommending next steps from Dr. Diana Yu, State Board of Health Co-Chair.

The NBS Lab is continuing to refine their method for detection of lysosomal storage diseases (LSDs) in infants. To date, we've tested over 110,000 samples. The data looks promising for five LSDs to be suitable for universal NBS, which is consistent with data from other investigators.

c. Plan for the Coming Year

With a favorable review by the State Board of Health, we will ask the Board to add SCID "when funding is available." We will seek the required legislative action to increase the fee to support the additional costs. We hope to receive fee increase approval by the 2013 legislature, to be effective July 1, 2013. Then, we will seek Board approval to add SCID. We continue looking for opportunities to move this forward more quickly, with a screening implementation date of August 2013, but may need to implement in fall-winter 2013.

The NBS Lab will continue to refine the lab method for detection of lysosomal storage diseases in infants through newborn screening. We should have sufficient data to determine if the method has a high enough sensitivity and specificity to be suitable for universal newborn screening (NBS). Also, future plans include the addition of two more lysosomal storage diseases,

Mucopolysaccharidoses (MPS) Type IV, and MPS VI.

Other planned activities:

1. We are in the investigatory stage of a process to evaluate the feasibility of utilizing a statewide courier service to transport NBS specimens from birth hospitals to our Lab to improve the turnaround time of results. Five couriers will provide bids.
2. We are involved in a national collaborative effort between the Association of Public Health Laboratories (APHL), CDC, and Health Resources and Services Administration (HRSA) to develop and distill essential NBS quality indicators for all components of the newborn screening system (from pre-analytic to post-analytic) in preparation for creating a new national dataset.
3. We applied for, and received, a \$20,000 APHL funding opportunity to develop electronic NBS reports. For this project entitled "Feasibility of Transmitting Newborn Screening Test Results to Submitters through a Health Information Exchange Hub operated by Washington's Health Care Authority" we will contract with our NBS data systems provider, Neometrics Inc., to develop and install an electronic data transfer module. This module will automatically generate NBS test results to be imported into a Health Information Exchange (HIE) Hub. After the data transfer module is installed, we will run trial imports to the HIE hub and work with hospitals (to be selected) to coordinate the data to their electronic health records (EHR). The HIE Hub is being developed and operated through our state's Health Care Authority (HCA).
4. We will continue discussions with the Puget Sound Blood Center's cord blood storage program to explore the possibility of using information from our hemoglobinopathy screening to establish the hemoglobin status of all infants whose blood is donated. Using our existing information will provide considerable savings over their current practice of having the blood tested independently.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	83718					
Reporting Year:	2010					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%			No.	No.
Phenylketonuria (Classical)	83086	99.2	21	2	2	100.0
Congenital Hypothyroidism (Classical)	83086	99.2	1010	76	76	100.0
Galactosemia (Classical)	83086	99.2	37	1	1	100.0
Sickle Cell Disease	83086	99.2	9	9	9	100.0
Biotinidase Deficiency	83086	99.2	14	0	0	

Cystic Fibrosis	83086	99.2	689	23	23	100.0
Other Amino Acid Disorders	83086	99.2	51	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	83086	99.2	52	3	3	100.0
Other Fatty Acid Oxidation Disorders	83086	99.2	2	0	0	
Carnitine Uptake Defect	83086	99.2	68	1	1	100.0
Methylmalonic acidemia (Cbl A,B)	83086	99.2	105	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	83086	99.2	163	3	3	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	83086	99.2	14	6	6	100.0
Methylmalonic Acidemia (Mutase Deficiency)	83086	99.2	116	1	1	100.0
Other Organic Acid Disorders	83086	99.2	49	0	0	
Hemoglobin E-beta thalassemia	83086	99.2	1	1	1	100.0
Hemoglobin H disease	83086	99.2	6	6	6	100.0
Mild hemoglobin conditions or traits	83086	99.2	1200	0	0	
Glutaric acidemia type II (GA-II)	83086	99.2	52	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	57	55.7	55.7	55.7	57
Annual Indicator	55.7	55.7	55.7	72.8	72.8
Numerator					
Denominator					
Data Source		National Survey of CSHCN			

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	75	75	75	75	75

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Washington expects to see a moderate increase in this indicator as more CSHCN are seen in medical homes. Accordingly target of achieving 75% by 2016 was set.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Annual performance objective falls within the 95% confidence interval of the current rate. Future targets were increased this year to 57% through 2015 to match the national average reported in the most recent NS-CSHCN survey. When data from the current NS-CSHCN are released in Fall of 2011 the present targets will undergo a through review based on the new information.

Data come from survey and state numerator/denominator are not available.

Notes - 2009

Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Annual performance objective falls within the 95% confidence interval of the current rate. In 2007, following the release of the most recent survey, discussions with program staff led to the target of 55.7% to be established through 2014.

Data come from survey and state numerator/denominator are not available.

a. Last Year's Accomplishments

DOH's CSHCN program helped families partner in decision making at all levels by contracting with Seattle Children's Hospital Center for Children with Special Needs (SCH) to develop and facilitate new family advisor training. 52 parents of children with special health care needs attended 5 training sessions. They learned techniques to facilitate effective family support group meetings. According to the Journal of Early Intervention (1999), effective support groups are

beneficial to reducing parental stress and increasing self-efficacy, 2 components of family satisfaction.

We supported parents to attend the annual Infant and Early Childhood Conference (IECC), an education, information, and resource venue for families and providers of young children with special needs. Our staff presented a workshop on CSHCN-specific programs and resources. We supported parents Duncan Seminar attendance, a 1-day training and information session -that - focuses on children with developmental disabilities.

Our CSHCN program includes a full time Family Involvement Coordinator. She ensures - all areas of CSHCN program work focuses on family perspective. We contracted with the Arc of Washington State's Parent to Parent Programs (arcwa.org), Fathers' Network (fathersnetwork.org), and for the first time, the Family to Family Health Information Center. They provided information, resources, and family support to parents and siblings of children with special health care needs. They attended our quarterly Communication Network meetings and updated us on issues related to family involvement. -

We contracted with WithinReach, Washington's Healthy Mothers, Healthy Babies organization, to operate and promote Answers for Special Kids (ASK). This toll-free line provides information on: early intervention in communities; school district contracts; summer camp/recreation programs; and other information specific to children with delays or chronic illness. We organized 2 trainings for their multi-lingual call center staff to update information on resources and referral processes for families who have a child with a special need.

Families partnered in Community Asset Mapping projects with the University of Washington (UW) Medical Home Leadership Network. This process helps identify autism-specific and other developmental delay resources, gaps, and needs at the community level. CSHCN funded this work and the UW Nutrition Program's support of family involvement in Washington's community feeding teams (<http://depts.washington.edu/cshcnnut/feeding>). Feeding teams often obtain parents input when they are being established. We funded UW's annual feeding team workshop. Parents were often invited for the panel presentation. Parents were invited to participate in presentations on nutrition for children with autism. A UW registered dietician led these presentations at IECC and 2 rural Lewis County sites.

Parents recruited for participation on councils, committees, focus groups and other trainings received a stipend, child care, and mileage reimbursement.

We recruited culturally diverse parents to participate at Combating Autism Advisory Council (CAAC) and subcommittee meetings. Two parents attended all 4 meetings and shared information about their children, to guide this work. They shared resources from meetings with their communities and community efforts and issues with CAAC. They also reviewed material being developed and gave feedback on its usefulness in their community and culture. The Family Involvement subcommittee developed My Child's Map to Services. It highlights a parent's story about an organization that promised a cure for her child. It is a reminder for parents about making informed decisions about treatments for their child. Parents from this group reviewed material from the CDC Learn the Signs Act Early (LTSAE) campaign (especially for cultural appropriateness) and shared autism awareness information and material in their community.

We used Autism grant funds to contract with the Autism Society of Washington to enhance their website. This resulted in updated resources and an events calendar that covers all regions of the state. We updated DOH's website with autism information, materials, resources, and links.

We provided support for a MCH Family Mentor to attend the annual Association of MCH Programs (AMCHP) conference, participate in visits to Capitol Hill, and the nomination of a new AMCHP Family Scholar.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fund a full FTE Family Involvement Coordinator on staff to ensure that all areas of CSHCN program work focus on family perspectives.			X	
2. Recruit parents to participate in councils, committee, focus groups, and trainings.		X		
3. Support parent participation in councils, committees, focus groups, and trainings with stipends, child care, and mileage reimbursements.		X		
4. Develop and facilitate trainings that help families participate in all levels of planning and development and facilitate effective family support group meetings.		X		
5. Operate a toll-free ASK line to provide information specific to children with delays or chronic illness to families.			X	
6. Ensure family representation in policy development through Medical Home Leadership Network, local health jurisdictions, Autism projects and ongoing dialogue through CSHCN Communication Network.		X		
7. Support family participation in presentations on topics and issues concerning children with special health care needs.		X		
8. Promote the CDC Learn the Signs Act Early (LTSAE) campaign			X	
9.				
10.				

b. Current Activities

In July 2011, we received a grant to increase routine developmental screening for all children in the context of Medical Homes. We worked with the Washington Chapter of the American Academy of Pediatrics to create a training module. It trains medical practice staff to implement a screening program as well as the importance of family centered care. It will be presented by an AAP pediatrician and a family advisor, and will emphasize family/professional partnerships. We contract with 3 family support organizations that participate in grant planning, review the module, and help recruit new family advisors.

We contract with Seattle Children's Hospital to conduct family advisor trainings and facilitate the Families as Teachers program for pediatric residents and UW professional students.

We distribute LSAE campaign material through partnerships in four rural Eastern Washington counties. LSAE material in Spanish helps educate Hispanic parents about developmental milestones and the importance of intervention when a child has a delay.

We collaborate with the Division of Behavioral Health and Recovery on a mental health Systems of Care planning grant to improve mental health services for children on Medicaid. This work includes family and youth roundtables and supports a parent to travel to a national meeting for training and grant work. We contract with UW Medical Home Leadership Network to support parent involvement in Community Asset Mapping projects and Medical Home teams.

c. Plan for the Coming Year

Children with special health care needs whose families' partner in decisions fits within two maternal and child health priorities identified in the 2010 Five Year Needs Assessment: Optimal mental health and healthy relationships; and Quality screening, identification, intervention and care coordination for the MCH population.

The CSHCN program will recruit and train parents to work with pediatricians to train other medical practices on how to implement a routine developmental screening program (including screening for mental health). This training will include information on how to refer a child for early intervention services and how to access care coordination.

We will continue contracts with three family support organizations, Parent to Parent, Fathers Network, and Family to Family Health Information Center. They will share information, resources, and best practice with families who have children with special needs. They will also support family/professional partnerships. We will contract with Seattle Children's Hospital to ensure that new family advisors receive training to participate effectively in multiple levels of program work. This work will include participating in training, steering committees, and policy development. It will also ensure that new pediatric residents and university professional students understand the difficulties families of children with special needs face on a daily basis.

The contract with the University of Washington Medical Home Leadership Network will continue to involve parents in the Community Asset Mapping process and Medical Home teams.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	53	48.6	48.7	48.8	49
Annual Indicator	48.3	48.3	48.3	48.3	45.5
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	50	50	50	50	50

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001

and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Work on getting Washington's children, including CSHCN, into medical homes is on-going and a priority. Given the resources being put into the effort the expectation is to see the percent of CSHCN in medical homes rise over the next few years. A target of 50%, an increase of almost 5 percentage points, has been set to be achieved by 2016.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Work undertaken by the CSHCN program over the past few years has led to the expectation that a rate of 49% is achievable, so the future target has been set there. When data from the current NS-CSHCN are released in Fall of 2011 targets will undergo a through review based on the new information.

Data come from survey and state numerator/denominator are not available.

Notes - 2009

Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM03. A new annual performance objective of 48.5% was developed in 2007 based on discussion with program staff. An annual increase of 0.1 was chosen, and has been extended through 2014.

Data come from survey and state numerator/denominator are not available

a. Last Year's Accomplishments

DOH's CSHCN program contracted with local health jurisdictions (LHJs) to increase awareness of, access to, and staff participation in medical homes in communities. LHJ CSHCN coordinators piloted methods of collecting data on outcomes related to Omaha System pathways, Health Care Supervision, and Communication with Community Resources. They submitted this data to us to document their effectiveness in providing care coordination as part of a medical home in their communities. We used an MCHB technical assistance grant to support a training conference for coordinators. Technical assistance came from the University of Minnesota. Budget cuts resulted in the loss of a CSHCN program FTE. As of May 2011, we no longer have the CSHCN nurse leading these activities, thus progress has slowed.

We developed four new Child Health Notes to distribute to the Medical Home Learning Network (MHLN). We updated resources on the Medical Home website to reflect the changing environment for medical home and complement DOH's medical home collaborative activities. Seattle Children's Hospital Center for Children with Special Needs maintained health promotion materials and links to resources that support the implementation of medical homes. This information is aimed at both families and providers.

The CSHCN program participated in and provided the voice of children and families to the

broader DOH Patient Centered Medical Home Collaborative.

The CSHCN program strengthened medical homes for children by supporting a Community Asset Mapping Project. This project improved local screening, identification, training, and referral streams in additional communities. We funded this project with our federal autism grant, which ended August 2011. After the autism grant ended, we continued collaborating with UW Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program to strengthen medical homes for children with autism and continue Community Asset Mapping.

We continued efforts to improve developmental screening in the context of a medical home. We participated in and provided support for the statewide Developmental Screening Partnership Committee, which gave statewide partners input on a plan to implement universal screening.

We joined an interagency effort to secure federal funding for a Systems of Care planning grant to improve mental health services for children with severe emotional disturbances. We emphasized the need to integrate community mental health services within each child's medical home.

We contracted with the University of Washington (UW) to integrate CSHCN Nutrition Network dietitians and Washington feeding teams with the MHLN. We encouraged family advisors to be part of each MHLN team. We contracted with Parent To Parent, Fathers Network and other family organizations to identify local parents interested in collaborating with MHLN teams.

We funded care coordination for four Maxillofacial Review Boards. These boards provide family-centered care and assure that all children seen by them have a medical home. In collaboration with the DOH Oral Health Program, the CSHCN program promoted the concept of medical home and dental home to providers and families.

In July, 2011, we received a Great MINDS grant to improve medical homes for all children in Washington. We began developing a partnership with the Washington Chapter of the American Academy of Pediatrics to promote medical homes for all children, with family-centered care and formalized developmental screening to identify young children with delays early and link them to community resources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increased awareness of medical homes statewide by supporting the Medical Home Leadership Network.				X
2. Increased awareness of, access to, and staff participation in medical homes within communities by contracting with local health jurisdictions.		X		
3. Provided leadership to spread medical home concept through strategic planning.		X		
4. Provided the voice of children and families to the agency Patient Centered Medical Home Collaborative				X
5. Implemented the Autism Grant to promote medical homes for children and youth with autism.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Our Family Involvement Coordinator participates with the DOH Patient Centered Medical Home Collaborative. The coordinator is working to assure that medical homes include a pediatric focus and are family-centered.

We are developing 4 new Child Health Notes to distribute to MHLN and updating Medical Home website resources and materials. CSHCN Nutrition Network dietitians and Washington feeding teams are being integrated with MHLN. We continue to work with and support family organizations to identify parents interested in collaborating with MHLN teams.

We collaborate with LEND to strengthen medical homes for children with autism and continue Community Asset Mapping, participate in Systems of Care grant activities (ends Sept. 2012), and continue Great MINDS grant activities.

LTSAE is identifying young children with delays and using the WithinReach hotline to connect them with local medical homes to address their concerns.

We are participating in a national effort with the state Department of Early Learning to blend medical homes with early childhood systems building.

c. Plan for the Coming Year

Children with special health care needs who have a medical home fit within three MCH priorities identified in the 2010 Five Year Needs Assessment: Health equity; Access to preventive and treatment services for the MCH population; and Quality screening, identification, intervention and care coordination for the MCH population. We will work to promote healthy starts and ongoing wellness and promote access to quality health services.

We will continue to collaborate to promote medical home concept and access in Washington. We will renew the UW MHLN contract to maintain the network of community-based practices and expand participation into new practices, particularly those identified through the federal Great MINDS grant. MHLN will provide training to strengthen parent/provider partnerships. They will disseminate information to providers through website, listserv, conference calls, electronic newsletter, and topical marketing tools, like Child Health Notes. MHLN will monitor information and materials about medical home best practices developed in other states and federal programs. They will offer technical assistance to local teams and provide honoraria to leverage community resources.

Great MINDS will support planning and implementing a Medical Home Summit in early 2013, for Medical Home Leadership Network teams. The Community Asset Mapping Project begun during the federal autism grant will continue in collaboration with LEND. It will be supported by Great MINDS. It will strengthen medical homes for children with autism in additional communities and improve local screening, identification, and referral streams.

We will collaborate on an interagency Systems of Care grant application if the opportunity becomes available. If funded, this collaborative effort would continue to blend mental health issues and services more effectively into medical homes for children. We are collaborating with other department efforts in mental health planning.

The CSHCN program will continue to look for opportunities to impact state policies that affect the delivery of services in a medical home for children.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	66	67.5	69	70.5	65
Annual Indicator	65.3	65.3	65.3	65.3	65
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	75	75	75	75	75

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Medicaid has made a priority of reaching out to eligible children, including CSHCN, in Washington State and reaching as many presently uninsured kids as possible. Given this priority, an increase of ten percentage points, from 65% to 75% by 2016 was seen as an achievable goal.

Notes - 2010

Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

The target of 65% was established after discussions with program staff who felt that there has not been a significant increase in insurance coverage since 2007. With the major changes in the expansion of health insurance availability set to take effect in 2014, it was assumed that there will be an increase in the number of children covered, and therefore an increase in the target rate, to 75%. These are estimates of the effect of reform. When data from the current NS-CSHCN are released in Fall of 2011 targets will undergo a through review based on the new information.

Data come from survey and state numerator/denominator are not available.

Notes - 2009

Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Based on discussion with program staff an annual increase of 1.5 was chosen starting in 2007 and extended through 2014.

a. Last Year's Accomplishments

According to the 2010 NS-CSHCN WA met its target of 65%, which was the percent determined by the survey. Our CSHCN program shared information about medical coverage and health reform through CSHCN Communication Network, MCH and CSHCN Regional Teams meetings. The Communication Network routinely discussed access and financial coverage issues to improve coverage for CSHCN. We worked with the State Insurance Commissioner to share resources through the Insurance Consumer Hotline. We collaborated with health plans to improve patient education and outreach strategies.

The CSHCN program worked with the state Medicaid agency; Women, Infants, and Children Program (WIC), Newborn Screening Program and other health insurances to ensure coverage for therapeutic formulas and oral health services.

CHIF provides information on children with special health care needs served by Title V in Washington. CHIF is used by local health jurisdiction (LHJ) CSHCN programs. We contracted with Strategic Software Services to provide LHJs technical assistance in using CHIF. We analyzed data to identify children with insurance, types of insurance and other funding sources. Data sources included National Survey of CSHCN 2005-2006, National Child Health Survey 2007, and the Child Health Intake Form (CHIF). We made improvements to CHIF data collection.

We participated on the Center of Excellence in Quality of Care Measures for Children with Complex Needs as a part of the federal CHIPRA grant.

We participated on the Association of Maternal and Child Health Programs Board (AMCHP), Title XIX Advisory Committee and other interagency workgroups to consider health care reform and implement policies that impact benefit packages and provider reimbursement for enhanced services for children.

We worked with Combating Autism Advisory Council to identify issues and policies that needed improvement. These issues and policies affected children with autism and other developmental disabilities and include gaps in public and private insurance. Our federal Autism grant funded this work and ended in August, 2011. This work continued with support from the University of Washington (UW) Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program.

We provided limited funding for medically necessary diagnostic and treatment services not covered by other sources. We tracked these expenditures to make sure needs were met and expenditures were within available funding limits.

Nursing consultants, care coordinators and CSHCN coordinators provided information on adequate health insurance coverage to identified parents of children with special health care needs. Our CSHCN Nutrition Consultant completed annual formula fund use report and worked with the state Medicaid agency, Newborn Screening Program, and WIC to ensure coverage for therapeutic formulas. The CSHCN program worked with DOH's Oral Health Program, the state Medicaid agency, and other insurance companies to ensure adequate oral health coverage for children with special health care needs.

We contracted with Sacred Heart Children's Hospital (Eastern Washington) and UW (Western Washington) to improve access to nutrition services and supplements for CSHCN statewide. We provided nutrition reimbursement information to certified dietitians to assure access to nutrition services for children on Medicaid.

The CSHCN program worked with state Department of Social and Health Services (DSHS) Fostering Well Being program to coordinate services for foster children with complex medical needs.

We worked with Washington Family to Family Health Information Center (F2FHIC), Parent to Parent, Fathers Network, and other family partners to identify gaps in financing, help families navigate systems of care, and enhance communication between families and providers.

LHJ CSHCN coordinators provided information about adequate health insurance to newly identified families through both one-on-one meetings and parent support organizations.

In the effort to promote universal development screening, we worked with partners to begin seeking a public and private insurance reimbursement mechanism for developmental screening.

Through our federal autism grant, the CSHCN program convened the Combating Autism Advisory Council to provide a forum to identify gaps in public and private insurance for families with children with autism. They are developing strategies to improve coverage in the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Shared information and data about medical coverage and health reform through a variety of sources, including CSHCN Communications Network, MCH and CFH Regional Teams, family support organizations.		X		
2. Analyzed data from a variety of sources to identify children with insurance and the types of insurance and other funding sources they had. Sources included National Survey of CSHCN, National Child Health Survey, state Child Health Intake Form (CHIF).		X		
3. Worked with public and private organizations to identify issues and policies that needed improvement. This included identifying gaps in public and private insurance.				X
4. Worked with partners on universal developmental screening strategies			X	
5. Worked with other state agencies on outreach and quality assurance activities (one focus was on children in foster care)			X	
6. Worked to ensure coverage of therapeutic formulas and oral health services.	X			
7. Provided limited diagnostic and treatment funds to fill gaps in medically necessary services for children with no or inadequate coverage.	X			
8.				
9.				
10.				

b. Current Activities

Our CSHCN program uses statewide meetings to share information about medical coverage and health reform. We contract with family organizations to identify gaps in financing, help families navigate systems of care, and enhance communication between families and providers.

LHJ CSHCN coordinators provide information about insurance and eligibility to newly identified families.

UW and Sacred Heart Children's Hospital share information on coverage for Medical Nutrition Therapy and formula with dietitians statewide.

We work with the state Medicaid agency to ensure coverage for nutrition services, therapeutic formulas, oral health services, and other pediatric direct services and equipment. Our CSHCN program maintains a small safety net fund for medically necessary services and items not covered by other sources. They work with WIC and Medicaid staff to develop formula decision trees that show providers and families how to get therapeutic formula and be reimbursed for it.

CHIF provides insurance information on Title V children in Washington. WithinReach operates the state Family Health Hotline that includes information about insurance options.

We continue AMCHP and CHIPRA grant.

We work with partners to explore a public and private insurance reimbursement mechanism for developmental screening, delivery of pediatric care in a medical home, and treatments for autism. We continue to participate in the Combating Autism Advisory Council to develop strategies to improve coverage in the state.

c. Plan for the Coming Year

Children with special health care needs who have adequate insurance fits within the maternal and child health priority: Access to prevention and treatment services for the MCH population.

The CSHCN Communication Network will meet quarterly via videoconferencing to inform partners; share information on policies that affect children and their families; and collectively solve access issues.

The CSHCN program will invite Medicaid staff to quarterly staff meetings to maintain current knowledge about publicly funded health coverage and plans for implementation of health care reform. We will continue to provide input to HCA about adequacy of coverage for children with special needs in health reform.

We will continue to participate in the CHIPRA grant Center of Excellence in Quality of Care Measures for Children with Complex Needs activities.

We will contract with parent organizations to identify gaps in financing, help families navigate systems of care, and enhance communication between families and providers. We will continue to support parent advisors in our work. This includes the Title XIX Advisory Committee for the state Medicaid program. CSHCN program staff will participate on AMCHP Board, Title XIX Advisory Committee and other interagency workgroups to consider health care reform and implement policies that impact benefit packages and provider reimbursement for enhanced services for children (including CSHCN).

We will work with Fostering Well-Being to focus on coordinating benefits for foster children with complex medical needs. We will work with the state Insurance Commissioner and refer families with insurance issues to the Insurance Consumer Hotline.

We will participate on the WA Autism Advisory Council (supported by UW LEND in 2012). We will

look for funding to continue in 2013. The council provides a forum to identify gaps in public and private insurance for families with children with autism. They develop strategies to improve coverage and services in the state. We will work with the state Medicaid agency as they develop a benefit package for intensive early behavior intervention for children, including those newly diagnosed with autism. We will look for a public and private insurance reimbursement mechanism for developmental screening, delivery of pediatric care in a medical home, and treatments for autism.

LHJ CSHCN coordinators will provide information about eligibility for public health insurance.

The CSHCN Nutrition Consultant will work with the state Medicaid agency, the Newborn Screening Program, and WIC to ensure coverage for nutrition services and therapeutic formulas. We will contract with UW and Sacred Heart Children's Hospital to assure information on coverage for Medical Nutrition Therapy and formula is shared with providers including registered dietitians.

We will continue to provide limited funding for medically necessary diagnostic and treatment services not covered by other sources.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	76	85.5	85.6	85.7	87
Annual Indicator	85.4	85.4	85.4	85.4	62.6
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	57	57	57	57	57

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

A loss of capacity at the local level is expected to lead to a worsening of this measure. A decreased target of 57% has therefore been set through 2016.

Notes - 2010

Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM05.

Work undertaken by the CSHCN program has led to the expectation that 87%, the national average for this measure, is an achievable goal. When data from the current NS-CSHCN are released in Fall of 2011 targets will undergo a thorough review based on the new information.

Data come from survey and state numerator/denominator are not available.

Notes - 2009

Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM05. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1 was chosen through 2014.

a. Last Year's Accomplishments

The DOH CSHCN program, with state, community, and family partners, promoted community-based services that were accessible, coordinated, family-centered, and culturally competent. We provided LHJ CSHCN coordinators information on CSHCN, school nurses, and Early Support for Infants and Toddlers (ESIT). We distributed Care Organizers, Care Notebooks, and Autism Guidebooks to families and organizations.

We developed and distributed an Rx for Family Support Prescription Pad to providers. This preprinted prescription pad providers give to families who need non-medical resources. The pad includes phone numbers that offer non-medical resources. It contains an information release to allow providers and resource services to provide follow up. We distributed these through the Medical Home Leadership Network (MHLN), WA Chapter of the American Academy of Pediatrics, Washington Academy of Family Physicians, and LHJ CSHCN coordinators. We worked with the state Department of Social and Health Services (DSHS) Fostering Well Being program. This partnership focused on foster children with complex medical needs, and included coordination of local care. We worked with DSHS Behavioral Health Division on the Systems of Care planning grant to improve mental health services for children on Medicaid.

Our CSHCN Communication Network meetings improved community or state service systems by fostering discussions with state and regional partners. The state CSHCN director was on the Advisory Board for the National Center for Community Based Services. LHJ CSHCN coordinators shared community resources with families as indicated in the Omaha Systems Nursing Outcome Project.

We updated and added new resources to the Seattle Children's Center for Special Health Care Needs website (cshcn.org) and widely distributed a brochure with their contact information.

We contracted with the University of Washington (UW) and Sacred Heart Children's Hospital to share nutrition resources with children, their families, and providers through websites (depts.washington.edu/cshcnut and www2.providence.org/spokane/for-physicians/pediatric-professionals/Pages/NutritionResources.aspx), meetings, and other outreach activities. UW also supports community based feeding teams and the state CSHCN Nutrition Network.

We made sure our contractors' web-based resources link and avoid duplication. This gave families more streamlined access to these resources. We joined the Kinship Care workgroup to assure that the state DSHS Kinship Care Navigators have DOH materials and information to distribute to families and program information.

Our federal autism grant and ESIT funding enhanced developmental screening information provided by WithinReach's statewide information and referral line. Autism activities promoted community family/professional partnerships and linked families to resources and services by knowledge spread through council meetings, news updates, and Community Asset Mapping. Community Asset Mapping improved access to quality, comprehensive, coordinated, community-based systems of health care services for children and youth.

Community coalition building included a broad range of partners and systems that led to the establishment of new referral systems and diagnostic centers and promoted communities developing listservs to share information. We supported parent organizations that help families with newly diagnosed children navigate local communities for resources and services. Some communities use Ethnic Outreach Coordinators who provide culturally relevant services. Parent organizations developed resources for families of children with autism and distributed them broadly in local communities. These included My Child's Map to Services in English and Spanish. We received an expansion to our autism grant that allowed us to pilot the CDC's Learn the Signs. Act Early (LTSAE) campaign. This work focused on the Hispanic population in four counties in Eastern Washington. It provided targeted messages on early identification of developmental delays in the birth to four populations.

We funded 15 Neurodevelopmental Centers (NDC) to provide community-based resources and services. We supported community infrastructure and services for children with cleft lip, cleft palate, and other facial anomalies through Maxillofacial contracts with Public Health-Seattle & King County, Mary Bridge Hospital, Yakima Valley Memorial Hospital, and Spokane Regional Health District.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained network of CSHCN Coordinators and interagency collaborations to provide forums for system improvement that include families as partners; and provide learning opportunities about local, state, and national systems for CSHCN.				X
2. Supported Community Asset Mapping to improve access to quality, comprehensive, coordinated, community-based systems of health care services for children and youth			X	
3. Ensured that partners' websites link and avoid duplication				X
4. Enhanced the information available on the state's toll-free Family Health Hotline			X	
5. Supported parent organizations to help families with newly diagnosed children navigate systems.		X		
6. Funded Neurodevelopmental Centers (NDCs) to support community-based collaborations among NDCs, local health				X

agencies, and other partners.				
7. Assured and promote community-based service system through autism grant and contracts with University of Washington, Seattle Children's Hospital, Sacred Heart Children's Hospital, local health and others.				X
8. Maintain network of CSHCN Coordinators and interagency collaborations to provide forums for system improvement that include families as partners; and provide learning opportunities about local, state and national systems for CSHCN.				X
9.				
10.				

b. Current Activities

We work at the state level to link agencies, organizations, and groups around community-based care and services for children with special needs. We use community meetings, collaborations, partnerships, and funding to support CSHCN coordinators in local health and family support programs help families navigate systems. Our 2013 contract with LHJs will link more closely to MCH performance measures.

We hold quarterly Communication Network meetings with stakeholders and support WithinReach to operate a statewide toll-free hotline that helps families connect to local resources. Our Great MINDS grant provides technical assistance to help communities working on Community Asset Mapping organize and map resources and gaps to services. It uses parent/provider teams to provide developmental screening and local community resource training.

We work with partners to create a statewide developmental screening system. We work with Systems of Care grant partners on a strategic plan to improve the mental health system. We promote quality, community-based nutrition and feeding teams.

LTSAE reaches out to Hispanic families and others with children birth to 4 and provides information on developmental milestones and early identification of developmental delays.

We were awarded the 2012 Duncan Award from Seattle Children's for the CSHCN program's consistent support of a strong statewide system of services for children and their families. Cuts to Neurodevelopmental Centers did not occur.

c. Plan for the Coming Year

We work at the state level to link agencies, organizations, and groups around community-based care and services for children with special needs. We use community meetings, collaborations, partnerships, and funding to support CSHCN coordinators in local health and family support programs help families navigate systems. Our 2013 contract with LHJs will link more closely to MCH performance measures.

We will hold quarterly Communication Network meetings with stakeholders and support WithinReach to operate a statewide toll-free hotline that helps families connect to local resources. Our Great MINDS grant will provide technical assistance to help communities working on Community Asset Mapping organize and map resources and gaps to services. It will use parent/provider teams to provide developmental screening and local community resource and health equity training. All materials will be plain talked for easy translation.

We will work with partners to create a statewide developmental screening system. We will work with Systems of Care grant partners on a strategic plan to improve the mental health system. We will promote quality, community-based nutrition and feeding teams.

LTSAE will continue to reach out to Hispanic families and others with children birth to 4 and

provides information on developmental milestones and early identification of developmental delays.

OHC will restructure the 2013 contract with LHJs to make this performance measure a required contract activity.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	11.3	47.4	47.5	47.6	47
Annual Indicator	47.3	47.3	47.3	47.3	41.7
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	35	35	35	35	35

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

In Washington the primary project associated with this measure lost funding which has resulted in a serious curtailing of the work being done on it. A significant decrease in the measure is anticipated through 2016 and is reflected in the decreased targets of 35%.

Notes - 2010

Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the small sample size. The data for the two surveys are not comparable for NPM06 and the 2005-2006 survey may be considered baseline data.

Work on this measure has been hard and making a positive impact has proven to be difficult. Therefore a target of 47% has been set, which is similar to the percent reported in 2007. When data from the current NS-CSHCN are released in Fall of 2011 targets will undergo a thorough review based on the new information.

Data come from survey and state numerator/denominator are not available.

Notes - 2009

Indicator data come from the National Survey of CSHCN, conducted every 5 years by HRSA and CDC. The most recent data are from the 2005-2006 survey. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the small sample size. The data for the two surveys are not comparable for NPM06 and the 2005-2006 survey may be considered baseline data. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1 starting in 2009 was chosen through 2014.

a. Last Year's Accomplishments

According to the 2010 NS-CSHCN, WA did not make its target of 47% for this measure. The survey reported WA at 41.7%. However, the 95% Confidence Interval does include the target of 47%, (35.3%, and 48.0%).

The DOH CSHCN program provided funding to the University of Washington (UW) Adolescent Health Transition Project (AHTP). AHTP provided information about transition services, partly through a website (depts.washington.edu/healthtr) and maintained the AHTP website. AHTP collaborated with Seattle University Center for Change in Transition Services and other partners to build School Nurses and School Nurse Corp Administrators capacity. We encouraged including health information in transition Individualized Education Programs (IEP) for youth leaving high school. AHTP developed material to facilitate discussions with school nurses to move this work forward.

The CSHCN program worked with partners to revise the AHTP Notebook. This notebook contains resources on secondary education, community participation, and vocational rehabilitation. Due to budget cuts, we ended this contract June 2011. We met with partners, UW Leadership Education in Neurodevelopmental and Related Disabilities program (LEND), to discuss ways to continue this work. Our goal was to find opportunities to continue to build on our work of the last several years. The Idaho CSHCN program gave us permission to tailor their adolescent notebook for Washington youth and families. There are four notebooks, each for a different audience ages (12 to 15, 15 to 18, 18 and older and parents). Our notebooks are available on our Health Education Resource Exchange website (here.doh.wa.gov).

We contracted with Seattle Children's Hospital Center for Children with Special Needs (CCSN) to support and promote electronic access to information on transition to adulthood. This information is available on their website and Facebook account (cshcn.org/teens). The website added new content including: Preparing for Milestones and Transitions (dating, graduation, leaving home) and Transitioning to Adult Health Care (preparing for differences between pediatric and adult health care, health insurance basics, finding a new provider). CCSN also created a Transitioning

to Adult Health Care video. They developed an online quiz: Am I Ready? They used teens to test the usability of these tools and provided two educational programs for teens and parents. CCSN promoted these resources to community and parent organizations and to other hospitals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contracted with the University of Washington, Adolescent Health Transition Project and Center for Children with Special Needs at Seattle Children's to provide transition information about federal, state, and community programs and services.		X		
2. Partnered with public and private agencies/organizations to enhance transitions		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Although the CSHCN program could not continue to fund the Adolescent Health Transition Project (AHTP) its website remains active. AHTP added new content on the importance of including health information and goals in Transition Individual Education Programs (IEP). AHTP presented a webinar to school nurses on how to participate in the IEP planning process. The webinar emphasized the importance of including health related goals so students achieve as much independence as possible.

Seattle Children's Duncan Seminar focuses on adolescent transition. We attended and shared the newly developed adolescent transition notebooks. Seattle Children's Center for Children with Special Needs recruited youth for an advisory panel and provided feedback on the adolescent transition notebooks. This included discussing the best format to use. These notebooks are available on DOH's HERE website as downloadable PDF documents.

c. Plan for the Coming Year

Youth with special health care needs receiving transition services fit within five maternal and child health priorities: Optimal mental health and healthy relationships; Health equity; Healthy physical growth and cognitive development; Access to preventive and treatment services for the MCH population; and Quality screening, identification, intervention and care coordination for the MCH population.

The CSHCN program will continue to look for funding opportunities to assist DOH to meet this performance measure. We will work closely with the LEND on adolescent transition trends and practice in the state.

We will contract with Seattle Children's Hospital to promote awareness of and access to electronic versions of newly developed youth transition notebooks. They will also review and update web content and links for the youth employment section of their website (cshcn.org), plan and implement a networking forum that includes family members; youth; and nurses from public

health, schools, teen health centers, and hospitals. This forum will promote communication and care coordination and include a discussion of issues related to teen transition.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	79	79	80	80	80
Annual Indicator	73.9	77.7	75.4	73.7	
Numerator	62089	65960	67022	65887	
Denominator	84017	84891	88888	89399	
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	80	80	80	80	80

Notes - 2011

2011 data not currently available.

Notes - 2010

PERFORMANCE OBJECTIVES: Discussion with Immunization staff led to the decision to set the annual performance objective equal to the Healty People 2010 goal of 80 percent coverage for these antigens. The survey point estimate's 95% confidence interval of +/- 6.1% (67.6%, 79.8%) does not include the program's goal of 80% coverage.

Indicator data came from the National Immunization Survey 2010, Centers for Disease Control and Prevention (CDC). This estimate is based on the provider-verified responses for children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. The numerator is the calculated number of children with completed immunizations.

The 43133 rate reported in this measure counts three valid Hib shots, regardless of specific manufacture, as satisfying the requirement for valid Hib immunization in this age group.

Notes - 2009

PERFORMANCE OBJECTIVES: Discussion with Immunization staff led to the decision to set the annual performance objective equal to the Healty People 2010 goal of 80 percent coverage for these antigens. The survey point estimate's 95% confidence interval of +/- 4.9% (70.5%, 80.3%) includes the program's goal of 80% coverage.

Indicator data came from the National Immunization Survey 2009, Centers for Disease Control and Prevention (CDC). This estimate is based on the provider-verified responses for children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. The numerator is the calculated number of children with completed immunizations.

a. Last Year's Accomplishments

In 2010, the Office of Immunization and Child Profile (OICP) set a goal of 80% coverage for the 431331 series of vaccines (cdc.gov/vaccines/stats-surv/nis/tech-notes.htm). The National Immunization Survey (NIS) reported the Washington State immunization rate as 73.7%.

In the Spring the Legislature passed law that requires a form be used to certify the exemption for either medical, religious, or personal objections. It must include a statement, signed by a health care practitioner, that the parent or guardian has been informed of the benefits and risks of the immunization to the child.

OICP gave schools access to the immunization information system (IIS) to reduce convenience exemptions. OICP worked with the State Board of Health (SBOH) to update school and child care entry requirements. By September 2011, 89% of Head Start/Early Childhood Education and Assistance Programs (ECEAPs) were enrolled in IIS. By September 2011, 58% of children aged 19-35 months had complete IIS records for the 431331 vaccine series.

Quality assurance activities with contracted local health jurisdictions (LHJs) continued. They visited at least 50% of sites enrolled in Vaccines for Children (VFC) and 25% of sites enrolled in Assessment, Feedback, Incentives, and eXchange (AFIX). We trained, assisted, compiled, and shared provider coverage rate data with providers to help raise rates. We continued LHJ contracts to work with providers on vaccine use and storage and to assure community access to vaccination. We facilitated the order and receipt of vaccine.

We educated parents and providers about immunizations. We sent parents age-specific reminders of well-child checkups and immunizations via the Child Profile Health Promotion System. This reached 88.7% of parents with children under 6; our goal is 90%. We worked with partners on a toolkit to help providers talk with vaccine-hesitant parents. We revised the toolkit after piloting it in four clinics and developed a randomized control trial plan to test its impact. We implemented a community intervention campaign to make full immunization a community norm and support parents getting children immunized on time.

Early learning partners throughout the state promoted Child Profile and the importance of vaccines. We provide all recommended childhood vaccines to providers. We work with public and private partners to fund the universal Childhood Vaccine Program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Gave schools access to immunization information system to reduce convenience exemptions.				X

2. Worked with the State Board of Health to update school and child care entry requirements.				X
3. Provided quality assurance activities for sites enrolled in Vaccines for Children (VAC) and Assessment, Feedback, Incentives, and eXchange (AFIX).				X
4. Educated parents and providers about immunizations. This included sending parents age-specific mailings and revising a toolkit to help providers talk to vaccine-hesitant parents.			X	
5. Provided all recommended childhood vaccines to providers.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OICP educates healthcare providers and schools on IIS. We work with SBOH to update school/child care entry requirements and Head Start/ECEAPs to increase IIS use. We work with providers to increase the number of 19-35 month-olds who have complete records in the IIS.

We visit 50% of VFC-enrolled sites and at least 25% of AFIX-eligible sites. We train and assist providers and compile and share provider coverage rate data to raise rates. LHJs work with providers on vaccine use and storage and to assure access to vaccine. We assist with the order and receipt of vaccine.

We educate parents on immunizations by sending age-specific reminders of well-child checkups and immunizations through the Child Profile Health Promotion System. We work with partners to address vaccine hesitancy.

We monitor a toolkit trial aimed at vaccine-hesitant parents for its impact on immunization rates. We improve community intervention campaign strategies to make full immunization a community norm and support timely immunization.

Early childhood system partners continue to emphasize the importance of vaccines and promote Child Profile. WithinReach operates a Family Health Hotline and the parenthelp123.org website. These include information about vaccines, immunization schedules, and clinic locations.

We continue to provide all recommended childhood vaccines to providers. We continue to work with public and private partners to fund the Universal Childhood Vaccine Program.

c. Plan for the Coming Year

Nineteen to 35 month olds with appropriate immunizations fit within two maternal and child health priorities: Access to preventive and treatment services for the MCH population; and Quality screening, identification, intervention and care coordination for the MCH population.

OICP will educate and train healthcare providers and schools on IIS. We will work with SBOH to update school and child care entry requirements, with Head Start/ECEAPs to increase IIS use, and with providers to increase the number of 19-35 month-olds who have complete records in IIS.

OICP and LHJs will continue quality assurance activities. We plan to visit 50% of VFC-enrolled sites and 25% of AFIX-eligible sites. We will train and assist providers; compile and share provider coverage rate data to help raise rates; and contract with LHJs to work with providers on vaccine use and storage and assure access to vaccine. We will assist with the order and receipt

of vaccine.

OICP will educate parents and providers on immunizations. We will send parents age-specific reminders of well-child checkups and immunizations through the Child Profile Health Promotion System and work with partners to address vaccine hesitancy. OICP will monitor a randomized control trial of a toolkit aimed at vaccine-hesitant parents to see if it impacted immunization rates. We will work on the community intervention campaign to evaluate and improve strategies to make full immunization a community norm and support parents to get kids immunized on time.

Early childhood system partners will emphasize the importance of vaccine and promote Child Profile.

We will continue to collaborate with and support WithinReach to operate the Family Health Hotline and parenthelp123.org website. Both include information about vaccines, immunization schedules, and clinic locations. We will continue to provide all recommended childhood vaccines to providers and work with public and private partners to fund the Universal Childhood Vaccine Program.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	15.4	15.3	15.2	15.1	13.8
Annual Indicator	16.1	15.5	14.0	13.2	
Numerator	2217	2131	1868	1724	
Denominator	137767	137469	133798	131080	
Data Source		WA Center for Health Statistics	WA Center for Health Statistics	WA Center for Health Statistics	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	13.2	13.2	13.2	13.2	13.2

Notes - 2011

2011 data not currently available.

Notes - 2010

Meeting with program staff resulted in a decision to set the target at the current rate of 13.2 and maintain that rate through 2016. The program felt that various factors including the Pregnant/Parenting Teen Grant as well as increasing acceptance of long-term birth control among women of this age group would enable them to work to prevent pregnancies and keep the rate as low as it is presently.

The data are from the WA Center for Health Statistics birth certificate data.

The MCH Data Report, produced by the MCH Assessment section contains a chapter on adolescent pregnancy which highlights teen pregnancy by race and ethnicity of the girl as well as county of her residence in order to help identify disparities and areas of need. The report chapter is updated yearly as data become available.

Notes - 2009

Meeting with program staff resulted in a decision to set the target at the current rate of 13.8 and maintain that rate through 2015. The program felt that a new grant, the Pregnant/Parenting Teen Grant would enable them to work to prevent pregnancies and keep the rate as low as it is presently.

The data are from the WA Center for Health Statistics birth certificate data.

The MCH Data Report, produced by the MCH Assessment section contains a chapter on adolescent pregnancy which highlights teen pregnancy by race and ethnicity of the girl as well as county of her residence in order to help identify disparities and areas of need. The report chapter is updated yearly as data become available.

In 2012 the denominator for this measure was updated to reflect a more accurate estimate based on 2010 US Census data for this age group.

a. Last Year's Accomplishments

Washington met its previously set goal of 15.1 per 1,000 for 2010 with a rate of 13.2/1,000 births. This continues an observed trend since the late 1990s of a decrease in the teen pregnancy rate.

The Access, Systems and Coordination section (ASC) provided leadership to develop a statewide Washington Youth Sexual Health Plan. Organizations will be able to use the plan as a guide for planning programs, informing policy, obtaining funding, and educating stakeholders to support the sexual health of Washington's youth. It provides a framework and starting place for communities to address youth sexual health. It emphasizes adults' responsibility to ensure that accurate information, skill-building opportunities, and quality health services are available for all youth. It also recognizes that youth must be centrally involved in defining their own needs and identifying programs and policies that support their health. We involved a variety of organizations and individuals in this effort. We invited input through our website, gave webinars, and had stakeholder meetings to provide information and gather comments.

ASC provided technical assistance about comprehensive sex education to the state Office of Superintendent of Public Instruction (OSPI), individual schools, and school districts in order to make sure that students received accurate information in a way that best helped them make decisions about their health, including healthy relationships.

In accordance with a state law passed in 2008 we made sure that sexual health education curricula were reviewed for medical and scientific accuracy. We also responded to public inquiries about this issue.

We began implementation of the State Personal Responsibility Education Program (PREP) plan. PREP is a youth development program funded by the federal Administration on Children, Youth, and Families. We are working with CARDEA to establish a state Sexual Health Resource Center (SHRC) with select PREP communities. CARDEA is a non-profit organization with the capacity to provide training and technical assistance to local communities. They are also the regional training center for our region's Title X Family Planning Training Program.

The Sexual Health Resource Center will improve access to information for PREP communities and provide them technical assistance and training for implementing evidence-based sexual health and youth development curricula. These curricula, when implemented with fidelity, help

improve decision making skills and help youth make healthy choices. We began a process to select ten communities that have both high need and the capacity and commitment to implement PREP with fidelity.

ASC funded two School based health centers (SBHC). They provided comprehensive health care and education to high school students. This included primary, mental health, and reproductive health services. School based health centers make it easier for students to access health information and services. Our funding substantially supported the operation of these SBHC. One SBHC closed in July due to local funding cuts. They used our funding to assist clients during the transition.

ASC partnered with OSPI to begin updating the Graduation, Reality, and Dual-Role Skills (GRADS) framework and curriculum to meet state and national standards. GRADS is a school-based program for pregnant and parenting teens. The update will include updated information about family planning and a system to connect GRADS teachers so they can share information and mentor each other. GRADS is available in 18 high schools or alternative schools around the state. One goal of this project is to reduce subsequent pregnancies among teen parents. We funded this work with federal Pregnancy Assistance Funds.

The American Indian Health Commission (AIHC) of Washington State began implementing their Tribal Maternal and Infant Health Strategic Plan. The plan was a collaborative effort of the commission, tribes, urban Indian organizations, and state agencies. One plan priority is preventing teen pregnancy.

Some local health jurisdictions provided Nurse Family Partnership (NFP) programs with MCH Block Grant funding. One outcome of NFP is fewer closely-spaced subsequent pregnancies (<http://www.nursefamilypartnership.org/proven-results/Changes-in-mother-s-life-course>).

The state Health Care Authority Take Charge program and ASC provided birth control information and methods to teens.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided leadership to develop a statewide Washington Youth Sexual Health plan				X
2. Provided technical assistance and consultation about comprehensive sex education to the state Office of Superintendent of Public Instruction (OSPI), individual schools, and school districts.				X
3. Ensured that sexual health curricula used in public schools was medically and scientifically accurate.				X
4. Began implementing the State Personal Responsibility Education Program (PREP) plan for teen pregnancy prevention and youth development.			X	
5. Began updating Graduation, Reality, and Dual-Role Skills (GRADS) curriculum to meet state and national standards. GRADS helps pregnant and parenting teens finish high school, become economically independent, and reduce subsequent teen pregnancies.				X
6. Began implementing the Tribal Maternal and Infant Health Strategic Plan. A collaborative effort of the American Indian Health Commission, tribes, urban Indian organizations, and state				X

agencies, one plan priority is preventing teen pregnancy.				
7. Provided birth control information and methods to teens through Take Charge and Title X funded family planning initiatives.	X			
8.				
9.				
10.				

b. Current Activities

ASC provides funding for family planning services to local agencies for women and men, including teens. Services include birth control, STI/HIV testing and prevention, reproductive cancer screening, and sexual health education. In 2011, local agencies saw a total of 8,689 between the ages of 15 and 17 which averted an estimated 5,882 pregnancies in clients age 19 and younger.

ASC continues PREP work with CARDEA, OSPI, and DSHS. They provide training, and technical assistance to ten local agencies to implement and sustain delivery of PREP curricula. CARDEA created a website to provide information for PREP. CARDEA and DOH evaluate data from the agencies.

ASC assists OSPI in reviewing sexual health education curricula for medical and scientific accuracy as part of the Healthy Youth Act.

ASC is working with partners to promote and implement the statewide Washington Youth Sexual Health Plan. Organizations will be able to use the plan as a guide for planning programs, informing policy, obtaining funding and educating stakeholders to support the sexual health of Washington's youth.

PPTW works with schools and community organizations in targeted communities to improve education and health outcomes of pregnant and parenting teens, increase school dropout recovery rates, improve community support and linkages.

We support AIHC with funding and technical assistance as they implement the Tribal Maternal and Infant Health Strategic Plan. One plan priority is preventing teen pregnancy.

c. Plan for the Coming Year

Reducing the rate of births for adolescents age 15-17 fits within the maternal and child health priorities identified in the 2010 Five Year Needs Assessment: Reproductive and Sexual Health. Washington State's decreasing teen birth rates reflect the national trend.

In Washington, the unintended pregnancy rate is higher among teens living in more rural areas of the state. Family planning agencies in rural agencies serve teens and will look for new opportunities. In addition, seven of the ten agencies will implement PREP evidence-based curricula in rural areas.

When compared to non-Hispanic White adolescents; Hispanic, Non-Hispanic Black, and Non-Hispanic American Indian adolescents have significantly higher birth rates. ASC family planning agencies will reach out to these populations. Three PREP local agencies implement evidence-based curricula tailored to Non-Hispanic Black teens.

ASC will implement and evaluate PREP curricula in ten current local communities; expand PREP by selecting additional populations to serve in 2013; work with partners to implement the Washington Youth Sexual Health Plan; and assist OSPI in reviewing sexual health education curricula for medical and scientific accuracy. We will also update our Family Planning Plan.

The Pregnant and Parenting Teens and Women project will work with schools and community organizations in targeted communities to improve education and health outcomes of pregnant and parenting teens, increase school dropout recovery rates, improve community support and linkages.

We provide support to AIHC as they implement the Tribal Maternal and Infant Health Strategic Plan.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	50	50	50	50	51
Annual Indicator	50.4	50.4	51.2	51.2	51.2
Numerator	42971	42725	45200	43550	43513
Denominator	85260	84771	88281	85058	84987
Data Source		Washington State 2005 Smile Survey	Washington State 2010 Smile Survey	Washington State 2010 Smile Survey	Washington State 2010 Smile Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	45	45	45	45	45

Notes - 2011

The indicator of 51.2 (95% CI; 45.7, 56.7) is the best estimate we have for the rate of sealant placement in this population. We will continue to use this rate until new data are collected in the next Smile Survey in 2015.

Targets have been revised downward this year to reflect the reduction in funding for sealant programs in WA State and anticipated reduction in rates that will result.

The Smile Survey is conducted every 5 years. For the past two cycles of the Smile Survey the data have been collected and analyzed in a comparable manner. Previous versions of the Smile Survey did not closely follow this methodology and therefore only two data points exist, 2005 and

2010, preventing accurate trend analysis. .

The denominator is the number 8 year olds in WA and comes from the WA Office of Financial Management and reflects population estimates based on the 2010 Census for this age group. The numerator is calculated from the rate and the denominator.

Notes - 2010

The indicator of 51.2 (95% CI; 45.7, 56.7) is the best estimate we have for the rate of sealant placement in this population. We will continue to use this rate until new data are collected in the next Smile Survey in 2015.

Population data for 2010 are not yet available.

Notes - 2009

The Smile Survey is conducted every 5 years. For the past two cycles of the Smile Survey the data have been collected and analyzed in a comparable manner. Previous versions of the Smile Survey did not closely follow this methodology and therefore only two data points exist, 2005 and 2010, preventing accurate trend analysis. .

The denominator is the number 8 year olds in WA and comes from the WA Office of Financial Management, accessed via CHAT. The numerator is calculated from the rate and the denominator.

The Washington State Smile Survey is conducted by the Department of Health every five years. During the most recent survey in 2010, 48 Head start or ECEAP sites, representing 1,597 children and 53 public elementary schools with a Kindergarten or 3rd grade, representing 5,741 children were randomly selected across the state during the 2009-2010 school year. All preschool and elementary school children enrolled and present on the day of the screening were included in the sample unless the parent returned a consent form specifically opting out of the sample. Each child participating in the survey received an oral screening exam to determine the child's caries experience, treatment need and urgency, and dental sealants needs.

The Smile Survey is scheduled to be conducted again in 2015.

The Smile Survey was developed in Washington State has been adapted and implemented by several other states.

a. Last Year's Accomplishments

The target for 2010 of 50% of third grade children having sealants was met with 51.2% of kids having them as determined by the 2010 Smile Survey.

Third graders who received sealants fit within two maternal and child health priorities identified in the 2010 Five Year Needs Assessment: Access to preventive and treatment services for the MCH population; and Quality screening, identification, intervention and care coordination for the MCH population

Analysis of the 2010 Smile Survey showed that Washington met the Healthy People 2010 and 2020 Objectives related to dental sealants. Washington was the first state to see improvement in sealant related disparities, i.e., third grade children from racial/ethnic background, low-income families, and who spoke Spanish at home were more likely to have sealants than their White non-Hispanic counterparts. This may have been due to the impact of the State Sealant Guidelines and laws that allow dental providers into the school setting to treat the underserved.

The Washington State School Sealant Guidelines were updated in partnership with the Office of the Superintendent of Public Instruction, local oral health programs, professional licensing staff, and dental professionals. The process allowed partners input to and awareness of the online guidelines. These guidelines provide local public health, schools and providers information on how to establish school sealant programs. The guidelines stress the need to target schools with low-income students and high Free and Reduced Lunch rates, apply quality sealants in all

children regardless of their ability to pay, and report sealant data to public health for assessment and evaluation

Five LHJs funded by a federal grant HRSA-09-109 provided dental sealants for schools focusing on those with high FRL rates. The Oral Health Program worked to find funds to work with LHJs, the state coalition, and dental providers to identify new opportunities to continue and expand the school sealant programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Funded 5 LHJs to provide sealants.			X	
2. Promoted and coordinated sealant programs around the state.			X	
3. Developed evaluation plan for school sealant programs.				X
4. Collected statewide sealant data.				X
5. Worked with state coalition to improve coordination in state for sealant programs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Third graders who received sealants fit within two maternal and child health priorities identified in the 2010 Five Year Needs Assessment: Access to preventive and treatment services for the MCH population; and Quality screening, identification, intervention and care coordination for the MCH population.

This year we promoted school sealant programs by providing funding to 5 local health jurisdictions to support their efforts as recommended by recent Maternal and Child Health Bureau publications with federal grant HRSA-09-109. We worked in collaboration with the DOH School Health program. We continued fluoridation education in partnership with Office of Drinking Water; and oral health promotion, with other chronic diseases programs. The Program is working with the Office of the Superintendent of Public Instruction, local health jurisdictions, professional associations, Medicaid and Delta Dental to identify the extent of school sealant programs in the state.

c. Plan for the Coming Year

The oral health program plans to promote school sealant programs. This activity fits within the maternal and child health priority: Quality Screening, Identification, Intervention, and Care Coordination.

The Oral Health Program plans to continue promoting school sealant programs statewide as recommended by recent Maternal and Child Health Bureau publications. We will do this in collaboration with the DOH School Health program. We will also continue fluoridation education in partnership with Office of Drinking Water and oral health promotion with other chronic diseases programs.

We will continue working with the Office of the Superintendent of Public Instruction, LHJs, professional associations, Medicaid and Delta Dental to identify the extent of school sealant programs in the state. Once such assessment is finalized, a statewide forum on school sealant

programs will bring together many partners to share the assessment results. At the forum, we will develop ways to better work together to provide sealants for more low-income children in school settings. We will also seek additional funding to support oral health promotion and community water fluoridation education.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	2.4	2.4	2	1.5	1.5
Annual Indicator	2.0	1.1	1.5	1.5	
Numerator	26	14	20	19	
Denominator	1281739	1295245	1302700	1307767	
Data Source		WA Injury and Violence Program	WA Injury and Violence Program	WA Injury and Violence Program	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	1.5	1.5	1.5	1.5	1.5

Notes - 2011

2011 data not currently available.

Notes - 2010

After discussions with program and assessment staff this year it was decided to set the target at a goal of 1.5 per 100,000 through 2016.

In 2010 almost 30% of deaths in this age group, 5 of 17, where the status of the decedant it was specified, were to non-occupants of vehicles; specifically pedestrians or cyclists.

The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is from the Office of Financial Management 2010 US Census data for Washington State.

Although there have been some fluctuations, over the past 12 years, an overall decrease has been observed. Rates are prone to a great degree of variance due to small numerators.

Notes - 2009

Although there have been some fluctuations, over the past 12 years, an overall decrease has been observed. Rates are prone to a great degree of variance due to small numerators. Many years of data were used to assess the trends, therefore future targets may not appear to align

with the most recent indicators. After discussions with program and assessment staff this year we decided to revise the performance objective downward based on the data from the last four years. Given the persistent low rate it was decided to drop the target by .5 child per 100,000, to a goal of 1.5 per 100,000 through 2015.

The numerator is gathered from the Washington State Department of Health Injury and Violence Program. The denominator is from the Office of Financial Management Population Forecast. The data were accessed through the Community Health Assessment Tool (CHAT). The numerator is gathered from the Washington State Department of Health Injury and Violence Program.

a. Last Year's Accomplishments

In 2010 Washington met its target objective of 1.5 deaths per 100,000 children, with a mortality rate of 1.5/100,000. We continued to work with programs across DOH, local health jurisdictions (LHJs), and other stakeholders to prevent motor vehicle related deaths to children.

We assisted Child Death Review (CDR) coordinators with data collection, provided technical assistance, and encouraged communication among CDR teams. MCH staff participated in a national meeting of State CDR Coordinators, and maintained an electronic distribution list and web site to provide technical assistance and encourage communication among CDR Coordinators. Local CDR Coordinators added data to the multi-state database, a variety of organizations use this data to improve safety and prevention efforts. The DOH CDR web site includes a link to the National Center for Child Death Review & Prevention's web-based tool that describes best practice recommendations for injury prevention, including motor vehicle related injuries and deaths (<http://childinjuryprevention.org/main.html> accessed 5/15/12).

We worked with the DOH Emergency Medical Services & Trauma, Injury and Violence Prevention Program. They received a five-year grant from CDC to assess policies for child motor vehicle injury prevention. A policy subgroup of child passenger and traffic safety experts was convened to look at ways to improve safety of child as motor vehicle occupants, including Medicaid transportation. The strategic plan was completed by July 31, 2012. The grant focuses on policies at different levels - organizations, local jurisdictions, and statewide. Recommendations will be implemented over the next four years.

We continued to fund a portion of an injury prevention staff position that is the State Safe Kids Director. She assists in coordination of 18 local Safe Kids Coalitions. The coalitions concentrate on prevention of unintentional injuries for children, birth to 14. All the coalitions chose to focus on child passenger safety. Local coalitions checked car seats, distributed free and reduced cost car seats to families with low incomes, established permanent fitting stations, and educated and promoted awareness of child passenger safety. The coalitions cover a geographic area that includes more than 95% of all children in this age range.

We implemented the First Time Motherhood/New Parents Initiative grant from the federal Maternal and Child Health Bureau. This project supports prevention of motor vehicle crash deaths by promoting text4baby, a research-based mobile information service. Text4baby provides free weekly health promotion messages to pregnant women and new moms. These messages provide information to help them care for their health and give their babies the best possible start in life. They include information on vehicle safety, including the danger of texting while driving and the importance of using age appropriate car seats.

We administered the Healthy Youth Survey (HYS) in October 2010 and released the data in March 2011. HYS includes questions on drinking and driving, seatbelt use, and riding with a drinking driver.

The DOH Child Profile Health Promotion System sent child passenger safety information to parents of children from birth to 6 years old and we helped over ten schools implement Safe Routes to Schools Programs and worked with several communities on adopting Complete Streets

Ordinances.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reviewed unexpected deaths of children through local Child Death Review (CDR) teams.				X
2. Conducted surveillance of motor vehicle crash deaths to children using CDR and vital records data and disseminated data findings.				X
3. Collaborated with DOH Emergency Medical Services, Trauma, Injury, and Violence Prevention Program to promote statewide injury prevention activities.				X
4. Collaborated with other DOH programs to implement State Injury Prevention Plan.				X
5. Disseminated child passenger safety information to parents statewide through the Child Profile Health Promotion System.			X	
6. Administered 2010 Healthy Youth Survey statewide to students in grades 6,8,10, and 12.				X
7.				
8.				
9.				
10.				

b. Current Activities

We work with DOH Injury & Violence Prevention program (IVPP) to implement the State Injury & Violence Prevention Plan. We fund a portion of an IVPP staff to support Safe Kids Coalitions Through a CDC grant, IVPP is developing a strategic plan to address motor vehicle policy for children. Components include education of law enforcement, Medicaid transportation for children, and data collection on car seat checkups.

We assist LHJs in working with schools to implement Safe Routes to Schools Programs. We help municipalities develop and implement Complete Streets Ordinances. IVPP is funding LHJs to work with injury prevention advocates and include advocates in policy development trainings.

We assist local CDR coordinators with data collection, provide technical assistance, and encourage communication among CDR teams. We maintain an e-mail list and website to share information with CDR coordinators, including motor vehicle related safety.

We are implementing a statewide bus sign campaign to increase text4baby enrollment. Data from the first phase showed increased enrollment in bus sign areas.

The DOH Child Profile program sends child passenger safety information to parents of children from birth to 6 years old. We are working with IVPP and Child Profile on outreach to home visitors, providing Child Profile materials, including vehicle safety information.

Funds from IP were routed to HUBS for targeting local IP coalition and partners to attend policy related trainings.

c. Plan for the Coming Year

Reducing deaths of children aged fourteen and younger fits within the maternal and child health priorities identified in the 2010 Five Year Needs Assessment: Lifestyles Free of Substance Abuse and Addiction and Safe and Healthy communities.

We will work with DOH Injury & Violence Prevention program, including implementing the State Injury and Violence Prevention Plan. We will continue to fund a portion of an Injury & Violence Prevention staff FTE. This position will support Safe Kids Coalitions which conduct child passenger safety activities throughout the state. The motor vehicle policy plan for children will be implemented in phases during this time period. We plan to have all the strategies in place and be putting some of the new policies into place.

We will continue to pursue connections between home visiting, Child Profile and Injury & Violence Prevention. The DOH CHILD Profile program will send child passenger safety information to parents of children from birth to 6 years old.

We will assist local CDR coordinators with data collection, provide technical assistance, and encourage communication among local CDR teams. The State CDR Coordinator will participate in national and regional CDR training, coordination, and information exchange. We will maintain CDR web pages, including links to the National Center for Child Death Review and the best practices web-based resource.

We will administer the Healthy Youth Survey (HYS) in fall 2012 and release the data in spring 2013. HYS includes questions on drinking and driving, seatbelt use, and riding with a drinking driver.

We will assist schools and school districts implement Safe Routes to School programs. We will assist municipalities and community partners to develop and implement Complete Streets Ordinances. Both of these policies improve motor vehicle-related safety for children, as well as supporting other health and wellness outcomes.

Because the First Time Motherhood/New Parents Initiative funding will end August 2012, we will explore other options for promoting text4baby. Text4baby includes messages on vehicle safety, including the danger of texting while driving and the importance of using age appropriate car seats.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	53	53	58	58.5	60
Annual Indicator	57.3	58.0	59.9	60.2	
Numerator	50951	52357	53264	54343	
Denominator	88921	90270	88921	90270	
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	
Check this box if you cannot report the numerator because 1. There are fewer than 5					

events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	60.5	61	61.5	62	62.5

Notes - 2011

Data for this cohort are not available.

Notes - 2010

This measure changed in 2006, from breastfeeding at hospital discharge to breastfeeding six months or more after delivery. The Indicator rate comes from the National Immunization Survey, and can be highly variable due to small sample size.

Meetings with program staff resulted in a targeted increase of 0.5 per year through 2016. It was felt this was achievable due to breastfeeding in the workplace initiatives, increased WIC initiatives, and an overall societal support in Washington State for breastfeeding.

The denominator is the number of livebirths to WA residents in 2009. The numerator is calculated from the indicator and the denominator.

Notes - 2009

This measure changed in 2006, from breastfeeding at hospital discharge to breastfeeding six months or more after delivery. The Indicator rate comes from the National Immunization Survey, and can be highly variable due to small sample size. The 95% Confidence Interval (53.8%, 66.0%) included the target goal of 58% set previously.

Meetings with program staff resulted in a targeted increase of 0.5 per year through 2015. It was felt this was achievable due to breastfeeding in the workplace initiatives, increased WIC initiatives, and an overall societal support in Washington State for breastfeeding.

The denominator is the number of livebirths to WA residents in 2009. The numerator is calculated from the indicator and the denominator.

a. Last Year's Accomplishments

For children born in 2008, and reported on in the 2010 National Immunization Survey, the rate of breastfeeding at 6 months post-partum was 60.2%, which met the goal we set for this cohort of 58.5%.

We continued to focus on improving the percentage of infants still breastfeeding at 6 months of age. We have exceeded our target for this performance measure since 2005, thus we increased both our current and future targets. Women Infant and Children's (WIC) initiatives and initiatives to support breastfeeding in the workplace were influential factors in this program's success.

We recommended lactation support at delivery hospitals through the Perinatal Level of Care Guidelines. We also lead a cross-agency workgroup to work with the state Health Care Authority to restore breast pump benefits to state employees. Child Profile mailed health and safety information, including breastfeeding messages, to families.

DOH worked with the Washington Correctional Center for Women to develop a breastfeeding

policy, lactation support, and secure breast pumps for incarcerated women. Equipment was secured. Policy work and lactation support from the community is not fully complete and will continue to be addressed.

First Steps Maternity Support Services (MSS) screened pregnant and postpartum women for breastfeeding intent and knowledge, and coordinated with the WIC program to ensure women received breastfeeding messages and services. MSS had a 30% budget cut this state fiscal year.

The Breastfeeding Coalition of Washington and the WithinReach Family Health Hotline (FHH) and ParentHelp123.org website promoted breastfeeding and provided services and referrals. We used our First Time Motherhood/New Parents Initiative grant to develop innovative ways to market WithinReach's services. We also used these grant funds to promote text4baby.

DOH's Healthy Eating Active Living Program (HEAL) promoted workplace breastfeeding in its Health and Productivity work. The Oral Health Program worked with WIC to develop a promotion card and brochure with oral health messages designed specifically for breastfed infants 0-11 months.

WIC expanded breastfeeding peer support programs and ensured local agencies had access to breast pumps and training.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reviewed breastfeeding data from the Women, Infants, and Children (WIC) Client Information Management Systems (CIMS), and the National Immunization Survey.				X
2. Provided breastfeeding support and education to low income women receiving Medicaid through First Steps Maternity Support Services (MSS).			X	
3. Recommended lactation support at all hospitals with delivery services through the Perinatal Level of Care Guidelines document.				X
4. Through a state level breastfeeding workgroup, improved workplace support for breastfeeding mothers by drafting a workplace policy and developing building guidelines and staff breastfeeding resources.			X	
5. WithinReach Family Health Hotline (FHH) provided breastfeeding information and referrals to women and their families.			X	
6. Washington parents of children aged birth-6 years received Child Profile Health Promotion education materials in the mail that included breastfeeding support and tips based on AAP recommendations.			X	
7.				
8.				
9.				
10.				

b. Current Activities

The National Immunization Survey results for Washington State indicate that 60.2% of infants are breastfed at six months of age.

Many DOH programs, including WIC, collaborate to ensure women receive consistent breastfeeding messages, coordinated services, and support. CHILD Profile includes breastfeeding information in mailings to families with young children, Oral Health promotes oral health messages to breastfeeding mothers, and our HEAL program promotes breastfeeding in the workplace. We continue recommending lactation support at hospitals with delivery services.

The Breastfeeding Coalition of Washington, funded by WIC and housed at WithinReach, funds a maternity care practices initiative to improve hospital breastfeeding policies and procedures. A new QI initiative with hospitals will begin in 2012.

The WithinReach FHH and ParentHelp123.org website provides information and referrals in response to breastfeeding questions. First Time Motherhood/New Parents Initiative grant, through a contract with WithinReach, is implementing new outreach strategies to promote their services, including banner ads, widgets, and on-line videos. The Office of Healthy Communities (OHC) is using these grant funds to continue promoting text4baby.

DOH continues to work with Washington Correctional Center for Women to support breastfeeding by incarcerated women.

c. Plan for the Coming Year

Mothers who breastfeed their infants at six months of age fit within three maternal and child health priorities identified in the 2010 Five Year Needs Assessment: Adequate nutrition and physical activity; Optimal mental health and healthy relationships; and Healthy physical growth and cognitive development.

We will continue to monitor the percent of women breastfeeding their six month old infants through both WIC and National Immunization Survey data. The goal is to increase this rate by supporting breastfeeding initiation and duration in birthing hospitals and worksites. Healthy Eating Active Living (HEAL) will continue to partner with WIC and all OHC sections to fund and provide guidance to the Breastfeeding Coalition of Washington on the Maternity Care Practices Initiative to improve breastfeeding success in hospitals. Together we will continue to promote breastfeeding to a variety of individuals and organizations across the state. In 2012, a new QI initiative will begin to promote exclusive breastfeeding in birthing hospitals.

DOH programs will continue educating parents by provide relevant and timely information and messaging. CHILD Profile includes breastfeeding information in mailings to families with young children. The Oral Health Program will continue working with perinatal partners, such as WIC, to promote oral health messages to breastfeeding mothers, and HEAL will continue supporting and promoting breastfeeding in the workplace. We will also recommend lactation support at hospitals with delivery services as suggested in the Perinatal Level of Care Guidelines.

Maternity Support Services (MSS), managed by the Health Care Authority (HCA), will continue to coordinate with the WIC program so women receive consistent breastfeeding messages and coordinated services. MSS will also continue to screen pregnant and postpartum women for breastfeeding intent and knowledge, and provide health messages and support.

The WithinReach Family Health Hotline and ParentHelp123.org website will provide information and referrals in response to breastfeeding questions. First Time Motherhood/New Parents Initiative grant, through a contract with WithinReach will continue to promote their services.

DOH will continue to work with Washington Correctional Center for Women to support incarcerated women who are breastfeeding.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	96.5	97	97.5	97	97
Annual Indicator	95.3	95.7	95.6	96.4	96.8
Numerator	80067	81303	79963	78981	80981
Denominator	84043	84913	83666	81901	83616
Data Source		WA EHDDI program	WA EHDDI program	WA EHDDI program	WA EHDDI program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	97.5	97.5	98	98	98

Notes - 2011

Data reported by the Washington State Early Hearing-loss Detection, Diagnosis, and Intervention (EHDDI) program.

Discussions with program and assessment staff resulted in the maintenance of the goal of 98% screening of the state's newborn population into 2016.

Data exclude births which occur in military hospitals, and those parents who refused a hearing screen (1%). Homebirths attended by midwives who do not chose to conduct a screen are also missing and therefore not included. Some births to out of state residents may be included if they are reported by hospitals in Washington State.

Notes - 2010

Data reported by the Washington State Early Hearing-loss Detection, Diagnosis, and Intervention (EHDDI) program.

A consideration of present efforts and future plans for the program were used to set future targets. The national goal is to reach 95%, but since Washington State has already attained that, and 100% is not a realistic goal, a goal of 97% was set through 2011 with a 0.5 increase every two years, starting in 2012, following that.

Data exclude births which occur in military hospitals, and those parents who refused a hearing screen (1%). Homebirths attended by midwives who do not chose to conduct a screen are also missing and therefore not included. Some births to out of state residents may be included if they are reported by hospitals in Washington State.

Notes - 2009

Data reported by the Washington State Early Hearing-loss Detection, Diagnosis, and Intervention (EHDDI) program.

A consideration of present efforts and future plans for the program were used to set future targets. The national goal is to reach 95%, but since Washington State has already attained that, and 100% is not a realistic goal, a goal of 97% was set through 2011 with a 0.5 increase every two years, starting in 2012, following that.

Data exclude births which occur in military hospitals, and those parents who refused a hearing screen (1%). Homebirths attended by midwives who do not chose to conduct a screen are also missing and therefore not included. Some births to out of state residents may be included if they are reported by hospitals in Washington State.

a. Last Year's Accomplishments

In 2011, EHDDI's target was to test 97% of infants for hearing loss. They screened 96.8%. For the last five years, the Early Hearing-loss Detection, Diagnosis, and Intervention program (EHDDI) has been screening 95% or more of all children born in the state. All non-military hospitals and beginning in October of 2010, one military hospital, participated in the program. Of infants born in 2010, 96.4% of them were tracked by the EHDDI program and had a hearing screen before hospital discharge, an increase from the previous year. This is just below the 97% target we set for 2010.

We completed testing the new EHDDI tracking and surveillance system, which we started using in August of 2011.

We contracted with the Guide By Your Side™ (GBYS) program to support parents of infants who did not pass hearing screens or who were diagnosed with hearing loss. Trained parent guides provided unbiased information about hearing loss, services, communication approaches, and early intervention programs, and helped parents navigate these services.

In June 2011, we partnered with Seattle Children's Hospital (SCH) to convene a statewide meeting with audiologists who meet best practices for assessing infants for hearing loss. The purpose was to revise the best practices guidelines to meet current standards in the audiologic assessment of newborns and to provide more detailed guidelines for audiologists.

We collaborated with Washington Sensory Disabilities Services (WSDS) to provide trainings using the Sensory [Kids] Impaired Home Intervention (SKI-HI) curriculum. It was developed specifically for working with infants with hearing loss and their families. Early intervention providers in all but seven Washington counties have received training and coaching.

Lastly, we continued our contract with SCH to provide training and technical assistance to hospital hearing screeners and audiologists. We also contracted with a midwife to screen infants born out-of-hospital in three counties (Thurston, King and Snohomish). In addition, we developed a request for application to recruit four additional midwives to do out-of-hospital screenings in their community.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed and maintained an early hearing-loss detection, diagnosis, and intervention (EHDDI) tracking and surveillance system.				X
2. Contracted with Seattle Children's to promote universal newborn hearing screening in birthing hospitals.				X
3. Contracted with Washington Sensory Disabilities Services to provide early intervention training to county representatives.				X
4. Contracted with Guide By Your Side™ to provide unbiased		X		

support for families who have child with a newly diagnosed hearing loss.				
5. Contracted with midwives to provide newborn hearing screening opportunities at three home birthing and/or play centers in King and Pierce Counties.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Our revised Early Hearing-loss Detection, Diagnosis, and Intervention (EHDDI) tracking and surveillance system allows for timely and accurate follow-up to providers. We are working to establish a real-time data integration system with the Early Support for Infant and Toddlers (ESIT) birth to three database. If successful, EHDDI staff will provide an audiologic referral to the county Family Resource Coordinator (FRC) at diagnosis.

We are providing hospitals with hearing screening training and information during site visits. Seattle Children's Hospital (SCH) provides training and technical assistance to hospital hearing screeners and audiologists on these visits and throughout the year. We also provide hearing screening trainings to Head Start program staff as part of the Early Childhood Hearing Outreach (EHCO) initiative. Additional Midwives are screening babies born out-of-hospitals.

We collaborate with Washington Sensory Disability Services (WSDS) to provide SKI-HI curriculum trainings to early intervention providers and their team from individual counties. This curriculum is designed specifically for working with infants with hearing loss and their families.

We contract with Guide By Your Side™ (GBYSTM), trained parent guides who provide unbiased information and support for parents of young children recently diagnosed with hearing loss.

We are developing policies and procedures for contacting families directly, when we're unable to identify a provider for an infant.

c. Plan for the Coming Year

The EHDDI staff will prioritize information and investigate ways of determining how many infants with hearing loss are in early intervention by six months of age. The ESIT program's efforts to establish a real-time data and surveillance system for children from birth to three has proven to be challenging, but we will continue to collaborate and explore how we can achieve better data sharing.

In the coming year, we will develop a template with standardized data fields and definitions. We will also train the FRCs and early intervention providers to accurately complete the template and data entry. In addition, we will work with audiologists to initiate the referral for early intervention immediately following a diagnosis of hearing loss.

In addition, when we are unable to identify a current health care provider, we plan to implement our procedures for contacting parents directly.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	4	4	4	3	3
Annual Indicator	4.4	4.6	4.6	3.4	3.4
Numerator	72979	76954	77211	57139	56729
Denominator	1658605	1672915	1678507	1680572	1668497
Data Source		2008 Washington State Population Survey	2008 Washington State Population Survey	2010 Washington State Population Survey	2010 Washington State Population Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	3	3	1	1	1

Notes - 2011

The source of the Indicator rate is the 2010 Washington State Population Survey, from the Washington State Office of Financial Management. The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 18. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

Targets reflect the hope that with health care reform at the Federal level the number of uncovered children will be brought to a minimum with the expansion of insurance. It is understood that some populations, such as non-legal residents, will not be covered by any current reform so full complete coverage may not be possible before 2016.

The WA Population Survey will not be re-administered in 2012 and there are no plans for it to be brought back. Starting next year OHC will report the percent of uninsured children as determined by the American Community Survey (ACS). The methodology between the two surveys are different so caution should be taken in comparing the rates. In 2010 the ACS reported 6.4% of children in WA under 18 as being uninsured.

Notes - 2010

The source of the Indicator rate is the 2010 Washington State Population Survey, from the Washington State Office of Financial Management. The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 18.

Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

Recent reform in Federal Health Care policy will impact rates of coverage. Performance objectives are being left "as is" until the impact of the Federal reform at the state level becomes clearer.

Notes - 2009

The source of the Indicator rate is the 2008 Washington State Population Survey, from the Washington State Office of Financial Management. The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 18. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

Recent reform in Federal Health Care policy will impact rates of coverage. Performance objectives are being left "as is" until the impact of the Federal reform at the state level becomes clearer.

a. Last Year's Accomplishments

According to 2010 WA Population Survey, all but an estimated 3.4% of Washington children had health insurance. While this does not meet our target, it shows an improvement from the 2009 rate of 4.6%. Our threshold for state subsidized insurance for children is 300% of federal poverty level (FPL). This expansion is federally approved and receives state children's health insurance programs (SCHIP) matching funds.

In July 2011, administration of SCHIP moved from Department of Social and Health Services to Health Care Authority. The state legislature mandated this change to centralize state health care purchasing.

Our children with special health care needs (CSHCN) program worked with the Medicaid Purchasing Administration and other partners to provide information about health insurance options to children with special health care needs and their families.

DOH supported children's access to health insurance and health services by funding WithinReach's Family Health Hotline (FHH). This hotline, along with WithinReach's Apple Health for Kids Hotline and ParentHelp123.org website, helped families with children enroll in benefit programs, including Medicaid and SCHIP. During this reporting period, FHH responded to 5,461 callers with children who needed information about eligibility for state benefits programs (such as Medicaid and WIC) or in depth information about other services. The Apple Health for Kids Hotline talked to 9,707 people during this period. WithinReach mailed a postcard of useful phone numbers and websites to 5,116 callers.

9,850 families (27,361 individuals) used ParentHelp123.org to screen for benefits programs and apply online. ParentHelp123.org also provided information on health and healthy choices topics including: pregnancy, substance abuse and tobacco cessation, nutrition, physical activity, healthy relationships, breastfeeding, postpartum and interconception health, child development, parenting, immunizations, and oral health.

Our First Time Motherhood/New Parents Initiative supported activities to help families' access health insurance for their children. DOH and WithinReach developed an online video commercial to direct families and providers to the ParentHelp123.org website. This website helps people connect to and apply for health benefits. We also developed social media tools including banner ads and a search widget to promote WithinReach's services. We began a public bus sign campaign to promote text4baby, a free mobile information service that gives pregnant women and new mom's information to help them care for their health and give their babies the best possible start in life. It includes messages about how to get insurance for children. This initiative

is funded through a MCH Bureau grant.

Our PPTW project began working with partners to conduct local needs assessments to identify programs and resources to support pregnant and parenting teens in selected counties. We began working to increase awareness and coordination among different agencies that serve pregnant and parenting teens and increase case management services in the targeted communities. The increased services will include improved linkages to insurance for the teens and their babies.

Child Profile distributed age-specific health materials to Washington families of children (birth to six). Each mailing included information about phone and internet resources that provide more information about health insurance.

DOH participated in a cross-agency project to lead development of an evidence-based home visiting system. Federal home visiting funds are being used to improve home visiting services in selected at-risk communities. Services include helping families find insurance.

Washington received three Children's Health Insurance Program Reauthorization Act (CHIPRA) grants. Two are to connect high risk children and teens to insurance in two cities. One uses technology to automatically enroll newborns of mothers on Medicaid and set up kiosks to help families apply for insurance.

ASC funded two school based health centers (SBHC). These SBHC provided comprehensive health care and education to high school students and encouraged eligible clients to enroll in benefits programs. Our funding substantially supported the operation of the two SBHC. One closed in July due to local funding cuts. They used our funding to assist clients during the transition. Due to budget reductions we stopped exploring ways to fund more SBHCs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Family Health Hotline, Apple Health for Kids Hotline, and ParentHelp123.org linked families to children's health insurance and other programs.		X		
2. Child Profile included information about where to find information about children's health insurance in mailings to families of children.		X		
3. Two state-supported school-based health centers encouraged eligible clients to apply for benefits.	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

We monitor and share data on children's access to health insurance, with special attention to high risk groups. CSHCN works with partners to provide information about health insurance options to children with special health care needs and their families. DOH supports WithinReach's operation of ParentHelp123.org and FHH. WithinReach also operates Apple Health for Kids Hotline. These resources connect families to health insurance.

Our First Time Motherhood/New Parents Initiative is implementing tools to connect families to health insurance. Text4baby bus ads ran in selected communities in fall 2011. We are starting a second bus campaign. Text4baby enrollment increased significantly where the bus signs ran (34% increase). This initiative was originally a three year grant, but funding for the last year was cut. The contractor is working to finalize tool development and the project marketing plan within the shortened timeframe.

The Pregnant and Parenting Teens and Women Project enhances linkages among community programs and resources in 11 counties. It connects pregnant and parenting teens and their children to insurance.

Two local agencies and the state are using CHIPRA grants to connect newborns and high risk children and teens to insurance. Child Profile distributes age-specific health materials to Washington families.

Evidence-based home visiting is being provided in high risk communities and ASC funds one SBHC that encourages clients to enroll in benefits programs.

c. Plan for the Coming Year

Decreasing the percentage of children without health insurance fits within a maternal and child health priority: Access to preventive and treatment services for the MCH population.

Washington has few children who are not eligible for health insurance, most children in families with incomes up to 300% FPL are eligible for Medicaid or CHIP and past campaigns enrolled newly eligible children. We do not expect children's eligibility for public insurance programs to change much in the coming year or with Medicaid expansion under federal health care reform in 2014. The new federal minimum threshold for Medicaid eligibility is lower than the current state threshold for children's eligibility. Children in families with incomes above Medicaid and CHIP eligibility will have improved access to insurance starting in 2014.

The Urban Institute estimates that 49,115 Washington children age 0-18 are currently eligible but not enrolled in Medicaid. (<http://www.ofm.wa.gov/healthcare/UnderstandingNewlyCoveredPopulations>) We expect outreach efforts under health reform to enroll children who are eligible but not enrolled in Medicaid and to help people enroll in new insurance options. As we move forward with federal health care reform, DOH will monitor children's insurance coverage rates and work with partners to understand and respond to the expected impacts on children. We will continue to monitor and share data on children's access to health insurance.

The CSHCN program will continue activities related to increasing access to health care. CHILD Profile will distribute age-specific health material. We will continue to support and collaborate with WithinReach to promote the family health hotline and to connect families to health insurances.

Although our First Time Motherhood/New Parents Initiative funding ended, the new tools created through it will continue to be available. We plan to market these to connect pregnant women and new parents to health insurance and other resources using the marketing plan developed with grant funds.

The Pregnant and Parenting Teens and Women Project will continue working with agencies in 11 counties. We will work to enhance linkages among community programs and resources that serve pregnant and parenting teens and to increase case management services for pregnant and parenting teens. These services will include improved linkages to insurance for teens and their children. We will work to promote use of a new grant supported website for pregnant and parenting teens that will help link teens to resources.

Two local agencies and the state will continue using their CHIPRA grants to connect newborns and high risk children and teens to insurance.

Evidence-based home visiting services will expand through a recently awarded competitive home visiting supplement. This supplement adds about \$25 million to Washington's baseline grant.

We will continue to support and collaborate with one SBHC.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	29	29	29	30	30
Annual Indicator	29.4	30.4	30.3	30.0	29.6
Numerator	26081	29029	32120	32950	42328
Denominator	88709	95359	106173	109849	142878
Data Source		WA State Women Infants and Children Program			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	30	30	30	30	30

Notes - 2011

The source of these data are the Washington State Department of Health, Women, Infants, and Children (WIC) program. The numerator is the number of overweight (BMI > 85th percentile) children, ages 2 to 5 years, who receive WIC services during CY 2011. The denominator is number of children, ages 2 to 5 years, who receive WIC services during the reporting year.

The WA State MCH Data Report contains data on childhood overweight/obesity taken from the WA Healthy Youth Survey (HYS). Data from the HYS cover children in 6th, 8th, 10th and 12th grades. Topics covered in the Data Report include overweight/obesity by county of residence and grade as well as obesity by race/ethnicity and gender.

Notes - 2010

The source of these data are the Washington State Department of Health, Women, Infants, and Children (WIC) program. The numerator is the number of overweight (BMI > 85th percentile) children, ages 2 to 5 years, who receive WIC services during CY 2010. The denominator is number of children, ages 2 to 5 years, who receive WIC services during the reporting year.

The WA State MCH Data Report contains data on childhood overweight/obesity taken from the WA Healthy Youth Survey (HYS). Data from the HYS cover children in 6th , 8th , 10th and 12th grades. Topics covered in the Data Report include overweight/obesity by county of residence and grade as well as obesity by race/ethnicity and gender.

Notes - 2009

The source of these data are the Washington State Department of Health, Women, Infants, and Children (WIC) program. The numerator is the number of overweight (BMI > 85th percentile) children, ages 2 to 5 years, who receive WIC services during CY 2009. The denominator is number of children, ages 2 to 5 years, who receive WIC services during the reporting year

a. Last Year's Accomplishments

The 2011 rate for WIC recipients ages 2-5 with a BMI at or above the 85th percentile was 29.6%, a slight decrease from 2010. The Office of Healthy Communities and WIC continue to work towards a rate of 30% or less. WIC has a very comprehensive breastfeeding promotion program. It includes education, peer learning, and hospitals. HEAL provides a small amount of funding and staff time to support breastfeeding in hospitals which provides technical assistance to hospitals to create a supportive environment for moms and infants to breastfeed. DOH (HEAL, WIC and ASC) and the breastfeeding Coalition of WA are teaming up to launch Washington Steps Up, an initiative to increase duration and exclusivity of breastfeeding. Washington Steps Up rewards hospitals, worksites, childcare facilities, and community clinics that make it easy for moms to breastfeed.

We raised awareness of the importance of maintaining healthy weight and its impact on health of children, families, and communities by collaborating with other DOH programs, including Supplemental Nutrition Assistance Program Education (SNAP- ED), WIC, and Healthy Eating Active Living (HEAL). We collaborated with external partners, including the Department of Early Learning and eight local health jurisdictions to maintain or enhance existing programs focused on improving nutrition and physical activity in young children. The DOH-MCH@Listserv.WA.GOV distributed monthly, healthy nutrition and physical activity for children information to 480 clinical providers and educators across the state. The ECCS program supported a train-the-trainer event for I Am Moving, I Am Learning as part of the Let's Move Initiative. Over 80 people attended this event.

DOH collaborated with other state agencies and private organizations to begin implementing the Washington State Early Learning Plan (ELP). One ELP Ready and Successful Children outcome is: All children have optimal physical health...and nutrition. The ELP includes strategies that emphasize nutrition to support this outcome. ECCS support Regional Early Learning Coalitions to implement ELP strategies in local communities

CHILD Profile provided parents and providers of services for children access to regularly evaluated educational material related to nutrition and physical activity.

WIC, HEAL and WithinReach worked collaboratively with five hospitals to support hospital policies that promote breastfeeding. WIC trained staff to use a client centered, motivational interview approach to educate individual parents about nutrition. WIC started a peer counseling program that employs current or former WIC clients as breastfeeding peer counselors.

As of 2009, foods in WIC programs have lower calories, saturated fats and cholesterol; higher fiber; and more nutrient density. WIC strengthened policies to be more supportive of breastfeeding, and continues targeted outreach to Medicaid clients eligible, but not receiving

services.

The Access, Systems and Coordination section (ASC) collaborated with early childhood partners on strategies to support messages about nutrition and physical activity. ASC shared information and encouraged healthy behaviors, including nutrition and physical activity, with partners in prenatal, postpartum, infant, family, and youth projects.

We provided information on Bright Futures to internal and external partners including child care providers through the DOH's Bright Futures webpage. Bright Futures provides health messages on the importance of physical activity and nutrition for young children.

We implemented strategies of the Washington State Nutrition and Physical Activity Plan. This plan is a framework for developing policies and modifying environments to encourage healthy lifestyles. Objectives include increasing access to healthy food and opportunities for physical activity, and reducing food insecurity. We supported the University of Washington's Active Bodies Active Minds website. This website provides TV screen-time reduction information and resources for people who care for preschool-aged children. It contains information about modifying children's environments to encourage physical activity and healthy food choices.

All state funding for general WIC services was eliminated October 2010. WIC still trained staff on client centered services. At 75 sites across the state, 83 peer counselors provided breastfeeding support services to WIC clients. WIC also coordinated with Medicaid to enroll eligible Medicaid clients in WIC.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinated with internal and external partners to promote nutrition and physical activity.				X
2. Provided training and consultation regarding nutrition and physical activity to child care providers through child care health consultants.				X
3. Provided parents and providers of services for children access to regularly evaluated educational material related to nutrition and physical activity through CHILD Profile.			X	
4. WIC implemented new federal rule about WIC program foods.			X	
5. WIC worked with hospitals to promote breastfeeding.			X	
6. Added chapters on breastfeeding and on physical activity and nutrition to the "Nutrition Interventions for Children with Special Health Care Needs" publication.			X	
7.				
8.				
9.				
10.				

b. Current Activities

OHC works to raise awareness of the importance of maintaining healthy weight and its impact on health.. Child Profile provides educational material on nutrition and physical activity. HEAL promotes the principles of Let's Move Child Care, reduced screen time, breastfeeding, physical activity, and healthy food choices with partners and funds UW to develop policy briefs on links between obesity and early learning. We fund UW to conduct a training needs assessment for child care providers and licensors on best practices in obesity prevention.

ASC collaborates on evidence-based systems for child health, including healthy starts leading to healthy and successful children. We offer TA to families, early learning and medical providers, policy makers and the public. We review and monitor data, identify health and access issues in populations, and child and family health systems issues. We provide input into policies and systems to assure healthy eating and active living are encouraged.

WIC trains over 800 local staff on client centered services and targets outreach to eligible Medicaid clients not receiving services. WIC is exploring causes of low and high redemption rates of the WIC checks, with an emphasis on fruits and vegetables and low Tribal rates. We maintain a Bright Futures webpage with materials and links to resources. Healthy Communities Program works with five HC Hubs to focus on PSE efforts to improve access to healthy foods and physical activity.

c. Plan for the Coming Year

Children, ages 2 to 5, receiving WIC services that have a Body Mass Index at or above the 85th percentile fit within the maternal and child health priorities: Adequate nutrition and physical activity, and Access to preventive and treatment services for the MCH population.

WIC will continue to educate clients, retailers, and medical providers on the importance of breastfeeding and the WIC food package. WIC will continue to employ peer counselors who were previous WIC clients and use a client centered, motivational interviewing, approach to provide nutrition education to individual WIC clients. WIC will also continue to provide outreach to Medicaid recipients. In the next two years WIC will review and revise its nutrition education materials, including the use of electronic technology for education.

The new state budget preserves the WIC Farmer's Market program with a 40% decrease in funding level for this summer. We expect that this will decrease access to healthy food choices and increase food insecurity. While economic factors will make it difficult, we expect that the new food package, peer counseling, breastfeeding promotion, and client centered education will allow us to reach our target for this measure and to maintain that target rate.

We will continue to disseminate educational materials on nutrition and physical activity through Child Profile, HERE Website, and early learning partners; and continue the Bright Futures promotion activities and implementation strategies described in the Washington State Nutrition and Physical Activity plan. We will continue to inform, participate, and collaborate with state early learning partners. This helps ensure that health education materials are available to and used by professionals working with young children. These materials include information on physical activity, nutrition, and health education. We will also continue to give input as rules for childcare, foster care and group settings are revised in order to assure that healthy eating, physical activity and safety are emphasized.

HEAL will continue partnering to conduct a training needs assessment for child care providers and licensors on best practices in obesity prevention in child care. HEAL will fund UW to develop an on-line training based on the training needs assessment and to promote screen time policies and provide on-line training to child care providers. HEAL will fund Childhood Obesity Prevention Coalition to staff and guide an Early Learning Workgroup to improve policies and environments in a systematic manner to early learning facilities.

We will develop a one page document to help health care providers discuss healthy weight gain with parents and children and offer advice on setting goals related to healthy weight.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	9.1	9.1	9	9	9.3
Annual Indicator	9.4	11.2	9.3	8.9	
Numerator	8359	10110	8300	7697	
Denominator	88921	90270	89242	86480	
Data Source		Pregnancy Risk Assessment Monitoring System (PRAMS	Pregnancy Risk Assessment Monitoring System (PRAMS	Pregnancy Risk Assessment Monitoring System (PRAMS	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	9.3	9.3	9.3	9.3	9.3

Notes - 2011

2011 data not currently available.

Notes - 2010

Washington State is in the forefront of states in this measure with among the fewest women smoking during pregnancy of any state.

Recent budget cuts in tobacco prevention may be counterbalanced by increased taxes on cigarettes, as well as an increase in the percent of Hispanic women, who are much less likely to smoke, giving birth, so anticipating change and its direction, at this point, is difficult. A target of 9.3% from 2011 through 2016 was chosen.

The indicator is the percent of women who reported smoking in the third trimester of pregnancy in the Pregnancy Risk Assessment Monitoring System (PRAMS) in 2010. The denominator is the number of WA resident births in 2010. The numerator is calculated from the denominator and the indicator. The 95% confidence interval around the point estimate is 7-11.

Beginning with Phase 6 of the PRAMS survey the screening question for smokers changed from previous versions of the survey. Therefore, trends which include data from phases of the survey previous to Phase 6 for this topic may not be valid.

In the WA State MCH Data Report the smoking rate for women in the third trimester is reported by race/ethnicity, county of residence, age group and Medicaid enrollment. In addition to data on smoking in the last trimester the Data Report presents data on smoking before pregnancy and smoking after pregnancy.

Notes - 2009

Washington State is in the forefront of states in this measure. Recent budget cuts in tobacco prevention may be counterbalanced by increased taxes on cigarettes, as well as an increase in the percent of Hispanic women, who are much less likely to smoke, giving birth, so anticipating change and its direction, at this point, is difficult. A target of 9.3% from 2011 through 2014 was chosen, but given the decreases in the First Steps program and the WA State Tobacco Quit Line, an increase to 10% by 2015 has been set.

The indicator is the percent of women who reported smoking in the third trimester of pregnancy in the Pregnancy Risk Assessment Monitoring System (PRAMS) in 2009. The denominator is the number of WA resident births in 2009. The numerator is calculated from the denominator and the indicator. The 95% confidence interval around the point estimate is 7.4-11.6.

In the WA State MCH Data Report the smoking rate for women in the third trimester is reported by race/ethnicity, county of residence, age group and Medicaid enrollment. In addition to data on smoking in the last trimester the Data Report presents data on smoking before pregnancy and smoking after pregnancy.

a. Last Year's Accomplishments

In 2010 WA met its target objective of 9% of women smoking in the third trimester with a reported rate of 8.9% reporting that they smoked in the last three months of pregnancy.

Pregnancy Risk Assessment Monitoring System (PRAMS) data measured smoking rates before, during, and after pregnancy. It also measured disparities among groups. 2010 PRAMS data showed that 20% of women smoked three months before pregnancy; 57% of these women had stopped smoking by the third trimester of their pregnancy. Overall, 9% of women surveyed smoked during the last three months of pregnancy. Of women who reported smoking three months prior to pregnancy and quitting by their third trimester, 40% relapsed, and were smoking again 2-6 months after delivery.

According to PRAMS, 3% of non-Medicaid women smoked during the last 3 months of pregnancy, compared to 15% of Medicaid women.

We informed providers about the Medicaid Medical Program smoking cessation benefit, and disseminated information on the best practice guide for smoking cessation to medical providers. Due to state budget reductions the state Quit Line did not provide services to uninsured residents during this time period. Pregnant women on Medicaid have the highest smoking rates and those on fee-for-service are eligible for an intensive ten call program. We informed medical providers about the Quit Line fax referral system to increase its use and the use of other Quit Line services for pregnant women. In 2010, 346 pregnant women called the Quit Line and in 2011, 272 called. Of the pregnant women callers in 2011: 12 accepted a one-call program; 39 accepted the multi-call program; 23 had their general questions answered; 3 received materials only; 194 were transferred to services that their insurance covered. Quit Line staff report that pregnant women have not been using all ten calls.

The state Family Health Hotline (FHH) asked callers if there was a smoker in the home, offered Quit Line referrals as appropriate, and included the Quit Line number in a postcard mailed to callers. WithinReach runs our state FHH. They also provided information about how to get smoking cessation help on ParentHelp123.org. WithinReach mailed 5,116 postcards of useful phone numbers, and websites, including the Quit Line, to FHH callers.

We promoted text4baby, a free research-based mobile health promotion service. Text4baby

provides messages about health during pregnancy including messages about tobacco use. We began developing a bus sign campaign to increase enrollment in text4baby. Our First Time Motherhood/New Parents Initiative grant (Health-e Moms) provided funding for this campaign. We also used these grant funds to plan outreach to promote WithinReach services. This outreach will use innovative technology like widgets, bannerads, and on-line videos.

We used the OMCH listserv to send information on smoking cessation training and materials to health care professionals across the state.

First Steps screened all clients for tobacco use. There was a 30% reduction to First Steps funding this year.

Our Pregnant and Parenting Teens and Women (PPTW) grant funded activities to increase pregnant and teen parents' awareness of smoking cessation information. PPTW also works to increase teen parents' access to other information about making healthy choices for themselves and their families. PPTW partners with the state Office of Superintendent of Public Instruction's GRADS program. GRADS (Graduation, Reality, and Dual-Role Skills) are in-school programs for pregnant teens and young parents. GRADS focuses on positive self-esteem, pregnancy, parenting, academic achievement, economic independence, and preparation for graduation. The GRADS curriculum framework supports educating pregnant and parenting teens about smoking cessation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promoted the Medicaid Smoking Cessation benefit to providers.				X
2. Collected and referred to Pregnancy Risk Assessment Monitoring System (PRAMS) data to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups.				X
3. Informed and educated professionals and the public about Quit line services, including the fax referral program.				X
4. Disseminated best practice guide for smoking cessation for medical providers.				X
5. Through WithinReach, referred callers with tobacco in their home to the Quit Line as appropriate.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

First Steps screens all women for tobacco use and refers to the Quit Line (currently providing cessation services for pregnant women on Medicaid or other health insurance). Women on fee-for-service Medicaid can choose an intensive 10 call program. The State Legislature restored funding to the Quit Line, and in July 2012, services will again be available to all regardless of insurance. We may restructure the multi-call program so some take place post partum.

First Steps will continue to be funded at the 2012 level. This is the result of multiple reductions over several years. We do not know how this will impact program services. We use PRAMS data to track percentages of women who smoke during the last three months of pregnancy. We are

looking for opportunities to address smoking in pregnancy, particularly among low income and high risk women.

We disseminate smoking cessation best practice and training information to providers and inform them about the Quit Line fax referral system and train them to include smoking cessation as part of comprehensive care provided in patient centered health homes.

WithinReach operates the Family Health Hotline (FHH) and parenthelp123.org. They refer users to the Quit Line.

We are implementing a statewide bus sign campaign to increase text4baby enrollment. Data from the first phase show increased enrollment in bus signs areas.

PPTW works with schools and local health in 11 counties to improve education about smoking and access to cessation services.

c. Plan for the Coming Year

Reducing smoking during pregnancy fits within two maternal and child health priorities identified in the 2010 Five Year Needs Assessment: Tobacco and substance free living and Access to preventive and treatment services for the maternal and child population. Even though our smoking rates among pregnant women are lower than the national average, we continue to have a disparity between low income women and the rest of the female population, and smoking remains highest for women under 25 years and American Indian/Alaska natives.

Services to pregnant smokers are a high priority. The state budget restored Quit Line funding to re-establish services to uninsured residents. Eligible pregnant women can enroll in an intensive multi-call program. The multi-call program will schedule some calls during the post partum period when relapse is high. The state's poor economy may have a conflicting impact on smoking rates: Lower employment and less income may make people reluctant to spend money on cigarettes, but the resulting increased stress may tend to increase the desire to smoke. First Steps will continue to screen all women for tobacco use and refer to the Quit Line.

We will continue to track percentages of women who smoke during the last three months of pregnancy, using PRAMS data.

We will disseminate best practice and training information to providers and inform them about the Quit Line fax referral system. Providers will be trained in smoking cessation techniques as part of comprehensive care provided in patient centered health homes.

WithinReach will refer Family Health Hotline callers and ParentHelp123.org users to the Quit Line. New outreach strategies, including banner ads, widgets, and promotional on-line videos, promoting WithinReach services will be completely implemented bringing more pregnant women to the site for health information and referrals. This will include smoking cessation.

Because the Health-e Moms grant ended August 2012, we will explore other options for promoting text4baby. Text4baby includes messages about tobacco use. The new outreach tools for promoting WithinReach will continue to be used.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	8.8	8.7	7.9	7.8	7.7
Annual Indicator	8.0	7.6	10.0	8.0	
Numerator	40	36	47	37	
Denominator	497786	472122	470799	462128	
Data Source		WA Center for Health Statistics	WA Center for Health Statistics	WA Center for Health Statistics	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	7.6	7.5	7.4	7.3	7.2

Notes - 2011

2011 data not available.

Notes - 2010

The numerator for this rate is defined as the number deaths with ICD 10 Codes X60-X84 and Y87.0 and U03 for youth ages 15-19. The denominator is the estimated population for ages 15-19. The source for the data is the Washington Center for Health Statistics Death Certificate files (updated annually between September and October). Data were accessed via the Community Health Assessment Tool (CHAT).

The markedly increased rate for 2009 appears to be an anomaly as the rate for 2010 is much more in line with data from the recent past.. It was decided to leave present performance objective targets as they are, with a decrease of 0.1 per year.

Notes - 2009

The numerator for this rate is defined as the number deaths with ICD 10 Codes X60-X84 and Y87.0 and U03 for youth ages 15-19. The denominator is the estimated population for ages 15-19. The source for the data is the Washington Center for Health Statistics Death Certificate files (updated annually between September and October). Data were accessed via the Community Health Assessment Tool (CHAT).

An increased rate was noted for 2009. Discussions between MCH Assessment staff and Injury Prevention program staff could not identify a definitive cause for the increase, nor if it was part of an upward trend or an aberration. It was decided to leave present performance objective targets as they are, with a decrease of 0.1 per year and see if the current trend continues at which point performance objectives may be altered as necessary.

a. Last Year's Accomplishments

In 2010, WA did not quite meet its target goal of a 7.8 per 100,000 death rate with a reported rate of 8.0 per 100,000. We worked with other DOH programs, local health jurisdictions, and other partners to prevent youth suicide.

The DOH Coordinated School Health (CSH) program administered the 2012 CDC School Profile survey to a sample of 300 Washington principals and health teachers. The survey included

questions related to school violence and suicide policy and practice. CSH program worked with the Office of Superintendent of Public Instruction and other stakeholders to develop a set of School Profiles Fact Sheets using 2010 CDC School Profile data. One of the fact sheets is on violence and suicide prevention policy and practice.

The CSH Program Manager represented DOH on the state School Safety Advisory Committee, which includes youth suicide prevention. The CSH program convened monthly Interagency School Health Workgroup meetings, which included a focus on behavioral health.

We worked with the DOH Emergency Medical Services, Trauma, Injury, and Violence Prevention Programs and participated in the DOH Injury and Violence Prevention Workgroup. The purpose of this work is to coordinate injury and violence prevention work, which includes youth suicide prevention, across the agency and with various stakeholder groups. DOH contracted with the Youth Suicide Prevention Program, a non-profit organization, to provide suicide prevention education statewide.

We assisted Child Death Review (CDR) coordinators with data collection, provided technical assistance, and encouraged communication among CDR teams. MCH staff participated in a national meeting of State CDR Coordinators. We maintained an electronic distribution list and a web site to provide technical assistance to and encourage communication among CDR Coordinators. Local CDR Coordinators added data to the multi-state database. A variety of organizations use this data to improve prevention efforts.

The DOH CDR web site includes a link to the National Center for Child Death Review & Prevention's web-based tool that describes best practices recommendations for injury prevention, including youth suicide prevention. (<http://childinjuryprevention.org/main.html> accessed 5/4/12)

We administered the Healthy Youth Survey (HYS) in October 2010 and began sharing data findings in March 2011. HYS includes questions on depression, suicidal thoughts, suicide plans, and suicide attempts. A variety of public and private organizations used this data to plan and evaluate programs.

In Pierce County, a multidisciplinary team from their CDR team developed a standardized suicide investigation form that can be used by law enforcement and the medical examiner's office in investigations of youth and adult suicides. This form will help promote thorough investigations and consistency of information collected across jurisdictions. Data collected will be used to inform prevention strategies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with other DOH injury and violence prevention program to support youth suicide prevention.				X
2. Conducted surveillance of suicide deaths through Child Death Review (CDR) and disseminated data and prevention strategies.				X
3. Administered Washington State participation in multi-state CDR database.				X
4. Helped disseminate the State Injury Prevention & Violence Prevention Plan, which includes a chapter on suicide.				X
5. Promoted use of the National Center for Child Death Review & Prevention web-based tool that describes best practices and recommendations for injury prevention, including youth suicide prevention.			X	

6. Administered the Healthy Youth Survey to students statewide in grades 6, 8, 10 and 12				X
7. Collect School Profiles data biannually to track policy and practice related to youth suicide prevention.			X	
8.				
9.				
10.				

b. Current Activities

We participate in the DOH Injury and Violence Prevention Workgroup to coordinate DOH injury prevention activities, including implementing the State Injury and Violence Prevention Plan.

CSH administered the 2012 CDC School Profile survey to 300 principals and health teachers, including questions related to school violence and suicide policy and practice. It is administered every other year.

CSH also completed the School Profiles Fact Sheets, including one on violence and suicide prevention policy and practice. The fact sheets are shared with schools, public health leaders and other stakeholders statewide. CSH represents DOH on the state School Safety Advisory Committee, which includes youth suicide prevention. The CSH program convenes the Interagency School Health Workgroup, which includes a focus on behavioral health.

We assist local Child Death Review (CDR) coordinators with data collection, provide technical assistance, and encourage communication among local CDR teams. We maintain an electronic distribution list and a web site to provide information about CDR, including youth suicide prevention.

In Pierce County, the suicide investigation form was field tested with law enforcement and finalized. It was shared locally and nationally, through the National Center for Child Death Review.

Washington State passed legislation requiring suicide prevention continuing education training for mental health professionals licensed by DOH.

c. Plan for the Coming Year

Reducing the youth suicide rate fits within two priorities identified in the 2010 Five Year Needs Assessment: Social and Emotional Wellness and Safe and Healthy communities.

The CSH program will disseminate the School Profiles Fact Sheets, including a fact sheet on violence and suicide prevention policy and practice, to schools, public health leaders and other stakeholders

and the CSH Program Manager will represent DOH on the state School Safety Advisory Committee, which includes youth suicide prevention. The CSH program will convene monthly Interagency School Health Workgroup meetings, which include a focus on behavioral health.

We will assist local CDR coordinators with data collection, provide technical assistance, and encourage communication among local CDR teams. The State CDR Coordinator will participate in national and regional CDR training, coordination, and information exchange. We will maintain an electronic distribution list and CDR web pages, including links to the National Center for Child Death Review and the best practices web-based resource.

We will administer the Healthy Youth Survey (HYS) in fall 2012 and release the data in spring 2013. HYS includes questions on depression, suicidal thoughts, suicide plans, and suicide attempts.

We will continue to work with the DOH injury and violence prevention program to coordinate efforts to prevent and reduce injury, including youth suicide.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	87	86.1	86.2	86.2	86.3
Annual Indicator	85.8	82.6	82.4	83.4	
Numerator	774	754	674	689	
Denominator	902	913	818	826	
Data Source		WA Center for Health Statistics	WA Center for Health Statistics	WA Center for Health Statistics	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	86.3	86.4	86.4	86.5	86.5

Notes - 2011

2011 data not currently available.

Notes - 2010

The numerator is determined by the number of resident very low birth weight (VLBW) births that occur in-state delivered at a hospital providing perinatal intensive care (Level III). The denominator represents the total number of VLBW resident infants born in-state.

Notes - 2009

Discussions between program staff and assessment staff resulted in the preservation of the current targets with the rate increasing by 0.1 every other year.

The numerator is determined by the number of resident very low birth weight (VLBW) births that occur in-state delivered at a hospital providing perinatal intensive care (Level III). The denominator represents the total number of VLBW resident infants born in-state. The source for this data is the Washington Center for Health Statistics Birth Certificate Files.

a. Last Year's Accomplishments

In 2010, Washington State did not meet its target for 86.2% of very low birth weight (VLBW) infants delivered at facilities for high-risk deliveries. The 2010 Washington rate was 83.4%. It reflects shifting resources, specialists, and changing birth rates across counties.

MCH Assessment monitored and reported on the delivery sites of very low birth weight babies.

The state Perinatal Indicators Report included the percent of very low birth weight babies born at

appropriate level hospitals. This report was presented at the Perinatal Advisory Committee in September.

Perinatal Regional Network (PRNs) worked with the Washington State Hospital Association, Medicaid, and local hospitals to decrease births between 37-39 weeks. First quarter data showed the majority of the hospitals in the project reported decreased rates of births before 39 weeks gestation as well as a decline in cesarean section rates.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Updated and revised the Statewide Perinatal Level of Care document September 2010. This document outlines recommendations for high risk deliveries.				X
2. Monitored delivery sites of very low birth weight babies and advocated for delivery of these infants at tertiary care facilities.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2010, Washington State did not meet its target for 86.2% of very low birth weight (VLBW) infants delivered at facilities for high-risk deliveries. However, by 2011 we expect to exceed 90% because a number of hospitals have obtained a certificate of need to establish themselves as level 3 facilities.

OHC is monitoring and reporting annually on the delivery sites of very low birth weight babies through the Perinatal Indicators Report.

DOH contractors, the Washington State Hospital Association (WSHA), Medicaid, and local hospitals have been working together since 2009 to decrease births between 37-39 weeks. In addition, the department of health has signed on to the ASTHO/MOD challenge to decrease prematurity in Washington State by 2014.

c. Plan for the Coming Year

OHC will monitor and report on the delivery sites of very low birth weight babies through the Perinatal Indicators Report. This report will be presented at the Perinatal Advisory Committee annually.

DOH contractors, the Washington State Hospital Association (WSHA), Medicaid, and local hospitals will continue to work together to decrease births between 37-39 weeks.

We expect to exceed our target for the percent of very low birth weight infants delivered at facilities for high-risk deliveries. This will be due to a larger number of facilities becoming certified as level 3 facilities and having the capabilities of caring for very low birth weight infants. In addition, the department of health will continue partnering with ASTHO/MOD to decrease

prematurity in Washington State.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	81	81	77	77	77
Annual Indicator	76.3	77.0	77.6	80.1	
Numerator	61938	64561	65138	64955	
Denominator	81187	83870	83969	81107	
Data Source		WA Center for Health Statistics	WA Center for Health Statistics	WA Center for Health Statistics	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	80	80	80	80	80

Notes - 2011

2011 data not currently available.

Notes - 2010

The source for these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October). The numerator is the number of resident live births with a reported first prenatal visit before 13 weeks gestation. The denominator is the total number of resident live births. Missing data are excluded.

Discussions with program staff resulted in the establishment of the current rate of approximately 80% of women starting prenatal care in the 1st trimester through 2016.

In the WA State MCH Data Report the rate of women receiving prenatal care in the first trimester is reported by race/ethnicity, county of residence, age group and Medicaid enrollment. These data highlight some of the disparities which exist in the procurement of first trimester care for women in WA State.

Notes - 2009

The source for these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October). The numerator is the number of resident live births with a reported first prenatal visit before 13 weeks gestation. The denominator is the total number of resident live births. Missing data are excluded. In 2009 5.9% of records were missing data.

Discussions with program staff resulted in the maintenance of the current performance objective

goals. Staff felt that a decrease in the birth rate might alleviate a noted scarcity of OB capacity, especially for low income women.

In the WA State MCH Data Report the rate of women receiving prenatal care in the first trimester is reported by race/ethnicity, county of residence, age group and Medicaid enrollment. These data highlight some of the disparities which exist in the procurement of first trimester care for women in WA State.

a. Last Year's Accomplishments

We met our target for this measure. In 2010, 80.2% of Washington State births were to women who received prenatal care in the first trimester. From 2002-2007 there was a significant decrease in women who received prenatal care in the first trimester. This decline was across populations, geographic areas, and risk groups. There has been a reversal of this trend from 2007-2010, but we are still below the 2002 high.

Medicaid women have a lower rate of first trimester entry than higher income non-Medicaid women. First Steps connected low income women to prenatal services and worked to make sure that women know about the services that they are eligible for.

We worked to reduce health disparities with specific initiatives focused on Native American and African American women. We worked with the American Indian Health Commission (AIHC) to prioritize and implement recommendations in the AIHC 2010 Tribal Maternal and Infant Health Strategic Plan. We worked with a local health agency on activities focused on Pierce County's African American population to link pregnant African American women to First Steps and other programs to improve birth outcomes.

WithinReach's Family Health Hotline (FHH) and ParentHelp123.org website provided information on the importance of prenatal care services to pregnant women and to women and families contemplating pregnancy. WithinReach continued to link women with services including First Steps and prenatal care. In this timeframe 2,981 pregnant women called FHH for information about eligibility for state benefits programs like Medicaid and WIC, or in depth information about other services. 2,291 of these callers were already receiving prenatal care. A total of 6,491 related referrals were given to these callers. WithinReach mailed 5,116 postcards of useful phone numbers and websites to callers. ParentHelp123.org's pregnancy page was viewed 7,853 times, and 558 used WithinReach's on-line search tool to find Maternity Support Services providers.

WithinReach used funds from our First Time Motherhood/New Parents Initiative grant to develop innovative ways to market its services. We also used these grant funds to promote text4baby, a research-based mobile information service that provides free messages promoting healthy pregnancy. The messages include the importance of prenatal care.

The Pregnant and Parenting Teens and Women (PPTW) project began conducting local needs assessments to identify programs and resources to support pregnant and parenting teens in selected counties, as well as gaps in service. Initial work informed the development of a website specifically targeting pregnant and parenting teens. This website will provide information and resources about prenatal care and access. PPTW also works with GRADS (Graduation, Reality, and Dual-Skill Roles) programs. GRADS programs are in-school programs for pregnant and parenting teens. GRADS focuses on positive self-esteem, pregnancy, parenting, academic achievement, economic independence, and preparation for graduation. We are working to include the importance of prenatal care in GRADS curriculum.

Another component of PPTW worked with the Attorney General's Office and two statewide coalitions on domestic and sexual violence. They are developing and will pilot practice guidelines to help legal, health, and social services routinely and compassionately screen for domestic violence, sexual violence, and stalking and make referrals to needed services in a culturally relevant and appropriate way. Women who experience intimate partner violence victimization are

less likely to enter prenatal care early. (American Journal of Obstetrics & Gynecology 2006).

We tracked prenatal care entry data from a variety of resources to inform program planning. We shared this information with the State Perinatal Advisory Committee.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Through WithinReach, provided outreach to pregnant women to increase early enrollment in prenatal services.			X	
2. Promoted early prenatal care and First Steps enrollment to African American women.		X		
3. Explored ways to improve American Indian/Alaska Native prenatal care access.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

We monitor prenatal care entry, sharing trends with partners. We promote the Centering Pregnancy model of prenatal care through technical assistance and consultation.

We will support two efforts focused on reducing disparities in early entry to prenatal care: We work with AIHC to prioritize and implement recommendations in their 2010 Maternal and Infant Health Strategic Plan. Staff provides TA and clinical resources. We provide TA on building collaboration with obstetrical providers for AIHC's Strong Start application.

We work to link pregnant African American women in Pierce County to First Steps and other programs. Churches and other community organizations help identify and reach pregnant women in their communities.

We contract with WithinReach to operate FHH and do outreach, education, referrals, and coalition building. They provide information on the importance of prenatal care and links to First Steps and other service. WithinReach is developing and implementing new outreach strategies to promote their services. They include banner ads, widgets, and on-line videos. One banner ad will focus on the importance of prenatal care. We are promoting text4baby.

PPTW works in 11 counties to enhance links among community programs and resources. PPTW works with GRADS to include the importance of early entry prenatal care in lessons. The teen website launched in April 2012. The practice guidelines are being finalized and the pilots launched.

c. Plan for the Coming Year

Assuring access to prenatal care fits within two maternal and child health priorities: Healthy Starts, Access to preventive and treatment services for the maternal and child population; and Quality screening, identification, intervention, and care coordination.

We are not able to address the systemic and demographic issues that contribute to this problem within existing resources and over a short timeframe. These issues include insurance, provider supply, and changing birthrate. We expect to have an impact on these issues using our current strategies, as described below, but expect to see that impact gradually over many years. Teens, women on Medicaid and Native American women have lower rates of early prenatal care. Therefore we will focus our efforts on impacting these populations.

We will promote the CenteringPregnancy model of prenatal care to communities through technical assistance and consultation. Research has shown this model improved outcomes and increased patient and provider satisfaction. (www.centeringhealthcare.org/pages/research/research-evaluation.php)

We will work with AIHC to prioritize and implement recommendations in their 2010 Maternal and Infant Health Strategic Plan. This includes ongoing technical assistance and consultation related to pregnancy care.

We will work with Tacoma-Pierce County Health Department (TPCHD) to link pregnant African American women to First Steps and other programs. TPCHD will work with churches and other community organizations to reach pregnant women in their communities. The participating churches will identify ways to reach more pregnant women. We will promote use of evidence or research based practices to improve African American maternal and infant health in Pierce County.

We will contract with WithinReach to provide information on the importance of prenatal care and links to First Steps and other services. A website banner-ad on the WithinReach site will promote prenatal care. We will monitor website and service use to evaluate the effectiveness of new outreach strategies.

The Pregnant and Parenting Teens and Women project will work with local health jurisdictions in 11 counties to improve links among community programs and resources. PPTW will also improve connections between those resources and programs that serve pregnant and parenting teens. We will improve the teen pregnancy and parenting website by adding information. Additional pages will be finalized by August 2013. We will evaluate PPTW practice guideline demonstration sites. We will provide trauma informed care training for project partners.

D. State Performance Measures

State Performance Measure 1: *The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective				51	51
Annual Indicator		50.4	50.5	48.5	
Numerator		57679	56554	52037	
Denominator		114549	111884	107384	
Data Source		Multiple sources. See field notes	Multiple sources. See field notes	Multiple sources. See field notes	

Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	48.5	48.5	48.5	48.5	48.5

Notes - 2011

2011 data not currently available.

Notes - 2010

Discussions with program staff resulted in the decision to set the most recent unintended pregnancy rate as the target out to 2016. Lack of a statewide campaign to reduce unintended pregnancy coupled with the indicator's lack of change over the past few years was cited as reasons why significant improvements in the rate were not reasonable. It was felt that given the economy and lack of funding for services targeted at poor women, especially those on TANF, who have the highest rates of unintentional pregnancy, holding steady would be an achievement.

The numerator for this measure is derived from the number of resident live births multiplied by the estimated percentage of unintended pregnancies from the Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey, plus the number of resident abortions. The denominator is the number of resident live births plus the number of reported resident abortions.

While there are no large statewide campaigns to reduce unintended pregnancy, the State of Washington acknowledges the link between unintended pregnancy and poorer health outcomes and feels strongly that continuing to track the measure is worthwhile and a responsible action from a public health perspective.

Notes - 2009

Discussions with program staff resulted in the decision to leave the established performance objectives in place. Lack of a statewide campaign to reduce unintended pregnancy was cited as a reason why significant improvements in the rate were not likely possible. It was felt that given the economy and lack of funding for services, holding steady would be an achievement.

The numerator for this measure is derived from the number of resident live births multiplied by the estimated percentage of unintended pregnancies from the Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey, plus the number of resident abortions. The denominator is the number of resident live births plus the number of reported resident abortions.

$$\frac{(\text{resident live births} * \text{estimated percent unintended pregnancies}) + \text{reported resident abortions}}{(\text{resident live births} + \text{reported resident abortions})}$$

Birth and abortion data are from the Washington State Center for Health Statistics.

a. Last Year's Accomplishments

In 2010, Washington State met its target for the percentage of pregnancies that are unintended. The unintended pregnancy rate includes births and abortions. Pregnancy Risk Assessment Monitoring System (PRAMS) data looks at live births only. In 2010, approximately 36% of Washington State births resulted from unintended pregnancies. The rate is significantly higher for women who received Medicaid (51%) than for women who did not receive Medicaid (23%). The unintended pregnancy rate calculated using PRAMS and abortion data has remained constant in Washington State for many years even through the most recent economic downturn.

DOH focused on activities to increase access to and use of birth control. We do this through education and referral to services and through the Title X Family Planning Program. This program provides comprehensive reproductive health services to low income women. In 2011, they served

89,413 women, 65% were below 100% of the federal poverty level (FPL). An additional 27% had incomes between 100 and 251% FPL. In addition to Title X funds, Washington's family planning program includes Cuidese state funds. Cuidese places extra emphasis on providing cultural and linguistically appropriate birth control services for undocumented Hispanic women in Yakima, Grant, Chelan, Okanogan, and Skagit Counties.

CHILD Profile included messages about birth spacing and family planning. These messages go to all parents who gave birth in Washington. Our Practice Improvement section's Diabetes Program disseminated messages promoting family planning among women with diabetes.

We worked with the state Department of Corrections (DOC) and state Department of Social and Health Services (DSHS) to secure free birth control supplies to maintain pre-release initiation of birth control pills for incarcerated women. Approximately 20 women each month received birth control pills prior to release. State prisons do not have adequate funding to purchase contraception methods. DOC supplied oral contraception pills to start women on a method prior to release and provide women with a 3 month (if appropriate) supply of birth control upon release. Getting women on a method prior to release ensures that they have adjusted to the method and gives them time to establish family planning care in their community. Unfortunately, these supplies ran out and we were not able to find a drug company to donate additional pills.

WithinReach provided family planning information and referral assistance to 296 Family Health Hotline (FHH) callers and 3,268 Take Charge line callers. They also mailed 5,116 postcards of useful phone numbers and websites to callers. The postcard includes contacts for birth control and family planning.

First Steps Maternity Support Services (MSS) provided birth control information and helped clients access family planning services throughout pregnancy and post-partum.

The state Health Care Authority (HCA) continued the Take Charge and Family Planning Only programs through one year post-partum.

We developed a Reproductive Life Plan handout and had it translated into Spanish. We posted it on the department website, distributed it at annual conferences (Reproductive Health Update Conference, Advanced Practice in Primary and Acute Care Conference, and Washington State Obstetrical Association Conference), and emailed it to a variety of healthcare professionals and organizations. These included Washington's: MCH Listserv, Title X Family Planning Centers, College Health Directors, Perinatal Advisory Committee, Association of Community and Migrant Health Centers, and tribes. This handout was designed for use in family planning clinics, and college health centers, and by school nurses and private providers.

The Pregnant and Parenting Teens and Women Grant began a needs assessment to inform the development of Practice Guidelines for health professionals, law enforcement, prosecutors, and social service and systems advocates. The Practice Guidelines provide these target groups information about reproductive coercion. Reproductive coercion can increase unintended pregnancies.

The Washington State Family Planning Team (FPLT) formed in 2008. The purpose of the group is to develop a more holistic approach to family planning services. DSHS, DOH, HCA, Medicaid Office, LHJ, CHC, Tribes and non-profit agencies are members.

We describe additional activities focused on reducing teen pregnancy in the narrative for National Performance Measure 08

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Referred First Steps Maternal Support Services clients to family planning services.		X		
2. Developed Reproductive Life Plan handout and promoted use.			X	
3. Provided birth control education and referral to family planning services through WithinReach.			X	
4. Worked with the Department of Corrections and others to increase education and referrals for inmates prior to release.			X	
5. Provided comprehensive family planning services through Title X family planning and state Cuidese.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

See NPM 08 for activities focused on reducing teen pregnancy; staff from PPTW are finalizing Practice Guidelines and launching pilots to test them in three communities. We work with DOC and HCA to explore options for securing birth control supplies and to initiate pre-release birth control. Pre-release health education and service information are provided to the offenders. HCA's Take Charge and Family Planning Only programs provide services to eligible women through one year post-partum. We expect Take Charge, available to both men and women, eligibility to expand to 250% of federal poverty level in the next biennium.

WithinReach provides family planning information and referral assistance through the Family Health Hotline, and ParentHelp123.org. MSS provides birth control information and helps clients access family planning services throughout pregnancy and post-partum. CHILd Profile mailings include messages about birth spacing and family planning.

The DOH Family Planning and Adolescent Health unit contracts with local family planning agencies to provide comprehensive family planning services to low income women. This includes Title X family planning and state Cuidese. We are providing family planning resource materials and service referral information to DSHS Division of Behavioral Health and Recovery for use in substance abuse treatment programs for women. The MCH director co-leads the statewide Family Planning Leadership Team.

c. Plan for the Coming Year

Reducing the percent of unintended pregnancies fits within the maternal and child health priorities identified in the 2010 Five Year Needs Assessment: Reproductive and Sexual Health.

The rate of unintended pregnancies has remained fairly constant since 2005. We have a variety of ongoing efforts directed toward this measure; we will continue to track unintended pregnancy trends and work to keep the rate of unintended pregnancies from increasing by continuing our current efforts.

DOH will work to maintain access to and use of birth control, through education and referral to services and through the Title X and State Family Planning Programs. The Title X and State Family Planning Programs provide comprehensive reproductive health services to low income women.

CHILd Profile mailings will include messages about birth spacing and family planning.

We will work with DOH and HCA to secure free birth control supplies and maintain the pre-

release initiation of birth control pills. Getting women on a method prior to re-entry will better ensure that they have adjusted to the method and give them time to establish family planning care in their community.

WithinReach will provide family planning information and referral assistance through the Family Health Hotline, and ParentHelp123.org.

MSS will provide birth control information and help clients access family planning services throughout pregnancy and post-partum.

PPTW evaluate their Practice Guideline demonstration site pilots and provide trauma informed care trainings for PPTW project partners who serve violence survivors. Studies show women experiencing reproductive coercion are more likely to have unintended pregnancies.

HCA's Take Charge and Family Planning Only programs will provide coverage through one year post-partum. We expect Take Charge eligibility to expand to 250% of federal poverty level in the next biennium. Take Charge is available to both men and women.

See National Performance Measure 08 for descriptions of activities focused specifically on reducing teen pregnancy.

State Performance Measure 2: *Percent of children 6-8 years old with dental caries experience in primary and permanent teeth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					48
Annual Indicator		57.9	57.9	48.5	48.5
Numerator					124923
Denominator					257573
Data Source		2005 Smile Survey	2005 Smile Survey	2010 Smile Survey	2010 Smile Survey
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	48	48	48	50	50

Notes - 2011

The indicator comes from the 2010 WA Smile Survey. The 2010 Smile Survey sampled children in Kindergarten and 3rd Grades to arrive at the estimate reported here. Previous Smile Surveys in 2005 and 2000 surveyed children in the 2nd and 3rd Grades.

The denominator is from the Office of Financial Management and is the total of WA residents aged 6-8. The numerator is derived from denominator and the indicator, 48.5%

The 95% confidence intervals for the estimate of 48.5% are 44.5%, 52.6%.

After discussion with program and evaluation staff it was decided that given the recent severe cuts to oral health at the state and local levels during the recent fiscal crisis that it was likely that this rate will increase. It is hoped this increase can be contained as much as possible. A target

of 50% was set for 2015, the next year the Smile Survey is slated to take place, and extended into 2016.

Notes - 2010

The indicator comes from the 2010 WA Smile Survey. The 2010 Smile Survey sampled children in Kindergarten and 3rd Grades to arrive at the estimate reported here. Previous Smile Surveys in 2005 and 2000 looked at children in the 2nd and 3rd Grades.

The 95% confidence intervals for the estimate of 48.5% are 44.5%, 52.6%.

As the Smile Survey is only conducted once every five years the current target of 48% will remain the target until new data have been collected. The HP 2020 goal in OH-1.2, is to reduce the percent of 6-9 year olds with dental caries experience in primary or permanent teeth by 10%. If this goal is met in WA, the estimated percent of 6-8 year olds with caries in 2015 will be 46%. Thus, this is the target WA has set for 2015.

The next Smile Survey is scheduled to occur in 2015.

Notes - 2009

The indicator comes from the 2005 WA Smile Survey. The 2005 Smile Survey sampled children in the 2nd and 3rd Grades.

The 95% confidence intervals for the estimate of 57.9% are 54.5%, 61.2%.

a. Last Year's Accomplishments

Following the 2010 Smile Survey, WA reset its targets to 48.0% reflecting a hope that the rate would continue to decrease. Since new data will not be collected until 2015 it is not possible to determine if the target was met or not.

Results of the 2010 Smile Survey show 6-8 year old continue to have high rates of tooth decay. We reported results to partners, the public, and policy makers. We encouraged the State Oral Health Coalition and others to join the effort to implement the new State Oral Health Plan.

The hands-on clinical curricula for dental and medical providers based on the newly developed fact sheets for children with special needs have been extremely popular, used by several states and universities and has received thousands of hits on the website on which they are housed. (funded by HRSA grant 07-039). The fact sheets can be found here:

http://dental.washington.edu/departments/omed/decod/special_needs_facts.php

The program developed oral health promotion materials that were widely distributed and well received. Newly developed Oral Health Promotion Cards have brief talking points about oral disease prevention and care for all ages. They have been adopted by several health care facilities including Group Health. The Tooth Tutor Curriculum for children pre-kindergarten to 12th grade reflects new state guidelines and scientific evidence. We developed and maintained an online directory of community dental clinics and Medicaid providers for each county to facilitate access to dental care at www.doh.wa.gov/cfh/oral_health/findcare.htm. This information was no longer available with the closure of local oral health programs.

Tailored Oral Health messages to different MCH-related programs and populations (WIC, Head Start, First Steps, schools, etc.) and upon revision make available online in a fact sheet format.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed promotion materials with brief talking points about		X		

oral health disease prevention and care for MCH populations and all ages.				
2. Developed and maintained online directory of community dental clinics and Medicaid providers for each county to facilitate access to dental care.		X		
3. Funded 5 local health jurisdictions to implement school sealant programs for children 6-8.			X	
4. Maintained website with information on oral health promotion/education and access to dental care			X	
5. Collected statewide dental caries experience data.				X
6. Encouraged State Oral Health Coalition and others to lead implementation of the new State Oral Health Plan.				X
7.				
8.				
9.				
10.				

b. Current Activities

Children with dental caries experience fits within two priorities:: Access to preventive and treatment services for the MCH population; and Quality screening, identification, intervention, and care coordination.

State funds have been cut substantially to the Oral Health Program. This year we provided funding to 5 counties for school sealant programs. This grant ends August 31, 2012. We worked on fluoridation education in partnership with Office of Drinking Water, and worked on oral health promotion with other chronic disease programs.

In partnership with other state dental referral programs, we decided dental referral information would housed and shared with the public through the WA 2-1-1 Network call and online services.. 2-1-1 receives the highest number of calls statewide regarding requests for dental referrals. The Oral Health Program participated by providing updated information to the 2-1-1 network to ensure 211 has current dental referral information. Partners in this project include: Office of the Insurance Commissioner, Medicaid, WithinReach, Health Care Authority Community Health Services, dental and dental hygienists professional associations, Washington Dental Service Foundation, Office of Rural Health, Washington Association of Community and Migrant Health Centers, Washington Free Clinics Association, and others.

c. Plan for the Coming Year

The Oral Health Program will continue to support local health in their efforts to provide school-based dental sealants. We plan to seek funding to support school-based dental sealant programs in our state.

We will continue working with the Office of Drinking Water to promote community water fluoridation. We will facilitate opportunities for referral partners to provide the most current dental referral information to 2-1-1. We will continue to distribute oral health promotion materials such as our Oral Health Promotion cards and brochures to partners and non-dental health providers to make sure they have current, evidence-based oral health messages for families and children.

We will continue promoting the Tooth Tutor: A Simplified Oral Health Curriculum for Pre-K to grade 12. We will continue to work with external and internal partners to provide current evidence based oral health messages that integrate oral health into overall health including Healthy Eating Active Living, Tobacco, WIC, and other chronic disease programs

State Performance Measure 3: *The percent of children who received a standardized developmental screening.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					27
Annual Indicator		25.6	25.6	25.6	25.6
Numerator					
Denominator					
Data Source		2007 National Survey of Children's Health			
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	27	27	27	30	30

Notes - 2011

The indicator comes from the National Survey of Children's Health (NSCH). Respondents for children between 10 months and 5 years old (71 months) were asked whether they completed a questionnaire about their child's development, communication and social behaviors during the previous 12 months (K6Q12 in the NSCH). If the response to K6Q12 was "Yes", respondents were asked age-appropriate follow-up questions on language, behavior or social development likely to be covered in such a standardized questionnaire. Only respondents who answered yes to all items (K6Q12 and the two age-appropriate follow up questions) were scored as having completed a standardized screening instrument for being at risk for developmental, behavioral and social delays.

The most recent NSCH for which we have data was conducted in 2007

Notes - 2010

The indicator comes from the National Survey of Children's Health (NSCH). Respondents for children between 10 months and 5 years old (71 months) were asked whether they completed a questionnaire about their child's development, communication and social behaviors during the previous 12 months (K6Q12 in the NSCH). If the response to K6Q12 was "Yes", respondents were asked age-appropriate follow-up questions on language, behavior or social development likely to be covered in such a standardized questionnaire. Only respondents who answered yes to all items (K6Q12 and the two age-appropriate follow up questions) were scored as having completed a standardized screening instrument for being at risk for developmental, behavioral and social delays.

The most recent NSCH was conducted in 2007

Notes - 2009

The indicator comes from the National Survey of Children's Health (NSCH) and is the number of respondents who replied "yes" to the question k6q12 "Sometimes a child's doctor or other health care provider will ask a parent to fill out a questionnaire at home or during their child's visit. During the past 12 months, did a doctor or other health care provider have you fill out a questionnaire about specific concerns or observations you may have about [S.C.]'s development, communication, or social behaviors?"

Discussions between program and assessment staff resulted in the adoption of the target of 27% through 2014. An increase to 30% is targeted by the year 2015. As the NSCH is conducted on a four-year cycle, new data for 2015 are expected to be available then and it will be possible to determine if the target set for that year was achieved.

a. Last Year's Accomplishments

No new NSCH data are available at present to determine if WA has met its target of 27% of children having received a developmental screen in their provider's office, or not. We chose to track developmental screening so children with significant delays are identified early in life and have opportunities for early intervention, optimal health, and school readiness. As an initial step in building a universal state system, Washington chose to improve standardized developmental screening that both early education and medical providers will use. Washington is under-identifying children with delays and standardized developmental screening should help reverse this.

We partnered with the University of Washington Medical Home Project to form the Developmental Screening Partnership Committee (DSPC). Other committee partners include DOH [early hearing detection and intervention, Early Childhood Comprehensive Systems (ECCS), Project LAUNCH and Great MINDS], the state Department of Early Learning (DEL), WithinReach, state Medicaid agency, pediatricians, and many other public and private organizations.

Each piece of work moved us forward to the goal of creating a system that addresses screening, resources, care coordination, and data. DSPC worked with federal, state, and regional partners on a common vision for a state universal developmental screening system. A Strategic Framework for Universal Developmental Screening for Washington State was accepted and distributed. We developed an Outcome Map model theory of change that blends into the state Department of Early Learning efforts and gives a quick visual for different areas of work.

DSPC looked at successful activities in other states in order to create a system unique to Washington. WithinReach and DOH collaborated to apply for and received a Technical Assistance grant through Help Me Grow. This grant focuses on developmental screening. DSPC serves as a steering committee for the grant.

DSPC created workgroups focused on: Screening System, Resources & Care Coordination, Data Needs, and Reaching All Populations/Health Equity. Early Support for Infants and Toddlers American Recovery and Reinvestment Act (ARRA) funds helped support this effort through September 2011.

The Washington Chapter of the American Academy of Pediatrics (WCAAP) collaborated with us to submit a federal grant application. We received a Great MINDS (Medical Homes Include Developmental Screening) grant June 2011.

Washington received supplemental federal autism grant funds from the Centers for Disease Control (CDC). These funds support the CDC Learn the Signs Act Early (LTSAE) campaign. We developed LTSAE promotional activities to increase the awareness of developmental milestones among Hispanic parents with young children. LTSAE materials link families with resources and services in four Central Washington counties. LTSAE blended resources and educational materials into early learning organizations, community medical providers, and federal Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grant pilot activities in Yakima.

LAUNCH added the Ages and Stages Enterprise Developmental Screener to the Yakima pilot site and developmental screening information and resources to the statewide Family Health Hotline and ParentHelp123 website operated by WithinReach.

We used MCHB TA funds to support a speaker from Florida to share another state's experience in promoting universal developmental screening with the OSPC.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with interagency partners and stakeholders to raise awareness about the value of developmental screening.				X
2. Convened a statewide committee of key partners to develop a common vision for universal developmental screening.				X
3. Developed a common vision and strategic implementation plan to establish universal developmental screening.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DSPC is working to create a universal developmental screening system. There is broad support to implement a system that provides outcomes and measures that would benefit partners across state agencies, systems, and organizations serving infants and young children. DOH is structuring contracts with local health jurisdictions (LHJ) to target work on MCH national and state performance measures. LHJs will have the option of focusing efforts on this measure.

Our Great MINDS grant funds statewide efforts to establish the pediatric use of a standard developmental screening tool and follow-up care coordination. We partner with WCAAP to train parent/provider teams. These teams will help integrate family voices into pediatric practices and work to help them understand the value of and incorporate universal developmental screening in medical homes.

The Community Asset Mapping program is working to coordinate community services and resources and integrate local coalitions with providers.

We support WithinReach to operate a toll-free family health hotline and provide other outreach, referrals, education, coalition building activities, and universal developmental screening promotion. Our federal ECCS and LAUNCH grants support communities to build and integrate early childhood systems that address social-emotional development and children's mental health; early care and education; parenting and family support services.

c. Plan for the Coming Year

Children receiving a standardized developmental screening fits within the priorities identified in the 2010 Five Year Needs Assessment: Quality screening, identification, intervention, and care coordination and Healthy Starts.

With our partners, we will work to develop a system that provides screening tools, facilitates tracking, and helps link families to resources. Tracking will let us evaluate who is being screened, referred, and receiving additional services.

We are working toward setting up a comprehensive system that both early education and medical providers will use; this is a complex and time consuming process. It will also take time to change norms and assumptions around developmental screening. We expect to make steady progress toward both these goals and at the same time anticipate that it will be several years before we see improvements in the percentage of children screened.

We will continue to work with ECCS, Project LAUNCH, UW Medical Home Project, DEL, Within Reach, the Help Me Grow technical assistance grant, and other partners on the Developmental Screening Partnership Committee.

Great MINDS grant trainings will improve early and continuous screening for special health care needs within seven counties and multiple practices. We will work toward developing policies that support universal developmental screening through partnership and collaborations.

We will continue to link MCH state and national performance measures to LHJ contracts. We will inform local partners of statewide activities to assure alignment and provide technical assistance and ongoing learning sessions (webinars) to help them link their local activities to these measures.

DSPC will continue to integrate work between partners by aligning activities with agency work plans and outcomes. This will include the DEL Early Learning Plan and activities of their Race to the Top grant. We will continue to explore other states' developmental screening systems in order to learn from them. We will work on two pilots using the Ages and Stages Screener on line in Yakima and through WithinReach. These will be available to both parents and providers. We will help promote the use of LTSAE materials in Great MINDS trainings and in DEL's work with young children and families.

State Performance Measure 4: *The degree to which state has assisted in planning and implementing comprehensive, coordinated care in order to develop an integrated system of care for children, birth to eight.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					12
Annual Indicator				12	12
Numerator					
Denominator					
Data Source				WA Office of Maternal and Child Health	WA Office of Health Communities
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	13	13	14	14	14

Notes - 2011

This is a process measure. In each of the five years of the grant cycle a score is developed for each of the eight indicators of the measure. The score is from zero to three. The scores for each of the eight indicators are then totaled for the global score which is reported. The criteria noted below come from the performance measure created by the grantor to evaluate progress on the creation of the system of care.

Scores are in parenthesis

For 2011:

- Collaboration with Other Public Agencies and Private Organizations on the State Level (2)
- Collaboration with Other Public Agencies and Private Organizations on the Local Level: (2)
- Coordination of Components of Community-Based Systems (1)
- Coordination of Health Services with Other Services at the Community Level (1)
- Extent to which the statewide integrated system provides technical assistance and consultation (2)
- Extent to which the statewide integrated system provides education and training (2)
- Extent to which the statewide integrated system provides common data protocols (1)
- Extent to which the statewide integrated system identifies financial resources for communities engaged in systems development (1)

These are all the same scores which they received in 2010.

Notes - 2010

This is a process measure. In each of the five years of the grant cycle a score is developed for each of the eight indicators of the measure. The score is from zero to three. The scores for each of the eight indicators are then totaled for the global score which is reported. The criteria noted below come from the performance measure created by the grantor to evaluate progress on the creation of the system of care.

Scores are in parenthesis

For 2010:

- Collaboration with Other Public Agencies and Private Organizations on the State Level (2)
- Collaboration with Other Public Agencies and Private Organizations on the Local Level: (2)
- Coordination of Components of Community-Based Systems (1)
- Coordination of Health Services with Other Services at the Community Level (1)
- Extent to which the statewide integrated system provides technical assistance and consultation (2)
- Extent to which the statewide integrated system provides education and training (2)
- Extent to which the statewide integrated system provides common data protocols (1)
- Extent to which the statewide integrated system identifies financial resources for communities engaged in systems development (1)

a. Last Year's Accomplishments

In 2010, WA did not have a target, however, its score of 12 meets the target that was set for 2011. This measure supports the MCH Bureau's emphasis on systems development and integration and OHC role in promoting health, safety, and school readiness. Our activities are primarily funded by two federal grants: Early Childhood Comprehensive Systems (ECCS) and Project LAUNCH, activities at both the state and local levels.

ECCS has five components: access to health and medical home; social-emotional development and children's mental health; early care and education; parenting Education; and family support services.

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) promoted the wellness of young children (0 to 8) and their families through coordinated systems. It includes systems

coordination and direct services. Yakima County is our LAUNCH local area. LAUNCH's goals for systems development at both the state and local level are: increased access to developmental assessments, screenings, and services for young children and their families; expanded and improved use of culturally-relevant, evidence-based prevention and wellness promotion practices in a range of primary and early childhood settings; A workforce that understands young children's healthy development; Improved systems of care for young children and families at the local, state, and federal levels; and more children entering school ready to learn.

ECCS, LAUNCH, and CSHCN were part of a coordinating body that worked to develop a Universal Developmental Screening System. Over 70 cross-agency partners and stakeholders, including medical providers, collaborated to create a Theory of Change Outcome Map (TOC-OM) for this system. The map builds off of the state-wide work done on ELP to ensure healthy, ready children. Developmental screening bridges the health and early learning worlds of responsibility.

We promoted and included Strengthening Families protective factors for preventing child abuse and neglect; supported systems for addressing children's mental health and medical homes; supported early learning coalitions around the state, and worked with projects like Reach Out and Read Washington (Reach Out and Read partners with doctors to prescribe books and encourage families to read together.) We informed, collaborated with, and built partnerships that influence and sustain coordinated systems development in early learning.

We collaborated with WithinReach, DEL, WCAAP and others to explore using the Help Me Grow model for systems development in our state. This is a screening, linking, and referral system to connect families with providers and services.

The Department of Early Learning (DEL), and the public-private partnership, Thrive by Five Washington (Thrive) finalized the state Birth to Three Plan. A wide variety of stakeholders, including DOH, other public and private organizations and individuals collaborated on this plan. This plan was based on strategies and policies identified in the Washington State Early Learning Plan (ELP). Both plans emphasize parent partnership, equity, and local participation. They also emphasize the need for comprehensive, coordinated systems. Outcomes and strategies for the plans include Ready and Successful Children; Ready and Successful Parents, Families and Caregivers; Ready and Successful Early Learning Professionals; Ready and Successful Schools; and Ready and Successful Systems and Communities which lead to a Ready and Successful State.

We created an Infant Toddler TOC-OM. It allows people in nontraditional early learning roles to see the importance of their work, how it influences and fits into an integrated system of care for children. We convened dental referral committee and responded to the thousands of hits on the Oral Health Program's Find Care webpage and the dramatic increase in calls from the public for dental referrals by supporting Washington Information Network 2-1-1 as the primary dental referral source.

Our federal PPTW grant worked to develop community-level coordinated systems led by local health agencies to support pregnant and parenting teens.

DOH also provided input into Washington State's Early Learning Guidelines, professional development system, Family Child Care Home rules, Race to the Top Early Learning Challenge fund application, and ELP Biennial data summary. Our input assured that systems were comprehensive and supported optimal growth and development of children.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Began developing a universal developmental screening system.				X
2. Built partnerships that influence and sustain coordinated systems development in early learning.				X
3. Supported school readiness, socio-emotional development, and health and safety initiatives			X	
4. Finalized the Washington State Birth to Three Plan				X
5. Supported initiatives like Reach Out and Read Washington and Strengthening Families Washington			X	
6. Created an Infant Toddler Theory of Change Outcome Map. This allows people in nontraditional early learning roles to see the importance of their work, and how it influences and fits into an integrated system of care for children.				X
7. Convened dental referral committee and responded to hits on Oral Health Program's Find Care webpage and the dramatic increase in calls from the public for dental referrals by supporting WA Information Network 2-1-1.				X
8.				
9.				
10.				

b. Current Activities

We are building evidence/research based systems to support children birth to 8. We support, mobilize and provide partners with technical assistance, health education and consultation. We review, monitor, and report on data to identify population-level health and access issues and systems level child and family health issues. We develop and disseminate child health best practice materials to parents, and health and child care providers to improve access to relevant and accurate information. We are collaborating with partners to develop a universal developmental screening, referral, and care coordination system. We increase awareness and promote use of evidence and research based developmental screening tools.

PPTW works with schools and community organizations in targeted communities to improve education and health outcomes of pregnant and parenting teens, increase school dropout recovery rates, improve community support and linkages for targeted teens.

ECCS and Project LAUNCH continue work that supports comprehensive early childhood systems for children prenatal to eight. These grants emphasize school readiness, universal developmental screening, social and emotional development, and health and safety. Work is focused on both statewide and local initiatives.

We are implementing a state plan for coordinated care of infants identified with hearing loss. We promote integration of dental and medical homes and promote centralized dental referrals to underserved populations.

c. Plan for the Coming Year

Our work in early childhood helps ensure children are ready and successful in school. Several priorities support this measure: safe and healthy communities; access to preventive and treatment services; and quality screening, identification, intervention, and care coordination.

We will use the whole child approach to address children's needs. ECCS and Project LAUNCH will work with other DOH programs, public agencies, private organizations and systems, and individuals to integrate activities across health, social-emotional development and mental health, early care and education, and parent and family support. ECCS will focus on implementing the ELP and Birth to Three Plan to build a comprehensive statewide early learning system.

Project LAUNCH, in coordination with internal and external stakeholders and partners, will focus on implementing a system for Universal Developmental Screening, referrals and follow-up for children birth to three, at the state and local level. We will use stakeholder meetings to promote awareness and build support for a statewide system. We will work with WithinReach to pilot an online developmental screening, using the HelpMeGrow model. We will work with DEL to look for opportunities to embed developmental screening in early learning initiatives and systems.

We will continue to partner with DEL, DSHS, and Thrive to implement the federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), and other federal and state home visiting initiatives. MIECHV will be an integral component in developing a comprehensive statewide early learning system. ECCS and Project LAUNCH will coordinate with these efforts.

We will work closely with partners and stakeholders to facilitate ongoing communication and collaboration between state agencies, and public and private partners. We will participate in statewide early learning coalitions and advisory groups to provide support and input into health-related issues affecting children and families.

ECCS will promote implementation of the Strengthening Families Protective Factors across its partner initiatives, in order to support children and families and prevent child abuse and neglect. ECCS will contract with Thrive to work with ten Early Learning regional coalitions in order to support state-local coordination and participate in the State-Local Coordination Steering Committee in order to assure local communities have input and influence on the Early Learning Advisory Committee. ECCS will also promote the "Love. Talk. Play." media campaign through the Early Learning regional coalitions. Thrive launched this media campaign to help parents give their children the best possible start in life. The campaign does this by providing information about healthy growth and development and showing how parents can use everyday moments to support their children's healthy growth and development.

We have established an office-wide database of stakeholders across all constituency groups for planning.

State Performance Measure 5: *Percent of households with children (0-18yrs) in which the reporting adult has an Adverse Childhood Experience (ACE) score of 3 or more.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					28
Annual Indicator			28.7	29.3	
Numerator					
Denominator					
Data Source			2009 Behavioral Risk Factor Surveillance System	2010 Behavioral Risk Factor Surveillance System	
Is the Data Provisional or Final?				Final	
	2012	2013	2014	2015	2016
Annual Performance Objective	28	28	28	28	28

Notes - 2011

2011 data not currently available.

Notes - 2010

The source of this data is the 2010 Behavioral Risk Factor Surveillance System (BRFSS), Adverse Childhood Experiences (ACE) module.

Data for this measure will be updated as it becomes available in future administrations of the BRFSS which include the ACE module.

The target for this indicator was set after a conversation between program staff and assessment staff. As this is a new measure it was decided to set the goal at 28%, close to the baseline percent of 2009, and see if this percent changes. Adjustments to the targets will be considered as more data becomes available.

In our approach to addressing health disparities and the prevention of chronic disease in the MCH population, as well as the general population of Washington State, the Office of Health Communities has adopted the life course model as its guide. The use of this approach reflects our recognition that some of the elements which may affect an individual may have their origin preconception and, indeed, may be intergenerational. Our monitoring of ACEs data is intended to demonstrate our recognition of these influences and aid in our understanding of risk for bad health outcomes in the current adult population as well as potential bad outcomes in the future in those who are children now. Although this measure is not sensitive to quick change, it serves as a marker of the need to address this work and therefore we feel it very important to monitor it. Given the long lag between the occurrence of any adverse experiences and measurement of any given individual in the BRFSS for the presence of those experiences (the experience takes place in the childhood of the adult being interviewed, a lag of perhaps decades) there was no expectation that any program activity taking place presently will be reflected the percent of adults scoring high on the ACE measure at this time. We will continue to look for other measures which will give us similar information but will reflect and inform on the work that is being done presently.

Notes - 2009

The source of this data is the 2009 Behavioral Risk Factor Surveillance System (BRFSS), Adverse Childhood Experiences (ACE) module.

Data for this measure will be updated as it becomes available in future administrations of the BRFSS which include the ACE module.

The target for this indicator was set after a conversation between program staff and assessment staff. As this is a new measure it was decided to set the goal at 28%, close to the baseline percent of 2009, and see if this percent changes. Adjustments to the targets will be considered as more data becomes available. Given the long lag between the occurrence of any adverse experiences and measurement of any given individual in the BRFSS for the presence of those experiences (the experience takes place in the childhood of the adult being interviewed, a lag of perhaps decades) there was no expectation that any program activity taking place presently will effect the percent of adults scoring high on the ACE measure at this time.

WA continues to look for a more sensitive data source for this indicator.

a. Last Year's Accomplishments

MCH worked with stakeholders to prevent and reduce the negative impact of Adverse Childhood Experiences (ACEs). In November 2010, an Early Learning Symposium was held, sponsored by Casey Family Programs, hosted by DOH, other state agencies and Thrive by Five Washington. The symposium provided an opportunity for state leaders to learn together about emerging neurobiological and early childhood research. Several DOH staff, including Secretary Selecky, Health Officer and MCH Director, participated in the event. After this event, several MCH staff members participated in planning next steps for Washington State regarding the early childhood

science that links children's health, mental health, and school success. The cross agency, public and private planning group provided the foundation for WA being identified as the first Frontiers of Innovation State by the Harvard University Center on the Developing Child.

In 2011, state legislation passed creating an ACE Initiative (private-public partnership) to focus on preventing and reducing the negative impact of ACEs. DOH staff participated on a planning group for the ACEs Initiative. A report was submitted to the state legislature in December 2011.

The Mental Health Transformation Grant ended in September 2010 and the Prevention Advisory Group (PAG) transitioned to DSHS. The PAG continued to meet through early 2011 and then ended as leadership moved to working on the ACE Initiative.

In 2011, Washington included the ACEs module in the Behavior Risk Factor Surveillance Survey (BRFSS) for the third year in a row. The Family Policy Council has been working on analysis of the data.

MCH staff worked with the Department of Early Learning, DSHS, and the Council for Children & Families to develop a shared governance structure for the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) program. An updated state plan was submitted in June 2011. Several DOH staff members, including MCH staff, were involved in home visiting governance and planning groups. MCH staff continued to manage a contract with the Department of Early Learning for the first year of funding. Several MIECHV benchmark areas relate to ACEs including: prevention of child abuse, neglect or maltreatment and reduction of emergency room visits; reduction in crime; and improvements in coordination and referrals for other community resources and supports.

MCH staff implemented the Early Childhood Comprehensive Systems Grant (ECCS), Project LAUNCH, and Autism grants. ECCS worked to assure that statewide early learning systems are comprehensive and include a focus on social-emotional development and mental health support. Project LAUNCH provided funding to the Family Policy Council to support further analysis of state BRFSS ACE data. They worked on combining two years of ACE data into one data set. This included creating a new school district variable so analysis can be conducted for geographies smaller than counties. All three grants supported the state universal developmental screening initiative to develop a statewide system of early and universal screening.

The Autism grant supported 8 local coalitions in systems building and coordination. In June, grant funds supported a summit with autism diagnostic teams, the 8 coalition communities and mental health models and experts from across the state together to talk and learn how to develop and better coordinate systems of care. CSHCN partnered with DSHS Division of Behavioral Health and Recovery (DBHR) to write and implement a Systems of Care Grant. We worked with partners to develop a strategic plan to promote and develop a mental health system imbedded with values that support youth and family in a person-centered health home.

We used funds from our First Time Motherhood/New Parents Initiative grant to promote text4baby, a mobile information service that provides free weekly health promotion messages to pregnant women and new mothers. Messages include pre- and postpartum mental health awareness, including anxiety and depression, and phone numbers to call for help.

The DOH Child Profile Health Promotion System sent parenting and child development information to parents of children aged birth to 6 years. Mailings included several messages that help prevent and reduce the negative impact of ACEs. Parent of infants received information about postpartum depression in their mailings.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with state agencies and other stakeholders to use ACES data to inform practices, including community mobilization and home visiting.				X
2. Provided information to MCH staff on the ACE study and discussed its implications for our work.				X
3. Participated on the Mental Health Transformation Prevention Advisory Workgroup.				X
4. Implemented the Early Childhood Comprehensive Systems (ECCS) and Project LAUNCH grants and the State Early Learning Plan.				X
5. Sent parents information on parenting and child development via Child Profile Health Promotion System.			X	
6. Worked with state agencies and other stakeholders to complete the updated state plan for federal home visiting.				X
7. Worked with state agencies to develop a state strategic plan for children's mental health services statewide.				X
8.				
9.				
10.				

b. Current Activities

We work with stakeholders to increase understanding of ACE Study findings and apply them to policy, systems and practice interventions at state and local levels. We provided learning sessions to OHC staff on Life Course (foundation of OHC state plan), brain science and ACEs. In April, 2012, Kathy Chapman presented webinar on Lifecourse and chronic disease program implications to over 60 NACDD members.

We participate in cross agency partnerships related to ACEs, including Harvard Frontiers of Innovation work, the ACE Initiative, and state-level early learning and behavioral health groups. DOH will be represented on the Family Policy Council and Council for Children & Families through June, 2012 when they will be discontinued per state legislation.

We completed the 2-year Learn the Signs Act Early CDC supplement on Autism grant. This is a health promotion campaign about early identification of developmental delay.

We implement ECCS and Project LAUNCH grants. Both grants work with stakeholders and promote the Strengthening Families protective factors. Research shows that these protective factors reduce the incidence of child abuse and neglect.

We are implementing a statewide bus sign campaign to increase text4baby enrollment. Data from the first phase shows increased enrollment in bus signs areas.

The DOH Child Profile program sends information to parents of children from birth to 6 years old, including several messages that help prevent and reduce the negative impact of ACEs.

c. Plan for the Coming Year

Adverse Childhood Experiences has an impact on all priorities, especially: Tobacco and Substance Free Living, Social and Emotional Wellness, Safe and healthy communities.

This measure is an indication of our commitment to address ACEs and explore ways for the ACE Study findings to guide our work across DOH and with stakeholders. Since people's ACE scores do not change once they become adults, it will take a new generation for the measure data to

show significant change. Because of this, the trend is flat for this measure. We are not aware of data indicating how long it will take to change the percentage across the state or a more sensitive measure for this work.

We will participate in cross agency, public and private, partnerships related to ACEs, including the Harvard Frontiers of Innovation work, the ACE Initiative, and state-level early learning and behavioral health groups.

Beginning January 2013 all LHJ's will be required to select to work on SMART objectives related to either ACEs or developmental screening. We will provide training and TA.

We will participate in the cross agency governance of home visiting, including the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program. OHC Surveillance and Evaluation will work with WA University-Spokane (the evaluation contractor) on data collection, analysis, and evaluation of MIECHV.

We will implement ECCS and Project LAUNCH grants. Both grants work with stakeholders promote the Strengthening Families protective factors. Research shows that these protective factors reduce the incidence of child abuse and neglect.

Because the First Time Motherhood/New Parents Initiative grant ends August 2012, we will explore other options for promoting text4baby. Text4baby includes messages about pre- and postpartum mental health awareness, including anxiety and depression, and phone numbers to call for help.

The DOH Child Profile program will send information to parents of children from birth to 6 years old.

These mailings include several messages that help prevent and reduce the negative impact of ACEs. Parent of infants receive information about postpartum depression in their mailings.

ACEs work will be aligned with Coordinated School Health work. We will identify opportunities to promote trauma-informed school environments and school based health centers, including a licensed mental health provider. We will provide technical assistance to LHJs that want to promote these strategies in their communities.

CSHCN will promote the DSHS/DBHR Systems of Care grant work, including improved access to children's mental health services. The MCH director co-leads the DBHR state prevention mental health plan. This committee has recognized the significant connection between ACEs and substance abuse related issues and exploring providing education to recovery counselors about ACEs.

HCA is developing education for health providers in the Medicaid health plans about ACEs and the impact on health.

State Performance Measure 6: *Identify health disparities, develop and implement interventions to address disparities, and evaluate the effectiveness of interventions in achieving health equity.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective				3	3
Annual Indicator		2.5	2.8	2.6	2.3
Numerator					
Denominator					
Data Source		WA State Office of Maternal And Child Health	WA State Office of Maternal And Child Health	WA State Office of Maternal And Child Health	WA State Office of Healthy Communities
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	3	3	3	3	3

Notes - 2011

While the scoring criteria for this measure remains the same as in the past, the reorganization of MCH into a new Office has resulted in a different group of sections reporting on this measure.

This measure is the average score given by the three participating sections in the Office of Healthy Communities of the Washington State Department of Health, Prevention and Community Health Division. Each section self-evaluated and reported the following scores.

Scale is 1- 3; 3 is the highest score possible.

Practice Improvement 2
 Access, Systems and Coordination 3
 Community Based Prevention 2

overall score = 2.3

With the recent change in organization of the Office of Health Communities, comparisons to past scores for this measure are not valid.

Notes - 2010

This measure is the average score given by the various participating sections in the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family Health Division. Each section self-evaluated and reported the following scores.

Scale is 1- 3; 3 is the highest score possible.

Genetics 2
 CSHCN 3
 MICAH 3
 IPCP 3
 Oral Health 2

overall score = 2.6

Notes - 2009

This measure is the average score given by the various participating sections in the Office of Maternal and Child Health of the Washington State Department of Health, Community and Family

Health Division. Each section self-evaluated and reported the following scores.

Scale is 1- 3; 3 is the highest score possible.

Genetics 3
CSHCN 3
MICAH 3
IPCP 3
Oral Health 2

overall score = 2.8

a. Last Year's Accomplishments

The Office target is a score of 3. In 2011, we did not meet the goal, scoring 2.5. Within OHC, healthy equity became an overarching value; therefore, the MCH priority of Health Disparities is no longer listed as an MCH priority.

GSS improved access to hearing screening for rural and Hispanic families by working with midwives and we sent two pediatric audiologists to a national training. GSS contracted with the statewide Hands and Voices Guide By Your Side™ (GBYS) program. This parent support program for families of children with hearing loss had parent guides in our target areas.

The CSHCN Epilepsy Project ended in 2010. CSHCN continued to distribute the Spanish-language Epilepsy Care Organizers and other materials while supplies lasted. CSHCN Program used the CDC Learn the Signs Act Early campaign on developmental screening with Hispanic parents in Central Washington.

Our on-going partnerships included work with the: African American community, AIHC, Race Matters toolkit, Project LAUNCH and PHSKC. Maternity Support Services offered maximum level of service to African Americans and AI/NA's.

New initiatives in 2010 addressing health disparities were: AIHC developed a Tribal Maternal and Infant Health Strategic Plan on disparities in pregnant AI/NA women. We worked with AIHC to implement the plan. A new project funded by the Office of Adolescent Health supported pregnant and parenting teens. IPCP began the first ever Tribal Health Immunization Workgroup and continued work with the API Hepatitis B Task Force.

Oral Health worked with tribes on school sealants and fluoridation education to train dentists. We provided grant funds to 5 counties to support dental sealant programs in schools with a high FRL rate. We have an online brochure listing all tribal dental clinics in the state. The 2010 Washington State Smile Survey data showed improvement in sealant related disparities for 3rd graders receiving dental sealants and showed more non-white students received sealants than white students

The Coordinated School Health Program, in partnership with the state education agency, focused on addressing risk factors that affect both health disparities and academic achievement. Key cross cutting measures include child nutrition, insufficient exercise, depression and asthma. The publication "Research Review: School-based Health Interventions and Academic Achievement" was developed and promoted. The State Board of Health and the Governor's Interagency Task Force on Health Disparities are partners in this work as well.

MCH Assessment updates key reports, which identify disparities by demographic factors, and shares them with stakeholders.

TPC contracts with CHEF to provide outreach and technical assistance to public housing authorities that express an interest in adopting no-smoking policies. The program also contracts with a public relations firm, GMMB, to operate the web site www.smokefreewashington.com and to provide similar outreach and technical assistance to privately owned apartments so that they can develop and implement no smoking policies. A recent survey of apartment managers showed that about 17% of apartment buildings in the state have comprehensive smoke-free policies, up from under 6% in 2007.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assessed disparities and work with target communities to improve maternal and infant outcomes.			X	
2. Collaborated on educational and outreach activities to the Asian Pacific Islander, Native American, and African American communities, including community projects and screenings.		X		
3. Ensure that adolescents have access to age appropriate and culturally appropriate health services.				X
4. Used Race Matters Toolkit to view Early Childhood Comprehensive Systems/Kids Matter work through a racial equity lens and improve results across early childhood systems.				X
5. Improved access to care for children with epilepsy and seizure disorders, especially Hispanic population in medically underserved and rural areas of central Washington.				X
6. Coordinated training to providers and families, and impact existing benefit systems for CSHCN, particularly those with Autism Spectrum Disorder and other developmental disabilities.				X
7. Worked with targeted high-need community to promote wellness of young children and families.		X		
8. Implemented school based dental sealant programs targeting schools with 30% or more of children eligible for free and reduced lunch program.			X	
9. Implemented school-based dental sealant programs targeting schools with 30% or more of children eligible for free and reduced lunch program, all seen regardless of ability to pay.			X	
10. Promoted the link between health disparities and academic achievement with school and health partners.				X

b. Current Activities

The Genetics Services program develops linguistically and culturally appropriate materials for hospital-based screeners to use with parents about hearing screening. Students from Seattle Midwifery School are trained on newborn hearing screening and follow-up.

The CSHCN program participates in CDC Learn the Signs. Act Early campaign through 8/ 2012, targeting Hispanic parents of young children in Central WA.

The Great MINDS grant has been funded and targets minorities as well as tribes. African Americans and Native Americans are high risk for poor birth outcomes. We work with AIHC to implement the 2010 Maternal and Infant Health Strategic Plan and with PHSKC to organize a summit on perinatal health disparities. Work with TPCHD to outreach to pregnant African American women.

We are implementing the PPTW project: The GRADS curriculum is being updated; counties are developing sustainable community support systems which include connection to GRADS

programs; the teen website was launched ; and we are piloting the Practice Guidelines in three communities.

Kids Matter works to reduce disparities for children using the Race Matters toolkit. Project LAUNCH addresses child health issues in poor Hispanic and Native American residents.

The Health of Washington State chapters are being updated; the content includes identifying health disparities.

c. Plan for the Coming Year

OHC is committed to eliminating health inequities and achieving health equity as one of its guiding principles, which impacts all 8 OHC priorities. OHC does this by examining the root causes of poor health; using a life course perspective; cultivating shared responsibility; applying multiple strategies; and basing decisions on data and evidence/best practices.

OHC employs a part-time person to coordinate the Health Equity team, focused on building the capacity of programs to address health inequities through our public health practice. Examples of projects in our current action plan include: completing a staff survey to identify training needs and revised office functions to address health equity; developing an Equity Impact Review (EIR) training curriculum for staff to apply a "health equity lens" when making program decisions; providing model health equity language to managers to include in annual staff development plans; a menu of staff trainings and resources to help staff increase understanding of health equity; and collaborating with the Governor's Interagency Council on Health Disparities.

The Oral Health Program will send the Promotion Cards to a variety of non-dental health providers to support their efforts providing clients and patients who may not have access to dental services with oral health messages for all ages. We will work with partners to support Washington Information Network 2-1-1 (WIN2-1-1) to meet the needs of all WA residents needing oral health referrals.

ASC will continue ongoing monitoring of health data and research to identify and understand health disparities in MCH populations and develop strategies to address those disparities. In particular ASC will continue working with the AIHC to improve birth outcomes in the tribal community. We will continue working with the Tacoma Pierce County Health Department to improve birth outcomes in the African American community in high risk areas of Pierce County. Project LAUNCH will continue implementing evidence-based-practices to strengthen family and caregiver skills to promote positive social emotional development, with efforts targeted to Hispanics and Native Americans in Yakima County.

Teen pregnancy and birth rates are higher in African American, Hispanic and Native American teens. We will continue working to lower teen pregnancy and birth rates targeting communities with high rates of these teens. The Pregnant and Parenting Teens and Women Grant project will continue targeting its efforts to improve the lives of pregnant and parenting teens in high risk communities.

WithinReach will continue linking high risk pregnant women and families to programs and resources to support their health. Bi-lingual hotline staff and translation services will assure that they respond to all caller

Organizers of the central Puget Sound summit on eliminating perinatal health disparities are implementing the action plan developed at that summit.

State Performance Measure 7: *Decrease the rate of infant mortality among the Native American population.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					10.7
Annual Indicator		8.2	11.1	10.6	
Numerator		14	19	17	
Denominator		1705	1715	1602	
Data Source		WA Center for Health Statistics	WA Center for Health Statistics	WA Center for Health Statistics	
Is the Data Provisional or Final?				Provisional	
	2012	2013	2014	2015	2016
Annual Performance Objective	10.5	10.3	10.1	9.9	9.8

Notes - 2011

2011 data not currently available.

Notes - 2010

The annual objective targets were set based on a combination of Washington State data and HP 2020 goals. The reduction in infant mortality by 10% identified in the HP 2020 goal MICH-1.3 was used as the goal for the State Performance Measure. The average of the previous five year's Native American infant mortality rates (2005-2009), 10.9/1,000 births, was taken. A decrease of 0.2/1,000 births per year was identified as a target which would bring WA State close to the desired 10% decrease in Native American IMR, to 9.8/1,000 births, by 2015.

Due to the small numbers of deaths in any given year, individual year's data may not be indicative of the overall trend.

The data come from the WA Center for Health Statistics linked Infant Death file.

Notes - 2009

The annual objective targets were set based on a combination of Washington State data and HP 2020 goals. The reduction in infant mortality by 10% identified in the HP 2020 goal MICH-1.3 was used as the goal for the State Performance Measure. The average of the previous five year's Native American infant mortality rates (2005-2009), 10.9/1,000 births, was taken. A decrease of 0.2/1,000 births per year was identified as a target which would bring WA State close to the desired 10% decrease in Native American IMR, to 9.8/1,000 births, by 2015.

Due to the small numbers of deaths in any given year, individual year's data may not be indicative of the overall trend.

The data come from the WA Center for Health Statistics.

a. Last Year's Accomplishments

The IMR for 2010, 10.1/1,000 is lower than the previous five year average of 10.9/1,000 for 2005-2009. While Washington's overall IMR is the lowest in the nation, the rate for Native Americans is more than twice as high as rate for state population as a whole. In addition, there continue to be improvements in infant mortality for state population as a whole, but among Native Americans and Alaska Natives infant mortality has worsened since 1994, widening this disparity.

DOH's ASC section and WIC Nutrition Program worked with the American Indian Health Commission for Washington State (AIHC) to improve American Indians and Alaska Natives maternal and infant health outcomes. In fall 2010 AIHC finalized a comprehensive Tribal Maternal-Infant Health Strategic Plan. They shared this plan with tribal representatives and partners at their state-wide tribal health summit. ASC and WIC provided funding to AIHC to help tribes implement the plan.

ASC supported two regional community-based events focused on eliminating perinatal health disparities in central Puget Sound region. Participants at a Jan. 2011 kick-off event learned of disparity in Native American/African American birth outcomes as compared to rest of the region's population. They discussed root causes of those disparities and identified strategies to address these problems. Contractors reached out to Native American and African American community members to educate them about perinatal health disparities and prepare them to participate at the summit, participants began to build an action plan to address the root causes of unequal birth outcomes.

In Yakima County new and expectant mothers, including Native Americans, participated in Parents as Teachers programs sponsored by Project LAUNCH. These programs enhance parenting skills to prevent child abuse and improve child safety. Yakama Tribal childcare centers' staff attended a Project LAUNCH child development workshop. This training helped improve care and increase awareness of developmental delays. Project LAUNCH continued to build relations with the Yakama Tribes.

WIC continued working with 22 tribes and one Urban Indian health program to provide local WIC services and support breastfeeding. Medicaid-eligible Native American pregnant women were eligible for the highest level of First Steps Maternity Support Services and Infant Case Management.

Tobacco use is one of the top risk factor for Native American infant mortality. DOH's Tobacco Prevention program contracted with 13 tribes to reduce tobacco use. Through June 2011, DOH's Quit Line offered smoking cessation assistance to all callers. Since July 2011, these services have only been funded for Medicaid clients and some people with private insurance. The Quit Line offers extra services for covered pregnant women.

Our Pregnant and Parenting Teens and Women project worked with schools and community organizations to improve education and health outcomes of pregnant and parenting teens. Some targeted communities include Native Americans. The project began a needs assessment to inform development of Practice Guidelines to inform health professionals, law enforcement, prosecutors, and social service and systems advocates about reproductive coercion. Tribal representatives gave input at the state level and in some local communities. They also participated on stakeholder groups that provided input to build community infrastructure to support pregnant and parenting teens.

Our First Time Motherhood/New Parents initiative supported new ways to connect pregnant women and new parents to information and services to support their families' health using social media and new technology. We also planned a campaign to promote text4baby with ads inside public buses. In communities with higher Native Americans population, these bus ads used images created for and tested with Native Americans.

DOH participated in a cross-agency project to lead development of an evidence-based home visiting system. Federal home visiting funds (MIECHV) are being used to improve home visiting services in selected at-risk communities, some of which include Native Americans.

A Washington tribe and two tribal consortia were each awarded MIECHV grants. They plan to use home visiting programs to help assure effective coordination and delivery of information and

services to children and families in Tribal communities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with the AIHC and other partners to develop and begin implementing a comprehensive Tribal Maternal and Infant Health Strategic Plan.				X
2. Funded Parents as Teachers programs and a child development workshop that Native Americans participated in.		X		
3. Native American women were eligible to receive the highest level of First Steps Maternity Support Services.		X		
4. Collaborated with the American Indian Health Commission to enhance WIC services to American Indians and Alaska Natives.		X		
5. Promoted text4baby mobile information service for pregnant women and new moms to Native Americans			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

AIHC is promoting its Tribal maternal-infant health plan and helping individual tribes adopt strategies to improve infant health. Home visiting services are being provided in high risk communities, some of which include Native Americans. The state Department of Learning (DEL) is working with AIHC to find opportunities to improve home visiting in tribes. First Steps, WIC, and DOH Tobacco Prevention Program give pregnant Native Americans priority for services. Project LAUNCH enhances parenting skills and awareness of child development.

Pregnant and Parenting Teens and Women project is working to improve outcomes of pregnant and parenting teens. It is piloting Practice Guidelines about reproductive coercion.

First Time Motherhood/New Parents Initiative is implementing tools to connect families to information and services to support their health. Text4baby bus ads ran in selected communities in fall 2011. We are starting a second bus campaign in other communities and exploring options for putting signs in tribal transportation. Text4baby enrollment increased significantly where the bus signs ran (34% increase). This initiative was originally planned for three years, but funding for the last year was cut. The contractor is working to complete tool development and the project marketing plan within the shortened timeframe.

Organizers of the central Puget Sound summit on eliminating perinatal health disparities are implementing the action plan developed at that summit.

c. Plan for the Coming Year

Reducing infant mortality in Native Americans fits within several maternal and child health priorities: Tobacco and substance free living, Safe and healthy communities; Access to preventive and treatment services; and Quality screening, identification, intervention.

There is growing awareness of the infant mortality issue among tribes, Native American organizations, and state and local agencies. This may be due to AIHC's work promoting their Tribal Maternal-Infant Health Strategic Plan. Both DOH and AIHC are hearing from more

organizations that are working on aspects of tribal maternal infant health. Many of them are focusing on safe sleep and looking for information they can share about safe sleep that honors cultural practices. We will continue to try to find opportunities to support these efforts, coordinate between them, and share information. DOH will continue supporting AIHC's implementation of their plan. AIHC will continue promoting the adoption of evidence or research based practices to improve tribal maternal and infant health; promoting the plan; and providing consultation and technical assistance to individual tribes.

First Steps Maternity Support Services and Infant Case Management, WIC, and the DOH Tobacco Prevention Program will provide services to pregnant Native Americans. DOH's Quit Line funding was restored, and Quit Line smoking cessation services will again be available to all callers, regardless of insurance status, starting July 2012.

Project LAUNCH will continue working to enhance parenting skills and awareness of child development in Yakima County. They will continue to build relations with the Yakama Tribes.

Pregnant and Parenting Teens and Women will continue working with schools and community organizations in targeted communities to improve education and health outcomes of pregnant and parenting teens, increase school dropout recovery rates, improve community support and linkages for targeted teens. It will evaluate the reproductive coercion Practice Guideline demonstration site pilot projects.

The third and final year of the First Time Motherhood/New Parents Initiative grant was cut, so this work is not funded in FFY13. We will complete implementation of the new tools to connect pregnant women and new parents to information and services to support their families' health. Text4baby bus signs may remain in place in systems that chose to leave them up as a public service.

Evidence-based home visiting services will expand through a recently awarded competitive home visiting supplement. This supplement adds about \$25 million to Washington's baseline grant. DEL will continue working with the AIHC to explore ways to improve home visiting in tribes. The MCH Director promotes the AIHC plan with Healthy Community sites that coordinate with Tribes.

E. Health Status Indicators

/2013/Birth weight related measures:

HSI1a **Percent of LBW births**
HSI1b **Percent of singleton LBW births**
HSI2a **Percent of VLBW births**
HSI2b **Percent of singleton VLBW births**

Low Birth Weight/Very Low Birth Weight Indicators

Washington has been among the leading states in keeping its low birth weight (LBW) and very low birth weight (VLBW) rates low. In 2010, WA ranked third best in the nation in LBW and in 2009 was the state with the lowest VLBW rate in the nation. In 2010, the Washington LBW rate of 6.3% and VLBW rate of 1.0% surpassed the HP 2020 goals, 7.8% and 1.4% respectively. Like the nation, Washington's low birth weight has increased since the early 1990s. For the last four years, though, the rate has remained steady. Part of the increase, is due to the rise in multiple births. In order to explore factors other than

plurality, we often restrict analyses to singleton births. In 2010, the singleton LBW rate was 4.8%.

Despite Washington's favorable outcomes compared to the nation and other states, disparities in singleton low birth weight in Washington persist. The lowest income women, receiving temporary assistance for needy families (TANF) benefits as well as Medicaid had the highest singleton LBW rate (6.4%) from 2008-2010. These women were low income (generally < 50% the federal poverty level). Women receiving Medicaid benefits solely due to pregnancy had higher incomes (< 185% of the federal poverty level). Their singleton LBW rate was 5.0% during the same time period. Rates were lower for Undocumented women (4.5%), and women not receiving Medicaid coverage (4.0%).

Disparities also persist by race/ethnicity. From 2008-2010, singleton infants born to non-Hispanic African American (8.1%) and American Indian women (6.5%) are disproportionately affected with LBW compared to non-Hispanic white women (4.2%). Furthermore, teen mothers 15-19 years have higher singleton LBW rates (6.3%) compared to 4.4% among mothers 25-29 years. Similar disparities exist among VLBW births.

Along with the increase in LBW, preterm deliveries prior to 37 weeks gestation increased since the early 1990s. In 2010, preterm infants accounted for about 64% of all LBW babies. Late preterm births (those at 35-36 weeks gestation) account for over 70% of all preterm births and largely drove the increase in preterm deliveries. In addition, recent literature on early term infants (37 and 38 weeks gestation) recognizes that these infants, too, have higher morbidity and mortality than infants born after 39 weeks gestation. All preterm and late preterm rates are also higher among teens, non-Hispanic American Indians, Pacific Islanders and Blacks compared to non-Hispanic whites.

Epidemiologic staff at the Department of Health and at the Department of Social and Health Investigations Unit has been monitoring a variety of perinatal outcomes for several years. Descriptive analyses have been updated annually and reported to the Perinatal Advisory Committee (PAC). Those analyses have stratified outcomes by several socio-economic, geographic and demographic factors. In recent years, considerable attention has been focused on the increases in pre-term births and in the use of elective c-sections. Although our low birth weight and very low birth weight rates are some of the best in the nation, we know from European nations that we can improve. In addition, we would like to reduce disparities. We are focusing on overall perinatal systems improvement and targeted interventions to reduce disparities.

Based on our analysis, and input from stakeholders, we have chosen over the past year to focus on prevention of elective births before 39 weeks. We have formed a Perinatal Collaborative in partnership with Medicaid. Our efforts have shown a 65% reduction in all births prior to 39 weeks that are not medically indicated. Our new target is 5%. The efforts to reduce elective delivery prior to 39 weeks gestation will impact neonatal (first 28 days of life) morbidity and potentially longer term infant morbidity.

We are also focusing efforts on informing women about the importance of waiting for infants to reach term. We have joined with 34 other states in the ASTHO/MOD state challenge to reduce preterm births. We will be collaborating with partners to disseminate the March of Dimes educational materials "Healthy Babies are Worth the Wait" in a variety of venues. A communication plan has been developed which provides a unique partnership with the March of Dimes so that we can co-brand their materials and utilize other resources to help reduce prematurity and infant mortality in Washington.

We will continue to fund our perinatal regional centers to work on improving quality of the perinatal system and to promote births at the appropriate level hospital. Since tobacco is one of the causes of low birth weight births, we are continuing efforts to support tobacco

cessation in pregnancy through our 1-800 Quitline service. We are also working with several communities with high smoking and other risk factors, through our Healthy Communities program, to implement policy and environmental changes to encourage healthy eating, physical activity and reduce tobacco use.

We continue to collaborate with our state WIC program to provide outreach to pregnant women to encourage early prenatal care, provide referral for insurance coverage, and other services. We have enhanced the WithinReach Parent123 website to improve education available for pregnant women about healthy choices during pregnancy and resources available. We have a campaign to refer pregnant women to the website, through our Health-e Moms, First time Motherhood grant.

We are working to prevent teen pregnancies through our PREP program and our family planning program. We have developed a "Reproductive Life Planning Tool" to educate women about planning pregnancies, both for the first and subsequent pregnancies. The First Steps Maternity Support Services program continues to provide enhanced pregnancy services to the highest risk pregnant women funded by Medicaid. We are working with Pierce County to provide outreach to African American women to encourage them to participate in these services. We are also working with the American Indian Health Commission to identify and implement best practices for AI/AN women.

In this economic environment, we are working to partner across governmental and private sectors to continue to improve the health of women and infants. Our efforts focus on improving LBW and VLBW as well as other perinatal outcomes. We are striving to improve our systems and maintain safety net services for vulnerable populations.

Unintentional Injury Indicators

Injury Mortality (death file data source)

- HSI3a Mortality rate due to unintentional injury (= or < 14 y/o)**
- HSI3b Mortality rate due to MCV (= or <14 y/o)**
- HSI3c Mortality rate due to MCV (15 to 24 y/o)**

Injury Hospitalization (CHARS file data source)

- HSI4a Rate of non-fatal injuries, all causes (= or < 14 y/o)**
- HSI4b Rate of non-fatal injuries, MCV (= or < 14 y/o)**
- HSI4c Rate of non-fatal injuries, MCH (15-24 y/o)**

Rates of mortality and hospitalizations due to unintentional injury for young Washingtonians (aged <14) and for Washington young adults and adolescents (15-19 year old) have been on the decrease across the board over the past 14 years.

Mortality among children under age 14 due to unintentional injury, including injury sustained in a motor vehicle crashes (MVC), has been on the decrease. Since 1998, there has been a significant reduction in the rate of mortality in the <14 year old age group due to MVC, 2.1/100,000 children to 1.5/100,000. The reduction in mortality due to any injury in this age group went from 7, 2/100,000 to 4.2/100,000. Among adolescents and young adults, age 15 to 24 years, an even greater reduction in mortality due to MVC has been observed since 1998; 25.4/100,000 down to 11.6/100,000. All of these reductions in rates have been statistically significant and the trends over time are very clear. Combining data from 2006-2008, among children 0-19 years old, deaths due to injury were highest in those under one year of age and among 15-19 year olds. Males were also more likely than females to die from unintentional injury. Native American/Alaskan Native children were far more likely to die from unintentional injury than were youth in any other racial/ethnic group. The three leading causes of death in 0-19 year olds were MVCs, poisoning and

drowning, in that order.

Hospitalizations due to unintentional injuries in children under 14 years of age have undergone a significant decrease in rates since 1998. The rate of hospitalization in this age group has decreased from 167.3/100,000 in 1998 to 152.2/100,000 in 2010 for all injuries and from 25.1/100,000 in 1998 to 14.0/100,000 in 2010 due to MVC. For adolescents and young adults aged 15-24 years, the rate of hospitalizations due to injuries sustained in MVCs has likewise decreased from 112.5/100,000 in 1998 to 77.8/100,000 in 2010. Combining data from 2006 to 2008 nine counties in Washington had hospitalization rates among 0-19 year olds higher than the state average. These data also showed that the very young, <1 year of age, and those 15-19 had higher rates of hospitalization than the rest of the age group. Males were more likely to be hospitalized than females. For the population the leading cause of hospitalization was falls, followed by MVCs and finally being struck by or against an object.

Chlamydia Screening Indicators

STI Screening HSI5a Chlamydia rate in 15-19 y/o
HSI5b Chlamydia rate in 20-44 y/o

In Washington State Rates of Chlamydia infection have been on the rise in teens and adolescents age 15 to 19 years of age, as well as for women of child bearing age, 20 to 44 years old for the past 12 years for which we have data.

Since 1999 the rate of Chlamydia infection among females aged 15-19 has significantly risen from 18.7/1,000 in 1999 to 24.7/1,000 in 2011. For women aged 20-44 years the rate has also increased since 1999 from 4.4/1,000 to 9.5/1,000, which represents an even sharper increase in the rate per 1,000 than that seen in the younger age group. Some of this increase may be due to more aggressive case reporting, especially in the older age group, and to better laboratory surveillance, but it may also reflect an increase in new infections.

The Family Planning Adolescent Health and STD programs collaborate in all aspects of the Infertility Prevention Project (IPP). CDC funding began in 1992, but some state and regional funds continued to support delegate agency counseling and clinical staff. FPAR's nurse consultant and the STD program IPP coordinator represent Washington on the Region X IPP Executive Committee. These two programs develop complementary work plans each year; coordinate site visits to avoid duplication and share the information gathered during those visits; and co-host an annual conference call/webinar for delegate agencies. They share expertise externally as well. In 2010, they displayed jointly produced poster presentations at the National STD Conference and the National Clinical Training Center for Family Planning conference.

All Title X delegate agencies provide STD screening services to women and men in increasing numbers. Local public health-based service sites are closing due to budget shortfalls and changing local public health priorities. As of July 2011, only three of our 39 counties maintain dedicated STD clinics. Seven counties have combined their STD and family planning programs into one clinical service typically called a Reproductive Health Clinic. Twenty-nine counties have no clinic-based STD screening or treatment program. Throughout the state, family planning service sites are increasingly filling this service gap. They are known as the sexually transmitted disease experts as well as the contraceptive experts. Funding for these additional services is a large and constant challenge.

IPP recommends Chlamydia/gonorrhea tests for all female clients age 24 or younger and

males up to age 29. The project provides test supplies and laboratory services through public health laboratories in the state. To maximize the reach of the project, participating sites use commercial reference labs that will bill Medicaid or other insurers to process insured clients' tests. While beneficial for the client and the state's budget, this creates challenges to compiling accurate data on screening coverage and test volume. Participating sites also screen for other STDs as indicated by risk or exposure history. IPP provides local agencies with free medications to use for treatment.

To prevent STDs, our delegate agencies provide all clients with medically accurate education and counseling on STDs and HIV. They focus on identifying and reducing individual's risk. Counseling emphasizes the value of abstinence, limiting the number of sexual partners, and monogamy. They advise condom use in addition to contraceptive use whenever there is any question of potential disease transmission. Client histories include risky behavior profiles, past infection, and current signs or symptoms. The STD program provides free client literature and condoms to all family planning/IPP clinics. We require all service sites to adhere to the CDC guidelines for prevention, screening, and treatment as the accepted standard of care. Most of the 16 delegate agencies provide HPV vaccine to appropriate clients.

Attachment-ASTHO/MODPlanandSuccessStories//2013//

An attachment is included in this section. IVE - Health Status Indicators

F. Other Program Activities

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

CHILD Profile Health Promotion mailings remind parents of recommended EPSDT and immunization visits. The 17 mailings are sent to parents of kids aged birth to six years and are timed to American Academy of Pediatrics' well-child visits. CHILD Profile includes a health and development booklet for parents to keep track of EPSDT/well-child checkup information. The booklet is inserted in over 129,000 CHILD Profile mailings per year.

/2012/The booklet was included in 123,000 mailings this year./2012//

Child Development Charts

Three child development charts are mailed to 262,334 parents per year. The charts address five areas of the Washington State Early Learning and Development Benchmarks. In addition to being mailed to parents, they are available to the public through an online ordering system. In 2009, IPCP partnered with DEL to mail 7400 development charts directly to licensed child care providers.

/2012/The charts went to over 266,000 parents this year./2012//

Billing and Reimbursement for Genetic Services Project

Poor reimbursement for genetic services has been recognized as a national problem. With funding from the Western States Genetic Services Collaborative (WSGSC), Genetic Services Section staff gathered billing data and conducted key informant interviews with genetic counselors and billing personnel to characterize billing and reimbursement practices for genetic services in Washington State. The analysis, in progress, may uncover barriers and opportunities that Washington genetic clinic staff can address to improve reimbursement.

/2012/We will submit an article on reimbursement for publication./2012//

/2013/Work presented to WSGSC stakeholders and accepted for print by the Journal of Genetic Counseling./2013//

Action Plan for Oral Health and Children with Special Health Care Needs (CSHCN)

In 2007, OHP received a three year federal TOHSS grant to improve access to oral health services for CSHCN with minor to moderate chronic conditions and eligible for Medicaid and State Children's Health Insurance Program. The funding was used to implement a part of the Action Plan for Oral Health and CSHCN. We developed forty-five fact sheets related to oral health for CSHCN. The fact sheets cover 18 different chronic conditions included autism and epilepsy. Each condition has 3 fact sheets: for parents/caregivers, dental providers and medical providers. This is a very comprehensive effort and has no parallel nationwide.

/2012/See http://dental.washington.edu/departments/omed/decod/special_needs_facts.php for fact sheets.//2012//

First Steps Redesign Project

MPA and DOH worked with providers to redesign the First Steps Program effective July 1, 2009. The revisions were in response to a legislative directive to implement a 20% program budget reduction and refocus services on women at highest risk for poor birth outcomes, as defined by low birth weight and preterm birth rates. The redesign included determining a client's level of service based on the results of prenatal and post pregnancy screenings for targeted risk factors. Data and an extensive literature review informed the selection of the targeted risk factors. Quality improvement projects that focus on interventions and client outcomes will be initiated in the future.

/2012/Due to budget cuts, we no longer administers First Steps. MPA now has a more limited program.//2012//

WithinReach and the Family Health Hotline

WithinReach is a private, not-for-profit organization that connects Washington families to health and food resources, and promotes public awareness and education about specific health issues. DOH sponsor's WithinReach's Family Health Hotline, Washington's maternal and child health hotline. This hotline provides eligibility screening and referrals to Medicaid, WIC, and other programs. It also provides referrals and health education information about pregnancy, prenatal care, maternity support, childbirth, immunizations, family planning, and breastfeeding.

WithinReach also runs toll-free hotlines for children's health insurance information, family planning, and food insecurity. They also maintain ParentHelp123.org, a website that provides families an easy application process for state-sponsored health and food programs, connects families to resources in their community, and provides health information for pregnant women and families. DOH supports three statewide health coalitions run by WithinReach to promote public health awareness and education: the Immunization Action Coalition, Hepatitis B Coalition, and Breastfeeding Coalition.

Since 2008 MICAH has been working with WithinReach to improve tools pregnant women can use to get information and connect to programs and resources. We've added information about prenatal care, making health choices during pregnancy, breastfeeding, birth control after pregnancy, and related topics to the WithinReach website. A new search tool helps users find Maternity Support Services providers by zip code. We are also increasing outreach about WithinReach to providers who may refer their clients to it. (withinreachwa.org)

/2012/We fund ParentHelp123 upgrades and works with WithinReach on Health-e Moms and text4baby.

WithinReach will develop website aimed at pregnant/parenting teens and support systems for victims of violence.

WithinReach is a general resource for families with CSHCN and gives information about Learn the Signs.Act Early, developmental screenings and medical homes.//2012//

H1N1 efforts related to pregnant women and deliveries

MICAH developed two fact sheets related to H1N1 (swine flu) and pregnancy. The provider fact sheet contains information and resources for practice preparation and patient care. The fact sheet for pregnant women includes information about home preparation, protection against flu, planning for special needs during pregnancy, and links to additional resources. We also implemented enhanced surveillance of pregnant women hospitalized with H1N1 or maternal deaths related to H1N1.

/2012// OHC Assessment and communicable disease epidemiology staff worked on a CDC project about the health of infants born to women with severe H1N1 influenza during pregnancy.

Funding for Injury Prevention

OMCH provides block grant funds to the DOH Injury Prevention section to support part of a position that is the primary conduit between state, national and local Safe Kids coalitions. This position facilitates planning, makes funding decisions and monitors and evaluates the Safe Kids network in our state. The Local Safe Kids network interfaces with local health jurisdictions, Child Death Review (CDR) teams and others who work collaboratively to use CDR data to inform Safe Kids practices and policies.//2012//

OMCH Publications

MCH Assessment works with the other OMCH programs and external partners to write data reports, assessments and monographs useful in planning and operating maternal and child health programs. Many publications on issues of importance to the MCH population are available in print or via the internet site. Attached is an annotated list, with hyperlinks to DOH's Website, of recent OMCH publications which may interest public health stakeholders and policy makers nationwide.

/2012//An updated list of publications is attached, see Appendix 8.//2012//

/2013//The updated list of Publications is attached.//2013//

An attachment is included in this section. IVF - Other Program Activities

G. Technical Assistance

1. General Systems Capacity Issues

a. Cultural Competency

We want to provide training at four Children with Special Health Care Needs (CSHCN) regional meetings to local health jurisdiction (LHJ) providers on culturally competent ways to interview families of CSHCN. A training goal is to improve the quality of data on ethnicity, education, and income levels that local CSHCN providers collect from families. This will support program development. We need a trainer who can teach culturally competent interviewing strategies related to CSHCN and their families.

b. Genetics Services

Inadequate reimbursement for genetic services can limit access to them. In June 2009, the Genetic Services Section (GSS) held a forum for private and public payers, and genetic service providers (clinical and laboratory), to discuss billing and reimbursement for genetic services. We used the funding assistance to bring in participants from remote areas of the state. This meeting provided the foundation for 3 cost/utility studies on emerging gene testing options to be conducted through the University of Washington Center for Genomics Healthcare Equality.

c. Adoption

GSS will request funds to provide training to Washington State prenatal, pediatric and genetic service providers and adoption agency personnel about genetics issues in adoption. These include factors to consider before adoption for both prospective parents and for parents choosing to release their children for adoption. The Director and the Research Coordinator for the Office of Foster Care and Adoption at the University of Massachusetts Medical School will conduct the training.

/2012/The adoption workshop was well attended by genetic counselors and adoption professionals and highly rated.//2012//

d. Maternal, Infant, Children and Adolescent Health (MICAH)

The MICAH section received funding from MCHB to conduct a training for child care health consultants. Thirty-seven people from 27 agencies, mostly LHJs attended. Attendees received the new American Academy of Pediatrics, Medication Administration for Early Education and Child Care Settings training. It is a train-the-trainer model of teaching non-health professionals such as child care providers, how to safely use, store, and record medications.

Nine new consultants took classes based on the National Training Institute model with modules on consultation skills, cultural competency, childhood disease, Bright Futures, resource and referral, and CSHCN. There were more advanced sessions on environmental health, health literacy, nutrition and physical activity, the State Early Learning Plan, pandemic flu, and the importance of the Adverse Childhood Experiences Study (ACES). We distributed the new edition of the Bright Futures Guidelines.

The conference met the goal of providing specialized education to new child care consultants. Participants rated most sessions as "good" or "very good".

/2013/ASC requested TA funds in order that the state of Florida send a speaker to one of our developmental screening partnership meetings to share their state's experience with implementing statewide developmental screening.//2013//

e. Oral Health Funding Formula

In 2008, the Oral Health Program convened a group of local oral health experts to develop a new funding allocation formula to support oral health activities in LHJs. A collaborative approach to developing a funding formula is the Public Health Improvement Partnership Funding Allocation Review Process and Allocation Principles. TA funds supported travel and expenses attendees meetings and helped achieve a true collaborative experience. The new funding formula was implemented for the 2009-2010 biennium.

f. Smile Survey

The Oral Health Program has provided training and technical assistance to the implementation of the 2010 Smile Survey. This survey is a dental screening for children in Head Start, kindergarten, and third graders. Data from the survey of children's oral health will drive program planning at the state and local level to improve the oral health of children.

/2012/ DOH and partners are using the results, released in March 2011, to support and target program implementation.//2012//

g. CSHCN Public Health Nursing Outcomes

The CSHCN Program wants to collect outcomes on the services provided to children with special health care needs and their families by local public health nurses. They will use problems identified through the Omaha System framework and align them with the CSHCN national

performance measures. TA Assistance has been requested for Karen Monsen, PhD, MS, RN, a national expert on the Omaha System, to facilitate six monthly conference calls and provide expert consultation to the 39 CSHCN Public Health Nurses. Dr. Monsen will also be asked to provide input on methods of data collection and data analysis.

/2012/ This was completed in 2011. //2012//

/2013/Request funds to provide training at four (CSHCN) regional meetings to LHJ providers on culturally competent ways to interview families of CSHCN.//2013//

h. Local Health Jurisdictions (LHJs)

OMCH contracts with 35 LHJs to address maternal and child health needs in local communities. The LHJ Activity Plan and Statement of Work are the mechanisms we use to describe local options for using these funds, track which activities each LHJ is performing, and collect data on them. They also form the basis for billing.

The LHJ Activity Plan and Statement of Work were last revised prior to 2001. OMCH needs to update the LHJ Activity Plan and Statement of Work to align with OMCH priorities and performance measures, reduce duplication of effort, and increase the relevance of data collected.

We will request assistance to convene a workgroup consisting of OMCH staff and representatives from LHJs. This workgroup would work collaboratively to revise these documents and the systems around them. The result will be a stronger, more efficient partnership for delivering MCH programs statewide.

/2012/ Initial steps of this on-going work were completed in 2011//2012//

/2013/TA funds will be requested to provide training to LHJ's in 6 regional locations to provide training on needs assessment, gap analysis, writing SMART objectives, and provide training on how to use the new on-line reporting system, either in person or via webinar. Training will also be provided on life course, health equity, developmental screening and ACES.//2013//

i. State DOH Capacity

/2013/Request funds for training to increase our knowledge and capacity to implement the ACA and to co-sponsor a Region X Academy on the topic of Life Course.//2013//

2. State Performance Measure Issues

3. National Performance Measure Issues

a. Immunization Rates

IPCP used funds to have local and national immunization experts train over 40 local health Perinatal Hepatitis B Coordinators from across the state on how to improve perinatal hepatitis B immunization rates for children and adults. The experts included Lisa Jacques Carroll, CDC Perinatal Hepatitis B Coordinator, and staff from a local hospital and an LHJ. It is too early to see a change in perinatal hepatitis B immunization rates.

b. Vaccine Hesitancy

IPCP may request funding to hold immunization training events for community partners, local health, and stakeholders to increase immunization rates and address parent immunization hesitancy.

c. Child Death Review Teams

This request relates to NPM10 on child deaths in motor vehicle crashes and NPM16 on youth suicide deaths. OMCH will request funds for 2011 to train local Child Death Review Teams (CDR), for whom training is a priority. Local CDR Teams provide surveillance and collect data from child death reviews. Their recommendations to local officials and groups inform strategies to reduce motor vehicle crashes and suicide. Developing skills in how to interpret data, develop strategies, and engage the community will make teams more effective

TA funds supported staff training in 2007 and a State CDR Conference in 2009. The 2007 training focused on the transition to use of the national CDR data system. The 2009 conference had sessions on doll reenactment in Infant Death Investigations, data issues and best practices for CDR Teams and prevention recommendations.

OMCH plans to request funding for a 2011 CDR Conference.

4. Data Related Issues

a. Western Regional MCH Epidemiology Conference

The annual MCH Epidemiology conference is always held in the Southeast US (e.g. Florida or Georgia). MCH epidemiology staff from the Western US, particularly the Northwest, have difficulty traveling that far. This makes maintaining skills in needs assessment and in MCH epidemiology difficult. OMCH requests that MCHB fund and promote a western regional MCH epidemiology conference.

/2012/MCHA staff went to the MCHB Western Regional conference in June, 2011. //2012//

/2013/Need to continue to build capacity and expertise in qualitative research methods. EPI staff needs training on how to use Geographic Information System //2013//

b. Qualitative Assessment and Analysis

We plan to request funding for training and technical assistance to family organizations to increase their capacity to survey and assess quality of life issues they work to improve. For example, staff from Fathers Network want to develop a valid survey tool to measure the impact on the relationships with partners and children of men who regularly participate in Fathers Network activities.

c. Qualitative Research Methods

We need to continue to build capacity and expertise in qualitative research methods. The OHC Assessment section has increasingly been asked to use and provide technical assistance on qualitative methods to complement quantitative methods or as stand-alone methods in planning program-specific evaluations and OMCH needs assessments.. Most of the staff in MCHA has expertise solely in quantitative methods. Staff is requesting TA funds for staff training to build internal capacity related to conducting qualitative evaluation.

Our staff needs funds for training on how to interface Office products with SAS and STATA to produce reports. This will save precious staff time and provide timely data reports for key MCH stakeholders.

/2012/ Our staff got in-house STATA training from DOH.//2012//

/2013/Our staff needs funds for training on how to use Geographic Information System to produce accurate maps and reflect all forms of geographically needed information on various risk factors and diseases relevant to MCH population. Training on qualitative methods also needed.//2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	9002043	8904678	8892505		8799423	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	7573626	2023367	7573626		1850634	
4. Local MCH Funds <i>(Line4, Form 2)</i>	14000	0	5000		0	
5. Other Funds <i>(Line5, Form 2)</i>	1500000	7176690	1900000		7352800	
6. Program Income <i>(Line6, Form 2)</i>	0	0	0		0	
7. Subtotal	18089669	18104735	18371131		18002857	
8. Other Federal Funds <i>(Line10, Form 2)</i>	13028977	12048367	25098969		10637698	
9. Total <i>(Line11, Form 2)</i>	31118646	30153102	43470100		28640555	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	2925000	1531432	2485000		1260200	
b. Infants < 1 year old	2373000	3389810	1899000		1764280	
c. Children 1 to 22 years old	4518454	6204896	4573000		6329805	
d. Children with	5798000	5162067	6571000		7024715	

Special Healthcare Needs						
e. Others	685000	941002	1044000		813729	
f. Administration	1810000	875528	1799131		810128	
g. SUBTOTAL	18109454	18104735	18371131		18002857	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	610000		1199750		600000	
b. SSDI	100000		100000		112477	
c. CISS	140000		140000		150000	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	7545078		15333713		364964	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
Family Plan Title X	0		0		3909120	
Preg & Parent Teens	0		0		1814681	
PREP	0		0		1081909	
SAMHSA	0		0		916000	
Title XIX Match	0		0		1688547	
ARRA EHR-IIS E-Hlth	0		836522		0	
HRSA Home Visiting	0		1311814		0	
Oral Hlth Workforce	0		500000		0	
SAMHSA Proj Launch	0		916000		0	
St Personal Responsa	0		1081909		0	
Supp Preg & Par Teen	0		1779261		0	
T-19 Federal	0		1900000		0	
ARRA	876000		0		0	
EHDDI	191899		0		0	
Healthy Childcare WA	350000		0		0	
Medicaid Fed & Other	1800000		0		0	
Oral Hlth Dent Ntwk	500000		0		0	
SAMHSA ProjLaunch	916000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	655000	365700	456000		378060	
II. Enabling Services	3836000	3408183	4212000		3060486	
III. Population-Based Services	2706000	7751659	2507000		7939260	
IV. Infrastructure Building Services	10912454	6579193	11196131		6625051	
V. Federal-State Title V Block Grant Partnership Total	18109454	18104735	18371131		18002857	

A. Expenditures

Overall expenditures for activities related to pregnant women increased by 94% over FFY08, by 4% for Infants less than 1 year, by 2% for children 1-22 years, by 3% for CSHCN; 65% for all others and 40% for administration.

The increase in spending for pregnant women comes primarily from state funding for miscarriage management and oral health. The increases for infants and children 1-22 are due to vaccines. The 65% increase to Others is due to Genetics Services activities. A state proviso for Parkinson's Disease Registry meant that the Genetic Services section was addressing issues for older individuals. Administrative spending increased by 40% due to capturing additional overhead in other state funding.

LHJ's receive approximately 60% of the total MCHBG award each year. Beginning in CY2007 OMCH instituted a 2.7% phased-in reduction to Local Health Jurisdictions. To accommodate the cut OMCH developed a funding formula in concert with representatives from the LHJ's and OMCH staff. The formula included a base amount for each LHJ and additional funds for each one determined by such statistics as county Medicaid births.

OMCH funding levels to LHJ's remained at their CY2007 allocations despite continued cuts in activities at the state level. Of interest is a comparison of LHJ spending in FFY08 with FFY09. While timing differences affect the amount of expenditures reported, the office was able to determine changes in spending patterns.

An increase of almost 10% in overall LHJ expenditures supports the earlier assertion regarding the economic squeeze at the local level. Counties are more likely to bill in a timely manner and to use all their allocation.

In FFY08 OMCH projected shifts in LHJ spending by level of the pyramid and this did occur. A 78% decrease in Direct Services indicates that LHJ's were making decisions regarding discontinuing direct service activities and finding other community resources that could fill the gaps. It also indicates that LHJ's are taking advantage of MCHBG's flexibility to use their allocations for activities that are usually not covered by other funding sources. LHJ's increased spending in Enabling Services by about 14%; Population-Based Services by 13% and Infrastructure by 17%. These latter categories speak to efforts to protect core capacity and systems.

/2012/Washington Department of Health, Community and Family Health Division has provided guidance to OMCH to only budget the match or maintenance of effort amount (whichever is greater) to not over commit general fund state that may be used for other matching requirements, but may report all expenditures that may result in overmatch. This has resulted in expenditures of state general funds exceeding the budgeted amounts. This will be reviewed. Total office expenditures decreased significantly over FY09. This large negative variance is due to decreases in expenditures in one of the Health Service Account matching funds. Spending in most

categories decreased significantly due to spending cuts and cost cutting measures to address the state's continued and projected budget shortfalls. At the state level early reductions in allocations were implemented in July 2010. Vacancies remained unfilled, spending on travel, equipment, and meeting meals was delayed, curtailed or eliminated. Contracts were subjected to additional approval processes creating delays in funding to contractors.

Since block grant and state funds are blended to fund many staff and contracts, delays for state funds also impacted Block Grants funds as well. At the local level, budget impacts created similar changes including staffing shortages that affected billing for services. While OMCH lost some significant funding in state dollars, the completion of a federal grant on Epilepsy and a long standing contract, the office also gained some significant federal funding, such as ARRA grants. New grants in the areas of Childhood Home Visiting, Support for Pregnant and Parenting Teens, State Personal Responsibility and Education occurred at the end of FY10. Consequently, the impact will vary across programs based on the mix of state cuts and new federal funding. For variations in Forms 3, 4, and 5 please see notes section and Appendix 10.//2012//

/2013/ Form 3: The budgeted Federal allocation for FFY11 was based upon the previous year's award (FFY10) however, the Washington State Department of Health received a slight decrease of 1.09% for FFY11 (Notice of Grant Award dated 7-15-2011).

The budgeted Total State Funds reflects Washington State's maintenance of effort (1989) of \$7,573,626: the difference in what was budgeted and what was expended for FFY11 is due to changes in how the state is documenting its match requirement. \$2,023,367 came from the State General Fund and the remaining balance of \$5,616,862 came from "Other Funds" which is a portion of the Washington State Universal Vaccine Purchase Account (fund 965) through the Office of Immunization and Child Profile (within the WA State - DOH). Previously this account was listed as State General Funds but the appropriation was correctly identified as "Other" local dedicated funding. The remaining funds in the "Other Funds" category comes from the Public Health Supplemental Account (\$11,168 fund 319), and the State General Funds (\$1,548,660) set aside to pull down Medicaid match (non-matchable to Title V) for related MCH activities.

In FFY10, we reported over-match and guidance was given at the August 2011 grant/fiscal review to bring the estimates into better alignment with actual/projected expenditures. The reduced expenditures in Other Federal Funds are the result of cuts to EHDDI and SSDI; and non-renewal of ARRA Projects; Children's Oral Healthcare Access; Oral Health Workforce Dental Network; and Epilepsy categorical grants as well as availability of Medicaid match funding. Overall, there was a difference of 8% between FFY11 budgeted versus actual expenditures. In Forms 4 and 5 the overall expenditures were just slightly below the budgeted amount in individual population and pyramid level categories. This is due to the \$1.6 mil in General Fund State cuts to MCH funding in the second year of the 09-011 biennium. These cuts were mandated by the State Legislature and impacted services to the MCH populations throughout the state.//2013//

B. Budget

Throughout FFY09 the downturned economy and unemployment rate of over 9% meant state agencies had to find more areas for cuts. In early 2009, OMCH developed and implemented tiered rankings to cut lower priority activities by \$1.9 million. Unspent state proviso funds in Cord Blood Rule-making and Cord Blood Collection comprised other cuts. Additional reductions occurred from savings due to staff vacancies.

These cuts became permanent for the 2009-2011 biennium. OMCH cut \$1.8 million and 3 FTE's to meet the Governor's 1% freeze. Activities related to these cuts included not funding a contract for a school-based health clinic; stopping a media literacy program; not filling vacant positions; not purchasing and disseminating the Epidemiology and Prevention of Vaccine Preventable

Diseases book. In the 2009-2011 biennium, other programs such as Cord Blood Pilot, Sex Education Curricula Review, Neurodevelopmental Centers, the Autism Task Force and Miscarriage Management were eliminated or reduced to be phased out. Total permanent funding cuts in General Fund State were \$2.8 million with an additional \$24.5 million in vaccine funding that was slated for termination May, 2010.

In January 2009, state agencies were called upon to contribute unspent state general funds from early savings. OMCH lost 1.9 FTE's and \$140,000.

The legislative session this year brought into existence the Washington Vaccine Association, which will restore Washington to a universal vaccine state at an appropriation of \$52 million. OMCH will lose 1 FTE, \$77,000 in Oral Health technical assistance work, and \$77,000 in contract funds to the LHJ's. Another \$438,000 in administrative efficiencies and cuts to program activities will take effect on July 1, 2010. Activities that comprised those amounts were technical assistance to LHJ's around oral health issues, a staff position and funding for project work concerning web design and maintenance. Some Early Hearing Detection and Diagnosis activities will be curtailed.

In the past two years, OMCH has lost approximately \$2 million (app 29%) of state general fund for operations.

State agency staff will also experience temporary layoff days in the coming State Fiscal Year. Current estimates are 10 days. DOH will present the reduction plan to achieve the agency's target amount.

In the face of budget cuts, partners and stakeholders such as the Local Health Jurisdictions have indicated cessation of more locally funded maternal and child health program activities.

Continued unemployment in Washington State means increased pressure for services to the MCH population. The state economist projects that it will be 2012 before the economic upswing will be felt at the state government level.

Changes in funding mean realigning fiscal decisions and office priorities. The Immunizations Program received economic stimulus funding, which will conclude in FFY11. Just prior to the start of FFY11 the CSHCN section has a grant, Epilepsy, which will come to an end. The Oral Health program recently received funding for state dental network activities. A long-standing contract, Healthy Childcare Washington will conclude 12/31/10.

To achieve more administrative efficiencies, OMCH will revise the Activity Plan and Statement of Work for both the Oral Health and MCH programs.

Within these budget parameters, OMCH will deploy block grant resources to maintain core activities utilizing the MCHBG's funding flexibility. To that end FFY11 expenditures will go to 33.3% of activities to benefit Children 1 -22 years of age, 34.5% for CSHCN and 10% for Administration.

//2012/ During the current FFY11 year, OMCH experienced General State Fund cuts to several programs and services including Maternity Support Services, Neurodevelopmental Centers, Oral Health, and Assessment activities, along with administrative reorganization (the reorganization was mandated by the Legislature in the final 2010 Session budget). The Washington Legislature passed the budget for the 2011-2013 biennium and the initial budget cuts to MCH programs is \$1.6 million per year with additional reductions to General State Funds anticipated.

New federal grants such as Home Visiting, Pregnant and Parenting Teens and State Personal Responsibility and Education will help to shape the MCH program focus along with other categorical grant funding realized through the division and office modernization effort. The state's 1989 maintenance of effort (\$7,573,626) will continue to be supported with a combination of state general funds and with local funding available for match through the Washington Vaccine Association. The Washington Vaccine Association funding will fund a larger share of the match and maintenance of effort requirements.

In FFY12, estimated expenditures of 32.49% will serve Children 1-22 years; 38.42% for CSHCN and 5.8% for Administration. For variations in Forms 3, 4, and 5 please see notes section and Appendix 10.

//2012//

/2013/ According to the March state revenue forecast, "The Washington economy is recovering about as expected...and is narrowly outperforming the U.S. economy and we expect that trend to continue" Washington State Economic and Revenue Forecast Council, Retrieved May 25, 2012 from <http://www.erfc.wa.gov/forecast/revenueForecast.shtml>.

The federal budget sequestration will have a serious impact on MCH programs. The MCH director and section managers will review and prioritize MCH performance measures and indicators in order to prepare for anticipated reductions ranging anywhere from 8 to 20%.

The initial forecast for General Fund State revenue is expected to increase slightly by 6.6% for the 2013-2015 biennium, however, the cuts to Office of Healthy Communities MCH program will still reflect the \$1.6 million reductions for year 2 of this biennium. With this reduction the state will meet the Title V match requirement (1989 MOE) of \$7,573,626 for FFY13 through the available \$1.8 million General Fund State (24%) as well as a larger share of the Washington State Vaccine Association Account funding (76%). Increases to General Funds for the MCH program are unlikely.

The state will meet the 30/30 requirements in the following ways:

By contracting with the following entities: for CSHCN activities: Seattle Children's Hospital, Neurodevelopmental Centers, UW Medical Center, Providence Sacred Heart; Children 1-22 activities: School Based Health Centers, Office of Superintendent Public Instruction (OSPI), University of Washington and OSPI Healthy Youth Survey.

Local Health Jurisdictions (LHJ) CY2013 contracts will also meet the 30/30 requirement focusing on program activities and funding for NPM05 for Children with Special Health Care Needs; and SPM03 Developmental Screening or SPM05 Adverse Childhood Experiences for Children 1-22. For FFY11 the LHJs assisted the state overall in meeting the federal requirements: 30% CSHCN and 31% Children 1-22 despite budget cuts at the local level.

Sources of other Federal funds that will continue to support the MCH population in FFY13 include anticipated categorical grant funding through Universal Newborn Screening, Great Minds, State Systems Development Initiative (SSDI), Childhood Comprehensive Systems (CISS), Pregnancy Risk Assessment Monitoring (PRAMS), Title XIX Medicaid match, SAMHSA, State Personal Responsibility & Education (PREP), Support for Pregnant & Parenting Teens and Women and Family Planning Title X.

See Expenditure Section for details re: Forms 3, 4, and 5. In FFY13, even with impending cuts of at least 8% to the WA State MCH Federal Block Grant award expected, estimated expenditures of 35.16% will serve Children 1-22 years; 39.02% for CSHCN and 4.5% for Administration. These estimates are projected due to the required focus on specific MCH performance measure activities and outcomes required of the new CY 2013 Local Health Jurisdiction and office-wide contracts. An attachment is included in this section, Indirect Cost Rate

//2013//

An attachment is included in this section. VB - Budget

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.