



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

**State Narrative for
Washington**

**Application for 2009
Annual Report for 2007**



Document Generation Date: Monday, September 22, 2008

Table of Contents

I. General Requirements	4
A. Letter of Transmittal.....	4
B. Face Sheet	4
C. Assurances and Certifications.....	4
D. Table of Contents	4
E. Public Input.....	4
II. Needs Assessment.....	6
C. Needs Assessment Summary	6
III. State Overview	8
A. Overview.....	8
B. Agency Capacity.....	13
C. Organizational Structure.....	15
D. Other MCH Capacity	15
E. State Agency Coordination.....	17
F. Health Systems Capacity Indicators	24
Health Systems Capacity Indicator 01:	24
Health Systems Capacity Indicator 02:	25
Health Systems Capacity Indicator 03:	27
Health Systems Capacity Indicator 04:	28
Health Systems Capacity Indicator 07A:.....	30
Health Systems Capacity Indicator 07B:.....	32
Health Systems Capacity Indicator 08:	33
Health Systems Capacity Indicator 05A:.....	34
Health Systems Capacity Indicator 05B:.....	35
Health Systems Capacity Indicator 05C:.....	36
Health Systems Capacity Indicator 05D:.....	37
Health Systems Capacity Indicator 06A:.....	38
Health Systems Capacity Indicator 06B:.....	39
Health Systems Capacity Indicator 06C:.....	39
Health Systems Capacity Indicator 09A:.....	40
Health Systems Capacity Indicator 09B:.....	41
IV. Priorities, Performance and Program Activities	42
A. Background and Overview	42
B. State Priorities	42
C. National Performance Measures.....	44
Performance Measure 01:.....	44
Performance Measure 02:.....	47
Performance Measure 03:.....	51
Performance Measure 04:.....	55
Performance Measure 05:.....	58
Performance Measure 06:.....	61
Performance Measure 07:.....	64
Performance Measure 08:.....	68
Performance Measure 09:.....	70
Performance Measure 10:.....	73
Performance Measure 11:.....	76
Performance Measure 12:.....	79
Performance Measure 13:.....	82
Performance Measure 14:.....	85
Performance Measure 15:.....	87
Performance Measure 16:.....	91
Performance Measure 17:.....	93
Performance Measure 18:.....	95

D. State Performance Measures.....	98
State Performance Measure 1:	99
State Performance Measure 5:	101
State Performance Measure 6:	104
State Performance Measure 7:	107
State Performance Measure 8:	112
State Performance Measure 9:	113
State Performance Measure 10:	115
E. Health Status Indicators	117
F. Other Program Activities	118
G. Technical Assistance	121
V. Budget Narrative	125
A. Expenditures.....	125
B. Budget	127
VI. Reporting Forms-General Information	131
VII. Performance and Outcome Measure Detail Sheets	131
VIII. Glossary	131
IX. Technical Note	131
X. Appendices and State Supporting documents.....	131
A. Needs Assessment.....	131
B. All Reporting Forms.....	131
C. Organizational Charts and All Other State Supporting Documents	131
D. Annual Report Data.....	131

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.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

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

Riley Peters, Director
Washington State Department of Health
Office of Maternal and Child Health
111 Israel Road SE
Post Office Box 47835
Olympia, WA 98504-7835

Phone: (360) 236-3502
Email: riley.peters@doh.wa.gov

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; expires May 31, 2009.

E. Public Input

Input for the MCH Block Grant application involved multiple stakeholder groups, including families and family organizations. These groups are actively engaged with specific MCH sections and populations, and sometimes more than one population group. They represent communities, healthcare professionals, universities, state agencies, local health jurisdictions, and other organizations. They are knowledgeable and articulate about MCH needs and emerging issues.

Involving stakeholders in our MCH Block Grant Application and Five Year Needs Assessment Process allows for greater appreciation and understanding of work at all levels and mutual learning, problem solving, and growth. Stakeholders provided input throughout development of our Five Year Needs Assessment. Progress was shared regularly as the OMCH Director, managers, and staff met with stakeholders. Presentations were made to multiple groups as we began to frame the assessment and identify potential MCH priorities. Feedback from presentations was overwhelmingly positive. The framework and language in the draft priorities resonated with all groups and they commented about how beneficial it would be for them and for state level work.

Stakeholders continue to be included in shaping the final MCH priorities through the existing communication channels, workgroups, etc. In this way, the priorities and related performance measures continue to be relevant for all of Washington State.

/2007/OMCH made sections of the block grant available for public comment on DOH's Web site. The complete application will be available via OMCH's Web site later this year.//2007//

/2008/ Public input was requested as in 2007. We sent an announcement about the opportunity to review and comment on this year's application via email to over 360 parents, partners, and colleagues. A 10-day review period resulted in 3 comments. 2 of them were very positive and complementary regarding the planned activities/programs. One was a suggestion about how to better represent the role of service providers for CSHCN and collect and use data regarding CSHCN. The entire application and annual report will be available on OMCH's Web site after final submission to HRSA in September 2007.

CSHCN conducted 2 focus groups of parents of children with special health care needs. Discussions focused on the activities described in the performance measures, history of the block grant, and federal expectations for states.//2008//

/2009/In addition to the ongoing public input we solicit, we again posted the 2009 application to our website. We received 5 comments, all positive. 2 encouraged continued support of family organizations. One suggested addressing rising transportation costs and their impact on access to care. The entire application/annual report will be available on OMCH's Web site after submission to HRSA in September 2008.

CSHCN recruited a group of emerging family leaders with children with special needs to learn the history of the block grant and review proposed CSHCN activities. They were invited to continue working with the section to revise the process of determining activities to support performance measures for CSHCN. Meetings with this group will continue.//2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Process, Partnerships, and Identifying Priorities

In 2004 and 2005, the Washington State Department of Health (DOH) Office of Maternal and Child Health (OMCH) undertook a comprehensive strategic planning approach to identify priorities for addressing the needs of the maternal and child population. This involved working with internal partners within DOH and external partners throughout the state. External partners included local public health staff and Public Health Nursing Directors, the Perinatal Advisory Committee, University of Washington School of Nursing, Department of Social and Health Services, Children with Special Health Care Needs Communication Network, regional perinatal programs, March of Dimes, Healthy Mothers Healthy Babies (now known as WithinReach), Children's Hospital and Regional Medical Center, and the Genetics Advisory Committee.

The 2005 Needs Assessment (NA) was developed based on the following principles adopted by the OMCH Management Team: 1) commitment by the OMCH Management Team to lead the NA, 2) focus on promoting health and wellness, 3) commitment to incorporate the NA into system-wide strategic planning for OMCH, 4) integration of work activities across all OMCH sections, 5) involvement of staff in integrated work groups, and 6) use of existing stakeholder groups to gather input, review process, and validate results. The resulting 2005 NA involved a three-step process 1) identifying the needs of the population, 2) assessing the capacity within the state to meet those needs, and 3) prioritizing the needs through work with stakeholder groups. Subsequent development of the priorities included working with stakeholders to refine the scope and purpose of each priority. By the end of 2006, OMCH and its partners had selected nine priority outcomes for maternal and child health in Washington State:

- 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 MCH population
- 9) Quality screening, identification, intervention, and care coordination

Using the Priorities and Continued Assessment of Capacity and Needs

Washington's maternal and child health (MCH) priority outcomes are supported by many activities. Efforts in 2007 and 2008 focused on using the priorities to guide difficult budget decisions in the face of substantial federal cuts to the block grant. We also adapted activities for efficacy and sustainability. Each priority is described and connected to state and national public health agendas in an issue brief. OMCH annually updates the MCH Priority Issue Briefs to reflect changes in activities and data related to each priority. Issue briefs updated in June 2008 can be viewed as an attachment to Section IIC of the 2008 block grant application. The following are a few examples of how the MCH priority outcomes are used by OMCH and its agency and local partners.

- 1) OMCH used the priorities to frame discussions and presentations within the agency and with external partners. For example, Priority Three: Optimal Mental Health and Healthy Relationships provided the framework for a presentation to Master's in Public Health (MPH) students in the University of Washington Maternal and Child Health program.

- 2) Priority Five: Safe and Healthy Communities was used by the Department of Health's Injury Prevention program to identify activities supported by OMCH for a grant application.
- 3) The OMCH management team relied on the priorities to guide them through difficult budget decisions in the face of block grant reductions.
- 4) A workgroup of local public health representatives and OMCH program representatives used the MCH priority outcomes to help make decisions about changes to the funding formula for the distribution of block grant funds to local public health jurisdictions.
- 5) The Community and Family Health Division within DOH used the MCH priority outcomes to help shape the division's strategic planning process called "Mission, Values, and Priorities (MVP)."
- 6) The Child and Adolescent Health section within OMCH used the MCH priorities in its strategic planning process.
- 7) MCH Combined Teams regularly share the MCH priority outcomes with local public health partners and seek input from them about the MCH priorities.
- 8) Authors used the MCH priorities to frame the introduction to the Maternal and Child Health chapter in the "2007 Health of Washington State" report, a comprehensive data report on multiple health indicators.

//2009/In April 2008, the OMCH Health Disparities Work Group completed the issue brief for Priority Four: Health Equity through collaborating with the OMCH management team. In May 2007, the two groups held a retreat to discuss health disparities work in OMCH. Each section in the office contributed to the content of the issue brief by helping to draft the focus statement, expectations and objectives. Each section also identified key data and notable activities for inclusion in the document.

The 2005-09 MCH priorities and the issue briefs developed for them were used in 2007-08 to guide the development of three new state performance measures. The new measures will replace three retired measures. Presently, the new measures represent process measures. Over time, the Office of Maternal and Child Health plans to transition these process measures into outcome measures. The 2005-09 MCH priority goals will continue to influence the development and results of Washington's state performance measures.

OMCH has attempted to integrate ongoing needs assessment planning and evaluation into our work. To facilitate this OMCH recently provided two program evaluation trainings to all OMCH staff. The first session was an introduction to program evaluation, based on the CDC Framework for Program Evaluation. The second session discussed advanced evaluation techniques, question development, data collection, development of an analytic plan, and interpretation of results.//2009//

More detailed descriptions of the 2005 Needs Assessment methodology and results are available in Washington's 2006 and 2007 Maternal and Child Health Block Grant applications.

An attachment is included in this section.

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 cooler and drier east of the Cascade Range.

Population Density(1)
(See attached map)

In 2007, the average population density in Washington was 97.5 persons per square mile. The national rate from the 2000 Census was reported at 79.6 persons per square mile. Nearly 80 percent of Washington's population is 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.

Geography, climate, and economic resources influence Washington's population distribution. Population density ranges from 875 persons per square mile in King County to 3 persons per square mile in Garfield and Ferry counties.(2) 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.

Economy

Washington State continues to struggle with an economic slowdown resulting from a combination of factors. The burst dot.com bubble and the decline of airplane demand after September 11, 2001 significantly affected Washington's technical and industrial economic base. In addition, the first case of bovine spongiform encephalopathy (BSE or "mad cow disease") was found in Mabton, Washington in November 2003. This resulted in economic challenges for Washington's beef farmers and agriculture industry. In November 2003, the State's seasonally adjusted unemployment rate was 7.2 percent. Washington's unemployment rate remains one of the highest in the nation, ranked as 38th. The state's unemployment rate was 5.5 percent (as of April 2005) compared to 5.4 percent nationally (February 2005).

//2007/Washington State's economy remains slow after the 2001 downturn. In March 2006, Washington's unemployment rate was 4.6 percent, which is comparable to the national unemployment rate of 4.7 percent (April 2006). Washington is ranked 30th among all the states for unemployment.//2007//

//2008/In March 2007, the State's seasonally adjusted unemployment rate was 4.6 percent. Washington's unemployment rate remains one of the highest in the nation, ranked as 38th. The state's unemployment rate was 5.0 percent, which is a statistically significant decrease from the 2005 rate of 5.5 percent. However, it is still higher than the national average of 4.6 percent (March 2007).(3)//2008//

//2009/The state faces the same challenges many other states throughout the country face with respect to budget deficits, rising unemployment, a declining real estate market, housing foreclosures, and rising fuel prices. The most recent revenue forecast from June 2008 projects a state General Fund decrease of 50 million for the coming state fiscal year and 118 million for the next state biennium.

(<http://www.ofm.wa.gov/news/release/2008/080619.asp>) In addition, the seasonally adjusted unemployment rate in Washington rose to 5.3%, the first time in 20 months it has

risen above 5% (<http://www.esd.wa.gov/newsandinformation/releases/may-unemployment-stats-08-034.php>)/2009//

Several years of economic doldrums, combined with spending constraints and spending limits from voter-approved initiatives, have produced a continuing budget crisis for Washington. 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, with the result that many local programs are struggling financially. Economic hard times also increase the need for public health services, so the current decrease in funding is having a major impact on local public health. As the economic and state fiscal crisis continues, future reductions in local public health are expected. LHJs are currently being forced to reduce staff and programs.

/2007/Federal funding cuts and state general fund shortfalls continue, making it necessary to further reduce funding to state and local public health programs.//2007//

/2008/The Washington State Legislature passed legislation in 2007 to support additional funding for local public health. The legislation requires local public health departments to use funds provided by the Legislature to address core public health functions. "Health services that promote healthy families and the development of children" is one of six activities listed in the definition of core public health functions of statewide significance. The amount of funds received by local public health will depend on the funding provided by the Legislature in each budget cycle; this amount can fluctuate. In 2007-09, approximately \$20 million will be distributed among the 35 local public health agencies in Washington.//2008//

Population

Washington's population continues to grow. The 2000 Census indicated the state's population was 5,894,121, an increase of 21.1 percent since the 1990 Census.(4) The Washington Office of Financial Management's (OFM) preliminary intercensal population estimate for the state in 2004 was 6,167,800.(5)

/2007/ The population of Washington State more than doubled between 1960 and 2005. Fifty to seventy five percent of the growth is the result of net migration and the rest is from natural increase. OFM's preliminary intercensal population estimate for 2005 was 6,256,400.//2007//

/2008/OFM's intercensal population estimate for 2006 was 6,375,600.(5)//2008//

/2009/OFM's intercensal population estimate for 2007 was 6,448,000.(5)//2009//

According to the 2000 Census, Washington ranked seventh in the country in numerical population growth and tenth in percentage population growth since 1990.(6) However, from 1995-2000 growth slowed to an average of 1.3 percent per year and since 2000, has averaged 1.1 percent per year. Since 1995, natural population increase (births minus deaths) has remained fairly constant, while net migration (people moving into the state versus people moving out) has decreased from 68,300 in 1995 to an estimated 23,100 in 2003.

/2007/OFM is projecting a significant increase in the number of people migrating to Washington in the coming years.//2007//

/2008/In the past ten years, the state population has increased approximately 12 percent. (4) //2008//

/2009/Net migration (people moving into the state versus people moving out) increased from 34,600 in 2004 to 74,000 in 2007. (7)//2009//

Race/Ethnicity in Washington State

The majority of Washington's population identifies itself as White and non-Hispanic. In the 2000

Census, 81.8 percent of Washington's population reported its race as White, 5.5 percent Asian, 3.2 percent Black, 1.6 percent American Indian or Alaskan Native, 0.4 percent Native Hawaiian and other Pacific Islander, and 3.9 percent Other. Individuals who reported two or more races accounted for 3.6 percent. Finally, 7.5 percent of the population reported Hispanic or Latino ethnicity.(9)

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 percent of the overall population in 1990 to 21 percent (1,241,631) of the population in 2000. The state population of Asian/Pacific Islanders increased by 78 percent; Blacks by 35 percent; and American Indians, Alaska Natives, and Aleuts by 29 percent.

/2009/The most recent population estimates produced by the WA State Office of Financial Management in 2006 predict a general increasing trend among the population of non-White and Hispanic residents.(5)//2009//

The Hispanic population in Washington State has more than doubled since the 1990 Census, from 214,570 in 1990, to 441,509 in 2000. 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 percent in 1990 to 47.1 percent in 2000; Franklin County saw an increase from 30.2 percent to 46.7 percent; and Yakima County saw an increase from 23.9 percent to 35.9 percent. While Hispanics make up a large proportion of the population in these counties, most Hispanics live in King, Pierce, and Snohomish counties. The majority (74.7 percent) of Hispanics in Washington are from Mexico, 20.6 percent are from "other countries" (Central and South America), 3.7 percent from Puerto Rico, and 1.0 percent from Cuba.(10) In 2000, there were approximately 289,000 migrant and seasonal farm workers and dependents living in Washington, most of whom were Hispanic. 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 (CMHC) for their health care.

Blacks and Asian/Pacific Islanders are predominantly located in urban areas west of the Cascades. Approximately 50 percent of each population resides in King County alone. There are also 29 federally recognized American Indian tribes throughout Washington with varying populations and land areas. Two additional tribes are seeking federal recognition.

Languages

According to the 2000 Census, approximately 15 percent, or 168,000, of Washington's children age 5-17 years speak a language other than English at home. Of these children, 43 percent speak Spanish, 29 percent speak Asian and Pacific Islander languages, 26 percent speak other Indo-European languages, and 4 percent speak other languages. A similar figure of 14 percent, or 512,000, of the adult population age 18-64 years does not speak English at home. Of those who do not speak English at home, 88 percent of the children and 75 percent of the adults speak English "very well" or "well." Twelve percent of the children and 25 percent of the adults, speak English "not well" or "not at all."(11) Approximately 40,700 Spanish-speaking students were enrolled in the English as a Second Language program in Washington State for the 1999-2000 school year. Other languages with high enrollments were Russian (5,500), Vietnamese (3,200), Ukrainian (2,900), Korean (1,800), Cambodian (1,400), and Tagalog (1,000). (11)

Age

In 2003, there were 80,482 resident births in Washington State. The 2000 Census population counts show that almost 22 percent, or 1.29 million of the estimated 5.9 million people in Washington in 2000, were women of reproductive age (age 15-44 years). Nearly 29 percent, or 1.68 million, were children age 19 years and younger. There were over 125,000 women age 15 to 17 years. Adolescent pregnancy rates (age 15-17 years) declined in Washington from 57.9 per 1,000 women in 1990 to 28.8 per 1,000 women in 2003.(12) 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. The school age population (age 5-17 years) is expected to remain stable through 2010 and then gradually increase. In 2004, there were an estimated 1,120,913 children and adolescents aged 5 to 17 years. (13)

/2007/In 2004 there were 81,715 resident births in Washington State.//2007//

/2008/In 2005, there were 82,625 resident births in Washington State. Adolescent pregnancy rates (age 15-17 years) declined in Washington from 57.9 per 1,000 women in 1990 to 27.6 per 1,000 women in 2005.(12) In 2007, there were an estimated 1,148,084 children and adolescents aged 5 to 17 years. (13)//2008//

/2009/In 2006, there were 86,485 births in Washington State. Birth and pregnancy rates among women 15-24 years declined substantially from 1990-2003, but no clear pattern has emerged recently. In 2006, there were an estimated 1,317,975 children and adolescents aged 5 to 17 years in Washington.(19)//2009//

Urban/Rural

Seventy-two percent of population growth over the past decade occurred in the western portion of the state, 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 have lower median household incomes, higher poverty rates, and higher unemployment rates. A recent review of health status indicators found some differences between the health status of rural and urban residents, though it is difficult to assess specifically whether the decreased health status is linked to rural location, isolation, or decreased access to care.(14)

Poverty and Health Insurance

According to the 2004 Washington State Population Survey, an estimated 24.5 percent of Washington households had a family income below 200 percent of the Federal Poverty Level (FPL), compared to 18.8 percent in 2002. An estimated 9.9 percent of households had an income below the 100 percent of the FPL.(15) Data on households with children is not yet available, but according to the 2002 Washington State Population Survey, an estimated 35 percent (approximately 574,000) of children in Washington were living below 200 percent of the FPL (FPL = \$18,392 for a family of four in 2002), compared to 33.4 percent in 2000. An estimated 18 percent (about 284,000) of the children were living below 100 percent of the FPL and 11 percent (about 180,000) were living at or below 50 percent of the FPL.(16)

/2007/According to the 2004 Washington State Population Survey, an estimated 38 percent (approximately 640,985) of children in Washington were living below 200 percent of the FPL. An estimated 19 percent (about 322,188) of the children were living below 100 percent of the FPL and 10 percent (about 169,573) were living at or below 50 percent of the FPL.//2007//

/2008/According to the 2004 Washington State Population Survey, an estimated 22.1 percent of Washington households had a family income below 200 percent of the Federal Poverty Level (FPL), compared to 24.5 percent in 2004, and 18.8 percent in 2002. An estimated 8.0 percent of households had an income below 100 percent of the FPL.(15)//2008//

Findings from the 2004 Washington State Population Survey indicate the percent of Washington residents without health insurance is also increasing. Among the general population, 8.4 percent were uninsured in 2002 compared to 9.8 percent in 2004, a 17 percent increase. The percent of uninsured children increased approximately by 33 percent from 4.5 percent in 2002 to 6.0 percent in 2004, equaling over 98,000 uninsured children in Washington.(17)

/2008/Findings from the 2006 Washington State Population Survey indicate the percent of Washington residents without health insurance has decreased in the past two years, although this change is not significant. Among the general population, 9.3 percent were uninsured in 2006,

compared to 9.9 in 2004, compared to 8.4 percent in 2002, showing an overall increase of 11 percent. The percent of uninsured children decreased from 5.9 percent in 2004 to 4.4 percent in 2006, this was not a statistically significant change.(17)//2008//

The Washington State Medical Assistance Administration (MAA) funds health care services to low income people in Washington, primarily through the federal/state Medicaid partnership. In 2003, Medicaid covered pregnant women up to 185 percent of the FPL and paid for prenatal care and deliveries for approximately 46 percent of state births.(18) The "Take Charge" program at MAA provides family planning for men and women with incomes at or below 200 percent of the FPL. The State Children's Health Insurance Program (SCHIP) provides health coverage for children of families with incomes between 200 percent and 250 percent of the FPL.
/2007/The Department of Social and Health Services Medical Assistance Administration (MAA) recently changed its name to DSHS Health and Recovery Services Administration (HRSA).//2007//

/2008/The Washington State Legislature passed legislation in 2007 to expand eligibility for state subsidized health insurance to children in families with incomes up to 250% of the federal poverty level (FPL). The income limit goes up to 300% FPL in 2009. In addition, families with incomes above 300% FPL will be able to purchase Medicaid coverage by paying the full cost. The legislation also provides incentives to primary care providers to become medical homes for children and families.//2008//

-
- (1) Washington State Office of Financial Management, US Census 2000 Maps
 - (2) Washington State Office of Financial Management, Population Density (Persons Per Square Mile, 2007 <http://www.ofm.wa.gov/popden/>)
 - (3) US Department of Labor, Bureau of Labor Statistics, March 2008.
 - (4) Washington State Office of Financial Management, Population Forecasting Division, Census 2000 results show Washington's population increased by over 1 million during the 1990s, 12/28/2000.
 - (5) Washington State Office of Financial Management, 2007 State Estimates.
 - (6) US Census Bureau, Census 2000 Redistricting Data (P.L. 94-171) Summary File and 1990 Census, 4/02/2001.
 - (7) Washington State Data Book 2007, Components of Population Change Table (PT02).
 - (8) Washington State Office of Financial Management, Population Forecasting Division, Washington's Population Growth Continues to Slow, 6/30/2000.
 - (9) US Census Bureau, Census 2000, Table DP-1, Profile of General Demographic Characteristics: 2000.
 - (10) 1990 and 2000 Census, Office of Financial Management.
 - (11) US Census Bureau, Census 2000 Supplementary Survey Summary Tables, Table PO35, Age by Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over.
 - (12) Washington State, Pregnancy and Induced Abortion Statistics 2006, Center for Health Statistics, April 2008.
 - (13) Washington State Office of Financial Management, Forecast of the State Population by Age and Sex, 1990 to 2030, May 2007.
 - (14) Schueler V, Stuart B. "Recent research and data on rural health in Washington State", Olympia, Washington, October 2000.
 - (15) Office of Financial Management, 2006 Washington State Population Survey, November 2006.
 - (16) Data provided by Washington's Office of Financial Management.
 - (17) Gardner, Erica. "The Uninsured Population in Washington State", 2006 Washington State Population Survey Research Brief No. 39 (Revised), Washington State Office of Financial Management, November 2006.
 - (18) Cawthon, Laurie. "Characteristics of Washington State Medicaid Women Who Gave Birth", DSHS Research and Data Analysis, 2/23/2005.

(19) 2006 Total Population Estimates by Age, Gender, and Race: Washington and Its Counties, Office of Financial Management. 05/01/2007
An attachment is included in this section.

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.

The office is responsible for administering the Title V Block Grant, the Centers for Disease Control and Prevention (CDC) Immunization Grant, and a variety of other federal grants pertinent to MCH priorities and performance measures. The office 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.

State statutes relevant to the Title V program authority and how they affect the Title V program remain the same as those outlined in pages 8-11 of the 1996 Block Grant Application. Capacity for better understanding of 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.

OMCH addresses health disparities through program activities driven by data demonstrating a need for targeted efforts to reduce or eliminate disparities. The office also established the OMCH Health Disparities Workgroup. This group was created several years ago to help sections within the office work together to address health disparities in the MCH population. The OMCH Health Disparities Work Group and the OMCH Management Team recently worked together to develop MCH Priority 4, "Health Equity." The groups met in May 2007 to identify program activities addressing health disparities and suggest ideas for the role and scope of the OMCH Health Disparities Work Group. Future work will emphasize using data to focus activities and drive decision making. In addition, the Community and Family Health Division established a division wide health disparities work group. Representatives from OMCH serve on this work group. The first task of the division work group is to survey all the programs in the division for information about activities that aim to address health disparities. Statewide, the Legislature passed legislation creating the Governor's Interagency Council on Health Disparities. The Department of Health is represented on the council. By 2010 the council must develop a plan to reduce health disparities for certain outcomes in specific populations. Several of the outcomes are related to maternal and child health.

Each of the six specialized sections within the office have the capacity to support programs to help create infrastructure and provide population based services, enabling services, and limited direct services to the maternal and child health population. Each section has a specific focus. Three sections focus on the major Title V populations: Maternal and Infant Health, Child and Adolescent Health, and Children with Special Health Care Needs. The other sections focus on issues that encompass the entire MCH population: Genetics, Immunization Program CHILD Profile, MCH Assessment. Following is a brief description of the basic role of each OMCH section. The Administration section is the seventh section in the office and supports all of the specialized sections. Funding is provided through a combination of sources including Title V, State General Funds, the Centers for Disease Control and Prevention, and Title XIX Medicaid

Administrative Match.

Maternal and Infant Health (MIH)

MIH, comprised of 9.45 full time equivalents (FTEs), works to improve birth outcomes by promoting quality health and support services for women of childbearing age, particularly focusing on pregnant and post-partum women and their infants. MIH works to identify and implement effective strategies to protect and improve the health of women, infants and families in Washington State. MIH has two primary goals: 1) to support women of childbearing age in making choices to adopt and maintain healthy behaviors; and 2) to ensure that women and infants, especially those in vulnerable populations have equal access to quality health services that meet their needs. This work is accomplished through monitoring trends in data, and by maintaining a 1-800 hotline resource and referral number, working collaboratively with private and public healthcare partners and contractors to improve access and quality of health services.

Child and Adolescent Health (CAH)

CAH, with 14.1 FTEs, works 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. Through its programs, CAH 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.

//2009/12.8 FTEs, CAH is also working to promote school-based health centers.//2009//

Immunization Program and Children's Health Immunization Linkages and Development (CHILD) Profile (IPCP)

In 2005 the Immunization Program merged with the CHILD Profile program to form the Immunization Program CHILD Profile (IPCP) section. IPCP is comprised of 24.6 FTEs. IPCP is 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 Chapter of the Academy of Family Practice, a Vaccine Advisory Committee of expert physicians, a statewide coalition, and all local health jurisdictions. IPCP maintains the states' Immunization Registry and coordinates the Health Promotion System for parents of young children.

Children with Special Health Care Needs (CSHCN) The CSHCN section has a total of 11.0 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, Children's Hospital and Regional Medical Center, 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.

Genetic Services

Genetic Services, with 8.0 FTEs, is focused on assuring high quality comprehensive genetic services and early hearing-loss detection, diagnosis, and intervention (EHDDI) throughout the

state. In these areas, this 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.

MCH Assessment (MCHA)

This section, with 12.65 FTEs, provides data, analysis, research, surveillance, and consultative support and management of all assessment activities within OMCH. Specific activities include leading the Five Year Needs Assessment process, reporting performance measures and health indicator status data; administering and analyzing Pregnancy Risk Assessment Monitoring System (PRAMS) data and developing data reports; 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 surveys and responds to data requests from OMCH, other programs within the Department of Health, local health jurisdictions, and other external stakeholders.

OMCH Administration

This section has a total of 6.55 FTEs and provides office management and administrative support to the sections of the Office of Maternal and Child Health by way of policy and fiscal development and oversight. Because it serves the entire MCH population and works with all of the sections within the office, the Oral Health Program is located in the Administration section. Its work is carried out 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, University of Washington School of Dentistry to improve oral health in the state.

C. Organizational Structure

The Department of Health is located within the Executive Branch of state government, with the Secretary of Health reporting directly to the Governor. DOH includes five major divisions, one of which is Community and Family Health. The Office of Maternal and Child Health (OMCH) is one of four offices within this division. In Washington State, the Children with Special Health Care Needs Program is part of OMCH.

The Department, through the Office of the Assistant Secretary for Community and Family Health and the Office of Maternal and Child Health is "responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V (Section 509(b)). All programs funded by the Federal-State Block Grant partnership are included under this administration (Form 2, Line 8)."

For a Department of Health organization chart, go to the following Internet link:

<http://www.doh.wa.gov/Org/org.htm>

For a Division of Community and Family Health organization chart, go to the following Internet link: <http://www.doh.wa.gov/cfh/CFHOrgChart/default.htm>.

For an Office of Maternal and Child Health organization chart, go to the following Internet link:

<http://www.doh.wa.gov/cfh/mch/documents/MCHOrg.pdf>.

D. Other MCH Capacity

The Office of Maternal and Child Health has a total of 83.95 FTEs with 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. OMCH also

employs a parent of a child with special health care needs as a full-time family consultant 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 Consultant takes a leadership role in activities to increase family involvement in children with special health care needs (CSHCN) 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 Consultant 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 Consultant for OMCH is one of four delegates from Washington to the Association of Maternal and Child Health Programs (AMCHP). The family perspective is an integral component of developing high quality, culturally competent programs and public policy.

The majority of staff are located in Olympia, Washington. The Genetic Services section is located in Kent, Washington near Seattle.

Following are brief biographical sketches of DOH senior management and managers within OMCH:

Mary Selecky has been the Secretary of Health for nine years. 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.

Mary Wendt is the Assistant Secretary for the Division of Community and Family Health. Mary joined DOH after nearly eight years with the Washington State Department of Social and Health Services, 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.

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.

Riley Peters, PhD 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 20 years and served as the manager of the MCH Assessment section for four years prior to becoming the director of OMCH.

Kathy Chapman, manager of the Maternal and Infant 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.

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 and a founding member of the Coalition of State Genetic Coordinators.

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.

Judy Schoder, became manager of the Child and Adolescent Health section in June 2006. She received a Bachelor of Science degree in nursing from Idaho State University in Pocatello, Idaho and a Master of nursing degree from the University of Washington. Judy was previously the adolescent health consultant for the Washington State Department of Health (DOH) for 18 years. Prior to working at DOH, Judy was a public health nurse in Ithaca, New York.

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.

/2009/Shumei Yu, MD, Manager of the MCH Assessment section, holds a MD and a Master's in Public Health from Beijing Medical University, and a PhD in 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 four years./2009//

E. State Agency Coordination

The following describes how sections and programs in the Office of Maternal and Child Health coordinate efforts and work with others in the Department of Health (DOH), other state agencies, local health jurisdictions, academic institutions, and private organizations.

Working with other offices and programs throughout the Department of Health
(1) MCH Assessment (MCHA): The MCHA section manager and other DOH epidemiology staff participate in a monthly department-wide Assessment and Operations Group (AOG) to set standards for all assessment functions within DOH, coordinate assessment activities, and facilitate communication across the department. This collaboration has resulted in improved coordination with the Center for Health Statistics and local health jurisdiction (LHJ) assessment staff. Representatives from MCHA work with the DOH Family Violence Prevention Workgroup, which also includes representatives from Injury Prevention Program, Emergency Medical Services (EMS), and Family Planning. They meet monthly to coordinate activities and plan, evaluate, and secure resources to decrease family violence. The Tobacco Control and Prevention Program works closely with the Pregnancy Risk Assessment Monitoring System (PRAMS) survey

by helping to fund the survey and by providing guidance on tobacco-related questions and analysis.

(2) Children with Special Health Care Needs (CSHCN): CSHCN works with the Women, Infants, and Children Program to coordinate coverage for special formulas for children covered by Medicaid, and provide cross-training; and with the Office of Newborn Screening to ensure coverage for nutrition products for children with metabolic disorders.

(3) Child and Adolescent Health (CAH): CAH's program Healthy Child Care Washington works with the Division of Environmental Health, the Immunization Program CHILD Profile, and Child Death Review on SIDS prevention and oral health. The Tobacco Control and Prevention Program collaborates with CAH on developing the Healthy Youth Survey and provides major funding for this survey.

//2009/CAH works with the MCH Oral Health Program and DOH Office of Health Promotion (OHP). CAH administers the Early Childhood Comprehensive Systems (ECCS) Grant and works with all OMCH sections to improve systems across the 5 required ECCS components. In promoting the development of school-based health centers, CAH coordinates with OHP and other stakeholders, on implementation of the Coordinated School Health Grant.//2009//

(4) Maternal and Infant Health (MIH): MIH works with the DOH Office of Community and Rural Health on women's health, access to obstetric care, and domestic violence prevention. MIH collaborates with the HIV/AIDS and Family Planning and Reproductive Health Programs (FPRH) and other contractors through the MCH/HIV Workgroup. The focus of this workgroup is to develop effective policies and programs for HIV/AIDS prevention and care in the MCH population and increase the number of medical providers who recommend HIV testing for all pregnant women. MIH also works with FPRH to reduce unintended pregnancies and promote the Medicaid Take Charge Program. MIH joins with the Tobacco Control and Prevention Program to develop the Maternity Support Services tobacco cessation project and train providers. The two programs collaborated to successfully advocate for improved Medicaid coverage of smoking cessation treatment for pregnant women. The Tobacco Control and Prevention Program provides funds to the WithinReach toll-free Family Health line, which now asks callers about tobacco use and includes Tobacco Quit Line information in their prenatal and child health education packets. The Tobacco Control and Prevention Program funds MIH to exhibit tobacco-related materials at continuing medical education events. MIH works with the Women, Infants, and Children (WIC) Program to promote breast-feeding, exchange data, enhance referrals, address access to care issues between WIC and First Steps. MIH provides training and materials to WIC program staff on methods for identifying and intervening with victims of domestic violence and child abuse. MIH and WIC have collaborated to revise the parent education booklet titled, "Nine Months to Get Ready," which is used for client education by WIC and Maternity Support Services providers. MIH leads a cross-division work group on preconception health, which includes representatives from infectious disease, reproductive health, chronic diseases and health promotion. The Women's Health Resource Network (WHRN) is a forum for agency-wide input and response to current and emerging women's health issues and service gaps including data on women's health, policy related to program services, quality assurance and standards development, and changes in the health care system. The goal of the WHRN is to assist DOH in building state and local capacity to address the needs of women and their health concerns throughout their lives. WHRN includes representatives from 16 Community and Family Health and Environmental Health programs.

(5) Genetic Services Section (GSS): GSS Early Hearing Loss Detection, Diagnosis, and Intervention (EHDDI) staff are collocated with the Office of Newborn Screening dried blood spot staff at the Public Health Laboratory. This allows for strengthened networking and the sharing of resources for similar procedures.

(6) Immunization Program CHILD Profile (IPCP): IPCP works with the Office of Environmental

Health and Safety to determine priority environmental health risks for children and develop educational materials to increase parental knowledge of how they can protect their children from several environmental toxins. The Office of Environmental Health Assessments and CHILD Profile developed the "Protect Kids from Toxics" brochure which explains the risks of ingesting high levels of mercury and how to limit exposure to mercury and other toxic substances. The "Lead Can Poison Your Child" insert was developed to educate parents about lead exposure and testing. IPCP has an agreement with the Communicable Disease Epidemiology Program to provide rash illness investigation and reporting. CHILD Profile partners with the Injury Prevention Program to provide product safety messages to Washington State parents with children between birth to six years of age. The Women Infants and Children Program and IPCP collaborate on nutrition materials for CHILD Profile mailings and share information about emergency preparedness planning. IPCP works with the Women, Infants, and Children (WIC) Program to comply with federal requirements and enhance immunization rates.

(7) MCH Administration and the Oral Health Program: Multiple programs in OMCH work with the Injury Prevention Program, and OMCH uses Title V Block Grant funds to partially fund data collection and reporting of intentional and unintentional injuries, youth suicide, and family violence. The Oral Health Program works with the DOH Offices of Community and Rural Health, Facilities and Services Licensing, and Health Professions Quality Assurance to increase access to dental care and to promote dental homes within medical homes. The Oral Health Program collaborates with the DOH Environmental Health Division, Epidemiology Program, Office of Health Promotion, and HIV/AIDS Program to enhance preventive oral health care and address unmet needs. OMCH also works with the Office of Drinking Water on fluoridation. The Maternity Support Services Program (MSS) educates providers regarding pregnancy and oral health and makes educational materials available to women on Medicaid.

Working with other state agencies

(1) Washington State Board of Health (SBOH): 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. OMCH and SBOH staff serve on a mental health advisory committee convened by the Governor's office.

/2009/OMCH provided input into the SBOH paper on a public health approach to mental health, developed for the Mental Health Transformation Project in 2007./2009//

(2) Department of Social and Health Services (DSHS): OMCH programs collaborate with many facets of DSHS. The agencies collaborate to maximize federal administrative match, build on the strengths of each department to promote the best outcomes for clients, generate and use data needed by both agencies, provide coordinated program services for clients, and provide complementary services and avoid duplication.

An interagency agreement between Health and Recovery Services Administration (HRSA) (Title XIX) (formerly MAA) and OMCH has existed for 14 years. Partnerships between OMCH and HRSA have developed with the mutual goal of assuring quality health services for pregnant women, infants, children, and adolescents served by Medicaid. We expect that recent changes in Medicaid administrative match allowances will reduce funding for these activities. The following are examples of the many ways we work with HRSA.

OMCH participates on the Medicaid External Quality Review Organization Contract committee (EQRO), the DSHS HRSA Early Periodic Screening Diagnosis and Treatment (EPSDT) Improvement Committee, and the HRSA Immunization Partnership Committee. In 2007, OMCH worked with HRSA to facilitate a statewide EPSDT Improvement Summit.

//2009/MIH manages the Medicaid MSS and childbirth education programs as part of the interlocal agreement. These programs target women under 185% Federal Poverty Level. The CSHCN section manager serves on the Title XIX Interagency Advisory Committee.//2009//

Children with Special Health Care Needs section staff, in partnership with HRSA and local health jurisdictions work with Medicaid managed care plans to meet requirements of the Centers for Medicare and Medicaid Services (CMS) 1915B waiver requiring HRSA to identify, track, and coordinate care for children in managed care who are also served by Title V, and to allow families to request an exemption from managed care if needed. Plan representatives have become a part of the quarterly CSHCN Communication Network meetings. The CSHCN Program is also working with managed care plans to identify practical ways for providers to develop and provide medical homes for all children. DOH works with HRSA and Health Care Authority to develop performance measures for providers, health plans, and other partners involved in health care delivery, especially publicly funded health coverage.

DSHS HRSA provides administrative match for the Pregnancy Risk Assessment Monitoring System (PRAMS) activities not covered by the Centers for Disease Control and Prevention grant. PRAMS data are stratified by Medicaid recipient status and used by the First Steps program to evaluate the effectiveness of program services. The Immunization Program CHILD Profile's (IPCP) partnership with HRSA resulted in matching funds for immunization and CHILD Profile activities, data sharing agreements, HRSA participation in developing the health promotion materials for parents, and HRSA participation in the CHILD Profile Advisory Group. DSHS HRSA and IPCP are working together to maintain and expand partnerships with the state's health plans. The CSHCN Section works with HRSA to improve access to and quality of health services for children with special health care needs through CSHCN Communication Network meetings and to implement quality assurance measures and data sharing for Title V children in Medicaid managed care. CSHCN assists DSHS HRSA with implementing recently expanded publicly funded health coverage for children.

//2009/Expansion of publicly funded health coverage includes provision of care within a medical home. New legislation in 2008 will fund primary care pilots to implement medical home for all patients using a learning collaborative model currently being used by DOH in CSHCN medical home teams.//2009//

The Immunization Program works extensively with DSHS HRSA on the Vaccines for Children (VFC) Program to ensure VFC-qualified children receive adequate immunizations. OMCH provides state funding match for Medicaid prenatal genetic counseling services. OMCH staff oversee the program and work with DSHS HRSA to ensure that up-to-date billing instructions are in place. Medicaid also covers genetic counseling services for new parents up to 90 days after birth.

The OMCH Oral Health Program collaborates with DSHS HRSA on access to dental services for children receiving Medicaid services. OMCH and DSHS HRSA both participate on a statewide oral health coalition and meet together regularly on the Access to Baby and Child Dentistry (ABCD) Initiative and other access issues.

OMCH participates with the Division of Alcohol and Substance Abuse (DASA) on an oversight committee for developing, implementing, and evaluating a comprehensive treatment program for chemically dependent pregnant or parenting women and their young children.

OMCH works with the Children's Administration (CA), which includes Child Protective Services (CPS), Child Care, Foster Care, and other offices on subjects of joint concern. These include chemically dependent pregnant women, child maltreatment, Child Death Review, and mental health. A cross-office and cross-agency group meets to improve services and coverage for children in foster care who are considered to be children with special health care needs. OMCH

works with CA, the Mental Health Division (MHD), and the University of Washington (UW) to train foster parents to use the Bright Futures mental health materials.

/2009/The foster parent training project ended August 2007. Child care was moved to the Department of Early Learning when it was created in 2006./2009//

OMCH continues to provide the DSHS Mental Health Division (MHD) with data to comply with the Center for Medicaid and Medicare Services (CMS) requirements for the Medicaid 1915B waiver. This information provides the means to identify the number of children with special health care needs served by both Title V and MHD. DOH is represented by OMCH staff on the Children's Treatment and Services subcommittee of the MHD Mental Health Planning and Advisory Committee.

The CSHCN section maintains a Memorandum of Understanding with Disability Determination Service (DDS) and Social Security Administration (SSA) in order to provide information to families of children under the age of 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.

OMCH participates with the Division of Developmental Disabilities' Infant Toddler Early Intervention Program (ITEIP) in coordinating efforts to implement Part C of the Individuals with Disabilities Education Act (IDEA). Through an Interagency Agreement with DSHS, the Department of Community, Trade, and Economic Development (CTED), the Department of Services for the Blind, and Office of Superintendent of Public Instruction (OSPI), OMCH works to ensure a comprehensive statewide system of early intervention services for eligible infants and toddlers with disabilities (birth to 3 years) and their families. The Immunization Program CHILD Profile has an interagency agreement with DSHS to distribute brochures that include development information for parents of children between age 3 and 18 months. The brochures provide parents with the resources to access early intervention services.

Genetic Services works with the 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.

(3) Office of Superintendent of Public Instruction (OSPI): OMCH maintains many partnerships with OSPI. The Immunization Program CHILD Profile (IPCP) works with OSPI's Health Services Supervisor on issues involving immunization requirements for school entry. IPCP works with OSPI to distribute child development and school readiness information. CSHCN participates in monthly OSPI school nurse corps meetings. Washington State received a Coordinated School Health Grant from CDC. This is a partnership between DOH and OSPI. CSHCN and CAH participate on the Coordinated School Health Interagency Committee, and work to align this effort with related adolescent health and mental health planning initiatives.

The CSHCN Program works with OSPI to identify appropriate health outcomes for children with special health care needs, including participation in a new youth transition planning initiative, Building Bridges, being piloted in several school districts statewide that targets at-risk youth and those with special needs. OMCH also participates on an interagency team called STEPS (Sequenced Transition for Education in Public Schools) that addresses transition issues for children birth to school age. Funding provide by OMCH to support some staff time for school nursing was cut in 2007. However, despite the cut in funding, OMCH and OSPI school nurse collaboration continues. School Nurse Corps supervisors participate in MCH Regional meetings. Representatives from multiple DOH programs, OSPI, Community Trade and Economic Development (CTED), DSHS, the Liquor Control Board, and the Governor's Family Policy Council (FPC) make up the Healthy Youth Survey planning committee. These same organizations, along with other state and local agencies, are members of the Washington State Partnership for Youth (WSPY). The purpose of WSPY is to develop a plan for improving adolescent health in Washington State. The CAH Youth Development Team collaborated with OSPI and other stakeholders to develop the Guidelines for Sexual Health Information and Disease Prevention as

directed by the state Legislature.

//2009/OSPI and other stakeholders serve on the School-Based Health Center Interagency Group that OMCH convenes. A representative from OSPI also serves as a member of the Autism Task Force, which is supported by staff from OMCH.//2009//

(4) Department of Early Learning (DEL) was created in 2006. OMCH has many partnerships with DEL including serving on the Early Learning Advisory Council and collaborating to provide health consultation to child care providers.

(5) University of Washington: DOH collaborates with the University of Washington in a project using the State Capacity Grant for Prevention of Secondary Disabilities. This project is supported by a cooperative agreement with the Centers for Disease Control and Prevention to assess the types and prevalence of secondary disabilities and form local advisory councils to promote a public awareness campaign and implement strategies to prevent secondary disabilities. Genetic Services works with the UW Center for Health Policy and the Institute for Public Health Genomics on a variety of training and research endeavors. The Immunization Program CHILD Profile contracts with the UW to evaluate the CHILD Profile (CP) Health Promotion System and maintain the CP Web site.

//2009/The State Capacity Grant for Prevention of Secondary Disabilities ended in June 2008.//2009//

OMCH uses MCH block grant funds to contract with programs within UW's Center on Human Development and Disability (CHDD) that receive Leadership Education for Neurodevelopmental Disabilities (LEND) grants. These contracts 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. CAH works with the UW School of Education, Early Childhood, and Teen Telecommunications Network to foster leadership on issues of parents and teens and pre-teens at the state and local levels. OMCH works with the UW School of Pediatric Dentistry on oral health issues that impact pregnant women, infants, children, and youth.

//2009/(6) Mental Health Transformation (MHT) Grant: In 2005, Washington was one of seven states to receive a federal MHT Grant. DOH, several sections of DSHS, OSPI, DEL, consumers, providers, and other stakeholders serve on the MHT Work Group, which guides the implementation of the grant. DOH, OSPI, DSHS and the State Board of Health participate on the MHT Prevention Advisory Group, working to promote a public health approach to mental health and increase capacity for prevention and early identification of mental health problems. OMCH/CAH has worked to keep public health and early learning stakeholders informed of opportunities to coordinate with and influence this work.

(7) Council for Children and Families (CCF): CCF, previously the Washington Council for the Prevention of Child Abuse and Neglect, works to prevent child abuse and neglect before it happens (primary prevention) by promoting protective factors, including positive parent-child relationships, non-punitive discipline, and an understanding of child development. DOH, DSHS/Children's Administration, OSPI, and DEL serve on the Council along with other stakeholders.//2009//

Working with Local Health Jurisdictions (LHJs)

In Washington State, OMCH contracts with 35 LHJs to address maternal and child health needs in local communities. OMCH program staff work closely 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 Public Health Nursing Directors to develop key activities, outcomes, and indicators for local public health OMCH provides technical assistance and data support for the local CDR teams throughout the state. Some of the activities provided by LHJs are described

in the performance measure narratives. A report of LHJ activities is available by contacting the Office of Maternal and Child Health at 360-236-3502 or mch.support@doh.wa.gov.

Working with Hospitals and Other Specialized Services

(1) Children's Hospital and Regional Medical Center (CHRMC): OMCH works with CHRMC through a contract with the Center for Children with Special Needs (CCSN) to provide information to families, providers, and policy makers regarding health issues for children with special health care needs and their families. The Genetic Services section also contracts with CHRMC to provide technical assistance to birthing hospitals in Washington that are initiating or already conducting Universal Newborn Hearing Screening. CHILD Profile collaborates with CHRMC to develop and disseminate injury prevention materials for parents of children birth to six years in Washington State.

(2) Mary Bridge Children's Hospital and Health Center (MBCHHC): MBCHHC is the site of one of 16 MCH supported neurodevelopmental centers (NDCs) and the Maxillofacial Review Team for Southwest Washington. Previously, MBCHHC assisted CSHCN in developing and disseminating guidelines to primary care providers for the care of high-risk infants as part of their discharge plan. However, the contract ended on 6/30/06 and was not renewed because of cuts in MCH block grant funding.

(3) Regional Genetics Clinics (RGC): Seventeen RGCs are located throughout the state and are funded to provide clinical genetic services for the MCH population as well as provide educational outreach to their communities. Data generated by the RGCs are used for program planning and policy development.

(4) Perinatal Regional Network (PRN): In 2007, cuts in Medicaid funding led to changes to the regional perinatal program. It became the Perinatal Regional Network (PRN), which coordinates state and regional quality improvement projects to decrease poor pregnancy outcomes. Previously, the Regional Perinatal Program operated through contracts with OMCH with four regional perinatal programs. These programs provided consultation and training to health care providers with a focus on specialized care for high-risk pregnant women and neonates.

(5) Perinatal Advisory Committee (PAC): The statewide Perinatal Advisory Committee, staffed by OMCH, brings together representatives from tertiary care centers, professional organizations, consumer groups, and state agencies to review and assess perinatal health issues and advise DOH and DSHS, HRSA in developing policies and practices to improve perinatal outcomes.

(6) Community Health Clinics (CHC): CHCs play a major role in providing access to direct health services as LHJs continue to move toward core public health functions. Most CHCs are also First Steps providers and participate in First Steps education updates sponsored by OMCH and HRSA. Community Health Clinic Dental Clinics participate with the OMCH Oral Health Program to collaborate on community-based preventive oral health programs such as school sealants and as a referral base for WIC and Head Start children.

(7) Neurodevelopmental Centers (NDC): The CSHCN section provides funding to support the infrastructure of 16 neurodevelopmental centers across the state. These centers 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 state funding to provide a structure for specialty services with support from other payers for services, other state agencies, and community resources.

/2009/Working With Tribes

OMCH works with the DOH tribal liaison to explore ways to expand and improve communication with tribes in Washington State. Specific actions include working with the American Indian Health Commission (AIHC), and expanded use of the DOH Tribal

Connections Web site. In response to a joint DSHS/DOH data presentation to the AIHC, a subcommittee of the AIHC was formed to work on strategies to improve health outcomes in Native American mothers and children. Representatives from DSHS, DOH MIH and the First Steps program, WIC, and tribal liaisons have had 2 meetings to frame purpose and begin exchanging information. MCH Assessment has worked closely with the Northwest Area Indian Health Board and the Seattle Urban Indian Health Institute on maternal and infant assessment issues. We have also worked on a joint project to improve birth certificate completion by Native American mothers and to improve response rates to the PRAMS survey//2009//

Working with Communities, Foundations, and Organizations

(1) Foundation for Early Learning (FEL): CHILD Profile and FEL work together to revise and distribute both the birth to 18 months and the 18 months to 4 years development charts for parents. The charts address social, emotional, physical, language, motor, and cognitive development and provide parents with specific activities that will support their child's development. FEL also partnered with CHILD Profile to distribute a booklet titled "Getting School Ready" to parents of 4-year olds in Washington State. OMCH collaborated with FEL and the Head Start State Collaboration Office to develop Kids Matter, a strategic plan for assuring children are healthy and ready for school through the Early Childhood Comprehensive Systems Grant.

(2) Sensory Disabilities Services: The Genetic Services section contracts with Washington Sensory Disabilities Services to train providers across the state to work with children who are deaf or hard of hearing, and to conduct a birth-to-three educational module at their annual Deaf Family Weekend.

/2009/(3) Epilepsy Foundation Northwest: The CSHCN section is collaborating with the Foundation in a three year grant awarded to DOH intended to improve community-based system of services for children and youth with epilepsy. The grant activities will focus on medically underserved and rural areas of central Washington, and target communities with a significant Hispanic population.//2009//

F. Health Systems Capacity Indicators

Introduction

The Health Systems Capacity Indicators (HSCI) are a group of national indicators designed to measure the capacity of each state to serve certain populations. They address both access and availability to services and programs, often by Medicaid and SCHIP eligibility, and are measured annually. Each HSCI includes a discussion of the factors influencing whether the HSCI has been maintained or has improved, the efforts being made by the program to develop new strategies, interpretations of the data trends, and any association between the measure and the State Systems Development Initiative (SSDI) grant.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	25.8	27.8	29.2	25.3	25.3
Numerator	1029	1113	1187	1042	
Denominator	399183	400939	405992	412285	
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	Provisional

Notes - 2007

No data available.

Notes - 2006

Data for this Health Systems Capacity Indicator (HSCI01) are gathered from the Comprehensive Hospital Abstract Reporting System (CHARS), Washington State's hospital discharge database. The numerator represents the number of hospital discharges for children less than 5 years of age who had a primary diagnosis of asthma (ICD-9 codes 493.0-493.9). The data was accessed using VISTAPHw software.

Notes - 2005

These data come from the Washington State Hospital Discharge database (CHARS) and are updated annually. The numerator represents the number of hospital discharges for children less than 5 years of age who had a primary diagnosis of asthma (ICD-9 codes 493.0-493.9). The denominator represents the number of children less than 5 years of age in Washington from Office of Financial Management.

Narrative:

Data for this Health Systems Capacity Indicator (HSCI01) are gathered from the Comprehensive Hospital Abstract Reporting System (CHARS), Washington State's hospital discharge database. Hospitalization rates for asthma include only in-patient hospitalizations. While rates have fluctuated over the past five years (decreasing from 2000 to 2003, but increasing slightly in 2004 and 2005), the trends show an overall decrease which is reflected in the most recent data from 2006.

OMCH promotes awareness and prevention of asthma issues in young children through the promotion of Bright Futures guidelines as the standard for well-child care, the promotion of medical home for all children, and the system of child care health consultation (Healthy Child Care Washington). Child care health consultants are public health nurses who are knowledgeable about asthma recognition and treatment; and they assist child care providers to recognize, cope with, and prevent asthma, and to work with parents. Child care health consultants also address issues of obesity and physical activity, and providing healthy environments for young children, all of which can prevent or reduce the severity of asthma. Healthy Child Care Washington accesses the latest medical information on asthma through its pediatric health advisor, and connections with the American Academy of Pediatrics. The Promoting Bright Futures in Washington initiative is working with the Medical Home Leadership Network to address asthma and other chronic disease issues, with parents and health care providers.

OMCH is a grantee of Early Childhood Comprehensive Systems, which, through its plan called Kids Matter, aims to improve health and health care in early childhood. The Office also participates in partnerships to improve children's health, such as the public-private partnership called Thrive by Five, and the multi-agency group that aims to improve utilization of Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
--	-------------	-------------	-------------	-------------	-------------

Annual Indicator	98.6	98.6	99.1	99.0	99
Numerator	32487	35011	36986	38087	
Denominator	32948	35509	37322	38472	
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	Provisional

Notes - 2007

2007 HEDIS data not yet available

Notes - 2006

These data are based on the Washington State 2006 HEDIS Report from the Department of Social and Health Services and reflect the estimated statewide proportion of children who turned 15 months old during the reporting year, who were enrolled from 31 days of age in Medicaid or SCHIP and who received at least one well child visit. Data from seven managed care plans (who serve approximately 70% of the Medicaid enrollees less than 15 months) contributed to this report. Children not covered by managed care plans include those on SSI, in foster care, and residents who live in counties without a managed care option. The 2006 HEDIS percentage was used as an estimate for 2007, since no new data are available.

Notes - 2005

Data: $36,986/37,322 = 99.1\%$

Note: These data are based on the Washington State 2005 HEDIS Report from the Department of Social and Health Services and reflect the estimated statewide proportion of children who turned 15 months old during the reporting year, who were enrolled from 31 days of age in Medicaid or SCHIP and who received at least one well child visit. Data from seven managed care plans (who serve approximately 70% of the Medicaid enrollees less than 15 months) contributed to this report. Children not covered by managed care plans include those on SSI, in foster care, and resident who live in counties without a managed care option. The 2005 HEDIS percentage was used as an estimate for 2006, since no new data are available.

Narrative:

In 2006, 99.0 percent of Medicaid enrollees less than age one year had at least one initial periodic screen. These data, which were gathered from the Department of Social and Health Services (DSHS) 2006 HEDIS Report, reflect an increased proportion of Medicaid enrolled infants since 2000 who received at least one periodic screening. However, data collection methodology has fluctuated in recent years and caution should be taken when interpreting trends.

First Steps Maternity Support Services (MSS) providers serve about 70 percent of women eligible for Medicaid paid prenatal care and delivery. First Steps Maternity Support Services providers assist women to identify a healthcare provider for their infant prior to delivery and support women for 2 months postpartum in keeping well child exams. Families eligible for Infant Case Management continue to receive support, reinforcement and referrals as necessary for well child care up to one year of age.

The federal Early Childhood Comprehensive Systems Grant (ECCS) and Washington's efforts through Kids Matter continue to identify Medical Home as a priority for all children aged 0-5 years. Kids Matter Awareness and Utilization surveys continue to show a variety of state and local stakeholder activities are being implemented related to this goal. Kids Matter and other representatives from OMCH participated in a new project from WithinReach that assists parents

and families to access medical coverage, and promotes children receiving periodic health screens. The ParentHelp123.org website is inviting and interactive, helping thousands of families assess their potential eligibility for state benefit programs, including Medicaid and Food Stamps, and fill out program applications on-line. This web resource provides low-income families with a single access point to free and low-cost health insurance, food assistance and many other resources--all in one place, 24 hours a day. Over 32,000 people have visited www.ParentHelp123.org and 8000 families have been screened for potential program eligibility using ParentHelp123's Benefit Finder. The website is screening approximately 1500 families a month and over 4000 applications have been completed.

The Maternal and Infant Health (MIH) Section seeks to improve the percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen through supporting the Family Health hotline operated through an organization called WithinReach. The hotline refers parents to resources to help them enroll in and access Medicaid services for their children. In addition, First Steps Maternity Support Services (MSS) and Infant Case Management (ICM) have developed a new strategic plan which focuses on populations where health disparities exist.

In 2007, state legislation was passed to increase eligibility to state subsidized insurance to 250% of the federal poverty level (FPL) for children, with an increase to 300% FPL in 2009. OMCH is working closely with DSHS, other agencies and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	NaN	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	0	1	1	1	1
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

Notes - 2007

Data was unavailable for 2007. Provisional data report approximately 189 children less than 15 months of age during the reporting year who were covered by the State Children's Health Insurance Plan. However, we don't expect to be able to report on this measure for 2007 because data specific to CHIP enrollees are not available through HEDIS for this age group. Washington CHIP covers from 200 to 250% of the poverty level.

Notes - 2006

HEDIS Data was unavailable for 2006. In 2006 there were approximately 180 children less than 15 months during the reported year who were covered by the State Children's Health Insurance Plan. However, we don't expect to be able to report on this measure for 2006 because data specific to CHIP enrollees are not available through HEDIS for this age group. Washington CHIP covers from 200 to 250% of the poverty level.

Notes - 2005

The data from the previous years reflects all CHIP enrollees, not just children less than 1 year. In 2005, there were approximately 255 children less than 15 months during the reporting year who were covered by the State Children's Health Insurance Plan. A little over half of these children were enrolled in managed care plans. Their well child experience is included in the Washington State 2005 HEDIS Report from the Department of Social and Health Services. Because data specific to the CHIP enrollees are not available through HEDIS for this age group, we are currently unable to report on this measure. Washington CHIP covers from 200 to 250% of the poverty level.

Narrative:

Data are unavailable. Data for this indicator (HSCI03) have been gathered from the DSHS HEDIS Report. However, data from previous years reflected all SCHIP enrollees 0-18 years. In 2006, there were approximately 180 children less than 15 months covered by SCHIP, about half of whom were enrolled in managed care plans. Their well-child experience is included in HEDIS, but because the numbers are so small, a separate estimate for children less than 15 months on SCIP is not available.

OMCH is in a different agency than the SCHIP program; OMCH collaborates with DSHS, but does not directly control the SCHIP program.

First Steps Maternity Support Services (MSS) and Infant Case Management (ICM) also refer and link SCHIP eligible children to providers who offer periodic screening services, including immunizations and well-child care.

The federal Early Childhood Comprehensive Systems Grant (ECCS) and Washington's efforts through Kids Matter continue to identify Medical Home as a priority for all children aged 0-5 years. Kids Matter Awareness and Utilization surveys continue to show a variety of state and local stakeholder activities are being implemented related to this goal. Kids Matter and other representatives from OMCH participated in a new project from WithinReach that assists parents and families to access medical coverage, and promotes children receiving periodic health screens. The ParentHelp123.org website is inviting and interactive, helping thousands of families determine their eligibility for state benefit programs, including Medicaid and Food Stamps, and fill out program applications on-line. This web resource provides low-income families with a single access point to free and low-cost health insurance, food assistance and many other resources--all in one place, 24 hours a day. Over 32,000 people have visited www.ParentHelp123.org and 8000 families have been screened for potential program eligibility using ParentHelp123's Benefit Finder. The website is screening approximately 1500 families a month and over 4000 applications have been completed.

In 2007, state legislation was passed to increase eligibility to state subsidized insurance to 250% of the federal poverty level (FPL) for children, with an increase to 300% FPL in 2009. OMCH is working closely with DSHS, other agencies and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	66.3	61.6	68.0	66.3	65.7
Numerator	41128	41243	43866	47222	
Denominator	62080	66926	64482	71244	

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	Provisional

Notes - 2007

Data not yet available.

Notes - 2006

These data were obtained from the First Steps Database, Washington State Department of Social and Health Services, and are gathered from 2006 Washington State Birth Certificate Files.

The numerator represents the number of resident women (ages 15-44) with a live birth whose Adequacy of Prenatal Care Utilization index is greater than or equal to 80%. The denominator represents all resident women (ages 15-44) with a live birth during the reporting year.

Notes - 2005

Assessment of prenatal care entry is based on information collected on the birth certificate. The numerator represents the number of resident women (ages 15-44) with a live birth whose Adequacy of Prenatal Care Utilization index is greater than or equal to 80%. The denominator represents all resident women (ages 15-44) with a live birth during the reporting year.

In 2003, WA began using a new birth certificate based on the 2003 US Standard Birth Certificate. The National Center for Health Statistics (NCHS) indicates that, "the 2003 revision of the birth certificate introduced substantive changes in item wording and also to the sources of prenatal information....Accordingly, prenatal care data for the two revisions are not comparable."

Because of the birth certificate change in 2003, approximately 18% of the data now fall outside the range of acceptable weight (400-6000 grams) or are missing the number of prenatal care visits and month prenatal care visits began. As a result of the high rate of missing data, it is difficult to ascertain whether the observed indicator represents an actual change in practice or is the result of lack of complete reporting.

Narrative:

Data collection of first trimester entry to prenatal care changed in Washington in 2003 with our adoption of the 2003 revisions to the US Standard birth certificate. (Washington State was a leader in adopting the new version; there is no deadline for states to change to the new revision) For this reason, these data are not comparable to earlier data, and are not comparable to current US data, nor data collected from most other states.

Approximately 38% of all women (Medicaid and Non-Medicaid) who began prenatal care after the first trimester could not get prenatal care as early as they wanted according to 2004-2006 Washington data from the Pregnancy Risk Assessment Monitoring Survey (PRAMS). Barriers to early care reported by these women include: not having enough money or health insurance to pay for care (about 41%); not having a Medicaid card, Healthy Options card or medical coupon (about 40% of women whose prenatal care and/or delivery was paid for by Medicaid); not being able to get an appointment when they wanted one (about 36%); not knowing they were pregnant (about 32%) (2002-2003 data); no transportation to clinic or doctor's office (about 17%); no one to care for other children (about 15%); and doctor or clinic would not start as early as wanted (about 13%).

Additional system-wide barriers to providing early prenatal care include the recent increase in

both Washington State's overall number of births, and in the percent of births covered by Medicaid. Both have increased by about 10% since 2002, and we have no data to see whether the numbers of obstetric providers have also increased.

OMCH seeks to increase the percent of women (ages 15-44 years) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index through supporting MSS services that aim to get women into early and continuous prenatal care. It is a goal to refer women to prenatal care as soon as they enroll in Medicaid. Also, the Family Health toll-free line refers women for care and insurance (i.e. Medicaid) for prenatal services. Staff at DSHS identify Medicaid eligible women in their databases who are not receiving MSS or prenatal care and refer them to local providers.

MIH provides information on our website regarding resources for women seeking prenatal care.

The Center for Health Statistics continues to work with hospitals to work on completeness of birth record data. The Birth Data Quality Query System allows each birthing hospital to check on how complete their data currently is for selected birth certificate items. Hospitals can see how they compare to the state as a whole or to hospitals with similar birth volumes and how their data quality has changed over time.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	88.9	86.5	87.3	88.0	88
Numerator	605313	600174	590014	593536	
Denominator	681046	694133	676232	674373	
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	Provisional

Notes - 2007

Data not yet available

Notes - 2006

2005 Indicator – 88.0%

Numerator - 593536

Denominator - 674373

Technical Note: The source of these data is the Client Services Database (CSDB), Research Data and Analysis, Washington State Department of Social and Health Services; and Office of Financial Management (OFM). The numerator represents clients aged 1 to 21 years who are receiving medical assistance; it includes both managed care and fee for service clients. The data in the denominator are the total number of medically eligible clients aged 1 to 21 years old.

*SCHIP children are included in managed care

*Data is gathered from the CSDB (Client Service Database), which does not get medical managed care encounter information. Therefore it does not measure the types of services received for children enrolled in managed care. Being on a managed care plan counts as

'receiving medical services' , possibly because dollars were expended for their premium payment.

Medically Eligible Title XIX description:

Clients who are eligible to receive medical services for which the state receives federal Title XIX matching funds. Title XIX of the Social Security Act funds:

(1) medical assistance on behalf of families with dependent children, whose income and resources are insufficient to meet the costs of necessary medical services, and of aged, blind, or disabled individuals.

(2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

Notes - 2005

2005 Indicator – 87.3%

Numerator - 590014

Denominator - 676232

Technical Note: The source of these data is the Client Services Database (CSDB), Research Data and Analysis, Washington State Department of Social and Health Services; and Office of Financial Management (OFM). The numerator represents clients aged 1 to 21 years who are receiving medical assistance; it includes both managed care and fee for service clients. The data in the denominator are the total number of medically eligible clients aged 1 to 21 years old.

*SCHIP children are included in managed care

*Data is gathered from the CSDB (Client Service Database), which does not get medical managed care encounter information. Therefore it does not measure the types of services received for children enrolled in managed care. Being on a managed care plan counts as 'receiving medical services' , possibly because dollars were expended for their premium payment.

Medically Eligible Title XIX description:

Clients who are eligible to receive medical services for which the state receives federal Title XIX matching funds. Title XIX of the Social Security Act funds:

(1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and

(2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

Narrative:

In 2006, 88.0% of potentially Medicaid eligible children in Washington received a service paid for by the Medicaid Program. Data are gathered from the DSHS Client Services Database (CSDB) and the Office of Financial Management. Trends over the previous few years from 2000 to present have shown a slightly decreasing trend of about 1.0% per year.

OMCH collaborated with Department of Social and Health Services/Health and Recovery Services Administration (DSHS HRSA) to develop a plan to increase the quality of and access to the Early Periodic Screening Diagnosis and Treatment program (EPSDT.) EPSDT provides well-child check-ups for children ages birth to 18 years. EPSDT improvement workgroups have been established to develop strategies for three specific areas of EPSDT including: quality improvement; incentives for quality screen; health literacy and consumer education; and pilot projects. OMCH staff have partnered with HRSA to lead and facilitate these workgroups. There may be increased work through EPSDT due to the Governor's focus on health insurance. OMCH is working closely with DSHS, other agencies and stakeholders to increase enrollment of children to the newly expanded state subsidized insurance through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	55.0	53.9	56.5	57.0	59.1
Numerator	74122	72821	73259	76404	78397
Denominator	134749	135052	129672	133948	132761
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

Notes - 2007

These data come from the Department of Social and Health Services Medical Assistance Administration. The numerator represents the number of Medicaid enrolled children 6-9 who received any dental service in 2007. The denominator represents the total number of children ages 6-9 enrolled in Medicaid in 2007, in both Healthy Options (the MAA managed care program) and fee-for-service.

These data are provisional.

Notes - 2006

These data come from the Department of Social and Health Services Medical Assistance Administration. The numerator represents the number of Medicaid enrolled children 6-9 who received any dental service in 2006. The denominator represents the total number of children ages 6-9 enrolled in Medicaid in 2006, in both Healthy Options (the MAA managed care program) and fee-for-service.

In 2006 the rate of EPSDT eligible children who received dental services during the year was 57.0 %, an increase over prior years, following a slightly increasing trend evident since 2000. These data are gathered from the DSHS Health and Recovery Services Administration (HRSA).

Notes - 2005

These data come from the Department of Social and Health Services Medical Assistance Administration. The numerator represents the number of Medicaid enrolled children 6-9 who received any dental service in 2005. The denominator represents the total number of children ages 6-9 enrolled in Medicaid in 2005, in both Healthy Options (the MAA managed care program) and fee-for-service.

Narrative:

In 2007 the rate of EPSDT eligible children who received dental services during the year was 59.1%, an increase over prior years, following a slightly increasing trend evident since 2000. These data are gathered from the DSHS Health and Recovery Services Administration (HRSA). Data collection methodology has fluctuated over previous years, therefore caution should be taken when interpreting trends.

OMCH seeks to improve outcomes related to this measure through the following efforts. The Early Childhood Comprehensive Systems Grant (Kids Matter) includes medical homes as one of

the focus areas for promoting improvement and coordination in services for young children and their families. OMCH staff partner with other state agencies on an EPSDT Improvement Team to promote and improve access to and implementation of EPSDT across the state. The OMCH Oral Health Program promotes access to dental care for low income children.

The Oral Health Program provides funding to local health jurisdictions to conduct assessment for oral health capacity, develop partnerships to improve capacity and provide linkage and referral for children to the Access to Baby and Child Dentistry (ABCD) program.

In the future, OMCH staff will continue to work with partners to develop new strategies through the Bright Futures Guidelines work, Early Childhood Comprehensive Systems Grant (Kids Matter), and EPSDT Improvement Team. The Oral Health Program will continue to look for opportunities to promote access to dental care for low income populations.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	10.3	7.7	6.1	5.9	5.5
Numerator	1171	910	875	897	860
Denominator	11418	11893	14300	15217	15720
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

Notes - 2007

The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and the Federal Social Security Administration (SSA). The numerator is the unduplicated number of children under the age of 18 with a CHIF form completed indicating they have SSI coverage in 2007 (860). The age of 18 is used as SSA does not report numbers under age 16 separately. The denominator is from state-specific data from Children Receiving SSI, 2007. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payor of last resort.

Notes - 2006

The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and the Federal Social Security Administration. The numerator is the unduplicated number of children under the age of 18 with a CHIF form completed indicating they have SSI coverage in 2006 (897). The denominator is from state-specific data from Children Receiving SSI, 2006. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payor of last resort.

This data reflects children under the age of 18 instead of under the age of 16, because the SSI releases data with this cutoff. Therefore, any adjustment would only be a crude estimation.

Notes - 2005

The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and the Federal Social Security Administration. The numerator is the unduplicated

number of children under the age of 18 with a CHIF form completed indicating they have SSI coverage in 2005 (875). The denominator is from state-specific data from Children Receiving SSI, 2005. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payor of last resort.

This data reflects children under the age of 18 instead of under the age of 16, because the SSI releases data with this cutoff. Therefore, any adjustment would only be a crude estimation. It is not possible to get an accurate percentage estimation for the gap between ages 16 and 18.

Narrative:

These data are gathered from the State CSHCN Program's Child Health Intake Form (CHIF), a program enrollment form completed at the local health jurisdiction and submitted to CSHCN quarterly. The number of state SSI beneficiaries who are less than 18 (SSA does not calculate data separately for < 16 year olds) years old is calculated from the annual Children Receiving SSI report produced by the Social Security Administration. Data from 2007 indicate that approximately 5.4% of State SSI beneficiaries received rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program, which is a decrease from the ten percent rate in 2003. Data collection methodology has fluctuated in recent years, making rates erratic; therefore caution should be taken when interpreting trends.

In Washington State the CSHCN program's focus is in building systems of care, not providing or funding direct services. All children who are approved for SSI receive full Medicaid benefits. The benefits package provides unlimited therapies to children. The CSHCN program works closely with the state Medicaid agency to assure access to these services. Local CSHCN programs assist families in applying for appropriate benefits, including SSI and Medicaid. Our target is purposefully low to reflect the service system in the state. The state CSHCN program continues to be involved with the Medicaid agency to provide input on policies and rules regarding benefits, billing and reimbursement. The state CSHCN Program created and continues to support a system of regular regional and statewide meetings to provide ongoing discussion regarding barriers and opportunities for children with special needs, including health coverage benefits. Regular attendees in these meetings include the state Medicaid agency, other state agencies, health plans, family organizations and a variety of providers.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	matching data files	7.1	5.9	6.5

Narrative:

These data come from the First Steps Database (FSDB), which links Medicaid claims data with birth and fetal death certificates annually. The FSDB, housed at DSHS, produces a number of reports on pregnancy and newborn health indicators. OMCH collaborates with DSHS and communities to plan and implement strategies for improvement where indicated.

These data show that Medicaid recipients have higher proportions of low birthweight than do non-Medicaid recipients. However, since 1990 the Medicaid singleton low birthweight rate has remained stable, while the non-Medicaid singleton low birthweight rate has increased.

A new strategy to improve data collection in DSHS is their conversion to a new electronic billing system with broader capabilities for collecting data on clients and providers.

OMCH publishes an annual report titled The Perinatal Indicators Report that provides information about selected indicators, health status, and behaviors of pregnant and postpartum Medicaid and non-Medicaid women.

The MCH Data and Services Report is regularly updated and provides data and information about related services associated with this HSCI in order to guide future decision-making.

The Perinatal Regional Network, Washington State's regionalized perinatal program, uses state and federal funds to coordinate and implement state and regional quality improvement projects to decrease poor pregnancy outcomes for which Medicaid clients are at disproportionately increased risk. These projects often assess healthcare access for pregnant women and newborns and compare Medicaid vs non-Medicaid data.

The state Perinatal Advisory Committee (PAC), staffed by MIH, meets three times per year with professional healthcare organizations such as March of Dimes, and Washington State chapters of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists. The PAC serves to identify and prioritize new and emerging statewide perinatal concerns and make recommendations through work groups that address perinatal issues, including services and outcomes for Medicaid and non-Medicaid women and their newborns. The PAC provides consultation and recommends prioritized solutions to the Department of Health and DSHS.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2005	matching data files	5.6	4.1	4.8

Notes - 2009

The overall number for this HSI differs from the CY 2006 period infant mortality rate for outcome measure #01. Outcome measure 01 is a period mortality rate and reflects the total number of infant deaths during CY2006 divided by the total number of live births in CY 2006.

Narrative:

These data come from the First Steps Database (FSDB), which links Medicaid claims data with birth and fetal death certificates annually. The FSDB, housed at DSHS, produces a number of reports on pregnancy and newborn health indicators. OMCH collaborates with DSHS and communities to plan and implement strategies for improvement where indicated.

These data show that Medicaid recipients have higher proportions of infant deaths than do non-Medicaid recipients. While both rates have declined since 1990, the mortality rate of infants whose mothers received Medicaid experienced a greater decline.

A new strategy to improve data collection in DSHS is their conversion to a new electronic billing system with broader capabilities for collecting data on clients and providers.

OMCH publishes an annual report titled The Perinatal Indicators Report that provides information about selected indicators, health status, and behaviors of pregnant and postpartum Medicaid and non-Medicaid women.

The MCH Data and Services Report is regularly updated and provides data and information about related services associated with this HSCI in order to guide future decision-making.

The Perinatal Regional Network, Washington State's regionalized perinatal program, uses state and federal funds to coordinate and implement state and regional quality improvement projects to decrease poor pregnancy outcomes for which Medicaid clients are at disproportionately increased risk. These projects often assess healthcare access for pregnant women and newborns and compare Medicaid vs non-Medicaid data.

The state Perinatal Advisory Committee (PAC), staffed by MIH, meets three times per year with professional healthcare organizations such as March of Dimes, and Washington State chapters of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists. The PAC serves to identify and prioritize new and emerging statewide perinatal concerns and make recommendations through work groups that address perinatal issues, including services and outcomes for Medicaid and non-Medicaid women and their newborns. The PAC provides consultation and recommends prioritized solutions to the Department of Health and DSHS.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	68.4	87.7	78.6

Notes - 2009

These data come from a different source than do those reported in NPM 18.

Narrative:

These data come from the First Steps Database (FSDB), which links Medicaid claims data with birth and fetal death certificates annually. The FSDB, housed at DSHS, produces a number of reports on pregnancy and newborn health indicators. OMCH collaborates with DSHS and communities to plan and implement strategies for improvement where indicated.

These data show that Medicaid recipients are less likely to receive first trimester prenatal care than non-Medicaid recipients.

A new strategy to improve data collection in DSHS is their conversion to a new electronic billing system with broader capabilities for collecting data on clients and providers.

OMCH publishes an annual report titled The Perinatal Indicators Report that provides information about selected indicators, health status, and behaviors of pregnant and postpartum Medicaid and non-Medicaid women.

The MCH Data and Services Report is regularly updated and provides data and information about related services associated with this HSCI in order to guide future decision-making.

The Perinatal Regional Network, Washington State's regionalized perinatal program, uses state and federal funds to coordinate and implement state and regional quality improvement projects to decrease poor pregnancy outcomes for which Medicaid clients are at disproportionately increased risk. These projects often assess healthcare access for pregnant women and newborns and compare Medicaid vs non-Medicaid data.

The state Perinatal Advisory Committee (PAC), staffed by MIH, meets three times per year with professional healthcare organizations such as March of Dimes, and Washington State chapters of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists. The PAC serves to identify and prioritize new and emerging statewide perinatal concerns and make recommendations through work groups that address perinatal issues, including services and outcomes for Medicaid and non-Medicaid women and their newborns. The PAC provides consultation and recommends prioritized solutions to the Department of Health and DSHS.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	matching data files	59.6	72.3	66.3

Notes - 2009

These data come from a different source than do those reported in HSCI 04.

Narrative:

These data come from the First Steps Database (FSDB), which links Medicaid claims data with birth and fetal death certificates annually. The FSDB, housed at DSHS, produces a number of reports on pregnancy and newborn health indicators. OMCH collaborates with DSHS and communities to plan and implement strategies for improvement where indicated.

One major health indicator tracked by OMCH is the percent of pregnant women with adequate prenatal care (observed or expected prenatal visits are greater than or equal to 80% of the Kotelchuck index): These data show that Medicaid recipients are less likely to receive adequate prenatal care (based on Kotelchuck index), than non-Medicaid recipients. OMCH's efforts to improve this indicator include First Steps Maternity Support Services activities and data monitoring, analysis, and publication. MIH also worked with specific communities where the disparity between Medicaid and non Medicaid first trimester entry into prenatal care was greater than the state average. We are identifying specific systems barriers in an effort to problem-solve. In addition, MIH has attempted to improve the quality and completeness of birth certificate filing data to improve our ability to assess prenatal care entry and adequacy. This was done through a state-wide QI project in which contractors worked with targeted hospitals to increase the

completeness of the prenatal data on the birth filing record, specifically targeting the date of first prenatal care, pre-pregnancy height and weight, and date of last menses.

A new strategy to improve data collection in DSHS is their conversion to a new electronic billing system with broader capabilities for collecting data on clients and providers.

OMCH publishes an annual report titled The Perinatal Indicators Report that provides information about selected indicators, health status, and behaviors of pregnant and postpartum Medicaid and non-Medicaid women.

The MCH Data and Services Report is regularly updated and provides data and information about related services associated with this HSCI in order to guide future decision-making.

The Perinatal Regional Network, Washington State's regionalized perinatal program, uses state and federal funds to coordinate and implement state and regional quality improvement projects to decrease poor pregnancy outcomes for which Medicaid clients are at disproportionately increased risk. These projects often assess healthcare access for pregnant women and newborns and compare Medicaid vs non-Medicaid data.

The state Perinatal Advisory Committee (PAC), staffed by MIH, meets three times per year with professional healthcare organizations such as March of Dimes, and Washington State chapters of the American Academy of Pediatrics and American College of Obstetricians and Gynecologists. The PAC serves to identify and prioritize new and emerging statewide perinatal concerns and make recommendations through work groups that address perinatal issues, including services and outcomes for Medicaid and non-Medicaid women and their newborns. The PAC provides consultation and recommends prioritized solutions to the Department of Health and DSHS.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2006	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2006	250

Narrative:

These data come from DSHS.

The Washington State governor has focused increased attention on health, specifically that of children. Any change in eligibility is impacted by DSHS forecast of caseload and budget.

In 2007, state legislation was passed to increase eligibility to state subsidized insurance to 250% of the federal poverty level (FPL) for children, with an increase to 300% FPL in 2009. OMCH is working closely with DSHS, other agencies and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2006	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2006	250

Narrative:

These data come from DSHS.

The Washington State governor has focused increased attention on health, specifically that of children. Any change in eligibility is impacted by DSHS forecast of caseload and budget.

In 2007, state legislation was passed to increase eligibility to state subsidized insurance to 250% of the federal poverty level (FPL) for children, with an increase to 300% FPL in 2009. OMCH is working closely with DSHS, other agencies and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2006	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2006	

Notes - 2009

SCHIP eligibility applies to children only

Narrative:

These data come from DSHS.

The Washington State governor has focused increased attention on health, specifically that of children. Any change in eligibility is impacted by DSHS forecast of caseload and budget.

In 2007, state legislation was passed to increase eligibility to state subsidized insurance to 250%

of the federal poverty level (FPL) for children, with an increase to 300% FPL in 2009. OMCH is working closely with DSHS, other agencies and stakeholders to increase enrollment of children through outreach to prospective families and to increase access through enhanced provider reimbursement for services and improvements in quality indicators.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:

Access to data from other programs and agencies is built from gaining the trust from these programs and agencies. OMCH, especially MCH Assessment, works to gain and maintain that trust. MCH Assessment maintains access to analytic data files and up-to-date documentation for: vital statistics, hospital discharge data, linked vital statistics and hospital discharge data, Pregnancy Risk Assessment Monitoring System data, Healthy Youth Survey, Behavioral Risk Factor Surveillance data, National Immunization Survey, National Survey of Children's Health, National Survey of Children with Special Needs, and in-house survey data. These data are used extensively for reports and presentations within OMCH, DOH and with external stakeholders to promote the use of data to inform policy discussions and program planning. In addition, the MCH Assessment manager participates on the Assessment Operations Group which is a cross-agency

group dedicated to communication among epidemiologists and assessment staff across the DOH. The group meets monthly and discusses analytic guidelines, methodology, surveys in the field, data-sharing, ethics, confidentiality, data security and IRB-related concerns, and potential collaborations.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	1	No
Healthy Youth Survey	3	Yes

Notes - 2009

Narrative:

There are two major factors that influence the OMCH's ability to maintain and/or improve this indicator. First, the Tobacco Settlement Fund has been critical to Washington's ability to capture data on smoking behaviors among school students. Every two years, Washington conducts the Healthy Youth Survey (HYS), which gathers information about behaviors among public school students. The Tobacco Settlement Fund contributes almost two thirds of the operational costs of the survey. Secondly, the HYS is led by a multi-agency work group. OMCH works with other state agencies and partners to develop questions for the HYS. The ability of this workgroup to resolve issues that cross agency boundaries has been instrumental in the on-going political support the survey has maintained.

IV. Priorities, Performance and Program Activities

A. Background and Overview

During the 2005 5-year Needs Assessment the office worked with partners throughout the state to identify nine priorities. In 2006-07, the office continued to consult with its partners and refine the priorities. Briefly, the changes involved merging two related priorities into one comprehensive priority and creating a new priority related to promoting health equity. Issue briefs were developed for each priority to clearly state the focus, objective, and expectations for setting each priority. The current list of MCH priorities is reflected in Form 14. See Section IIC for an updated Needs Assessment Summary about how the priorities are used to guide and describe the work of the Office of Maternal and Child Health.

The 5-year needs assessment completed in 2005 was coordinated with the development of a 5-year organizational and performance plan. The needs assessment describes the process and the products generated during this assessment and planning period. It includes population priorities, performance measures, activities, and outcome measures. The 5-year organizational and performance plan includes an assessment of the work we do and how we do it in relation to the 9 priorities developed through the 5-year needs assessment. One result of these efforts was being able to contribute to the Community and Family Health (CFH) Division's 2-Year Strategic Plan. The 2005 Needs Assessment process and resulting MCH priorities helped shape the CFH Strategic Plan and served as the basis for developing the Division's priorities.

The 5-year needs assessment included stakeholder involvement, data collection and analysis, and a thorough review of program activities to redefine the priorities for the MCH population in Washington State. The priorities developed through the 2005 needs assessment process are very similar to those developed in the 2000 needs assessment; however, they are more universal and address the needs across the MCH population rather than specific groups within the MCH population. The 2005-09 priorities represent our goals for sustaining and improving the health of women, infants, children, adolescents, and their families. The needs assessment process served to reaffirm that Washington's MCH programs are appropriately focusing resources on the most pressing needs of the MCH population in the state.

In most cases, the needs reflected in the 2005-09 priorities are more pronounced than they were in previous years due to significant reductions, and in some cases complete elimination, of program funding at the federal and state levels, and increased economic hardship statewide. Maternal and child health programs throughout the state continue to face financial challenges. The MCH priority outcomes developed through the 2005 Needs Assessment help guide discussions and ultimately decisions about budget cuts and program alignment with state and national performance measures. MCH Block Grant reductions most significantly affect National Performance Measures 1, 3, and 4 and State Performance Measure 5. Results of budget cuts are described in the performance measure narratives.

Detailed descriptions of OMCH's work on the national and state performance measures are provided in this section under items, "C. National Performance Measures," and "D. State Performance Measures." Three new state performance measures are introduced in the 2009 application and 2007 annual report. The new measures represent process measures that will, over time, lead to the development of outcome measures. The new outcome measures will be aligned with the MCH priorities and will measure the collective efforts of multiple sections in the office.

B. State Priorities

2005 -- 2009 OMCH Priorities

As part of the 2005 Five Year Needs Assessment, OMCH developed nine priorities. A crosswalk between the 2000 - 2004 priorities and the 2005 - 2009 priorities and a crosswalk between the old

state performance measures and the new state performance measures are included with the 2006 Application and 2004 Annual Report.

The following summarizes the relationship between Washington State's OMCH priorities and the state performance measures, national performance measures, outcome measures, and health systems capacity indicators.

//2009/This crosswalk tool was updated for the 2009 block grant application and 2006 annual report to reflect the removal of some state performance measures and the addition of new ones.//2009//

Adequate nutrition and physical activity

NPM11, 15
OM 1-5
SPM07
HSCI 5, 9a
HSI 1a-b, 2a-b

Lifestyles free of substance use and addiction

NPM10, 15
OM 1-5
SPM08
HSCI 1, 9b
HSI 1a-b, 2a-b, 3a-c, 4a-c

Optimal mental health and healthy relationships

NPM02, 6, 11, 16
OM 6
SPM09
HSCI 4

Safe and healthy communities

HSCI 1
NPM10, 16
OM 6
SPM08, 9
HSI 3a-c, 4a-c

Health Equity

SPM10

Healthy physical growth and cognitive development

NPM06, 11, 12
SPM07, 8, 9,

Sexually responsible and healthy adolescents and women

NPM08, 18
SPM01, 8, 9
HSCI 4
HSI 5a-b

Access to preventive and treatment services for the MCH population

NPM03-7, 9, 12-14, 17-18
OM 1-5
SPM01, 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
 SPM06, 8, 10
 HSCI 2-5, 7

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	2003	2004	2005	2006	2007
Annual Performance Objective	99.7	99.7	95	100	100
Annual Indicator	89.3	100.0	100.0	98.9	100.0
Numerator	50	88	99	91	101
Denominator	56	88	99	92	101
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	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

2007 data are provisional.

Notes - 2006

PERFORMANCE OBJECTIVES: The Newborn Screening program expects to maintain 100% of screen positive newborns receiving timely follow up. Therefore, for the period of 2007-2012, the future objectives will be 100%.

The percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, hemoglobinopathies, and congenital adrenal hyperplasia with appropriate referral. Over time laboratory cutoffs have been adjusted for some conditions to decrease the detection of infants with conditions that are NOT clinically significant and don't require treatment.

These data come from Form 6. The numerator is the number of live born infants born 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 2006, 99% of newborns received a newborn screening. The state currently screens for PKU, congenital hypothyroidism, galactosemia, sickle cell disease, congenital adrenal hyperplasia, MCAD deficiency, biotinidase, maple syrup urine disease (MSUD), homocystinuria and Cystic Fibrosis. See Form 6 for details on conditions.

Notes - 2005

PERFORMANCE OBJECTIVES: The Newborn Screening program expects to maintain 100% of screen positive newborns receiving timely follow up. Therefore, for the period of 2006-2010, the

future objectives will be 100%.

The percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, hemoglobinopathies, and congenital adrenal hyperplasia with appropriate referral.

These data come from Form 6. The numerator is the number of live born infants born in Washington that were reported by the Office of Newborn Screening as screened and were a confirmed case that received treatment. The denominator is the number that were screened and were a confirmed case. Only preliminary data exists for the year 2005. The state currently screens for PKU, congenital hypothyroidism, galactosemia, sickle cell disease, congenital adrenal hyperplasia, MCAD deficiency, biotinidase, maple syrup urine disease (MSUD), and homocystinuria. See Form 6 for details on conditions.

a. Last Year's Accomplishments

The Newborn Screening (NBS) Program tested over 99% of infants born in Washington State (with the exception of those born at the three military hospitals) for ten treatable disorders. (Fig 4a, NPM01, Act 1, 2) This includes Cystic Fibrosis (CF), which was added to the newborn screening panel on March 15, 2006. As with the other congenital disorders on the panel, diagnosis and treatment of the twelve infants with CF identified in the first nine months of screening helped prevent severe health complications of the disorder in infancy that might have otherwise occurred. The NBS Program worked closely with the region's CF clinical treatment and diagnostic centers to develop links to follow-up protocols and short and long-term services.

The NBS Program administered both the laboratory and follow-up services necessary for a complete newborn screening system. (Fig 4a, NPM01, Act 3-9) These included monitoring birth records to assess the completeness of screening, laboratory testing, advising health care providers about appropriate diagnostic and treatment follow-up response to test results, evaluating short and long term outcomes, and providing communication and education regarding the program. Appropriate follow up of abnormal screening results facilitated prompt diagnosis and appropriate treatment for virtually all screen positive infants. (Fig 4a, NPM01, Act 4) There was only one infant with a mild form of sickle cell disease that was lost to follow-up because of the parent's unwillingness to pursue the recommended diagnostic work-up and a clinical evaluation by a pediatric hematologist.

The NBS Program and the State Board of Health filed the paperwork to begin considering other disorders recommended by the American College of Medical Genetics for inclusion in Washington's screening panel. A Technical Advisory Committee convened to consider two of the five criteria that the Board of Health considers for adding new conditions to the screening panel: efficacy of early treatment and availability of effective screening and diagnostic tests. Next we convened a NBS Advisory Committee with broad representation from organizations and individuals who are affected by or interested in the newborn screening panel. This committee considered the work of the Technical Advisory Committee and evaluated the conditions against the other three criteria: prevention potential and medical rationale, public health rationale, and cost-effectiveness; before making recommendations to the Board.

In 2007, the state Legislature provided the NBS Program with state general funds to replace funding from a \$3.10 per birth fee that was authorized in 2006 to help support specialty clinic care. The same legislation also placed a \$3.50 per birth fee into the newborn screening statute RCW 70.83. This fee provides additional funds to support clinical care for those with disorders detected through newborn screening. Previous restrictions on these funds limited their use to supporting care for specific disorders. Current language allows us to use these funds to support any condition that is specified for newborn screening by the State Board of Health. In 2007, the Legislature also approved our request for state general funds to make up for lost revenue in our Metabolic Treatment Product program due to reductions in Medicaid reimbursement.

The NBS Program collaborated with researchers from the Pacific Northwest Research Institute (PNRI) to investigate type1 (also known as juvenile, or insulin dependent) diabetes through The Environmental Determinates of Diabetes in the Young (TEDDY) study. This study is funded through a grant from the NIH as part of a large multi-center, multi-national prospective study to look for environmental triggers type 1 diabetes. The study is recruiting participants from newborns who have high-risk genetic profiles. If parents consent to participate in the study, we provide the researchers a small sample of leftover blood from the child's newborn screening specimen. (Fig 4a, NPM01, Act 10)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Newborn Screening (NBS) Program will ensure that all screen positive infants receive timely diagnosis and, if needed, are enrolled in clinical management. In 2008, the Legislature approved a request for state general funds through June 2009 to ma				X
2. Perform screening tests for all mandated conditions on approximately 170,000 specimens.			X	
3. Follow-up to assure that appropriate diagnostic and clinical services are provided in response to screening test results.			X	
4. Contract with pediatric specialists and comprehensive care clinics to provide expert diagnostic and treatment services for infants with abnormal screening results.				X
5. Update and develop new professional and lay educational information via different venues: Web sites, provider manuals, on-site hospital visits, disorder-specific fact sheets and pamphlets, etc.				X
6. Determine family eligibility for financial and support services and coordinate through state and county CSHCN programs and medical homes.		X		
7. Purchase and distribute medically necessary formulas and low-protein foods for individuals with PKU and other metabolic disorders.		X		
8. Collect long-term outcome data to evaluate the benefit of various components of treatment, compliance, and intervention.				X
9. Maintain and improve data system linking newborn screening records with hearing screening.				X
10. Continue to work with researchers to evaluate potential screening tests for other treatable childhood disorders; currently Type 1 Diabetes, lysosomal storage diseases, and cytomegalovirus (CMV) infection.			X	

b. Current Activities

The Newborn Screening (NBS) Program works with the Board of Health in considering additional disorders for the screening panel. An Advisory Committee completed a review of the conditions against four of the Board's five criteria for adding new conditions. The criteria are: prevention potential and medical rationale, availability of treatment, public health rationale, and availability of suitable screening technology. All but one of the candidate disorders received majority support for all of the criteria. The condition that was not supported, 3 methylcrotonyl-CoA carboxylase deficiency (3MCC) was judged deficient in prevention potential and medical rationale and public health rationale. The NBS Advisory Committee then evaluated each of the conditions for cost benefit based on analyses developed by the NBS Program in consultation with a health economist. The 16 members of the advisory committee voted unanimously that the costs of

screening were justified by the potential benefits. Recommendations were presented to the Board at a public hearing on May 14, 2008. The Board adopted the recommendation to add 15 new conditions to the panel. The NBS Program will implement expanded screening to include any disorders that may be added to the newborn screening panel by the Board of Health in the summer of 2008.

c. Plan for the Coming Year

The Newborn Screening (NBS) Program will ensure that all screen positive infants receive timely diagnosis and, if needed, are enrolled in clinical management. In 2008, the Legislature approved a request for state general funds through June 2009 to make up for lost federal funding that has historically helped support clinical care for infants with phenylketonuria (PKU).

The NBS Program participates in evidence-based research studies that show promise for improving the health of infants and children by preventing illness and death caused by conditions identifiable at birth. Involvement in these studies is consistent with the goal of identifying conditions early and facilitating timely follow-up and clinical management to help prevent or ameliorate damaging effects from the condition. (Fig 4a, NPM01, Act 10)

1) We will work closely with the Early Hearing loss Detection, Diagnosis, and Intervention (EHDDI) program. EHDDI uses data from NBS records in a system that is based on the newborn screening specimen card and data system. The system allows them to perform follow-up of hospital based infant hearing screening similar to the follow-up we provide for the dried blood spot screening. (Fig 4a, NPM01, Act 9)

2) We will assist researchers from the Pacific Northwest Research Institute in retrieving residual dried blood spots for the National Institutes of Health funded project The Environmental Determinants of Diabetes in the Young (TEDDY) study. (Fig 4a, NPM01, Act 10)

3) We will work with the University of Washington Biochemical Clinic to evaluate a novel approach to detect lysosomal storage diseases in infants through newborn screening. This work is supported by a grant from the National Institutes of Health. We assisted in modifying the university's research proposal titled Novel Technologies in Newborn Screening for Lysosomal Storage Diseases to address concerns raised by our Washington State Institutional Review Board (WSIRB). The study has been modified to use anonymous (as opposed to identified) specimens that are residual to required screening. The study protocol approved by the WSIRB will focus on one of the lysosomal storage diseases, Fabry. It is hoped to expand to include the additional disorders Pompe, and mucopolysaccharidosis type 1 at a later time. The protocol will involve screening the residual specimens and submitting positive samples to the University of Washington for genetic testing for the disease. (Fig 4a, NPM01, Act 10)

4) We will work with researchers from the University of Washington in utilizing residual dried blood spot specimens for the Gustavus and Louise Pfeiffer Foundation study titled Role of Cytomegalovirus (CMV) Infection in Pediatric Hearing Loss. (Fig 4a, NPM01, Act 10)

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	2003	2004	2005	2006	2007
Annual Performance Objective	54.9	54.9	56	56.5	57
Annual Indicator	54.9	54.9	54.9	54.9	55.7
Numerator					

Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	55.7	55.7	55.7	55.7	55.7

Notes - 2007

Indicator data come 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.

Notes - 2006

PERFORMANCE OBJECTIVES: The National Survey of CSHCN has only been conducted twice, preventing the ability to conduct meaningful trend analyses. Goals will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 0.5% was chosen through 2012.

Notes - 2005

PERFORMANCE OBJECTIVES: The National Survey of CSHCN was only conducted once and new data won't be available until 2007, thus preventing the ability to conduct trend analyses. Trends will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 0.5% was chosen through 2010.

The source is the CHSCN Survey from the MCHB. No new data were available

a. Last Year's Accomplishments

In 2005-06 55.7% of parents of children with special health care needs (CSHCN) reported yes to this measure on the National Survey of Children with Special Health Care Needs (NS-CSHCN). This is approximately a 1% increase from 2001.

Office of Maternal and Child Health (OMCH) staff completed an MCH Family and Consumer Involvement Survey to help determine (1) current involvement of families and other consumers in MCH programs, (2) program and staff needs related to involving families and consumers, and (3) methods of improving or increasing family and consumer involvement in MCH programs. A summary of the findings will be used as one guide for selecting future activities to increase family and consumer involvement within OMCH. Those completing the survey indicated they want the following tools and strategies to increase use of family and consumer input: (1) development of a document or database of current involvement, (2) training and technical assistance for staff and for families, and (3) mentoring.

The National Survey of Children with Special Health Care Needs (NS-CSHCN), the National Survey of Children's Health, and other Washington State data sources were used to inform program and policy development.

The CSHCN Family Involvement Coordinator (FIC) attended sessions at Institute for Patient and Family Centered Care Conference focused on involving families and patients in needs assessment, survey design, and other areas of decision making within a hospital setting. (Fig 4a, NPM02, Act 1) The CSHCN FIC mobilized partnerships and informed and educated others through her involvement with the MCH Region X team, the Association of Maternal and Child

Health Programs (AMCHP) Family and Youth Partnership Committee, and the Parent Help 123 Advisory Board. The FIC facilitated and provided Medical Home presentations on family-professional partnership and family support and mentored family leaders. The role of families in telling their stories to influence policy and program development was demonstrated at an office all staff meeting. The presentation featured a DVD of parents telling their family health care stories at Children's Hospital and Regional Medical Centers (CHRM) Grand Rounds.

Parents participated in MCH Block Grant training and review of the 2008 application. Plans were confirmed to continue to expand the number of parents who are provided training to be familiar with federal and state MCH agencies and programs and to provide input in planning activities and to review the draft version of the block grant.

Washington Parent to Parent and Washington Fathers Network were involved in policy and program development through contract activities and participation in the Communication Network. The Family to Family Health Information Center partnership was enhanced by the coordinator's participation in Communication Network meetings along with other parent organization representatives. CSHCN worked closely with Washington Family to Family Health Information Center, Family Voices Region X, State Interagency Coordinating Council, Medical Home, LEND, and other WA Family to Family Network members to inform, educate, and mobilize partnerships. Families received stipends for their involvement.

The Autism Task Force (ATF) recommendations were drafted with parent input, and incorporated into a final report submitted to the Governor. In early 2007, the Legislature responded with funding to continue convening the ATF to develop implementation plans for the top recommendations and produce a guidebook for families. In July 2007, initial recommendations were prioritized to continue momentum toward legislative change.

"Effective Presentations: Teaching Through Stories," a family leadership training curriculum was developed and piloted through contract with CHRM. The CSHCN section began exploring potential sites for future trainings, including the annual AMCHP conference.

An analysis of the Web sites of the CSHCN Section's contractors resulted in better links between contractor's Web sites and with the CSHCN Section Web site.

Families reviewed and provided comments on Bright Futures Oral Health materials for children with special health care needs. Information informed the development of an action plan.

We supported community-based feeding teams, which include parents as members, through a contract with the University of Washington. (Fig 4a, NPM02, Act 2)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with MCH Assessment to provide ongoing analysis of available data on children with special needs, including family involvement, the NS-CSHCN, the NS-Children's Health and other Washington State data sources.				X
2. Ensure family representation in policy development through Medical Home Leadership Network, local health jurisdictions and other contractors, partnership with Washington Family to Family Network and through ongoing dialogue at CSHCN Communication Net				X
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

We are looking for ways to use the data from the MCH Family and Consumer Involvement Survey to enhance family involvement across the office.

Assessment and CSHCN staff are reviewing data from the National Survey of Children with Special Health Care Needs (NS-CSHCN) to assess progress in our state, and prepare for the 5 year needs assessment. CSHCN staff are taking program evaluation and assessment training. (Fig 4a, NPM02, Act 1)

Family advisors are involved in CSHCN regional meetings, Medical Home Leadership Network (MHLN) teams, Communication Network, Family To Family Health Information Center, MCH Block Grant training, Washington Family to Family Network, Medical Home strategic planning and other activities, Association of Maternal and Child Health Programs (AMCHP), MCH Region X, and Family Voices Region X. The "WE CAN Partnerships" grant proposal, epilepsy and oral health grants, and the "Effective Presentations: Teaching Through Stories" curriculum provide new ways for families to be involved. Additional roles for family leaders include assisting with establishing a way to select activities to improve our state's standing in the National Performance Measures.

The Autism Task Force continues through June 2008. Parents are providing input for a legislatively mandated guidebook being completed by the Autism Task Force, which is supported by staff from the CSHCN Section. (Fig 4a, NPM02, Act 2)

c. Plan for the Coming Year

The CSHCN Section will work with MCH Assessment on analysis of available data such as the National Survey of Children with Special Health Care Needs (NS-CSHCN), the National Survey of Children's Health, and other Washington State data sources on children with special needs, including family involvement.

MCH Family and Consumer Involvement Survey results will be used to create a plan for improving methods across OMCH to support family and consumer involvement.

Input obtained through MCH Block Grant training and review sessions, Medical Home Leadership Network (MHLN) team parents, epilepsy and oral health grant parent and youth advisors, and Washington Family to Family Network, will be reviewed and used as appropriate to update and enhance the Families as Decision Makers/Family Professional Partnership Strategic Plan. (Fig 4a, NPM02, Act 1)

CSHCN will ensure family representation in policy development through continued contracts with the University of Washington Medical Home Leadership Network, local health jurisdictions. Washington State Parent to Parent, Washington State Fathers Network, and other contractors. Family advisors and partners will continue to participate in CSHCN Communication Network meetings, MCH Block Grant trainings, MCH Region X, and AMCHP, including the Family and Youth Partnership Committee. CSHCN will pursue opportunities to provide Title V family leadership training, family advocacy and support resources, and family consultant tips and tools for parents and youth.

CSHCN will continue its partnership with Washington Family to Family Network, Family To Family Health Information Center, and Family Voices Washington and Region X.

New areas of focus will be the partnership with the University of Washington LEND Program in developing its family faculty and Autism projects. CSHCN will place increased emphasis on seeking opportunities to develop Medical Home family professional partnerships at the community level, using variations on a theme from the WE CAN Partnerships grant proposal. (Fig 4a, NPM02, Act 2)

"Effective Presentations: Teaching Through Stories," will be taught in two locations and families who take the training will be provided with opportunities to become trainers and use the curriculum in their own communities. The training will be provided to parents and youth who participate in the epilepsy grant.

Existing family consultant tips and tools will be consolidated into a revised family advisor training toolkit for use by WA family advisors.

Opportunities to market and promote CSHCN Section work products including the Autism Task Force Family Guidebook, recently developed care coordination tools, and newly translated Medical Home brochures and other documents will be pursued.

Community-based feeding teams, which include parents as members, will continue to be supported through a contract with the University of Washington. (Fig 4a, NPM02, Act 2)

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	2003	2004	2005	2006	2007
Annual Performance Objective	53.6	53.6	53	53	53
Annual Indicator	53.6	53.6	53.6	53.6	48.3
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	48.6	48.7	48.8	48.9	49

Notes - 2007

Indicator data come 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. A new annual performance objective of 48.5% was developed based on discussion with program staff. an annual increase of 0.1% was chosen through 2012.

Notes - 2006

PERFORMANCE OBJECTIVES: The National Survey of CSHCN has only been conducted twice, preventing the ability to conduct meaningful trend analyses. Goals will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 0.1% was chosen through 2012.

Notes - 2005

PERFORMANCE OBJECTIVES: The National Survey of CSHCN was only conducted once and new data won't be available until 2007, thus preventing the ability to conduct trend analyses. Trends will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 0.5% was chosen through 2010.

The source is the CHSCN Survey from the MCHB. No new data were available.

a. Last Year's Accomplishments

In 2005-06 48.3% of parents of children with special health care needs (CSHCN) reported yes to this measure on the National Survey of CSHCN (NS-CSHCN).

MCH Assessment and CSHCN sections authored a chapter for the 2007 edition of The Health of Washington State (HWS) report entitled "Medical Homes for Children and Adults." The HWS is a regularly updated report that assesses health status and related topics important to the Washington State Department of Health's mission of protecting and improving health in Washington. It provides information for making policy decisions, prioritizing efforts, managing programs, developing budgets, and allocating resources. The medical home chapter included both child and adult data from the 2003 National Survey of Children's Health and 2004-06 Washington State Behavioral Risk Factor Surveillance System (BRFSS). This is the first time a chapter on medical home has been included in the HWS report. (Fig 4a, NPM03, Act 1)

Parents, state agencies, medical home teams, and others revised the Washington State Medical Home Strategic Plan and agreed on a common definition for Medical Home. CSHCN lead Department of Health, State Board of Health, and other agencies in sharing information about activities each was doing related to medical home. Medical homes were promoted through developing marketing tools, a conference of current medical home teams, and discussion of reimbursement for care coordination. The Washington State Medical Home website, www.medicalhome.org, was expanded to include the additional tools for providers and parents. The website and tools were promoted through the development and distribution of a Medical Home bookmark.

CSHCN worked with the Catalyst Center to form a Care Coordination Team within a Medical Home workgroup. The workgroup included representatives from CSHCN, state agencies, health plans, the Medical Home Leadership Network (MHLN), Kids Get Care, the Washington Chapter of the American Academy of Pediatricians, Children's Hospital and Regional Medical Centers, Family Voices, and the Office of Superintendent of Public Instruction to develop a Washington State definition of care coordination and build financing strategies for care coordination within the medical home model. These strategies included identification of CPT codes that allow for billing for elements of care coordination and medical home. Another strategy was to participate in activities related to legislation that encourages medical homes for all. A Care Coordination fact sheet was developed by the workgroup to use as talking points for legislative activities and to share with their own agencies. (Fig 4a, NPM03, Act 2)

CSHCN funded care coordination for three Maxillofacial Review Boards, all of whom provide family-centered care and assure all children seen by the Boards have a medical home.

Local medical home teams aimed to better coordinate care for families who seek specialty medical services outside their local areas. (Fig 4a, NPM03, Act 3)

CSHCN convened a meeting of CSHCN contractors to ensure all CSHCN-sponsored websites linked resources and materials related to medical homes for ease of use for providers and families.

MCH Assessment and CSHCN developed a Medical Home fact sheet and a Medical Home Data Monograph, using data from 2003 National Survey of Children's Health. Data from this monograph was presented to the Medical Home Strike Team and shared widely with medical home partners. These documents provided a platform for advances in Medical Home awareness and promotion.

New state legislation that became effective in July 2007 extended Medicaid and other publicly-funded health coverage for children and encouraged links to medical homes.

The Early Childhood Comprehensive Systems program (Kids Matter) promoted Medical Home as a strategy to enhance access to health care. The Kids Matter project manager is on the Medical Home Strike Team.

Through a contract with the University of Washington, CSHCN nutrition network dietitians have integrated training and activities with the MHLN.

The Child and Adolescent Health section included Medical Home objectives in their strategic plan including (1) Medical Home concept be understood and endorsed among early childhood and adolescent health providers; and (2) Bright Futures Health Guidelines be integrated with medical home activities/contracts.

CSHCN and MCH Oral Health Program introduced and promoted Medical Home concepts to dental providers. (Figure 4a, NPM03, Act 4)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with MCH Assessment to provide analysis of available data on children with special needs, including the NS-CSHCN, the NS-Children's Health and other Washington State data sources.				X
2. Contract with the Medical Home Leadership Network to support the Medical Home website, increase awareness of medical homes statewide and build the Medical Home Leadership Network.				X
3. Contract with local health jurisdictions for activities that increase awareness of, access to, and staff participation in medical homes within their communities.		X		
4. Provide leadership to spread the medical home concept through strategic planning.				X
5. Implement the Epilepsy Grant to promote medical homes for children and youth with epilepsy.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH Assessment and CSHCN are reviewing data of the latest National Survey of Children with Special Health Care Needs (NS-CSHCN). (Fig 4a, NPM03, Act 1).

The CSHCN Program and Medical Home contractors will participate as planning members and team leaders for statewide Learning Collaboratives on medical homes. (Fig 4a, NPM03, Act 2)

The CSHCN Nursing Consultant is having discussions with Coordinators in each CSHCN Region on medical home promotion and participation. Maxillofacial Review Boards are encouraged to connect the children they serve to a medical home. (Fig 4a, NPM03, Act 3)

CSHCN Family Involvement Coordinator is working with Medical Home to increase family-professional partnerships at the local practice level.

CSHCN continues to work with state agency partners to implement the 2007 legislation to extend Medicaid and other publicly-funded coverage for children and connect them to medical homes. CSHCN will assist with outreach development of performance measures about medical home.

Kids Matter continues to promote Medical Home as one of their strategies to enhance access to health care.

Medical home concept was promoted in the Oral Health Regional meetings in 2008 focused on services for children with special health care needs. (Figure 4a, NPM03, Act 4)

Through a contract with the University of Washington, CSHCN nutrition network dietitians and Washington feeding teams continue integration with the MHLN. (Figure 4a, NPM03, Act 4)

c. Plan for the Coming Year

CSHCN will work with MCH Assessment to provide analysis of available data on children with special needs, including the NS-CSHCN, the National Survey of Children's Health and other Washington State data sources. Results will be shared with stakeholders statewide through activities such as updating the Medical Home Data Monograph and presenting results at stakeholder meetings. (Fig 4a, NPM03, Act 1)

Continue to contract with the MHLN to support the Medical Home website, increase awareness of medical homes statewide and build the medical home leadership network. CSHCN Program and UW Medical Home contractors will continue to work with Medical Home learning collaboratives in both planning and implementation in response to new legislation. CSHCN staff participate on several committees and subcommittees established by the Department of Social and Health Services (DSHS) to implement measures required by the legislation, including the incorporation of medical homes as a key component in improving the delivery of health care services for children in the state. (Fig 4a, NPM03, Act 2)

Continue to contract with local health jurisdictions for activities that increase awareness of, access to, and staff participation in medical homes within their communities. This will include providing ongoing information to CSHCN Coordinators and families about connecting children to medical homes and participating on medical homes as part of the MHLN. (Fig 4a, NPM03, Act 3)

CSHCN Program will provide leadership to spread the medical home concept through strategic planning, including ongoing participation in DOH Medical Home Strike Team, promotion of medical homes through grant activities, and continuing to work on interagency committees to improve reimbursement for activities related to medical homes and care coordination.

As a result of last year's legislation, Medicaid established a Children's Health Improvement workgroup to plan and implement various components that could affect Medical Home. OMCH staff sit on multiple workgroups

Through a contract with the University of Washington, CSHCN nutrition network dietitians and Washington feeding teams will continue integration with the MHLN.

CSHCN will continue to promote Medical Home concept in the Oral Health Grant for children with

special health care needs. (Fig 4a, NPM03, Act 4)

CSHSN will promote the medical home concept to families, providers, care coordinators and specialists through the "Epilepsia en Washington" federal grant. (Fig 4a, NPM3, Act 5)

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	2003	2004	2005	2006	2007
Annual Performance Objective	64.4	64.4	63	64.5	66
Annual Indicator	64.4	64.4	64.4	64.4	65.3
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	67.5	69	70.5	72	73.5

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

PERFORMANCE OBJECTIVES: The National Survey of CSHCN has only been conducted twice, preventing the ability to conduct meaningful trend analyses. Goals will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 1.5% was chosen through 2012.

Notes - 2005

PERFORMANCE OBJECTIVES: The National Survey of CSHCN was only conducted once and new data won't be available until 2007, thus preventing the ability to conduct trend analyses. Trends will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors, policy changes in other state agencies, and program decisions about how these factors could influence future targets. An annual increase of 1.5% was chosen through 2010.

The source is the CHSCN Survey from the MCHB. No new data were available.

a. Last Year's Accomplishments

In 2005-06 65.3% of parents of children with special health care needs (CSHCN) reported yes to this measure on the National Survey of Children with Special Health Care Needs (NS-CSHCN). This is essentially the same as in 2001 (64.4%)

MCH Assessment and Children with Special Health Care Needs (CSHCN) staff planned for analyzing insurance coverage data from the 2005--2006 NS-CSHCN once it was released. (Fig 4a, NPM04, Act 1)

CSHCN worked on making improvements to the Child Health Intake Form (CHIF) data collection system and to improve the quality of the data. Strategic Services provides support to Local Health Jurisdiction (LHJ) staff to improve reporting and use of their local data. This data provides information to track trends in insurance coverage as well as other information about children. The data is shared with the Medicaid agency's Exemption Unit so that children with special health care needs can opt out of managed care at the family's request. Of the more than 11,000 children enrolled in Title V local programs, fewer than 500 have requested to opt out of managed care. This speaks to the level of services that the Medicaid agency requires the contracted health plans providing managed care to offer to Medicaid clients. Additionally, because of provider concerns about reimbursement rates, providers are not always willing to provide services to children with fee-for-service Medicaid. (Fig 4a, NPM04, Act 2)

Many partners, including health plans, attended the quarterly CSHCN Communication Network meetings. The group routinely discussed access and financial coverage issues. At one meeting significant time was spent on finding out more about new publicly funded health coverage, Cover All Kids, which became law in July 2007. The Network group also had a presentation from the Medicaid agency's Transportation and Interpretation Unit to clarify how these services can be accessed.

Cover All Kids increased publicly funded health insurance to children in families with incomes at or below 250% FPL beginning July 2007, and will change to 300% Federal Poverty Level (FPL) beginning January 2009. CSHCN staff are active members of the Outreach Workgroup and the Quality Assurance and Reimbursement Workgroup which were formed to address the requirements of the legislation.

CSHCN staff continued to work closely with Medicaid and other statewide programs, such as Foster Care and Early Intervention and the Title XIX Advisory Committee, on health care access and coverage issues for children with special needs.

CSHCN worked with the Family to Family Health Information Center, Family Voices, Washington Family to Family Network (WFFN), Parent to Parent, Father's Network, Within Reach and other partners to increase families' access to information about financing and insurance.

In May 2007 CSHCN with partner state agencies Health and Recovery Services Administration and the Office of the Insurance Commissioner presented a session on funding sources for infants and toddlers with disabilities at the annual Infant and Early Childhood Conference.

The section worked with the state Medicaid agency, the Newborn Screening Program, and WIC to ensure coverage for therapeutic formulas.

CSHCN worked with the MCH Oral Health Program, the state Medicaid agency, other insurance companies to ensure adequate oral health coverage for children with special health care needs. (Fig 4a, NPM04, Act 3)

CSHCN provided limited funding for medically necessary diagnostic and treatment services not covered by another other source through the CSHCN Coordinators to assist clients in their communities. (Fig 4a, NPM04, Act 4)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with MCH Assessment to provide analysis of available data on children with special needs, including the NS-CSHCN, the NS-Children's Health and other Washington State data				X

sources.				
2. Collect and analyze statewide program information from Child Health Intake Form (CHIF) and Health Service Authorizations to identify children who have insurance.				X
3. Collaborate through various interagency forums such as Communication Network, Medicaid Integration Team, the Washington Family to Family Health Information Center (Family Voices) and interactions with managed care plans.				X
4. Provide limited diagnostic and treatment funds to fill gaps in medically necessary services for children with no or inadequate coverage.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH Assessment and CSHCN are reviewing data from the latest NS-CSHCN to measure progress in health coverage for children with special needs. (Fig 4a, NPM04, Act 1)

CSHCN is reviewing 2007 CHIF client data on third-party payment sources. Strategic Services supports LHJ staff using this data system. (Fig 4a, NPM04, Act 2)

CSHCN Communication Network, Medicaid Integration Team (MIT) and MCH Regional Teams continue to be venues to share information about medical coverage. Collaboration with health plans focuses on patient education and outreach strategies.

CSHCN actively assists HRSA in outreach activities to increase enrollment of children in publicly funded health coverage. Local CSHCN Coordinators are involved in informing families and assisting with applications.

CSHCN consults with the Within Reach Family Health Hotline and web-based ParentHelp123. Funding was reduced in July 2007 to Within Reach due to reductions in the MCH Block Grant to Washington State.

CSHCN continues to work with Family to Family Health Information Center/Family Voices, Parent to Parent, and Fathers Network developing strategies for health insurance access. (Fig 4a, NPM04, Act 3)

In July 2007 OMCH reduced funding for diagnostic and treatment services due to reductions in the MCH Block Grant. A very limited amount of funding is now available to fill gaps in services. (Fig 4a, NPM04, Act 4)

CSHCN continues to work with partners to ensure coverage for therapeutic formulas and oral health services.

c. Plan for the Coming Year

CSHCN staff and MCH Assessment staff will be doing further analysis, making presentations and developing documents such as fact sheets and issue briefs using 2005--2006 NS-CSHCN data for Washington state. Other data sources will also be explored for other applicable information about children with special needs in our state. (Fig 4a, NPM04, Act 1)

Continued improvements will be made to data collection for the Child Health Intake Form (CHIF) which is used by each of the local CSHCN programs to provide statewide data on children served by Title V in the state. CSHCN staff will continue to review and analyze the data submitted to identify children who have insurance and the types of insurance and other funding they rely on for services. (Fig 4a, NPM04, Act 2)

The Communication Network will continue to meet quarterly at the state level as a way to inform partners and share information about not only policies that affect children with special needs and their families, but to collectively solve access issues. The internal Medicaid Integration Team will continue monthly meetings between CSHCN state staff and HRSA staff to deal with specific issues regarding health coverage and to ensure CSHCN staff is aware of the most current information about publicly funded health coverage. CSHCN will work with Washington Family to Family Health Information Center, Family Voices, 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.

CSHCN staff will continue to participate in the Title XIX Advisory Committee and other interagency workgroups to implement new legislation that impacts benefit packages and provider reimbursement for enhanced services for children.

Epilepsia en Washington will be supporting Department of Social and Health Services (DSHS) efforts for outreach to the Hispanic population with appropriate materials and information about health coverage for their children, especially those with special health care needs. (Fig 4a, NPM04, Act 3)

CSHCN will continue to provide limited funding for medically necessary diagnostic and treatment services not covered by other sources. Increased tracking will be done to ensure projected needs and expenditures are within available funding limits. (Fig 4a, NPM04, Act 4)

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	2003	2004	2005	2006	2007
Annual Performance Objective	74.1	74.1	74.6	75	76
Annual Indicator	74.1	74.1	74.1	74.1	85.4
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	85.5	85.6	85.7	85.8	85.9

Notes - 2007

Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. 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 PM #05. New annual performance

objectives were established based on discussions with program staff. An annual increase of 0.1% was chosen through 2012.

Notes - 2006

PERFORMANCE OBJECTIVES: The National Survey of CSHCN has only been conducted twice, preventing the ability to conduct meaningful trend analyses. Goals will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 0.1% was chosen through 2012.

Notes - 2005

PERFORMANCE OBJECTIVES: The National Survey of CSHCN was only conducted once and new data won't be available until 2007, thus preventing the ability to conduct trend analyses. Trends will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 1% was chosen through 2010.

The source is the CHSCN Survey from the MCHB. No new data were available.

a. Last Year's Accomplishments

In 2005-06 85.4% of parents of children with special health care needs reported yes to this measure on the National Survey of Children with Special Health Care Needs (NS-CSHCN). Because of a change in methodology, this measure cannot be compared to the one reported in 2001.

The Children with Special Health Care Needs (CSHCN) section worked with MCH Assessment to analyze available data on community based systems for children with special needs, especially reviewing data sources in the state to inform this measure. (Fig 4a, NPM05, Act 1)

The Care Coordination within a Medical Home (CCMH) work group met monthly to further develop and implement effective financing strategies, including development of a fact sheet and identification of CPT codes for providers that cover elements of care coordination and medical home. Members of the workgroup disseminated care coordination information to interested stakeholders such as providers, parents, health plans, and other agencies. Care coordination activities were integrated into the Medical Home Strategic Plan.

Recommendations from the WISE Grant were used to guide planning activities, interagency collaborations, and grant proposals, including the Family to Family Health Information Center application, financing care coordination efforts, family leadership training activities, and strategic planning. (Fig 4a, NPM05, Act 2)

Results of an evaluation of the WorkFirst referral process between Department of Social and Health Services (DSHS) caseworkers and CSHCN Coordinators were shared with CSHCN Coordinators. Recommendations from the evaluation were implemented and additional training was provided.

CSHCN involvement with Within Reach's ParentHelp123 online access project continued to increase access to services in the community through online eligibility finder. CSHCN family advisors provided input into decision-making at Within Reach and provided in-service training to the Within Reach Information Resource Specialists about children with special health care needs, the CSHCN program and the six national performance measures about children with special needs.

Children's Hospital and Regional Medical Centers (CHRMC) developed a web-based Emergency Preparedness toolkit with community resources and instructions for parents as part of its current contract with CSHCN. A bookmark was developed and shared with community and agency

partners.

CSHCN maintained the links between the community-based feeding teams and the CSHCN Nutrition Network for referral services. A Child Health Note, Tube Feedings, has been added to the Medical Home Leadership Network (MHLN) website. (Fig 4a, NPM05, Act 3)

The Caring for Washington Individuals with Autism Task Force (ATF) submitted its report to the Governor December 2006. Recommendations were to improve the delivery and coordination of autism services in the state. (Fig 4a, NPM05, Act 3)

CSHCN implemented a competitive grant process to fund neurodevelopmental centers (NDCs) across the state. Two additional centers became grantees bringing the total to sixteen. The NDCs are funded with state dollars but interface with other Block Grant funded activities. (Fig 4a, NPM05, Act 4)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with MCH Assessment to provide analysis of available data on children with special needs, including the NS-CSHCN, the NS-Children's Health and other Washington State data sources.				X
2. Develop and implement strategies using the outcome evaluation from WISE pilots, the National Epilepsy Learning Collaborative and other organizations regarding community care coordination.			X	
3. Maintain the 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 children with special				X
4. Contract with Neurodevelopmental Centers (NDCs) to support community-based collaborations among NDCs, local health agencies, and other partners.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Staff are reviewing data from the latest NS-CSHCN about community systems. (Fig 4a, NPM05, Act 1)

CCMH work group addressed financing issues and developed a fact sheet and identified applicable CPT codes. Care coordination information was shared with stakeholders, and activities were integrated in the Medical Home Strategic Plan. (Fig 4a, NPM05, Act 2)

The section worked to improve collaboration between community-based feeding teams and the CSHCN Nutrition Network and MHLN. CSHCN and staff at University of Washington Center on Human Development and Disability (UW CHDD) trained 14 pediatric community nutritionists and provided training to two communities to establish feeding teams.

The section continues work with Within Reach's ParentHelp123 Family Health Hotline but with

reduced funding due to decreased MCH Block Grant funds. Family advisors provide in-services to the Within Reach hotline phone staff. Family advisors are participating in developing the Medical Home Strategic Plan.

The section is providing support to the ATF through June 2008, to develop implementation plans and estimated costs for the recommendations from the 2006 ATF report.

The CSHCN Nursing Consultant is visiting each CSHCN Region to survey CSHCN Coordinators to develop recommendations to prioritize activities to benefit clients and providers. (Fig 4a, NPM05, Act 3)

Using state monies CSHCN funds 16 NDCs to support infrastructure that delivers services in a medical home model. (Fig 4a, NPM05, Act 4)

c. Plan for the Coming Year

The CSHCN Assessment Coordinator will work with MCH Assessment to provide analysis of available data on children with special needs age 0-18 years whose families report the community-based service systems are organized so they can use them easily, including the NS-CSHCN, the NS-Children's Health and other Washington State data sources. (Fig 4a, NPM05, Act 1).

According to the NS-CSHCN, 2005/06, about 15% of the families interviewed in Washington responded that services were not organized in ways that they could use them easily. Taking sampling error into account, poorly organized, unorganized or lack of community-based service systems impact between 25,000 and 37,000 children with special health care needs from birth to 18 years of age in the state. The CSHCN section will work with stakeholders and others to develop ways to improve systems.

Through the project Epilepsia en Washington, we will be building on our present activities with the National Epilepsy Learning Collaborative, increasing the communications between parents, primary care providers, specialists, school nurses, and other organizations that manage the care of children and youth with epilepsy. We will be developing standardized tools, such as Seizure Action Plan form, Care Coordination Plan, and Medication List; and testing these tools with a variety of providers pursuing a common tool which could be used by all providers in our state. (Fig 4a, NPM05, Act 2)

The CSHCN section will work with the MCH Oral Health Grant staff to develop a training curriculum about oral health for children with special health care needs for health care providers and dental providers who serve this population in their community.

The section will maintain the links between the community-based feeding teams and the CSHCN Nutrition Network for referral services. (Fig 4a, NPM05, Act 3)

OMCH and the CSHCN section will evaluate the possibility of expanding the number of neurodevelopmental centers through a competitive granting process. (Fig 4a, NPM05, Act 4)

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	2003	2004	2005	2006	2007
Annual Performance Objective	5.8	5.8	8.3	9.8	11.3

Annual Indicator	5.8	5.8	5.8	5.8	47.3
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	47.4	47.5	47.6	47.7	47.8

Notes - 2007

Indicator data come 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 NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. New annual performance objectives were established based on discussions with program staff. An annual increase of 0.1% was chosen through 2012.

Notes - 2006

PERFORMANCE OBJECTIVES: The National Survey of CSHCN has only been conducted twice, preventing the ability to conduct meaningful trend analyses. Goals will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 1.5% was chosen through 2012.

Notes - 2005

PERFORMANCE OBJECTIVES: The National Survey of CSHCN was only conducted once and new data won't be available until 2007, thus preventing the ability to conduct trend analyses. Trends will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 1.5% was chosen through 2010.

The source is the CHSCN Survey from the MCHB. No new data were available.

a. Last Year's Accomplishments

In 2005-06 47.3% of parents of children with special health care needs reported yes to this measure on the National Survey of Children with Special Health Care Needs (NS-CSHCN). Because of a change in methodology, this measure cannot be compared to the one reported in 2001.

The Children with Special Health Care Needs (CSHCN) section worked with Adolescent Health Transition Project (AHTP) to move forward on the 5 year Strategic Plan for Adolescent Health Transition. A component of the Strategic Plan included obtaining input on tools and resources needed by providers to assist in transitioning youth to adult providers. Pediatric and adult providers who contacted the AHTP with questions were invited to form a Special Interest Group (SIG) to share interests and concerns in their practices and communities about adolescent health transition.

CSHCN and MCH Assessment staff developed a survey for primary care providers to obtain information on strategies that would help them accept adolescents into their practices when they age out of pediatric services.

CSHCN contracted with Center for Children with Special Needs at Children's Hospital and

Regional Medical Center (CHRMC) to conduct an on-line survey among youth with special needs that assessed their knowledge of medical care plans and how they used them. Key findings included (1) independence level was not significantly associated with age; (2) top preferred learning preferences reported by all respondents were web-based information and web-based interactive learning, (3) parents were identified as being the most helpful in promoting independence in respondents' health care. Top strategies for promoting independence included (1) having written information about the health condition in case of emergency, (2) school credit related to personal health care management, and (3) information about how to access new health care services if needed. Youth reported having someone to accompany them to their first appointment, someone to make sure their health records were transferred to their new doctors, and having a written health care plan were the strategies viewed as most helpful in supporting transition. The results of the survey will be used for program planning purposes, such as identifying opportunities for promoting self-management and providing support for teens and young adults as they transition to adult care. (Fig 4a, NPM06, Act 1)

The revised Adolescent Transition Notebook continued to be available on-line, in hard copy, and on CDs for those who work with adolescents with special health care needs. (Fig 4a, NPM06, Act 1)

CSHCN continued to partner with the Child and Adolescent Health (CAH) section of OMCH on the Washington State Partnerships for Youth (WSPY), working to develop an adolescent health plan. (Fig 4a, NPM06, Act 2)

CSHCN worked with MCH Assessment to analyze available data on youth with special needs. A white paper was developed on disability disparities in youth and publicized through broader youth initiatives to be used to develop strategies for addressing disparities. (Fig 4a, NPM06, Act 3)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with the University of Washington, Adolescent Health Transition Project and Center for Children with Special Needs at CHRMC to provide transition information about federal, state, and community programs and services.				X
2. Partner with the CAH section, OSPI, Family Educator Partnership Project, Epilepsy Foundation Northwest, National Epilepsy Learning Collaborative, Division of Developmental Disabilities and Division of Vocational Rehabilitation to enhance transition s				X
3. Work with MCH Assessment to provide analysis of available data, including the NS-CSHCN on adolescents with special needs, the Washington State Healthy Youth Survey and other data sources.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN contracts with AHTP assess the usefulness of provider tools. Ideas for future provider tool development are being obtained through the primary care provider survey and the SIG.

Membership in the SIG now includes providers from Sacred Heart Children's Hospital in Spokane and Group Health Cooperative to identify and link adolescent health transition activities statewide.

The AHTP promotes adolescent transition materials with an emphasis on school nurses, CSHCN Coordinators, families, providers, and other community partners. (Fig 4a, NPM06, Act 1)

CSHCN staff participate in Office of the Superintendent of Public Instruction's Building Bridges Project to provide materials, including the AHTP Transition Notebook, and contacts for developing the health component in pilot projects to help youth at risk to stay in school and be successful. The Epilepsia en Washington Project works with the University of Washington Regional Epilepsy Center to develop tools and material that will facilitate a smooth transition for children and youth with epilepsy from pediatric to adult providers. (Fig 4a, NPM06, Act 2)

CSHCN and MCH Assessment completed a survey in the spring of 2008 for primary care providers in regard to solutions for improved transition for youth from pediatric to adult care. Data entry was completed in May 2008 and results are being analyzed and then will be used for developing tools to help providers bring youth with special needs into their practices. (Fig 4a, NPM06, Act 3)

c. Plan for the Coming Year

CSHCN will contract with the University of Washington Adolescent Health Transition Project (AHTP) to provide information about transition from federal, state, and community programs and services. Activities will include maintenance of the AHTP website and continuation of the Special Interest Group composed of physicians interested in improving the health care system to transition youth with special needs from pediatric to adult providers. In addition, work will continue on the AHTP Notebook to include revisions recommended by a Washington State parent support organization. (Fig 4a, NPM06, Act 1)

CSHCN will continue to share information and promote the materials developed by the AHTP about adolescent transition with the CAH section, Office of the Superintendent of Public Instruction, the Epilepsy Learning Collaborative, Division of Developmental Disability and Division of Vocational Rehabilitation to enhance transition services and access to them. The Epilepsia en Washington Project will promote the creation of a Youth Advisory Group and a youth with epilepsy "tell your story" DVD to create awareness about the experiences of children and youth with this medical condition. CSHCN will continue to partner with the CAH section of OMCH and other stakeholders on the Washington State Partnership for Youth. (Fig 4a, NPM06, Act 2)

CSHCN will work with MCH Assessment to provide analysis of available data, including the 2005 -- 2006 NS-CSHCN on adolescents with special needs, the Washington State Healthy Youth Survey and other data sources. (Fig 4a, NPM06, Act 3)

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	2003	2004	2005	2006	2007
Annual Performance Objective	75	76.4	77	78	79
Annual Indicator	75.3	77.7	77.8	77.6	77.6
Numerator	61045	61962	62309	64358	
Denominator	81069	79745	80089	82935	
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	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	79	80	80	81	81

Notes - 2007

No data yet available.

Notes - 2006

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. Recent WA rates were as follows: 2003 = 75.3%, 2004 = 77.7%, and 2005 = 77.8%. Therefore, a one percent increase every two years was chosen.

Numerator data came from the National Immunization Survey 2006, 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 estimated number of children with completed immunizations. Denominator data came from the Washington State Office of Financial Management.

Notes - 2005

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. Recent WA rates were as follows: 2003 = 75.3%, 2004 = 77.7%, and 2005 = 77.8%. The 75th percentile state was at 83.9%. Therefore, a one percent increase every two years was chosen.

Numerator data came from the National Immunization Survey 2005, 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 estimated number of children with completed immunizations. Denominator data came from the Washington State Office of Financial Management.

a. Last Year's Accomplishments

In 2006 77.6% of children 19-35 months old received the full schedule of age appropriate immunizations. This is approximately a 1% increase from 2001.

By September 2007, Head Start and Early Childhood Education and Assistance Program gained access to the CHILD Profile Immunization Registry to aid parent report of immunization status.

The Immunization Program CHILD Profile (IPCP) and MCH Assessment reviewed medical records. IPCP and CDC continued national-level reviews of immunization rates for Washington.

IPCP contracted with local health jurisdictions (LHJs) for Assessment Feedback Incentives Exchange (AFIX) site visits on at least 25% of enrolled provider sites. New staff received technical assistance. IPCP continued strategic planning for Vaccines for Children/AFIX site visits. (Fig 4a, NPM07, Act 1)

IPCP encouraged Washington tribes to partake in projects to enhance vaccination coverage

rates. IPCP participated in the Washington State American Indian Health Commission. (Fig 4a, NPM07, Act 2)

IPCP worked with the State Board of Health on changes to the school and child care immunization requirements that update school and child care entry requirements for diphtheria, tetanus, and pertussis to align with the Advisory Committee on Immunization Practices' 2006 immunization schedule. The changes became effective July 1, 2007.

LHJs worked with providers to ensure proper use and storage of vaccines. Some LHJs administered vaccinations.

CHILD Profile Health Promotion sent parents well child checkup and immunization reminders. About 410,000 families receive the 1.3 million mailings each year. (Fig 4a, NPM07, Act 3)

The CHILD Profile Immunization Registry provider recruitment plan continued. The statewide expansion goal is to get 95% of children's records by the end of 2008. By the end of 2007, 78% were received. (Fig 4a, NPM07, Act 4)

IPCP worked toward the Healthy People 2010 objective of 80% immunization rates of children aged 19--35 months for the 4:3:1:3:3:1 series. (Fig 4a, NPM07, Acts. 3, 5)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with LHJs and others to complete immunization AFIX visits to enrolled private provider sites.				X
2. Contract with federally recognized tribes to help build capacity to assess immunization coverage rates.				X
3. Send parents age-specific reminders of the need for well-child checkups and immunizations via CHILD Profile Health Promotion.			X	
4. Maintain and increase the number of health care providers participating in the CHILD Profile Immunization Registry to improve access to historical records and use the system's immunization recommendation schedule.				X
5. 4th DTaP Initiative to increase timely administration of the 4th DTaP dose and overall immunization rates.		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Head Start/ECEAP use the registry.

IPCP and OMCH disseminate feedback and analyze results from hospital-based medical record and policy/procedure review.

IPCP contracts with LHJs to do VFC/AFIX site visits on 25% of enrolled immunization providers. State staff visit 5% yearly. Provider coverage rate data are shared. Site visit planning continues.

IPCP provides technical assistance to tribes to help raise vaccination rates. IPCP participates in the American Indian Health Commission.

IPCP and the State Board of Health work on changes to school and child care immunization requirements, aligning with the 2008 immunization schedules.

IPCP contracts with local health agencies who work with providers on proper vaccine use and storage. LHJs ensure access to vaccination by partnerships or direct administration.

CHILD Profile Health Promotion works to increase the number of parents who are sent well child and immunization reminders.

Implementation of the registry provider recruitment plan continues. The goal is to get 95% of records by the end of 2008.

IPCP works on several initiatives to improve vaccination rates by focusing on vaccines that bring rates down; education; sending parent reminders; guiding the ordering and receipt of vaccine; getting providers using the registry, giving them vaccine information, and visiting them.

Kids Matter tells providers of the importance of immunization and helps raise immunization of kids aged 0--5 years.

c. Plan for the Coming Year

As of April 2008 55% of Head Start/ECEAP programs have agreements to use the Immunization Registry. The goal is to have 100% of programs with agreements by December 2008. IPCP continues to work with schools to use the registry. This will help reduce convenience exemptions.

IPCP and MCH Assessment sections will disseminate survey feedback from a hospital-based review of medical records and policies and procedures, and will work with LHJs and hospitals.

IPCP will continue contracting with LHJs to complete VFC/AFIX site visits on at least 25% of all enrolled immunization provider sites in Washington. State staff will complete site visits to 5% of providers yearly. IPCP will continue providing training for new staff and technical assistance as needed. Data regarding provider immunization coverage rates will be shared with LHJs. IPCP will continue strategic planning for VFC/AFIX site visits, including increased use of the Immunization Registry.

IPCP will continue to encourage Washington tribes to participate in projects that include activities to enhance vaccination coverage rates. Technical assistance may be provided. IPCP will participate in the Washington State American Indian Health Commission.

IPCP will continue working with the State Board of Health on changes to school and child care immunization requirements. The changes update school and child care entry requirements to be consistent with the Advisory Committee on Immunization Practices' Recommended Childhood and Adolescent Immunization Schedules.

All local public health agencies will continue to have contracts with IPCP. LHJs will continue to work with local providers to ensure proper use and storage of vaccines. LHJs will continue assuring community access to vaccination either by administering vaccinations directly or facilitating vaccination through community partnerships.

IPCP will work to increase the percentage of children aged 19--35 months in the CHILD Profile Immunization Registry who have complete records from 41% to 50% by September 2009.

IPCP continues making progress toward the Healthy People 2010 objective of 80% immunization rates of children aged 19--35 months for the 4:3:1:3:3:1 series by: focused health promotion and community awareness efforts on vaccines that bring the series rate down; parent education on the importance of immunization; parents checkup reminders; facilitating the ordering and receipt

of vaccine; getting providers using the registry; giving providers vaccine information; and visiting provider offices. The current Hib shortage might affect rates.

Kids Matter (KM) will continue to inform and encourage early childhood providers of the importance of immunizations as a priority area in the KM Framework and included in the 5 required components of the Early Childhood Comprehensive Systems (ECCS) Grant. KM will continue to increase messages through ECCS work and integrate across components so there is increased recognition of immunizing kids aged 0--5 years.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	16.5	16.1	14	15.5	15.4
Annual Indicator	15.3	15.5	14.9	15.2	15.2
Numerator	1976	2006	1966	2062	
Denominator	128868	129120	132042	135315	
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	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	15.3	15.2	15.1	15	14.9

Notes - 2007

Data not yet available.

Notes - 2006

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. In 2005, discussions took place regarding the flattening off of the rate at 14.0. The 75th percentile state was at 15%, which is where Washington is at. Therefore, a 0.1 annual decrease was chosen.

Notes - 2005

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. In 2005, discussions took place regarding the flattening of the rate to 14.0. The 75th percentile state was at 15%, which is where Washington is at. Therefore, a 0.1 annual decrease was chosen.

a. Last Year's Accomplishments

A steady trend over the last decade indicates a decline in teen pregnancy and birth rates in Washington State, until 2003. Since then there were no significant changes in the rate. In Washington for 2003-2005 combined, live births to women 15-17 years old were significantly higher among Hispanics, American Indians, Alaska Natives, and blacks than among whites and Asians and Pacific Islanders.

The Healthy People 2010 goal is to reduce teen pregnancy rates. Washington State exceeded this goal in 2006 and fares well compared to other states. In 2006, 27.6 per 1000 female adolescents aged 15-17 became pregnant in Washington, the same rate as 2005. Pregnancy

rates are estimated from birth, abortion, and fetal loss records. It is possible to calculate birth rates, but not pregnancy rates by race and Hispanic origin, because reported abortion data frequently lacked information about race and Hispanic origin. Recently, we have been observing increases in pregnancy and birth rates among women over 25, and we are carefully watching the trends among younger women, especially given the demographic and economic changes in the state.

The Child and Adolescent Health section (CAH) revised and implemented a statewide abstinence public awareness campaign targeting 10-14 year olds and their parents. The campaign was launched in June 2006 and ran through July 2007.

CAH funded 12 sites to implement an abstinence-focused media literacy curriculum. Curriculum improvements were made based on evaluation results. (Fig 4a, NPM08, Act 2, 3)

The Healthy Youth Act, a new law, required the Office of Maternal and Child Health (OMCH) and the Office of the Superintendent of Public Instruction (OSPI) to review sexual health education curricula, to determine consistency with the Guidelines for Sexual Health Information and Disease Prevention. DOH, in coordination with OSPI developed an implementation plan for this law.

CAH worked with other state and local agencies to provide consultation and build capacity for comprehensive sex education and use of the Guidelines. (Fig 4a, NPM08, Act 4)
 CAH funded a school-based health center to deliver health care to students, including reproductive health care. (Fig 4a, NPM08, Act 5)

CAH sponsored a statewide conference on adolescent health, including information related to teen sexual behavior. This conference was attended by over 200 professionals and received positive evaluations. (Fig 4a, NPM08, Act 1)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Sponsor a statewide adolescent health conference for professionals working with youth.				X
2. Implement and monitor the abstinence-focused statewide public awareness campaign "No Sex No Problems" that targets youth ages 10 through 14 years and parents of young teens.			X	
3. Expand use of abstinence-focused media literacy curriculum (TISAM) to 12 community-based sites and continue evaluation.		X		
4. Partner with state and local agencies to continue to provide technical assistance, consultation and build capacity around comprehensive sex education through the use of DOH-OSPI Guidelines.				X
5. Fund two school based health centers to deliver health care and education to students, including reproductive health care.	X	X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CAH works with OSPI to review sexual health education curricula to determine consistency with the Healthy Youth Act OMCH reviewed over 60 curricula for medical and scientific accuracy. CAH and OSPI developed a list of curricula that comply with the Act, and will make them available to

schools and organizations across the state. OMCH in collaboration with OSPI and other organizations is planning four regional trainings for school personnel on the Healthy Youth Act (Fig 4a, NPM08, Act 4)

CAH staff attended conferences and trainings in an effort to research and investigate strategies to reduce disparities among target populations for teen pregnancies and sexually transmitted infections.

CAH is funding two school based health centers that provide health care to students including reproductive health care. CAH is funding 11 planning grants for school based health centers across the state. (Fig 4a, NPM08, Act 5)

Due to changes in state law, DOH was unable to continue the abstinence only media literacy projects in public schools. OMCH is conducting formative research and will implement a pilot project that will convert our abstinence only media literacy curriculum into a comprehensive program.

The future of the abstinence only media campaign is uncertain. CAH submitted an application to the Administration on Children and Families for the Abstinence Education Program and was not funded. CAH reapplied in January 2008, but has not received a response.

c. Plan for the Coming Year

While overall birth rates among youth aged 15-17 have remained the same over the last year, rates have increased among Hispanics, American Indians, Alaska Natives, and blacks. As a result, OMCH will expand the comprehensive based media literacy project to nine sites across the state focusing efforts on those groups with higher rates. We will evaluate the program.

OMCH will review curricula for medical and scientific accuracy as requested by the public. In coordination with OSPI we will update the curricula list annually. OMCH will continue to provide technical assistance, consultation and build capacity around comprehensive sex education. (Fig 4a, NPM08, Act 4)

CAH will expand funding for school based health centers that are providing health care to students including reproductive health care. CAH will fund a total of four centers. (Fig 4a, NPM08, Act 5)

OMCH plans to sponsor a statewide adolescent health conference, including a focus on health disparities related to teen pregnancies. (Fig 4a, NPM08, Act 1)

It is unlikely that CAH will continue the abstinence public education campaign and media literacy projects in 2008, due to the uncertainty of the Title V Abstinence Education Program. CAH will continue to explore other funding opportunities to address teen pregnancy prevention.

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	2003	2004	2005	2006	2007
Annual Performance Objective	49.3	49.6	55.5	55.5	50
Annual Indicator	55.5	55.5	50.4	50.4	50.4
Numerator	46009	45689	41460	41460	
Denominator	82900	82322	82261	82261	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	50	50	50	50	50

Notes - 2007

No data available

Notes - 2006

PERFORMANCE OBJECTIVES: The Smile Survey is only conducted every 5 years, and therefore only two data points exist, preventing accurate trend analysis. The 75th percentile state was at 49.4%. The Healthy People 2010 goal of 50% was chosen as the future objective through 2012, since it is attainable and will be an improvement on the historical decrease of dental sealants.

The Washington State Smile Survey is conducted by the Department of Health every five years. During the most recent survey in 2005, thirty nine Head start or ECEAP sites and sixty-seven public elementary schools with a 2nd or 3rd grade were randomly selected across the state during the 2004-2005 school year. All preschool 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. Elementary schools could choose to use either an active or passive consent process. 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 indicator of 50.4% is gathered from the 2005 SMILE Survey. Denominator data came from the Washington State Office of Financial Management. The numerator is derived from these data.

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

Notes - 2005

PERFORMANCE OBJECTIVES: The Smile Survey is only conducted every 5 years, and therefore only two data indicators exist, preventing accurate trend analysis. The 75th percentile state was at 49.4%. The 2000 result of 55.5% was chosen as the future objective through 2010, since it is attainable and is still an improvement from the 2005 result.

The 2005 Washington State Smile Survey is conducted by the Department of Health every five years. During the most recent survey, thirty nine Head start or ECEAP sites and sixty-seven public elementary schools with a 2nd or 3rd grade were randomly selected across the state during the 2004-2005 school year. All preschool 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. Elementary schools could choose to use either an active or passive consent process. 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 indicator of 50.4% is gathered from the 2005 SMILE Survey. Denominator data came from the Washington State Office of Financial Management. The numerator is derived from these data.

a. Last Year's Accomplishments

In 2005, 50.4% of third graders in public schools had protective sealants.

The Office of Maternal and Child Health (OMCH) implemented a statewide surveillance system to monitor the prevalence of dental sealants and other oral health indicators. The program began work on the oral disease burden document in 2006. Surveillance data were collected and analyzed and a report -- 'The Impact of Oral Disease on the Lives of Washingtonians - The Washington State Oral Disease Burden Document' was published in July 2007. The burden document was disseminated in the state through an official press release.

The OMCH oral health staff reviewed Medicaid and other data on provision of sealants through annual consultation with the Department of Social and Health Services (DSHS), HRSA and private providers delivering services in schools. (Fig 4a, NPM09, Act 3, 4)

Legislation passed in 2007 required the Department of Health to submit a report to the legislature evaluating the effectiveness of school sealant programs in the state. OMCH oral health program staff worked with the Office of Health Professions Quality Assurance (OHPQA) to develop an evaluation plan and data collection tools. (Fig 4a, NPM09, Act 3)

One member of the Oral Health Program staff was assigned as the state sealant coordinator. The coordinator worked with local health jurisdictions (LHJs) to implement new sealant programs. We were successful in starting a new sealant program in Whatcom County in 2006. (Fig 4a, NPM09, Act 2)

The OMCH offered oral health funding to all LHJs through the consolidated contracts process. LHJ activities may include support for, and referral to, sealant programs. (Fig 4a, NPM09, Act 1)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide funding to all LHJs through MCH consolidated contracts; LHJ provide sealants or contract or coordinate services with other dental providers.		X	X	
2. Promote and coordinate sealant programs around the state.				X
3. Developing evaluation plan for school sealant programs.				X
4. Collect statewide sealant data.				X
5. Work with state coalition to improve coordination in state for sealant programs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OMCH offered oral health funding to all LHJs through the consolidated contracts process for 2007-08. LHJs use these funds to provide sealants, either directly or through contracting or coordinating services with other dental providers. Nineteen counties have contracts with the Oral Health Program to provide school sealant services in their counties during 2007-08. (Fig 4a, NPM09, Act 1)

The OMCH Oral Health Program and OHPQA held discussions with the dental hygienists to discuss the data collection tool and parameter of the data that will be reported. Data collection for the sealant program started in December 2007. (Fig 4a, NPM09, Act 5, 4)

The Oral Health Program will work with LHJs and dental providers to start new school sealant programs. We are working with Spokane County to start new sealant programs in 2007-08. (Fig

4a, NPM09, Act 2)

The program is also working with the Washington State Oral Health Coalition to develop a statewide system to improve coordination with dental providers, LHJs and school administration and schools to increase access to sealant programs. (Fig 4a, NPM09, Act 5)

c. Plan for the Coming Year

LHJs that participate in providing sealants will provide OMCH Oral Health Program with a sealant data report. The data will be analyzed and a report will be submitted to the Legislature in December 2008.

The OMCH Oral Health Program will work with the LHJs, state coalition, and dental providers to identify new opportunities to expand the school sealant programs in the state. (Fig 4a, NPM09, Act 5)

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	2003	2004	2005	2006	2007
Annual Performance Objective	2.9	2.9	2.5	2.5	2.4
Annual Indicator	2.9	1.8	3.1	1.7	1.7
Numerator	37	23	39	21	
Denominator	1256446	1257310	1259643	1270785	
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	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	2.4	2.3	2.3	2.3	2.3

Notes - 2007

2007 Data are not yet available.

Notes - 2006

PERFORMANCE OBJECTIVES: Although there have been some fluctuations, over the past 12 years, an overall decrease has been observed, possibly due to use of seat belts, child safety seats, and airbags. Rates are very variable because of 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. The 95% confidence interval of the rate in 2006 was (1.0, 2.5) which includes the performance objective (2.5), and we conclude the indicator and the objective are not statistically significantly different. Using a conservative approach, a 0.1 decrease every two years was chosen with a leveling off at 2.3.

Notes - 2005

PERFORMANCE OBJECTIVES: Although there have been some fluctuations, over the past 12 years, an overall decrease has been observed. However, the 2004 rate looks like an anomaly.

Rates are very volatile because trends are based on many years of data, therefore future targets may not appear to align with the most recent results. Using a conservative approach, a 0.1 decrease every two years was chosen. The continued benefit of seat belts, child safety seats, and airbags may contribute.

a. Last Year's Accomplishments

In 2006, the rate of deaths to children ages 14 and younger due to vehicle crashes was 1.7/100,000.

Seventeen of the 30 local health jurisdictions (LHJs) that had Child Death Review (CDR) teams continued to do some CDR. CDR is a community-based process for reviewing information about unexpected deaths of children, such as motor vehicle crash deaths, in order to make prevention recommendations. The data that are collected are used to generate reports that provide statewide and county data. The reports are presented to county commissioners, boards of health, and community groups. (Fig 4a, NPM10, Act 2, 3)

CHILD Profile distributed car seat, booster seat, and air bag safety information to parents of children aged 0-6 years. A new booster seat law went into effect July 1, 2007 and was reflected in information sent to parents. (Fig 4a, NPM10, Act 1, 9)

The Office of Maternal and Child Health (OMCH) continued to maintain the CDR web-based reporting system and provide limited technical assistance for local teams. Aggregate data reports and prevention strategies were provided to those who requested them. (Fig 4a, NPM10, Act 3, 5, 7)

OMCH was the Department of Health (DOH) lead for the Healthy Youth Survey, a statewide biannual survey to public school students in 6th, 8th, 10th and 12th grades which collects information on adolescent behaviors and health status. The survey includes questions on substance use, driving while impaired, and seatbelt use. These data are used by state agencies and organizations such as the DOH Injury and Violence Prevention program and Safe Kids coalitions across the state to target injury prevention work. (Fig 4a, NPM10, Act 5, 6, 7)

OMCH collaborated with the Prevention and Trauma section of the DOH Office of Emergency Medical Services (EMS) and Trauma on shared activities and priorities. (Fig 4a, NPM10, Act 5, 6, 7, 10)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate car seat, booster seat, and air bag safety information to parents statewide through CHILD Profile.			X	
2. Continue CDR reviews by local teams.				X
3. Conduct surveillance of motor vehicle crash deaths to children through CDR process and disseminate data.				X
4. Participate in Harborview Injury Prevention grant.				X
5. Collaborate with DOH Office of EMS and Trauma to promote statewide injury prevention activities.				X
6. Collaborate with DOH Office of EMS and Trauma to develop State Injury Prevention Plan.				X
7. Provide and disseminate data reports identifying risk factors, population statistics and recommendations.				X
8. Transition to multi-state data base for CDR.				X
9. Promote new booster law to LHJs and other partners.			X	
10. Disseminate monthly report on Safe Kids to others in OMCH.				X

b. Current Activities

OMCH provides limited technical assistance to 17 local CDR teams. OMCH Assessment responds to requests for data. Since 2005, OMCH has worked with the National MCH Center for CDR to explore the use of a multi-state database. In Spring 2008 OMCH decided to use this database. A transition plan is being developed. (Fig 4a, NPM10, Act 2, 3, 8)

In 2008 DOH received new state funds for the CDR program. OMCH will work with the Injury and Violence Prevention Program (IVPP) in Health Systems Quality Assurance to allocate these funds for local CDR teams in local health jurisdictions.

CHILD Profile distributes car seat, booster seat, and air bag safety information to parents of children aged 0--6 years. Information is refined as statewide data changes. (Fig 4a, NPM10, Act 1)

OMCH works with the Harborview Injury Prevention Resource Center to implement the Harborview Injury Prevention Grant, a CDC demonstration project, with six local CDR teams. The goal of the project is to link regional EMS injury prevention coordinators to local teams. As part of the demonstration project, Harborview is refining a web-based decision-making tool so CDR teams can review promising practices, strategies and evidence-based interventions. (Fig 4a, NPM10, Act 4)

OMCH collaborates with the DOH Office of EMS and Trauma, Prevention and Trauma section on activities that are shared priorities including development of a State Injury Prevention Plan. (Fig A, NPM10, Act 5, 6)

c. Plan for the Coming Year

OMCH will work with the 17 local CDR teams and provide technical assistance. Transitioning to a multi-state data collection system has begun and will continue. Historical data will also be added over time to the database. (Fig 4a, NPM10, Act 2, 8)

CHILD Profile will send car seat, booster seat, and air bag safety information to parents of children aged 0--6 years. Information will be refined as statewide data changes. (Fig 4a, NPM10, Act 1)

The Healthy Youth Survey will be implemented in October 2008 in schools across the state.

OMCH will partner with Harborview Injury Prevention Resource Center to look for new opportunities to collaborate after the CDC demonstration project ends. The web-based decision-making tool will be made available to all CDR teams. Possibilities for collaboration include on-site and web-based trainings, additional tools for the website and more connections with local injury prevention programs such as Safe Kids and EMS. (Fig 4a, NPM10, Act 4, 10)

OMCH staff will collaborate with the Prevention and Trauma section of the DOH Office of EMS and Trauma, on shared activities. Implementation of the State Injury Prevention Plan will begin using community partners to market the plan. (Fig 4a, NPM10, Act 5, 6)

OMCH will help promote the new booster seat law which went into effect July 1, 2007 to LHJs and other partners to educate the public. (Fig 4a, NPM10, Act 9)

Safe Kids Washington will distribute a combined monthly report of all Washington State Safe Kids Coalitions activity to OMCH. (Fig 4a, NPM10, Act 10)

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	2003	2004	2005	2006	2007
Annual Performance Objective				52	53
Annual Indicator	57.2	52.0	55.5	58.8	58.8
Numerator	46036	42492	45857	47323	
Denominator	80482	81715	82625	80482	
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	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	53	54	54	54	54

Notes - 2007

Data not yet available.

Notes - 2006

This measure changed in 2006, from breastfeeding at hospital discharge to six months or more after delivery. Rates are based on the National Immunization Survey, and are highly variable due to small sample size. The 95% confidence interval for 2006 was (54.2, 63.4) which includes the performance objective.

The source of this data (58.8%) is the 2006 National Immunization Survey (NIS) which is reported for children born in 2003. The numerator is based on the proportion of women who reported breastfeeding at six months or longer. The denominator was obtained from the live birth file, for Washington residents.

Notes - 2005

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. Although data at six months has only been available for the past two years, breastfeeding initiation data has been stable for years, as has breastfeeding at two months. Therefore, a one percent increase every two years has been chosen.

This measure has changed from previous years, from breastfeeding at hospital discharge to six months or more after pregnancy. The source of this data (52.0%) is the 2004 National Immunization Survey (NIS). The 2003 NIS results were 57.2%. The numerator is based on the proportion of women who reported breastfeeding at six months or longer. The denominator was obtained from the live birth file, for Washington residents.

a. Last Year's Accomplishments

The Office of Maternal and Child Health (OMCH) recognized breastfeeding as one of the most important public health interventions for helping to ensure healthy mothers and infants.

First Steps and the Women, Infant and Children Supplemental Nutrition Program (WIC) reviewed data on breastfeeding initiation and duration. The goal of this review was to evaluate progress in relation to the Healthy People 2010 goals and determine what interventions and changes within program were needed. In 2007, 43.9% of women served by WIC continued breastfeeding their

infants until 6 months of age (WIC data), which was below the Healthy People 2010 goal of 50%. This number was also lower than the 44.4% that was reported last year. The decrease in WIC breastfeeding rates was partially due to the change in how WIC data was collected. Another data source, the "National Immunization Survey" showed Washington State breastfeeding rates at 6 months of age to be at 56.6%. While the WIC number represents 44,000 women, all of whom are under 185% of federal poverty level, the NIS is a small sample but representative of the entire population of new Washington mothers. (Fig 4a, NPM11, Act 4)

The following work promoted increased breastfeeding rates by mothers in Washington State, especially women served by Medicaid:

First Steps continued to require Maternity Support Service (MSS) providers offer breastfeeding health messages to all clients. Requiring breastfeeding health messages in MSS ensured it as a priority in the program and with local providers. (Fig 4a, NPM11, Act 1)

First Steps online breastfeeding training was developed and reviewed by state and local providers to ensure readability, best practice, and local and national resources to support breastfeeding duration. The easy to understand, online training provided best practice resources and encouraged providers to participate in the training. (Fig 4a, NPM11, Act 2)

First Steps planned to update a guide listing resources for breast pump acquisition. Due to time restraints and other program priorities this update was not completed. (Fig 4a, NPM11, Act 1)

CHILD Profile mailed health promotion letters that included information on breastfeeding to parents of children aged birth-6 years.

OMCH recommended lactation support at all hospitals with delivery services through the Perinatal Level of Care Guidelines document. (Fig 4a, NPM11, Act 3)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide breastfeeding support and education to low income women on Medicaid through First Steps Maternity Support Services (MSS)		X		
2. Provide training for MSS providers in breastfeeding support and teaching techniques.		X		
3. Recommend lactation support at all hospitals with delivery services through the Perinatal Level of Care Guidelines document.				X
4. Collect Women, Infants, and Children (WIC) Client Information Management Systems (CIMS) data that measures breastfeeding rates at six months, trends, and disparities between groups.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

First Steps requires that breastfeeding health messages are provided to all Maternity Support Services (MSS) clients. Parents of children aged birth-6 years receive CHILD Profile Health Promotion letters that include information on breastfeeding. (Fig 4a, NPM11, Act 1)

First Steps and WIC continue monitoring client breastfeeding rates by reviewing duration data yearly from WIC Client Information Management Systems (CIMS). (Fig 4a, NPM11, Act 2, 4)

First Steps updates and distributes provider Breastfeeding talking points to assist them in communications that will support clients in sustaining breastfeeding long term. (Fig 4a, NPM11, Act 1)

First Steps and WIC continue to notify providers about local breastfeeding trainings and resources (Fig 4a, NPM11, Act 2).

First Steps offers providers online breastfeeding training and evaluates staff knowledge based on their test results. (Fig 4a, NPM11, Act 2)

OMCH recommends lactation support at all hospitals with delivery services through the Perinatal Level of Care Guidelines document. (Fig 4a, NPM11, Act 3)

The Washington State Breast Feeding Coalition housed at WithinReach promotes breastfeeding state-wide, and promotes policy supporting breastfeeding.

c. Plan for the Coming Year

Washington continues to be a leader in breastfeeding initiation. Both State and National data tell us that women often return to work before 6 months post-partum and women report significant barriers to breastfeeding upon return to work. Progress on this measure will depend upon changing work place environments and public policy to be more supportive of breastfeeding mothers.

First Steps will annually evaluate breastfeeding duration data from WIC CIMS to determine our progress in relation to the Healthy People 2010 goals and to assess for program improvement. CHILD Profile mail health promotion letters that include information on breastfeeding to parents of children aged birth-6 years. (Fig 4a, NPM11, Act 4)

Assisting women to continue breastfeeding after returning to work may increase the percent of women who continue to breastfeed their babies at 6 months. MIH is beginning discussion regarding strategy development in this area.

One of these potential projects will be to develop a First Steps plan to update and distribute a resource guide on reduced cost or free breast pumps. Research shows that a high percentage of women stop breastfeeding when they transition back to work and school because of limited support, knowledge of breast pumps, and resources. Providing these resources to local agencies will help agencies to support client breastfeeding duration when clients return to work and school. (Fig 4a, NPM11, Act 1)

First Steps providers will continue to be required to provide breastfeeding health messages and document interventions and client outcomes. Requiring breastfeeding health messages will ensure breastfeeding continues to be a priority in the program and with local providers. (Fig 4a, NPM11, Act 1)

First Steps will update and redistribute the provider breastfeeding talking points to assist providers in improving communication with clients regarding breastfeeding duration (Fig 4a, NPM11, Act 1)

First Steps will offer the online breastfeeding training and will keep providers informed of other local trainings related to breastfeeding. Staff who are properly trained on breastfeeding, and how to sustain duration, will be more confident in providing information and supporting client needs.

(Fig 4a, NPM11, Act 2)

OMCH will recommend lactation support at all hospitals with delivery services through the Perinatal Level of Care Guidelines document. (Fig 4a, NPM11, Act 3)

The Washington State Breast Feeding Coalition housed at WithinReach will continue to promote breastfeeding state-wide, and promote policy supporting 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	2003	2004	2005	2006	2007
Annual Performance Objective	70	90	90	90	96.5
Annual Indicator	81.0	88.0	94.4	96.5	95.3
Numerator	59619	69958	76241	77792	80067
Denominator	73649	79507	80728	80607	84044
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	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	97	97.5	98	98.5	99

Notes - 2007

Data reported by the EHDDI program.

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.

Data are provisional.

Notes - 2006

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. The national goal is to reach 95%, but since WA state has already attained that, and 100% is not a realistic goal, a 0.5% increase per year was chosen.

In CY 2006, 96.5% of infants born in Washington hospitals received newborn hearing screening.

Notes - 2005

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. The national goal is to reach 95%, but since WA state has almost attained that, and 100% is not a realistic goal, a 0.5% increase per year was chosen.

In CY 2005, 94.4% of infants born in Washington hospitals received newborn hearing screening.

a. Last Year's Accomplishments

In 2006, all birthing hospitals in Washington State had Universal Newborn Hearing Screening (UNHS) programs and, starting in November of 2006, all civilian birthing hospitals were reporting hearing screening results to the Early Hearing-loss Detection, Diagnosis, and Intervention (EHDDI) program. The national goal for newborn hearing screening is to screen 95% of infants prior to discharge or at least by one month of age. Data from the EHDDI tracking and surveillance system revealed that 95% of infants born in the first nine months of 2007 received an initial hearing screen before hospital discharge. 1% of the infants born during that period did not receive a hearing screen because parents refused the newborn hearing screen. 65% of the infants who did not receive their hearing screen before hospital discharge received a hearing screen at a later time, typically before one month of age. Based on these data, Washington State successfully achieved this performance measure last year. (Fig 4A, NPM12, Act 1)

Because hearing screening is most beneficial in conjunction with appropriate follow up, the EHDDI Program works to improve all aspects of the program: screening, follow-up for re-screens and diagnostic audiology, referral to early intervention services, and availability of trained early intervention providers. The EHDDI Program contracted with Children's Hospital and Regional Medical Center (CHRMC) to provide technical assistance to birthing hospitals, which helps improve screening quality and keep referral rates low. Under this contract, CHRMC also hosted the Washington State UNHS Coordinator's Meeting for both the east (Spokane, May 18, 2007) and west (Seattle on June 8) sides of the state. The purpose of this meeting is to provide an opportunity for UNHS coordinators and screeners to discuss their programs with other coordinators and professionals, and to gather new ideas to bring back to their UNHS programs. (Fig 4A, NPM12, Act 2)

EHDDI also contracted with Washington Sensory Disabilities Services (WSDS) to provide ongoing early intervention training to counties. Last year's training expanded to include an additional 8 counties, and county representatives also had the opportunity to participate in an online interactive course called "Improving Early Hearing Detection and Intervention Service Delivery: Infants & Young Children with Hearing Loss, Ages Birth - 5 Years." Masters level trained early intervention providers who specialize in services for children who are deaf or hard of hearing provided consultation and one-on-one on-site coaching to county participants. The WSDS contract also provided funding for seven families with birth-to-3 year olds with hearing loss to attend the annual family weekend, May 11-13, 2007, in Ellensburg, WA. (Fig 4A, NPM12, Act 3)

In spring of 2007 the EHDDI program contacted early intervention providers within Washington State and perform a "kids count," documenting kids ages 0 to 3 with hearing loss who have been served at their facility within calendar year 2006. This information was matched with demographic data in the EHDDI tracking and surveillance system to determine the percent of infants with hearing loss who were enrolled in early intervention services by 6 months of age. The kids count study suggested that entry into early intervention services did not occur until, on average, 218 days after birth (i.e., 7.3 months) which is greater than the established goal of intervention by 6 months of age.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and maintain an EHDDI tracking and surveillance system.				X
2. Contract with Children's Hospital and Regional Medical Center (CHRMC) to promote universal newborn hearing screening in birthing hospitals.			X	
3. Contract with Washington Sensory Disabilities Services to provide early intervention training to county representatives.			X	

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This year the EHDDI program began sending two additional hospital reports to UNHS program coordinators. These reports are designed to assist coordinators in identifying infants who need follow-up services and communicating information regarding these infants, that may not have previously been reported, to the EHDDI program. (Fig 4A, NPM12, Act 1)

In November 2007 a third EHDDI Summit was held in Wenatchee, Washington. EHDDI Summits are designed to expand coordination, planning, and awareness among primary care providers, other health professionals, parents, and other key stakeholders in EHDDI follow-up for all Washington counties.

The EHDDI program is analyzing data from a parent survey conducted to identify barriers that families face when their infant is referred for audiologic evaluation. Knowledge of these barriers will help EHDDI program strategize solutions to decrease the number of infants referred for diagnostic evaluations who fail to receive them.

In March 2008 the EHDDI program began a National Initiative for Children's Healthcare Quality (NICHQ) Learning Collaborative. This Learning Collaborative is a nine month project designed for teams to share and implement ideas for more timely, appropriate, coordinated, and family-centered care.

The EHDDI Program is contracting with CHRMC to provide technical assistance to birthing hospitals (Fig 4A, NPM12, Act 2) and with WSDS to provide ongoing early intervention training to counties. (Fig 4A, NPM12, Act 3)

c. Plan for the Coming Year

The EHDDI program will analyze data from the tracking and surveillance system to determine whether the national 1-3-6 goals are being met and evaluate the efficiency of the EHDDI system. Washington State's screening data will be reported to the Center for Disease Control (CDC) for its annual EHDI survey. (Fig 4A, NPM12, Act 1)

There are several enhancements to the EHDDI tracking and surveillance system that need to occur in the coming year. The EHDDI program will identify and contract with an IT vendor to improve and update the surveillance system currently in place to track hearing screening and diagnostic results and generate hospital quality assurance reports. (Fig 4A, NPM12, Act 1)

The EHDDI program will work with audiologists on using the web-based application used to report diagnostic evaluation results. The EHDDI program will also explore audiologists' willingness to enter diagnostic evaluation results of infants with risk factors for late onset hearing loss and information on all children evaluated up to five years of age. (Fig 4A, NPM12, Act 1)

In the coming year, the EHDDI program will also be exploring the feasibility of linking with or sharing Department of Social and Health Services (DSHS) Infant Toddler Early Intervention Program (ITEIP) data to monitor whether infants with hearing loss are entering early intervention services by 6 months of age. (Fig 4A, NPM12, Act 1)

The EHDDI program will use results from the parent survey completed last year to strategize

methods for reducing perceived barriers to obtaining audiology services; involving parents and communities in proposed solutions

The EHDDI Program will continue contracting with CHRMC to provide technical assistance to birthing hospitals (Fig 4A, NPM12, Act 2) and with WSDS to provide ongoing early intervention training to counties. The WSDS trainings next year will include collaborative trainings between Office of Deaf and Hard of Hearing (ODHH) Regional Centers and local Family Resource Coordinators (FRCs). (Fig 4A, NPM12, Act 3)

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	2003	2004	2005	2006	2007
Annual Performance Objective	6.3	6.2	5	5	4
Annual Indicator	4.5	6.0	6.0	4.4	4.4
Numerator	73077	98000	97158	72158	72979
Denominator	1623925	1638000	1619803	1639962	1658605
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
	2008	2009	2010	2011	2012
Annual Performance Objective	4	4	3	3	3

Notes - 2007

No new data available for percent of uninsured kids. Rate same as reported last year.

Notes - 2006

PERFORMANCE OBJECTIVES: The 2006 data reflects the continuing trend based on data from 1998-2006. Decreasing targets were chosen due to the new law going into effect July 2007, granting children health insurance. Phase 2 of this law goes into effect in late 2009.

The data source is the 2006 Washington State Population Survey, from the Washington State Office of Financial Management (OFM). 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.

Notes - 2005

PERFORMANCE OBJECTIVES: The Washington State Population Survey is conducted every two years. Based on previous years' results, the future target of five percent was chosen through 2010.

The data source is the 2004 Washington State Population Survey, from the Washington State Office of Financial Management (OFM). The State Population Survey is a telephone-based survey that takes place every two years, therefore the 2004 percent was used to create 2005 estimates. 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.

a. Last Year's Accomplishments

In response to the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) Improvement Summit held in September 2006, the Child and Adolescent Health (CAH) section worked with key organizations and agencies to implement a plan to improve use of EPSDT services. That plan included four key areas: pilot projects; quality improvement; health literacy and incentives for a quality screening. (Fig, 4a, NPM13, Act 2)

CAH worked to improve the use of EPSDT services and access to health insurance, with Department of Social and Health Services (DSHS) (Medicaid and child welfare), Washington affiliate of the American Academy of Pediatrics, Medicaid-contracted health plans, and other partners. (Fig, 4a, NPM13, Act 1, 2)

The Children with Special Health Care Needs (CSHCN) section funded the University of Washington Adolescent Health Transition Project (AHTP) to increase access to health care for youth with special needs transitioning into adulthood. The AHTP facilitated a Special Interest Group (SIG) of pediatric and adult providers. Staff from the Office of the Insurance Commissioner presented information to the SIG about insurance options for youth with special health care needs. (Fig, 4a, NPM13, Act 1)

The Office of Maternal and Child Health (OMCH) funded WithinReach to operate the Family Health Hotline which provides callers with health information and referrals to social service programs and local resources.

In 2007 a law was passed by the state Legislature that expanded health insurance coverage for children up to age 19 years. Eligibility is phased in by the family Federal Poverty Level (FPL) through 2009. The law also provided publicly funded insurance coverage to be available to children in families above the FPL, through actual cost premiums. Outreach and education efforts were very effective in reaching not only newly eligible children, but also children who had previously been covered by Medicaid. Within the first three months after the law went into effect in July 2007, nearly 9,000 children were enrolled for coverage. Outreach efforts were undertaken at the community level through the Medicaid agency's contracting with local health jurisdictions.

CSHCN participated in Governor directed workgroups to help represent the needs of children in the state. The section also contributed by providing legislative bill analysis and participation on interagency committees to implement the measures in the bill when passed into law.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate with other key organizations and agencies to ensure that children, teens, and their families have access to health care services.				X
2. Facilitate a state-level meeting to develop a plan to improve utilization of the Medicaid Early Periodic Screening, Diagnostic, and Treatment program.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In response to the EPSDT Improvement Summit held in 2006, CAH is working with key partners to implement the plan to improve use of EPSDT. The plan includes four key areas: pilot projects, quality improvement, health literacy, and incentives for a quality screening. (Fig, 4a, NPM13, Act 2).

The Department of Health participates on an interagency workgroup to enhance health literacy and identify performance indicators for health care in response to a state law increasing the number of children eligible for state-sponsored health insurance. (Fig, 4a, NPM13, Act 1)

CAH funds two school based health centers (SBHC) and 11 SBHC planning grants. SBHCs are required to establish linkages to medical homes of students enrolled in the SBHC. (Fig, 4a, NPM13, Act 1)

CHILD Profile distributes the "Healthy Kids Now!" insert in its health promotion mailings to parents of children aged 3-5 years. The insert refers parents to the KIDS NOW toll-free phone number and the ParentHelp123.org Web site, a program of WithinReach. (Fig, 4a, NPM13, Act 1)

OMCH funds WithinReach to operate the Family Health Hotline which provides callers with health information and referrals to social service programs, local resources, and health insurance.

CSHCN works with DSHS in outreach efforts for the children's health insurance legislation. Efforts included RFP review for media outreach contract, assisting DSHS in contracting with local health jurisdictions for community outreach and facilitating data sharing with WIC.

c. Plan for the Coming Year

In response to the EPSDT Improvement Summit held in September 2006, CAH will continue to work with key organizations and agencies to implement the plan to improve utilization of EPSDT services. The plan includes four key areas: pilot projects; quality improvement; health literacy and incentives for a quality screening. (Fig, 4a, NPM13, Act 2).

The Department of Health will continue to participate on an interagency workgroup to enhance health literacy and identify performance indicators for quality health care. This is in response to the state law that increased the number of children eligible for state-sponsored health insurance. (Fig, 4a, NPM13, Act 1)

CAH plans to continue to fund two school based health centers (SBHC) and 11 SBHC planning grants. The contract will require SBHCs to facilitate linkages to medical homes for each student enrolled in the SBHC. Strategies include, raising awareness of eligibility for state-sponsored health insurance, and assisting students to navigate health care systems. (Fig, 4a, NPM13, Act 1)

CHILD Profile plans to continue to distribute the "Healthy Kids Now!" insert in its health promotion mailings to parents of children aged 3-5 years. The insert refers parents to the KIDS NOW toll-free phone number and the ParentHelp123.org Web site, a program of WithinReach. (Fig, 4a, NPM13, Act 1)

OMCH plans to continue to fund WithinReach to operate the Family Health Hotline which provides callers with health information and referrals to social service programs and local resources. Operators will continue to assess callers' need for health insurance for themselves and their children and referred them to health insurance programs as appropriate.

CSHCN will continue to partner with DSHS to implement the outreach and education component of the children's health insurance legislation. Ongoing efforts to link data sets at the state agency level will provide client listings for local health jurisdictions to utilize in contacting families to assist

in enrollment of their children without health coverage. OMCH will disseminate information to partners, especially family organizations, to assist them with having the most current and useful information to inform families about possible coverage options for their children.

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	2003	2004	2005	2006	2007
Annual Performance Objective				29	29
Annual Indicator	23.1	29.3	29.2	28.9	29.4
Numerator	19760	25713	24679	25518	26081
Denominator	85632	87693	84520	88312	88709
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
	2008	2009	2010	2011	2012
Annual Performance Objective	29	29	29	29	29

Notes - 2007

PERFORMANCE OBJECTIVES: Trend analyses and discussions with WIC staff resulted in future targets of 29% through the year 2012. Maintaining current rates would be an improvement, showing that more children were not becoming overweight.

The source of this data is 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 2007. The denominator is number of children, ages 2 to 5 years, who receive WIC services during the reporting year.

Notes - 2006

PERFORMANCE OBJECTIVES: Trend analyses and discussions with WIC staff resulted in future targets of 29% through the year 2012. Maintaining current rates would be an improvement, showing that children were not getting more overweight.

The source of this data is the Washington State Department of Health, Women, Infants, and Children (WIC) program. The numerator is the number of children, ages 2 to 5 years, that receive WIC services during CY 2006. The denominator is number of children, ages 2 to 5 years, that receive WIC services during the reporting year.

Notes - 2005

PERFORMANCE OBJECTIVES: Prevalence of overweight children is increasing both nationally and in Washington state. A variety of environmental, genetic, and lifestyle factors are influencing this trend. Only BMI's based on the 95th percentile and above are available for national and state comparison. From 2001-2003 Washington's rates for children on WIC were much lower than the national rate, but the last two years show higher rates than the nation. This may be due in part, to the fact that different states report on different populations. In Washington, the only data provided to CDC is for children on WIC. Other states may report on the entire population of children under 5. Importantly, data collection methodology changed in 2004, therefore the increase should be interpreted with caution since it is likely that much of the change is due to

changes in data collection. Between the years 2004-2005, Washington State had a smaller percent increase than that seen in the nation.

For specifically the 85th percentile and above, the last two years of Washington State data have shown a leveling out of the BMI for children ages 2 to 5 years. Therefore, a leveling out of this rate is expected to continue, and the future objectives are an extenuation of the 2005 rate. As more data and information becomes available, this will be revisited.

The previous measure was removed (the percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program) and incorporated into Health System Capacity Indicator (HSCI) #7. The source of this data is the Washington State Department of Health, Women, Infants, and Children (WIC) program. The numerator is the number of children, ages 2 to 5 years, that receive WIC services during CY 2005. The denominator is number of children, ages 2 to 5 years, that receive WIC services during the reporting year.

a. Last Year's Accomplishments

CHILD Profile materials were mailed to parents of children aged birth to 6 years. The mailings contained age-appropriate nutrition information, including two nutrition brochures, and new, full-color growth and development charts. Physical activity information was incorporated into materials on child growth and development. (Fig 4a NPM14, Act 1)

Child care health consultants provided nutrition and physical activity information to child care providers working with infants and toddlers, during consultations and trainings. Materials and references were added to the tool kit child care health consultants use for provider education. (Fig 4a NPM14, Act 3)

Child and Adolescent Health (CAH) coordinated with internal and external partners to promote nutrition and physical activity in young children. A session on physical activity was part of the Healthy Child Care Washington (HCCW) Conference in May 2007, attended by child care health consultants, First Steps community health workers, and other early learning and health professionals. (Fig 4a, NPM14, Act 2)

CAH promoted the use of Bright Futures guidelines and materials, including physical activity and nutrition. (Fig 4a, NPM14, Act 4)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate nutrition and physical activity information to parents statewide through CHILD Profile.			X	
2. . Coordinate with internal and external partners to promote nutrition and physical activity.				X
3. Child care health consultants continue to provide training and consultation regarding nutrition and physical activity.				X
4. Promote use of Bright Futures guidelines including Physical Activity and Nutrition.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Maternal and Child Health (OMCH) promotes nutrition and physical activity through partnerships with internal and external groups who work to promote healthy activities and prevent obesity in children and youth of all ages, their parents, and pregnant women. (Fig 4a, NPM14, Act 2)

CHILD Profile includes physical activity and nutrition information in the CHILD Profile health promotion mailings. (Fig 4a, NPM14, Act 1)

Child care health consultants, OMCH, and the Washington State Child Health and Safety Advisory Committee, have given more presentations to child care providers on improving physical activity and nutrition. Two graduate nurse interns in OMCH have also worked on this issue, compiling and evaluating reviews of programs. (Fig 4a, NPM14, Act 2, 3)

The new Bright Futures Guidelines emphasize the theme of maintaining healthy weight. Trainings on the new Bright Futures are being given within the Department of Health and to external partners, such as child care health consultants and MCH staff at local health jurisdictions. (Fig 4a, NPM14, Act 2, 4)

c. Plan for the Coming Year

Child care health consultants will continue to recommend and help child care providers implement programs or activities to improve nutrition and physical activity for their children and staff. (Fig 4a, NPM14, Act 2, 3)

Bright Futures Guidelines, 3rd edition, will be integrated into the work of child care health consultants and home visitors, through training and guidance provided through OMCH. (Fig 4a, NPM14, Act 2, 4)

CHILD Profile will continue to include physical activity and nutrition information in the CHILD Profile health promotion mailings. (Fig 4a, NPM14, Act 1)

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	2003	2004	2005	2006	2007
Annual Performance Objective				10	9.1
Annual Indicator		10.3	9.2	9.2	9.2
Numerator		8417	7602	7990	
Denominator		81715	82625	86845	
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	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	9.1	9	9	8.9	8.9

Notes - 2007

Data not yet available.

Notes - 2006

PERFORMANCE OBJECTIVES: WA State is already among the leading states in the nation. Looking at data trends, a 0.1% decrease every other year was chosen.

This indicator is based on the proportion of women reporting smoking in the last three months of pregnancy and is from the Pregnancy Risk Assessment Monitoring System (PRAMS) for 2006. The denominator are the number of women delivering babies during the year and are from the Washington State Department of Health Center for Health Statistics. The numerator is derived from this data.

State performance measure 2 (Percent of pregnant women abstaining from smoking) is being discontinued in the future because the information is already captured within this national performance measure.

Notes - 2005

PERFORMANCE OBJECTIVES: Trend analyses based on the past six years have shown a decrease in women smoking in the third trimester of pregnancy. Washington has one of the lowest smoking rates in the nation, so a flattened rate is envisioned. Therefore, a 10% target was chosen through 2010.

The previous measure was removed (percent of low birth weight infants among all liveborn) and addressed under Health Status Indicator (HSI) #2A. The indicator is based on the proportion of women reporting smoking in the last three months of pregnancy during the calendar from the Pregnancy Risk Assessment Monitoring System (PRAMS) for 2003. The denominator are the number of women delivering babies during the calendar year and are from the Washington State Department of Health Center for Health Statistics. The numerator is derived from this data. Proportions have remained relatively stable over the previous few years: 11.8% (2002), 9.9% (2001), and 11.1% (2000).

Data were unavailable for 2004 and 2005, therefore data reflects the year 2003.

a. Last Year's Accomplishments

Maternal and Infant Health (MIH) informed providers of the Medicaid benefit to encourage providers to perform the smoking intervention with pregnant women. (Fig 4a, NPM15, Act 1)

The required Maternity Support Services (MSS) smoking cessation performance measure interventions were conducted with over 15,000 MSS clients and documented in each client's chart by First Steps provider staff. The interventions included client centered education and referrals focused on tobacco cessation/reduction during pregnancy and reducing/eliminating prenatal and pediatric exposure to second hand smoke exposure. Billings were monitored for agency compliance in offering these interventions to all Medicaid clients. (Fig 4b, SPM02, Act 1)

Tobacco Cessation during Pregnancy Trainings continued for over 200 First Steps Providers, increasing compliance with the performance measure requirements and supporting client centered interventions. (Fig 4a, NPM15, Act 2)

Pregnancy Risk Assessment Monitoring System (PRAMS) data measured smoking rates before, during and after pregnancy, quit rates, relapse rates, third trimester smoking trends, and disparities among groups. (Fig 4a, NPM15, Act 3)

MIH and partners informed First Steps and medical providers about the FAX Back Referral system and Quit Line which aimed to increase the use of the fax referral. (Fig 4a, NPM15, Act 4)

MIH and First Steps staff distributed the "Smoking Cessation during Pregnancy" best practice booklet to improve the quality of smoking cessation intervention by medical professionals. (Fig

4a, NPM15, Act 5)

Data about smoking and efforts to reduce smoking during pregnancy were used to ensure that quality improvement is measured and shared with First Steps Providers. (Fig 4a, NPM15, Act 6)

WithinReach Family Health Hotline operators asked callers if anyone in the home smoked, and if so, offered referrals to the Quit Line. WithinReach continued to include Quit Line materials in prenatal packets and child health packet through June 2008. The mailings were discontinued in July 2008. WithinReach reported 1,302 callers to the Family Health Hotline identified as smokers and 222 were referred to the state Quit Line. Of these, 875 said they were pregnant and 643 said there was a child in the home. There was some duplication in these counts as a caller could be both pregnant and have a child in the home. (Fig 4a, NPM15, Act 7)

The Tobacco Champion Project was an opportunity for First Steps staff to receive extra motivational interviewing and systems change training. (Fig 4a, NPM15, Act 2)

Local health jurisdictions provided smoking cessation activities targeting pregnant women. (Fig 4a, NPM15, Act 8).

The Office of Maternal and Child Health (OMCH) assisted the Tobacco Program to implement Phase one of the CDC funded Quit Line enhancement project focused on pregnant women and relapse prevention. The purpose of this phase of the project was to conduct a "Quit for You, Quit for Two" social marketing campaign, increase public awareness about the benefits of quitting tobacco usage/exposure by pregnant and parenting women, and promote the Washington state Quit line. (Fig 4a, NPM15, Act 9)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote the Smoking Cessation provider benefit for pregnant women through OMCH collaboration with DSHS HRSA.				X
2. Increase smoking cessation among low income women on Medicaid by providing tobacco cessation intervention training to First Steps providers including new modules addressing relapse prevention and health disparities by providing culturally competent i				X
3. Collect and reference PRAMS data to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups.				X
4. Inform and educate professionals about the FAX Back Referral program.				X
5. Disseminate the best practice guide for smoking cessation to medical providers.				X
6. Share tobacco data with First Steps providers and perinatal providers.				X
7. WithinReach refers callers with tobacco in their home to the Quit Line and sends tobacco cessation materials to callers as appropriate.			X	
8. Local health jurisdictions provide smoking cessation activities.				X
9. Work with the Tobacco Program to implement their CDC funded Quit Line enhancement project that focuses on pregnant women and relapse prevention.			X	
10.				

b. Current Activities

MIH informs providers of the Medicaid smoking cessation benefit (Fig 4a, NPM15, Act 1) and is helping revise the "Smoking Cessation During Pregnancy: Guidelines for Intervention" booklet. Health care providers and others will receive the booklet via email and it will be available online. (Fig 4a, NPM15, Act 5)

The Tobacco Champion Project offers 187 First Steps providers additional motivational interviewing and systems change training. (Fig 4a, NPM15, Act 2). WithinReach offers Quit Line referrals. (Fig 4a, NPM15, Act 7) Local health jurisdictions receive funds to provide smoking cessation services to pregnant women. (Fig 4a, NPM15, Act 8)

Data about smoking during pregnancy, efforts to reduce smoking during pregnancy, and relapse prevention are compiled and shared with providers. (Fig 4a, NPM15, Act 6)

First Steps providers receive information about the FAX Back Referral system. (Fig 4a, NPM15, Act 4)

Training for First Steps providers includes new modules addressing relapse prevention and health disparities. (Fig 4a, NPM15, Act 2)

The Office of Maternal and Child Health helps the Tobacco Program implement Phase Two of the Quit Line enhancement project. The purpose of this phase is to conduct and follow up on surveys conducted with 138 First Steps provider staff. Results are used to evaluate and guide implementation of a pilot project to increase usage of the Quit Line FaxBack referral system. (Fig 4a, NPM15, Act 9)

c. Plan for the Coming Year

MIH will inform providers of the Medicaid smoking cessation benefit. (Fig 4a, NPM15, Act 1)

MIH and its partners will inform First Steps providers and medical providers about availability and use of the FAX Back Referral system to increase utilization of the Washington State Quit Line services targeted to pregnant and parenting women. (Fig 4a, NPM15, Act 4)

WithinReach will offer Quit Line referrals. (Fig 4a, NPM15, Act 7)

Local health jurisdictions will have access to MCH block grant funds to provide smoking cessation activities that target pregnant women. (Fig 4a, NPM15, Act 8)

MIH and its partners will facilitate and provide technical assistance to First Steps providers, including implementation of systems changes, and compliance with the First Steps Tobacco Cessation during Pregnancy performance Measure.

The Office of Maternal and Child Health (OMCH) will assist the Tobacco Program and partners to implement Phase Three of the CDC funded Quit Line enhancement project focused on pregnant women who smoke and relapse prevention by promoting the Fax Referral Incentive Promotion Project. This phase of the promotion will evaluate data from the pilot project and will complement the tobacco cessation performance measure currently conducted by over 450 First Steps staff and should not create additional work. The purpose of this phase will be to offer an incentive to over 500 pregnant women who smoke thereby increasing their willingness to fill out the fax referral form and receive a call from the Tobacco Quit Line. (Fig 4a, NPM15, Act 9)

Participating agencies will receive a package with fax referral forms, \$10 gift cards and materials designed to support tobacco interventions. First Steps staff can offer the incentive. If the client agrees to fill out the form with the provider, she will receive a \$10 gift card to a store that offers products for both mother and baby. Once the referral form is faxed to the quit line, the client will

receive a call at a convenient time within 48 hours. At that time, they can choose to enroll in the free, pregnancy-specific tobacco cessation program offered by the quit line.

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	2003	2004	2005	2006	2007
Annual Performance Objective	8.5	8.4	8.9	8.9	8.8
Annual Indicator	9.6	10.2	9.1	8.5	8.5
Numerator	42	45	41	39	
Denominator	439282	442824	450402	459182	
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	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	8.7	8.6	8.5	8.4	8.3

Notes - 2007

Data not yet available.

Notes - 2006

PERFORMANCE OBJECTIVES: Trend analyses and interdepartmental discussions took place to choose future objectives. Rates are very variable and trends are based on many years of data, so future targets may not appear to align with the most recent results. The 95% confidence interval (6.1, 11.6) which includes the performance objective. Because of the small numbers, the rates are highly variable. A conservative annual decrease of 0.1 in the rate/year was chosen.

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 rate is per 100,000 population. The source for the data is the Washington Center for Health Statistics Death Certificate files (updated annually between September and October) and the Office of Financial Management, Intercensal and Postcensal Estimates of County Population by Age and Sex.

Notes - 2005

PERFORMANCE OBJECTIVES: Trend analyses and interdepartmental discussions took place to choose future objectives. Rates are very volatile because trends are based on many years of data, therefore future targets may not appear to align with the most recent results. A conservative annual decrease of 0.1% was chosen.

a. Last Year's Accomplishments

The Office of Maternal and Child Health (OMCH) worked with the Office of Emergency Medical Services and Trauma System (OEMSTS) to implement the Youth Suicide Prevention Plan (YSPP) to reduce teen suicide. YSPP activities focus on awareness, early intervention skills, and engaging communities to address suicide through prevention, early intervention, and skill building. Efforts continued to expand statewide partnerships. (Fig 4a, NPM16, Act 1, 4)

OMCH supported a database on child deaths and provided technical assistance to local Child

Death Review (CDR) Teams. The database lists strategies for youth suicide prevention. (Fig 4a, NPM16, Act 2, 3)

Local health jurisdictions used Title V block grant funds for youth safety activities, work with Emergency Medical Services (EMS) and other first responders on suicide response, and work with school personnel on emergency preparedness and safety plans. (Fig 4a, NPM16, Act 1, 4)

OMCH collaborated with the Prevention and Trauma section of OEMSTS on common priorities. Youth suicide is a focus area in the Washington State Injury & Violence Prevention Guide. (Fig 4a, NPM16, Act 1, 5)

OMCH advised the Harborview Injury Prevention Resource Center and supported a CDC demonstration project with six local CDR teams. A web-based decision-making tool was refined so that teams can review promising practices, strategies and evidence-based interventions. Suicide prevention was a designated area on the tool. (Fig 4a, NPM16, Act 7, 8)

In addition, OEMSTS applied for and received funding from the Substance Abuse Mental Health Services Administration (SAMHSA) for federal youth suicide prevention support. These funds augment state funded efforts and support work in more targeted communities such as Native American Tribes, homeless youth serving agencies, and college campuses. It also allows for the revision and updating of the state youth suicide prevention plan that was created in 1995.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with DOH Office of EMS and Trauma to support Youth Suicide Prevention Program (YSPP).			X	
2. Maintain the Child Death Review (CDR) database and provide local teams with strategies for suicide prevention in the community.				X
3. Conduct surveillance of suicide deaths through CDR and disseminate data.				X
4. Promote training and strategies of suicide prevention to local health jurisdictions and other partners.				X
5. Participate in the development and review of the State Injury Prevention Plan which includes a chapter on suicide.				X
6. Encourage local health jurisdictions to incorporate youth safety activities in their contract activities.			X	
7. Promote use of a web-based tool to CDR teams that describes best practices and recommendations for suicide prevention.			X	
8. Work with Harborview Injury Prevention Resource Center to make their web-based decision tool, which contains strategies and best practices, available to all CDR teams.				X
9.				
10.				

b. Current Activities

The OEMSTS leads implementation of statewide youth suicide prevention activities. OMCH provides support by promoting the programmatic activities, providing linkages to related activities, and providing critical data sources. (Fig 4a, NPM16, Act 1, 3)

OMCH provides 2006 Healthy Youth Survey data and collaborate with the DOH Division of Epidemiology, Health Statistics, and Public Health Laboratories to evaluate the Youth Suicide

Prevention Program (YSPP) by comparing data from schools implementing the program to schools not utilizing the program.

OMCH supports a database on child deaths and provides technical assistance for the remaining local Child Death Review Teams. By October 2008 the current DOH database will transition to a multi-state database. Local teams will contribute data, generate reports, and identify specific strategies for prevention of youth deaths including suicide. (Fig 4a, NPM16, Act 2, 3)

OMCH staff works with the OEMSTS on activities that are common priorities for both programs. The State Injury & Violence Prevention Guide is being promoted and implemented. Community partners help market the plan and implement strategies. In addition, OEMSTS is looking for opportunities to apply for continued grant funding to expand partner efforts and program activities. (Fig 4a, NPM16, Act 1, 4, 5)

c. Plan for the Coming Year

Local health jurisdictions will support various youth safety activities such as promoting safe storage of firearms, working with EMS and other first responders on how to respond to a suicide, and working with school personnel on emergency preparedness and safety plans including how to respond to a suicidal youth. (Fig 4a, NPM16, Act 4, 6)

The OEMSTS will continue to lead implementation of statewide youth suicide prevention activities. OMCH will provide support by promoting the programmatic activities, providing linkages to other related activities, and providing critical data sources that can lead to a reduction in the teen suicide rate. (Fig 4a, NPM16, Act 1, 3)

OMCH will provide 2008 Healthy Youth Survey data and collaborate with the DOH Division of Epidemiology, Health Statistics, and Public Health Laboratories to evaluate the Youth Suicide Prevention Program (YSPP) by comparing data from schools implementing the program to schools not utilizing the program. Recommendations from the 2009 evaluation will be incorporated into program planning to the extent possible.

OMCH will support a database on child deaths and provides technical assistance for the remaining local Child Death Review Teams. (Fig 4a, NPM16, Act 2, 3)

OMCH staff will work with the Prevention and Trauma section of OEMSTS on activities that are common priorities for both programs. The State Injury & Violence Prevention Guide will continue to be promoted and implemented during this period of time. Community partners will help market the plan and implement strategies. In addition, OEMSTS will apply for continued grant funding through SAMHSA and other sources to expand partner efforts and program activities. (Fig 4a, NPM16, Act 1, 4, 5)

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	2003	2004	2005	2006	2007
Annual Performance Objective			85	86	87
Annual Indicator	81.7	86.1	87.8	85.9	
Numerator	599	683	604	709	
Denominator	733	793	688	825	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	86.1	86.2	86.2	86.3	86.3

Notes - 2007

Data no yet available

Notes - 2006

PERFORMANCE OBJECTIVES: A combination of trend analyses and discussions were used to create the future objectives. The number of tertiary care hospitals has increased over time leading to improvements in this indicator, but is not expected to increase further. Therefore, an increase of 0.1 percent every two years was chosen.

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

Notes - 2005

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. The number of tertiary care hospitals has increased over time. Therefore, an increase of one percent every two years was chosen.

a. Last Year's Accomplishments

The Regional Perinatal Networks (PRN) implemented state and regional quality improvement projects aimed at improving poor pregnancy outcomes. Maternal Child Health (MCH) Assessment staff tracked the location where very low birth weight (VLBW) infants were delivered. During the project, hospital charts were reviewed to look at factors related to VLBW infants who were born at level 1 and 2 facilities. Due to staffing shortages in Maternal and Infant Health (MIH) we were not able to complete the chart review project as stated in last year's application. (Fig 4a, NPM17, Act 1, 2, 3)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor delivery sites of very low birth weight babies and advocate for delivery of these infants at tertiary care facilities.				X
2. The Perinatal Regional Network (PRN) will conduct a statewide QI project to determine why VLBW infants within the study period were born outside Level III OB facilities.				X
3. Fund Regional Perinatal programs to coordinate and implement QI projects to improve pregnancy outcome statewide, including advocating delivery of VLBW babies at tertiary level perinatal facilities.		X		
4. Continue LHJ provider referrals to prenatal care if clients are not already enrolled and support women to stay in prenatal care.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH Assessment monitors and reports the delivery sites of VLBW babies. Some findings include: 1) Number of level 3 facilities is increasing; 2) Number of babies born with VLBW is increasing at a greater rate than overall birth; 3) 35% of VLBW babies born at level 1 and 2 facilities, and 21% of VLBW babies born at level 3 facilities died. (Fig 4a, NPM17, Act 1)

In March, 2008 MCH Assessment staff presented data to the PRN coordinators about the characteristics of VLBW babies at level 3 versus non-level 3 facilities. Following the presentation the PRN coordinators discussed next steps and decided they will present the findings to the regional hospitals with the goal of increasing awareness.

c. Plan for the Coming Year

In analyzing data from 2006 regarding Very Low Birth Weight (VLBW) babies born in Washington State, the following was found: there were 871 VLBW born in Washington; 95% were to Washington residents (827); 74% were singletons; VLBW births account for about 43% of infant deaths in WA; 86% of VLBW infants were born at Level 3 perinatal facilities; Some risk factors for VLBW are reported more often at Level 3 facilities; and, Very low birth weight infants born at Level 1 or Level 2 facilities are more likely to have young mothers, have mothers who smoke, who lack prenatal care, or who have precipitous labor.

In the coming year MCH Assessment staff will continue to monitor and report the delivery sites of VLBW babies (Fig 4a, NPM17, Act 1). In addition the Perinatal Advisory Committee (PAC) will continue to explore the following questions: Can more be done to increase the proportion of VLBW infants born at Level 3 facilities in Washington? Can mothers be educated to recognize signs of pre-term labor? Can women with a history of preterm labor develop a plan to get to Level 3 if pre-term labor begins?

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	2003	2004	2005	2006	2007
Annual Performance Objective	84.2	85.1	83	80	81
Annual Indicator	80.8	79.6	79.2	78.5	78.5
Numerator	52885	53367	54648	59518	
Denominator	65475	67048	69038	75853	
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	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	81	82	82	83	83

Notes - 2007

No data yet available.

Notes - 2006

PERFORMANCE OBJECTIVES: A new birth certificate was implemented in 2003. The specificity of the question, which asks for the exact date of prenatal care initiation, has resulted in a high amount of missing data. In 2006, 12.7% of the data was missing for this measure.

Trend analyses based on data from 2003-2007 indicate a decrease in this measure. Additionally, there is a large disparity by Medicaid status. 68.4% of women receiving Medicaid received care beginning in the first trimester compared to 87.7% of women not receiving Medicaid. We are working closely with our partners in the Department of Social and Health Services to better understand the causes of both the disparity and decline in 1st trimester prenatal care and have jointly developed these targets.

Further, the National Center for Health Statistics (NCHS) indicates that, "the 2003 revision of the birth certificate introduced substantive changes in item wording and also to the sources of prenatal information....Accordingly, prenatal care data for the two revisions are not comparable." As a result, trend analysis crossing from 2002-2003 cannot be done. Trends can only be based on three years' worth of data (2003-2005).

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.

Notes - 2005

PERFORMANCE OBJECTIVES: A new birth certificate was implemented in 2003. The specificity of the question, which asks for the exact date of prenatal care initiation, has resulted in a high amount of missing data. In 2005, 16.1% of the data was missing for this measure. Because of the resulting high rate of missing data, it is difficult to ascertain whether the decrease in this performance measure is because of actual changes in practice or because of lack of complete reporting.

Further, the National Center for Health Statistics (NCHS) indicates that, "the 2003 revision of the birth certificate introduced substantive changes in item wording and also to the sources of prenatal information....Accordingly, prenatal care data for the two revisions are not comparable." As a result, trend analysis crossing from 2002-2003 cannot be done. Trends can only be based on three years' worth of data (2003-2005).

a. Last Year's Accomplishments

Perinatal Regional Network Coordinators (PRNs) completed the state quality improvement project and distributed data to help inform systems changes. This project provided information to hospitals about how to improve completeness of data on birth certificates, specifically, in the prenatal care section, in the following ways: increased understanding was needed of the purpose of birth certificate data by Healthcare professionals and medical records staff, increased hospital access to information about their own record of data completeness was needed, medical records staff needed full access to information and time to complete the record. Almost all target hospitals showed improvement. Some target hospitals made improvements and these changes were not yet reflected in the statistics. The staff at the Center for Health Statistics continued their ongoing education at hospitals throughout the state about improving completeness of birth certificate data and served as a resource for improving data collection quality and completeness (Fig 4a, NPM18, Act 6)

The Office of Maternal and Child Health (OMCH) contracted with local health jurisdictions (LHJs) to provide maternal and child health services, including routine referrals and assistance linking with Medicaid and prenatal care (Fig 4a, NPM18, Act 3)

Prenatal care utilization data was monitored, included in the Perinatal Indicators Report, and shared with the Perinatal Advisory Committee. Overall in Washington State, there appeared to be

a downward trend in first trimester care beginning in 2003, especially for low-income women and in some locales. The disparity in first trimester prenatal care access between Medicaid and Non-Medicaid women appeared significant. In 2003, Washington State was one of the first states to use the new birth certificate. With 20% missing data for entry into prenatal care the first couple of years, and only 3 data points, we were not ready to declare a trend. (Fig 4a, NPM18, Act 4)

The WithinReach Family Health Hotline (FHH) referred pregnant women to benefits programs including Medicaid and provided information about prenatal care services. During this period 6,323 pregnant women called the FHH. Of these callers, 2,280 were already receiving prenatal care. A total of 8020 related referrals were given to these callers. (Fig 4a, NPM18, Act 1)

In one county a contractor provided outreach to African American women to encourage early entry into prenatal care and enrollment in Maternity Support Services (MSS) by attending community events, church sponsored events and other community meetings. (Fig 4b, NPM18, Act 5)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and education through WithinReach to pregnant women to increase early enrollment in prenatal services.			X	
2. Continue MSS provider referrals to prenatal care if clients are not already enrolled and support women to stay in prenatal care.		X		
3. Continue LHJ provider referrals to prenatal care if clients are not already enrolled and support women to stay in prenatal care.		X		
4. Share prenatal care utilization data with MSS and perinatal providers.				X
5. Promote early prenatal care and MSS enrollment to African American women.		X		
6. Improve the quality and completeness of birth record filing data, including "date of first prenatal care" in order to accurately assess this performance measure.				X
7.				
8.				
9.				
10.				

b. Current Activities

Data reports and meetings are being used to alert the following stakeholders about the declining rates of first trimester prenatal care: First Steps providers, the Perinatal Advisory Committee, Tribes and urban Indian organizations, American Indian Health Commission, local health jurisdictions, and other groups working on access issues. OMCH is partnering with Department of Social and Health Services Medicaid program to assess barriers for Medicaid women. (fig 4a, NPM18, Act 4)

First Steps Database is disseminating a County Profiles report focusing on first trimester entry rates. Findings will be presented to stakeholder groups. Communities with lowest rates of first trimester prenatal care, and greatest disparity between Medicaid and Non-Medicaid births will be targeted. Community stakeholder meetings will be convened to gather information about issues affecting entry into prenatal care.

The staff at the Center for Health Statistics will continue their education at hospitals around the state and serve as a resource for improving data collection quality and completeness. (Fig 4a,

NPM18, Act 6)

OMCH continues to contract with LHJs to provide maternal and child health services. (Fig 4a, NPM18, Act 3) Prenatal care data is being monitored and distributed. (Fig 4a, NPM18, Act 4) The FHH refers pregnant women to benefit programs including Medicaid, and provides information about prenatal care. (Fig 4a, NPM18, Act 1)

c. Plan for the Coming Year

The percentage of women in Washington entering prenatal care in the 1st trimester has decreased by almost 3% in the past four years, with a larger decrease among Medicaid women. However, in the same timeframe the percentage of women entering prenatal care in the 2nd and 3rd trimesters have both increased, thus indicating a gradual shifting into care later in the pregnancy.

Birth outcomes can be impacted by a variety of factors including prenatal care, the woman's health status when she became pregnant, lifestyle choices, environmental factors such as poverty and social support, and access to other services, particularly for high risk women.

OMCH will continue to contract with local health jurisdictions to provide maternal and child health services, which may include routine referrals and assistance linking with Medicaid and needed prenatal care. (Fig 4a, NPM18, Act 3)

Prenatal care utilization data will continue to be monitored and distributed to First Steps providers, included in the Perinatal Indicators Report, and shared with the Perinatal Advisory Committee. (Fig 4a, NPM18, Act 4)

First Steps Database staff will continue to disseminate an updated County Profiles report focusing on first trimester entry rates. Findings will be presented to stakeholder groups to raise awareness of the issue. Stakeholders include Healthy Options plans, local health jurisdictions, Perinatal Advisory Committee, First Steps Maternity Support Services and Infant Case Management providers. Communities with the lowest rates of first trimester prenatal care, and/or greatest disparity between Medicaid and Non-Medicaid paid births will be targeted. Community stakeholder meetings will be convened to gather information about issues affecting entry into prenatal care. Stakeholders include health plans, Community Service Offices (CSOs), local health jurisdictions, medical providers, midwives, First Steps Maternity Support Services/Infant Case Management local providers, clients. These meetings will be convened in conjunction with other meetings, such as medical provider meetings, First Steps provider meetings, etc.

OMCH will develop community-specific strategies to address issues identified. Examples of strategies could include working with: CSOs and health plans to increase rapid linkage, enrollment, and outreach to pregnant women; DOH Office of Community and Rural Health to recruit obstetric care providers; and HRSA provider enrollment field staff to help existing providers address billing issues.

For state systems level issues, OMCH will develop state level strategies to address state system barriers.

The WithinReach Family Health Hotline will continue to refer pregnant women to benefits programs including Medicaid and to provide information about prenatal care services. (Fig 4a, NPM18, Act 1)

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	2003	2004	2005	2006	2007
Annual Performance Objective	53.9	52.8		52	52
Annual Indicator	53.2	49.5	51.7	51.0	
Numerator	56172	52596	55011	56923	
Denominator	105588	106283	106427	111635	
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	52	52	52	52	52

Notes - 2007

No data are yet available

Notes - 2006

PERFORMANCE OBJECTIVES: The unintended pregnancy rate in Washington has been stable for several years despite decreases in the abortion rate and declines in teen pregnancy rates.. Given the stability of this measure, the development of other family planning measures which may have more information is being investigated.

This numerator for this measure is derived from [the estimated percentage of unintended pregnancies from Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey *(resident live births + reported resident abortions. The denominator for this measure is the number of resident live births + reported resident abortions. Birth and Abortion data are obtained from the Washington State Center for Health Care Statistics Birth, Fetal Death, and Abortion files for 2006. PRAMS 2006 data are used.

Notes - 2005

PERFORMANCE OBJECTIVES: The unintended pregnancy rate in Washington has been very stable for several years. Given the stability of this measure, the development of other measures which may have more information is being investigated. Although the number of abortions has decreased, the percent of live births that are unintended has remained stable, keeping this indicator very stable over the past several years.

a. Last Year's Accomplishments

Approximately 37% of Washington State births resulted from unplanned pregnancies in 2006 [Pregnancy Risk Assessment Monitoring System (PRAMS) data] the rate is significantly higher for women receiving Medicaid (51%) than for women not receiving Medicaid (24%). However, Medicaid births from unintended pregnancies have significantly decreased from 56% in 2000 to 51% in 2005. The unintended pregnancy rate was approximately 51% in 2006. This rate includes births and abortions. The unintended pregnancy rate has remained constant in Washington State for many years.

The WithinReach Family Health Hotline, which provides family planning information and referral assistance, received 374 callers. The Take Charge toll free line, funded by the Department of Social and Health Services (DSHS), provides family planning referral assistance and was accessed by 4,764 callers. A total of 4,568 callers to these two lines were given either information or a referral related to their family planning need. (Fig 4b, SPM1, Act 1, 3)

Maternity Support Services (MSS) Family Planning training was revised and converted into web-based training modules. The goal was to increase provider access to training about Family planning interventions for MSS clients. MSS family planning performance measure billings were monitored for agency compliance in offering family planning education to all Medicaid clients. (Fig

4b, SPM01, Act 2, 4)

PRAMS data on unintended pregnancy was incorporated into the Perinatal Indicators Report and shared with the Perinatal Advisory Committee. This data was also made accessible via the Department of Health (DOH) website to First Steps agencies and local health jurisdictions (Fig 4b, SPM01, Act 5)

Every family that gave birth in Washington State receives the CHILD profile mailings. CHILD Profile included a message about birth spacing and family planning in the 30-day postpartum letter. A message about birth spacing was also placed in the 3-month letter. The letters were sent to women who delivered a baby during the specified time period and resided in Washington.

In an effort to provide medical professionals with a good source of info to share with patients about birth control options, the Office of Maternal and Child Health (OMCH) disseminated the new birth control brochure to providers.

OMCH explored collaborative activities with the Department of Corrections related to reproductive health education for female inmates in preparation for their release. OMCH worked with DSHS to expedite reproductive health services to this population upon release.

OMCH co-wrote the Unintended Pregnancy chapter in the "Health of Washington State," a comprehensive health report published by the Department of Health. (Fig 4b, SPM01, Act 5)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase referrals to family planning services and use of birth control.		X		
2. Provide Family Planning training to MSS agencies.				X
3. Promote Medicaid Take Charge Program to increase family planning services for men and women.		X		
4. Analyze reports on MSS Family Planning performance measure.				X
5. Help to write the Unintended Pregnancy chapter in the Health of Washington State, a comprehensive health report published by the Washington State Department of Health.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The WithinReach Family Health toll-free line provides family planning information and referral assistance. The "Take Charge" toll free line, funded by DSHS, provides family planning referral assistance (Fig 4b, SPM01, Act 1, 3)

Updated PRAMS data on unintended pregnancy is incorporated into the Perinatal Indicators Report and shared with the Perinatal Advisory Committee, and made accessible via the DOH website to First Steps agencies and local health jurisdictions. (Fig 4b, SPM01, Act 5)

CHILD Profile includes a message about birth spacing and family planning in the 30-day postpartum letter. A message about birth spacing is also in the 3-month letter. The letters are sent to women who have delivered a baby during the specified time period and resided in

Washington.

OMCH disseminates the new birth control brochure to providers.

OMCH is exploring collaborative activities with the Department of Corrections related to reproductive health education and service linkage for female inmates in preparation for their release. OMCH works with DSHS to expedite services to this population upon release.

c. Plan for the Coming Year

The WithinReach Family Health toll-free line will provide family planning information and referral assistance. The "Take Charge" toll free line, funded by DSHS will provide family planning referral assistance. (Fig 4b, SPM1, Act 1, 3)

Updated PRAMS data on unintended pregnancy will be incorporated into the Perinatal Indicators Report and will be shared with the Perinatal Advisory Committee, and made accessible via the DOH website to First Steps agencies and local health jurisdictions. (Fig 4b, SPM01, Act 5)

CHILD Profile will include a message about birth spacing and family planning in the 30-day postpartum letter. A message about birth spacing will be in the 3-month letter. The letters will be sent to women who will deliver a baby during the specified time period in Washington.

OMCH will continue to disseminate the new birth control brochure to providers.

OMCH will continue collaborative activities with the Department of Corrections related to reproductive health education and service linkage for female inmates in preparation for their release. OMCH will work with DSHS to expedite services to this population upon release.

State Performance Measure 5: *Promote the use of Bright Futures materials and principles by health, social service, and education providers in Washington State.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				70	85
Annual Indicator			40	65	80
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	95	100	100	100	100

Notes - 2007

PERFORMANCE OBJECTIVES: This new performance measure for the period of 2005-2009, is a process measure, which differs from the other measures, which are outcome-oriented. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each year). Since there are 20 benchmarks for the five year period, each benchmark is equivalent to five percentage points; at the end of the five years, 100% of the benchmarks seek to be attained. Each benchmark relates to the usage of Bright Futures materials and principles by providers in Washington State. The following new benchmarks have been attained.

Year 3

Conduct trainings or develop curricula/materials according to needs identified in assessment.

Evaluate Bright Futures oral health trainings.
Disseminate findings from Foster Parent Mental Health project

Notes - 2006

PERFORMANCE OBJECTIVES: This new performance measure for the period of 2005-2009, is a process measure, which differs from the other measures, which are outcome-oriented. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each year). Since there are 20 benchmarks for the five year period, each benchmark is equivalent to five percentage points; at the end of the five years, 100% of the benchmarks seek to be attained. Each benchmark relates to the usage of Bright Futures materials and principles by providers in Washington State. The following benchmarks have been attained.

Notes - 2005

PERFORMANCE OBJECTIVES: This new performance measure for the period of 2005-2009, is a process measure, which differs from the other measures, which are outcome-oriented. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each year). Since there are 20 benchmarks for the five year period, each benchmark is equivalent to five percentage points; at the end of the five years, 100% of the benchmarks seek to be attained. Each benchmark relates to the usage of Bright Futures materials and principles by providers in Washington State. The following benchmarks have been attained, including a few from Year 2 that were accomplished ahead of schedule.

Year 1

1. Form internal (DOH) Bright Futures working/advisory group
 - Presented Bright Futures to MIH, CAH, CSHCN. Recruited one person from each section to be the Bright Futures point person.
2. Plan for establishing inter-agency Bright Futures group—including for example schools or OSPI, American Academy of Pediatrics national and state chapters, family practitioners, Medicaid (DSHS), health plans
 - All of the above entities have been present at Bright Futures presentations, trainings, or other meetings.
3. Provide support and technical assistance to groups of professionals recently trained in use of Bright Futures: the school nurse corps supervisors, early childhood providers participating in Bright Futures in Early Childhood
 - Contact continues with trained group of SNC nurses and the idea of training teams to reach others with less access is being explored.
 - The Bright Futures in Early Childhood Project continues until June 30, 2006; a product and plan is being developed to disseminate lessons learned to other child care providers and health staff.
4. Develop plan for assessment of current use of Bright Futures by health, social service and education providers in the state
 - Surveys have been done of school nurses, child care health consultants, and early childhood education staff, on if and how they use BF; level of awareness.
 - Beginning evaluation of survey results.
5. Develop plan for using Bright Futures Oral Health in statewide trainings
 - Presented Bright Futures as a tool for oral health at annual meeting of local health jurisdiction oral health coordinators.
 - Continued coordination and dialogue between state oral health staff and Bright Futures staff and project participants.
6. Begin implementation of the grant-funded project to train foster families in mental health issues using Bright Futures
 - *Curriculum designed and training begun; to continue through spring 2006.

Year 2

7. Disseminate findings/successes/lessons learned from Bright Futures in Early Childhood Project

*Gathered preliminary evaluation data.

8. Begin assessment of the current use of Bright Futures by Washington State providers

*Surveys completed in year 1 of allied health providers.

a. Last Year's Accomplishments

This measure was chosen because Bright Futures is a tool and a best practice for increasing quality of health care and health education for children and families. By using and promoting Bright Futures, the Office of Maternal and Child Health (OMCH) is furthering the goals of the MCH Priorities: 1) Adequate nutrition and physical activity, 3) Optimal Mental Health and Healthy Relationships, 6) Healthy Physical Growth and Cognitive Development, 8) Access to Preventive and Treatment Services, and 9) Quality Screening, Identification, Intervention and Care Coordination.

The toolkit, Bright Futures Guidebook for Early Childhood Care and Education, was distributed statewide and nationally. Two hundred forty-two guidebooks were sent out from the Department of Health (DOH) per individual requests, and others were distributed at conferences and meetings (e.g., Washington Association for the Education of Young Children and child care health consultant meetings). (Fig 4b, SPM05, Act 2, 8)

The Bright Futures Oral Health (BFOH) Project was started. Activities included 1) review of BFOH materials by local oral health coordinators; 2) development of OH materials for WIC, Healthy Child Care Washington, First Steps, schools, and children with special health care needs (the latter in two versions, for professionals and for caregivers); and 3) review of materials by caregivers of children with special health care needs. (Fig 4b, SPM05, Act 5)

The Bright Futures for Children and Youth in Foster Care--Mental Health, program was completed. After a number of "train-the-trainer" sessions, all materials were given to Children's Administration (CA), where foster parent trainers connected with CA will continue the trainings. (Fig 4b, SPM05, Act 3)

The Medical Home Leadership Network Conference (May 2007) included Bright Futures as a point of group discussion and planning. (Fig 4b, SPM05, Act 8)

The Family Voices Bright Futures for Families Project was completed. (Fig 4b, SPM05, Act 7)

Work with the school nurse training teams, as well as some new trainings, have been on hold due to decreases in the federal MCH Block Grant, which necessitated discontinuing the contract with University of Washington (UW). (Fig 4b, SPM05, Act 4)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide training on the use of the Bright Futures guidelines and materials.				X
2. Complete the Bright Futures in Early Childhood Project by June 2006.			X	
3. Implement Bright Futures Mental Health trainings for foster parents.			X	
4. Form school nurse training teams.				X
5. Collaborate with DOH Oral Health staff to develop a consistent oral health message using Bright Futures.			X	
6. Build and maintain Washington Bright Futures Web site.				X
7. Participate in Family Voices Bright Futures for Families Project.			X	

8. Present Bright Futures projects at state and national conferences.				X
9.				
10.				

b. Current Activities

OMCH distributes the Bright Futures (BF) Early Childhood Guidebook by request and at conferences. (Fig 4b, SPM05, Act 1, 8)

The new BF Guidelines are presented to OMCH staff, so they are aware of the new guidelines and have a resource in the office. Presentations may extend to other DOH offices. (Fig 4b, SPM05, Act 1, 5)

Child care health consultants are encouraged to use BF. Specific trainings for new consultants are being planned, including follow-up with pilot sites and stakeholders in the BF in Early Childhood Project. (Fig 4b, SPM05, Act 1)

OMCH staff is providing information to early childhood professionals about the new edition of BF, especially the congruence with American Academy of Pediatrics periodicity schedule. Trainings and presentations will emphasize the themes of mental health promotion and maintaining healthy weight. (Fig 4b, SPM05, Act 1)

The Child and Adolescent Health (CAH) section staff reviews and revises the child care health consultants training modules for alignment with new BF Guidelines. (Fig 4b, SPM05, Act 1)

CAH staff fosters integration of BF in Early Childhood as part of the Early Childhood Comprehensive Systems grant and the Kids Matter Plan. (Fig 4b, SPM05, Act 1, 2)

The Washington BF website is a resource for DOH and the public about Bright Futures activities. (Fig 4b, SPM05, Act 6)

The BF Oral Health Project is being completed, reviewed by the UW, and materials will be translated into Spanish. (Fig 4b, SPM05, Act 5)

c. Plan for the Coming Year

CAH plans to use the third edition of Bright Futures Guidelines to evaluate existing materials, such as the Early Childhood Guidebook, for possible revision. CAH plans to increase outreach to health care providers about use of Bright Futures Guidelines in well-child care. This will include pre-service as well as continuing education for physicians, nurse practitioners, and other primary care providers. (Fig 4b, SPM05, Act 1)

CAH will continue to train child care health consultants, and possibly child care providers, on the DOH Bright Futures Oral Health curriculum. (Fig 4b, SPM05, Act 1, 5)

The Bright Futures Oral Health Project materials will be released to the public in December 2008. Trainings will be planned and implemented. (Fig 4b, SPM05, Act 1, 5)

State Performance Measure 6: *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	2003	2004	2005	2006	2007
Annual Performance Objective				52.2	58

Annual Indicator	55.6	55.6	59.0	59.0	59.0
Numerator	136477	136345	145873	147801	147801
Denominator	245462	245224	247243	250511	250511
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	57	56	55	54	53

Notes - 2007

PERFORMANCE OBJECTIVES: There are only two years of data available since the Smile Survey is administered every five years. As more data become available, additional analyses will be conducted to determine appropriate future objectives. A gradual decrease of 1% per year through 2012 was chosen.

The source of the data is the 2005 Washington State SMILE Survey, therefore there are no new data for 2007. The indicator reflects the proportion of 6-8 year olds with dental caries experience in primary and permanent teeth. The source of the denominator data is the Office of Financial Management Population Forecast. The numerator is calculated from both of these.

Notes - 2006

PERFORMANCE OBJECTIVES: There are only two years of data available since the Smile Survey is administered every five years. As more data becomes available, additional analyses will be conducted to determine appropriate future objectives. A gradual decrease of 1% per year through 2011 was chosen.

The source of the data is the 2005 Washington State SMILE Survey, therefore there is no new data for 2006. The indicator reflects the proportion of 6-8 year olds with dental caries experience in primary and permanent teeth. The source of the denominator data is the Office of Financial Management Population Forecast. The numerator is calculated from both of these.

Notes - 2005

PERFORMANCE OBJECTIVES: This is a new performance measure, and there are only two years of data available since the Smile Survey is administered every five years. As more data becomes available, additional analyses will be conducted to determine appropriate future objectives.

The source of the data is the 2005 Washington State SMILE Survey. The indicator reflects the proportion of 6-8 year olds with dental caries experience in primary and permanent teeth. The source of the denominator data is the Office of Financial Management Population Forecast. The numerator is calculated from both of these.

a. Last Year's Accomplishments

The Office of Maternal and Child Health (OMCH) implemented a statewide surveillance system to monitor oral health indicators. The program began work on the oral disease burden document in 2006. Surveillance data were collected and analyzed and a report, 'The Impact of Oral Disease on the Lives of Washingtonians - The Washington State Oral Disease Burden Document,' was published in July 2007. The burden document was disseminated in the state through an official press release.

Oral Health program staff implemented an OMCH Oral Health Strategic Plan, which aims at integrating oral health activities into the six OMCH Sections (Assessment, Maternal and Infant Health, Child and Adolescent Health, Immunizations, Genetics, and Children with Special and Health Care Needs).

OMCH continued to fund local health agencies to provide oral health education to families and programs through Bright Futures Oral Health and Tooth Tutor. CHILD Profile mailed health promotion letters that included information on oral health to parents of children aged birth-6 years.

(Fig 4b, SPM06, Act 6)

The OMCH Oral Health Program developed a Statewide Collaborative Action Plan on Oral Health Access for Children with Special Health Care Needs. The collaborative mobilized more than 30 organizations in the state who continue to communicate via a listserv.(Fig 4b, SPM06, Act 2)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Tailor Bright Futures Oral Health and Tooth Tutor messages to different MCH-related programs (WIC, Head Start, First Steps, etc.) and upon revision make available online in a fact sheet format.				X
2. Implement the Statewide Collaborative Action Plan on Oral Health Access for Children with Special Health Care Needs.		X	X	X
3. Organize two regional forums in August 2008 to bring partners together to implement the TOHSS grant.				X
4. Strengthen state oral health coalition and 32 local oral health coalitions, to help unite the different counties and oral health stakeholders.				X
5. Revise the definition of dental home as a correlate of medical home.			X	X
6. Continue to fund local oral health programs to educate families and MCH-related programs.			X	
7. Maintain website with information on oral health promotion/education and access to dental care.		X	X	
8.				
9.				
10.				

b. Current Activities

The OMCH Oral Health Program works with partners to tailor the Bright Futures Oral Health and Tooth Tutor messages to different MCH-related programs (WIC, Head Start, First Steps, etc.). Upon revision, the materials will be available online. (Fig 4b, SPM06, Act 1)

The OMCH is implementing the activities in the Statewide Collaborative Action Plan on Oral Health Access for Children with Special Health Care Needs. Using the HRSA TOHSS grant funding, the program is working with partners to implement the action plan. The OMCH is organizing two regional forums in August 2008 to bring partners together to implement the TOHSS grant. (Fig 4b, SPM06, Act 2, 3)

The OMCH Oral Health Program supports a strong state oral health coalition and 32 local oral health coalitions, which unites the different counties and oral health stakeholders. (Fig 4b, SPM06, Act 4)

The OMCH Oral Health Program works to revise the definition of dental home as a correlate of medical home. (Fig 4b, SPM06, Act 5)

The OMCH Oral Health Program funds local oral health programs to educate families and MCH-related programs. Parents of children aged birth-6 years receive CHILD Profile Health Promotion letters that include information on oral health. (Fig 4b, SPM06, Act 6)

The OMCH Oral Health Program maintains a website with information on oral health and access to dental care. (Fig 4b, SPM06, Act 7)

c. Plan for the Coming Year

The OMCH will work with University of Washington School of Dentistry to develop curriculum to train general dentists to provide comprehensive dental services to Children with Special Health Care Needs with minor to moderate chronic conditions. (Fig 4b, SPM06, Act 2)

The OMCH Oral Health Program will mobilize data resources and partners develop a state oral health plan.

CHILD Profile will continue mailing health promotion letters that include information on oral health to parents of children aged birth-6 years. (Fig 4b, SPM06, Act 6)

The OMCH Oral Health Strategic Plan will fund local health agencies and educate stakeholders and the public about the effective measures to prevent tooth decay. (Fig 4b, SPM06, Act 6)

State Performance Measure 7: *Strengthen statewide system capacity to promote health, safety, and school readiness of children birth to kindergarten entry.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				54	82.8
Annual Indicator			25.2	48.6	86.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	97.2	100	100	100	100

Notes - 2007

This is a process measure (work being accomplished is groundbreaking & harder to quantify), w/ 28 benchmarks (statements describing annual work), weighted ~3.6% each with the goal of 100% attainment by 2010.

1. Provide TA/training to CCHCs regarding Kids Matter (ECCS) & implementation activities.

- KM Full Report & web resources shared with 35 LHJs through CCHC listserv
- Shared KM 'Healthy Children Learn' document to 35 LHJs & statewide CCHC group, clarifying health role in EL & school readiness
- KM documents provided to state CCHC, providing TA/consultation to 35 LHJs.
- KM Framework (KMF) shared in 3 Regional CCHC Mtgs (39 counties)

2. Identify existing OMCH data to KM indicators & outcomes.

- Utilized MCH data report & KMF to supplement each other
- Identifying data within OMCH priorities that support 5 core components of KMF

3. Identify system level indicators for components of KM.

- Meeting with KM/ECCS Steering Committee discussed data development specific to EL & expectations of new Dept of Early Learning (EL)
- Indicators assessed through 2nd annual Awareness & Utilization Survey 1/07, to ~900 EL stakeholders (>50% return rate).
- Participated in "Redesign Workgroup" for the revision of the Washington EL & Development Benchmarks (identifies knowledge & behaviors 0-5 yrs) – critical to kindergarten assessment outcomes.

4. Communicate health & safety in school readiness efforts based on KM system level outcomes across OMCH.

- Presented KMF & EL Update all sections of OMCH

- Presented KMF & EL Update to Olympic MCH Regional Team & Southwest MCH Regional Team
- Shared results of Awareness & Utilization Survey & examples of usability
- Drafted 'Layer Cake Approach' tool, to provide options on utilizing KM
- 5.Link KM indicators & outcomes to OMCH 9 priorities.
- Identified the 6 OMCH Priorities that link to system, parent/caregiver, & child level outcomes identified in KMF
- KMF component areas represent work supporting Priority # 1,3,5, 6, 8, & 9
- 6.Provide TA & training to users of web-based data collection system (HCCWDC) for HCCW
- HCCW consultants have been exposed to KM & other Washington initiatives re: school readiness/health&school safety
- No electronic training currently being developed. Possibility in future using HCCW database.
- 7.Identify key HCCW policy messages & dissemination strategies
- Policy messages---health must be included in all major EL initiatives.
- HCCW to ensure health & safety standards part of quality rating improvement system for child care programs.
- Dissemination strategies: traditional & new trainings of CCHC's; policy updates via meetings/email/listserves
- 8.Create & disseminate annual report for HCCW
- Annual report being prepared, to indicate linkages between HCCW & ECCS.
- Annual report format being re-evaluated to present more comprehensive work of HCCW system.

Notes - 2006

This is a process measure (work being accomplished is groundbreaking & harder to quantify), w/ 28 benchmarks (statements describing annual work), weighted ~3.6% each with the goal of 100% attainment by 2010.

1

Notes - 2005

See SPM 5 for more details about benchmarks/process measures.

Benchmarks: Year 1

1. Identify state OMCH activities to promote health, safety, and school readiness of children 0-5 years old.
 - Created Inventory of EC services/programs across OMCH regarding health and school readiness
 - Developed matrix of EC activities within OMCH
2. Provide training, technical assistance (TA) and consultation to Child Care Health Consultants (CCHCs) to raise awareness regarding health, safety, and school readiness.
 - A full-time consultant is available to the child care health consultants to provide training and technical assistance.
 - Quarterly regional meetings regarding consultation for infants/toddlers in child care include CCHCs, licensors, health specialists, others involved in child care and training for providers.
 - CCHCs are connected to information and resources from the State Health and Safety Advisory Committee, and are offered a bi-annual conference on early childhood care.
- 3.Increase awareness and use of Early Childhood Comprehensive Systems (ECCS) plan (Kids Matter (KM)) by state & local partners.
 - Completed Awareness and Evaluation Survey of Kids Matter to document baseline data regarding awareness and utilization of KM plan among early childhood stakeholders. See Stakeholder Survey Report and Methodological Report March 2006.
- 4.Track OMCH school readiness efforts based on KM plan.
 - CHILD Profile integration of Early Learning Benchmarks into CHILD Profile Development Posters and Getting School Ready booklet integrated into mailings.
 - DOH Medical Home Strike Team integrating Kids Matter focus on Medical Home in children 0-5 years.

- CSHCN, Medical Home Grant and Strategic Planning Process utilizing KM Plan.
 - PHND-EC Logic Model development regarding PH services for children and families utilizing KM Plan.
 - Infant Mental Health Strategic Planning efforts utilizing KM Plan.
 - Mental Health Transformation Grant referencing KM Plan regarding prevention and children's mental health.
5. Facilitate OMCH Early Childhood Workgroup to address & increase integration regarding health, safety, and school readiness of children 0-5.
- Convened representatives from across sections in OMCH monthly to share integration opportunities between and among OMCH and Kids Matter and model reciprocal activities.
 - Determining the need to formalize workgroup with appropriate charter.
 - 'Integration Continuum', by Konrad reference document for integration opportunities identified as reference for work across OMCH & school readiness.
6. Add representatives of Healthy Child Care Washington (HCCW) to the State Joint Early Childhood Advisory Committee of KM.
- HCCW will be represented through the ECCS Lead and CAH-Early Childhood Team Lead.
7. Expand CCHC and CHILD Profile activities into HCCW system.
- Conducted trainings for CCHCs in CHILD Profile registry at limited number of pilot sites; examining feasibility (system and fiscal) of expanded use.

a. Last Year's Accomplishments

SPM07 supports the Office of Maternal and Child Health's (OMCH) role in promoting health, safety, and school readiness. This addresses the focus of the federal Early Childhood Comprehensive Systems (ECCS) grant which requires attention to five core components: access to health and medical home, social-emotional development and children's mental health, early care and education, parenting and family support. MCH Priorities 1, 3, 4, 5, 6, 8, and 9 are also supported through SPM07.

The Early Childhood Comprehensive Systems (ECCS) Grant focused on increasing systems capacity and integration of early childhood systems and services in Washington. (Fig 4b, SPM07, Act 4)

Two years of planning culminated in the outcome-based early childhood plan called "Kids Matter: Improving Outcomes for Children in Washington State." Three statewide system building efforts combined to create this plan: ECCS [OMCH/Department of Health (DOH)], the Foundation for Early Learning, and the Head Start-State Collaboration Office. Kids Matter's systems-building efforts were further integrated with Washington's Build Initiative efforts. (The Build Initiative is supported through the National Build Initiative, an Early Childhood Funders Collaborative.) Public and private partners across Washington State developed and support the use of this plan. (Fig 4b, SPM07, Act 4)

The Early Childhood Comprehensive Systems (ECCS) grant strategic plan, Kids Matter, Improving Outcomes for Children in Washington State, provided a framework and strategies to: 1) Improve early childhood outcomes; 2) Increase public will about early learning; and 3) Build and sustain public-private partnerships to facilitate changes in policies, programs and practices. Examples included: opportunities focused at building public-private partnerships related to Medical Home, Bright Futures (BF), Healthy Child Care Washington (HCCW), and early childhood systems capacity. (Fig 4b, SPM07, Act 3, 4, 5)

During 06-07 Kids Matter (KM) focused on awareness and use of the plan by expanding presentations across MCH regional meetings, local communities, and other stakeholders. In January 2007, the Child and Adolescent Health (CAH) section contracted with an evaluation consultant to update survey data regarding awareness and use of the Kids Matter plan. Over 900 early childhood stakeholders representing 39 state-local groups and organizations were surveyed. (Fig 4b, SPM07, Act 1, 2, 3, 5, 6)

CAH published Bright Futures Guidebook for Early Childhood Care and Education which integrated Bright Futures Guidelines into early care and education. This addressed both the health and early care and education components of Kids Matter. (Fig 4b, SPM07, Act 7, 8)

Child care health consultants provided consultation to child care providers of infants and toddlers as part of the Healthy Child Care Washington (HCCW) systems partnership. Efforts focused on better alignment of HCCW and ECCS/Kids Matter. (Fig 4b, SPM07, Act 9)

CHILD Profile mailed health promotion letters that included information on school readiness to parents of children aged birth-6 years. CHILD Profile also mailed the Getting School Ready booklet, created by Getting School Ready, a project of the Foundation for Early Learning. (Fig 4b, SPM07, Act 3, 5)

In fall 2007 a Kids Matter Guidebook was developed to assist local communities in doing strategic planning and prioritization using the KM Framework. State agencies and organizations have also used the KM Guidebook to assist in planning and prioritization. (Fig 4b, SPM07, Act 8)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Make formal presentations regarding Kids Matter to OMCH sections and external early childhood (EC) stakeholders.				X
2. Complete Awareness and Utilization Survey of broad EC stakeholder group regarding ECCS grant (Kids Matter).				X
3. Use Kids Matter in various grant-writing and contract opportunities across OMCH that incorporate the five required components of ECCS and align with the nine MCH priorities.				X
4. Increase coalition building efforts to expand public-private partnerships and implementation of the Kids Matter plan.				X
5. Integrate strategic planning activities across OMCH using Kids Matter framework.				X
6. Evaluate Kids Matter.				X
7. Integrate Bright Futures Guidelines across components of Healthy Child Care Washington (HCCW) and Kids Matter.				X
8. Continue community mobilization work with partners to encourage use of Kids Matter framework at the local level.				X
9. Continue to support the statewide network of child care health consultants.		X		
10.				

b. Current Activities

The KM plan is being used as a resource for state and local early childhood initiatives, including Strengthening Families in Early Care and Education, Born Learning, KM Venture Grants in two regions, replication projects for family, friend, and neighbor care providers. (Fig 4b, SPM07, Act 4, 5, 8)

KM messages include: keeping children and families as the focus; assuring that state agencies and organizations work together; facilitating cross-system collaboration between health and education; guiding state policies and actions to support local communities; and encouraging public-private collaboration (e.g. Department of Early Learning, Thrive by Five Washington and the Early Learning Advisory Council). (Fig 4b, SPM07, Act 1, 4, 8)

ECCS/KM framework and related efforts are coordinating with DOH's participation in the Washington State Mental Health Transformation (MHT) Grant. Implementation of ECCS/KM is an

MHT Grant implementation strategy submitted to the Governor's Office by DOH. Activities include continuing efforts to identify priorities for a more coordinated, statewide approach to prevention of mental health challenges in young children. (Fig 4b, SPM07, Act 4)

HCCW and ECCS staff in OMCH, and other early childhood stakeholders are promoting HCCW as a system-level partnership to coordinate policies and practices related to health, safety and optimal child development in child care, early learning, and after school settings. (Fig 4b, SPM07, Act 4, 8, 9)

c. Plan for the Coming Year

ECCS/KM as a member of the Strengthening Families Washington (SFWA) Steering Committee will expand partnerships and funding opportunities linking the Strengthening Families through Early Care and Education approach across state and local agencies. SFWA's Theory of Change will inform development of a state work plan with technical assistance and consultation provided by a grant from the National Build Initiative. (Fig 4b, SPM07, Act 1, 4, 5, 8)

ECCS/KM will use the KM Guidebook to inform strategic planning activities across OMCH and assist local early learning community coalitions in systems development efforts. Funding options will be investigated to build capacity for technical assistance and consultation as requested through the 2007 KM Awareness and Utilization Survey. (Fig 4b, SPM07, Act 1, 4, 5, 8)

ECCS/KM will pursue funding for two more KM/Build Initiative Venture Grants to encourage local public-private partnerships and Family, Friends, and Neighbors (FFN) Replication Projects to expand public-private partnerships at the local level and to integrate strategies aimed at the FFN population in local early learning systems development. (Fig 4b, SPM07, Act 4, 8)

DOH's MHT liaison and ECCS staff will increase activities focused on the linkage between early childhood and mental health promotion in state and local efforts. OMCH staff will continue to participate on the MHT Prevention Advisory Group and promote a public health approach to mental health for young children and their families. OMCH staff will continue to share information about MHT with early childhood stakeholders, including public health. (Fig 4b, SPM07, Act 4, 8)

ECCS staff will determine the next phases of the Kids Matter evaluation as the first three year phase of Awareness and Utilization is completed. KM partners, together with the evaluation consultant, will identify options to address the needs of multiple partners as related to cross-systems work and the components of ECCS. (Fig 4b, SPM07, Act 6)

ECCS/Kids Matter partners will work with new early learning initiatives to determine policy and finance options that cross all required components of the ECCS grant. (Fig 4b, SPM07, Act 4, 8)

CHILD Profile will continue mailing health promotion letters that include information on school readiness to parents of children aged birth-6 years. CHILD Profile will continue mailing the Getting School Ready booklet, created by Getting School Ready, a project of the Foundation for Early Learning. (Fig 4b, SPM07, Act 3, 5)

Child care health consultants, through HCCW, will receive training on how to incorporate new Bright Futures Guidelines, and the updated Kids Matter Plan, into their work with child care providers. (Fig 4b, SPM07, Act 7)

The KM plan includes the network of child care health consultants as an integral part. The consultants will be encouraged to be involved in ECCS and KM work and other early learning initiatives. (Fig 4b, SPM07, Act 9)

State Performance Measure 8: *Use an established framework for ensuring quality screening, identification, intervention, and care coordination for women, infants, children, adolescents, and their families.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2008	2009	2010	2011	2012
Annual Performance Objective					

Notes - 2007

No data available as this is a new State Performance Measure.

a. Last Year's Accomplishments

Not Applicable - this is a new measure

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Purchase and distribute recommended vaccines for children aged birth through 18 years.			X	
2. Increase use of EPSDT, quality screening, identification, and intervention.				X
3. Use Kids Matter Framework to inform early childhood stakeholders of the importance of quality screening, identification, intervention and care coordination.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Maternal and Child Health (OMCH) is developing a performance measure for the Quality Screening, Identification, Intervention, and Care Coordination priority. The Kids Matter Framework is one model used to identify steps for this state performance measure.

Immunization Program CHILD Profile purchases and distributes vaccine for all children aged birth through 18 years in Washington State. (Fig 4b, SPM 08, Act 1)

Collaborated with the Department of Social and Health Services HRSA to plan to increase the quality of/access to Early Periodic Screening Diagnosis and Treatment program (EPSDT), including quality improvement strategies, quality screening incentives, health literacy, consumer education, and pilot projects. (Fig 4b, SPM 08, Act 2)

Participates in the Washington State Medical Home Leadership Network to improve access to medical homes and coordinates state level planning/policy. medical homes improve health care;

increase use of EPSDT and well child check-ups; and facilitate early identification of issues, access to intervention, and coordination of healthcare. (Fig 4b, SPM 08, Act 2)

Child care health consultants encourage medical homes and quality well-child care by educating child care providers and families through consultations and trainings.

The Child and Adolescent Health section promotes Bright Futures (BF) as the standard for well-child care. BF is congruent with American Academy of Pediatrics Guidelines and Medicaid/EPSDT standards.

c. Plan for the Coming Year

This measure was chosen to give sections in the Office of Maternal Health (OMCH) a planning and tracking tool for the quality improvement initiatives they support. This aligns with the MCH priority on Quality Screening, Identification, Intervention, and Care Coordination. The selected framework will be used to guide sections through the process of beginning a quality improvement initiative or guide them to the next steps they need to take if the initiative is already underway. The data notes describe how this process measure will be reported in future block grant reports.

Representatives from sections within OMCH will participate on a work group to transition this process measure to an outcome measure for the Quality Screening, Identification, Intervention, and Care Coordination priority. Sections within OMCH will use the annual review period for the measure to plan for shared resources if needed. In addition, the following quality improvement initiatives that are underway will begin or continue to use the framework to guide them through the process of making change.

Immunization Child Profile (ICP) will purchase and distribute vaccine for all children aged birth through 18 years in Washington State. (Fig 4b, SPM 08, Act 1)

OMCH will continue to collaborate with Department of Social and Health Services HRSA in the development of a plan to increase the quality of and access to EPSDT, including strategies for quality improvement, incentives for quality screening, health literacy, consumer education, and pilot projects. (Fig 4b, SPM 08, Act 2)

OMCH will continue to participate in the Washington State Medical Home Leadership Network. Medical Homes improve health care and access for children and youth; increase the use of EPSDT and well child check-ups; and facilitate early identification of issues; access to intervention; and coordination of healthcare. (Fig 4b, SPM 08, Act 2)

The Early Childhood Comprehensive Systems (ECCS) grant reapplication will continue to focus on the importance of quality screening, identification, intervention, and care coordination as a primary component of state and local level early childhood systems efforts represented through the Kids Matter Framework. (Fig 4b, SPM 08, Act 3)

Child and Adolescent Health will continue to promote Bright Futures as the standard for well-child care.

Child care health consultants will continue to encourage medical homes and quality well-child care by educating child care providers and families through on-site consultations and trainings.

State Performance Measure 9: *Develop an outcome measure for the Washington State maternal and child health priority of Optimal Mental Health and Healthy Relationships.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2008	2009	2010	2011	2012
Annual Performance Objective					

Notes - 2007

No data are available. This is a new State Performance Measure.

a. Last Year's Accomplishments

Not applicable, this is a new performance measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate on the Mental Health Transformation Prevention Work Group.				X
2. Support the development of School Based Health Centers.				X
3. Implement the social, emotional and mental health component of the Early Childhood Comprehensive Systems (ECCS) Grant.				X
4. Encourage First Steps providers to complete the Perinatal depression web-training module collaboratively developed by First Steps and University of Washington.				X
5. Send parents information on parenting and child development via CHILD Profile Health Promotion.			X	
6. Promote social emotional and mental health consultation to child care, early learning providers.			X	
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Maternal and Child Health (OMCH) is developing a new state performance measure for the Optimal Mental Health and Health Relationships priority.

OMCH represents the Department of Health on the Mental Health Transformation (MHT) Grant Work Group. Child and Adolescent Health (CAH) staff participate on the MHT Prevention Work Group. (Fig 4b, SPM09, Act 1)

CAH supports the development of school based health centers, which provide primary care, reproductive health care and mental health care. (Fig 4b, SPM09, Act 2)

Social, emotional, and mental health is a focus area of the Early Childhood Comprehensive Systems grant. (Fig 4b, SPM09, Act 3)

Maternal and Child Health (MIH) First Steps staff is encouraging First Steps providers to complete the Perinatal depression web-training module and implement depression screening for pregnant and post-partum women. (Fig 4b, SPM09, Act 4)

Parents of children aged birth--6 years receive mailings via CHILD Profile regarding parenting

and child development. (Fig 4b, SPM09, Act 5)

OMCH is working with the Department of Early Learning and other stakeholders to promote mental health consultation to child care and early learning providers. Child care health consultants provide training and technical assistance regarding social emotional development, to child care providers serving infants and toddlers. (Fig 4b, SPM09, Act 6)

c. Plan for the Coming Year

This process measure was chosen to track the work of representatives from several sections in the Office of Maternal and Child Health as they examine activities supported by each section and identify an outcome measure that will capture the collective efforts of sections within the office. Optimal Mental Health and Healthy Relationships has been a priority for Washington State for many years. In reporting on the previous outcome measure we realized that many factors influence that outcome and the measure did not represent the direct result of our efforts in this area. This led to a decision to develop a measure that is more directly related to our work. This process involves the steps described as benchmarks for this measure. We aim to complete the work by April 2009.

OMCH will continue to inform and coordinate DOH's participation on the MHT Grant Workgroup. CAH staff will participate on the MHT Prevention Work Group. (Fig 4b, SPM09, Act 1)

CAH will support the development and implementation of school based health centers, which will provide primary care, reproductive health care and mental health care. (Fig 4b, SPM09, Act 2)

CAH will continue to implement the Early Childhood Comprehensive Systems (ECCS) Grant. In Washington this is part of a partnership called Kids Matter. Social, emotional, and mental health is one of the focus areas of ECCS/Kids Matter. CAH will work to infuse social, emotional and mental health promotion across the other focus areas of ECCS/Kids Matter: Medical Home, Early Care and Education, Parenting Education, and Family Support. Three levels of social, emotional and mental health outcomes are identified in the Kids Matter Framework, (1) Systems level -- increased availability of appropriate and coordinated mental health services for children, (2) Parent and caregiver level -- improved understanding and practice of nurturing behaviors to promote children's social-emotional development and mental health, and (3) Child level -- increased number and percentage of children entering kindergarten with age appropriate social-emotional skills. (Fig 4b, SPM09, Act 3)

CAH will continue to work to link ECCS/Kids Matter and the development of school based health centers with MHT and other mental health promotion activities. (Fig 4b, SPM09, Act 1, 2, 3)

CHILD Profile will mail parents of children aged birth--6 years information regarding parenting and child development. (Fig 4b, SPM09, Act 5)

CAH will continue to work with the Department of Early Learning (DEL) and other stakeholders to promote social emotional and mental health consultation for child care and early learning providers. Through an interagency agreement with DEL, child care health consultants will continue to provide training and technical assistance regarding social emotional development, behavior, and nurturing relationships to child care providers serving infants and toddlers. (Fig 4b, SPM09, Act 6)

State Performance Measure 10: *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	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator					
Numerator					
Denominator					
Is the Data Provisional or Final?					
	2008	2009	2010	2011	2012
Annual Performance Objective					

Notes - 2007

No data are available. This is a new State Performance Measure.

a. Last Year's Accomplishments

Not applicable - this is a new measure

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assess disparities and work with target communities to improve maternal and infant outcomes.			X	
2. Collaborate on educational outreach activities to the Asian Pacific Islander community, including community projects and screenings.		X		
3. Coordinate with other organizations and agencies to ensure that adolescents have access to age appropriate and culturally appropriate health services.				X
4. Use the Race Matters Toolkit to view the ECCS/Kids Matter work through a racial equity lens and improve results across early childhood systems.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Office of Maternal and Child Health Disparities Workgroup completed the Health Equity issue brief in spring 2008. Between May and August 2008, the work group co-hosted a series of interactive presentations featuring local speakers and video from the PBS series Unnatural Causes. Events were open to all Department of Health employees and training credit was given to attendees.

Maternal and Infant Health (MIH) staff met with representatives of community based projects targeting groups with disparities in health outcomes to collect information, establish networks of community leaders working on disparities issues, and to begin drafting a strategic plan for MIH action on disparities issues. (Fig 4a, SPM10, Act 1)

The Immunization Program CHILD Profile collaborates on educational outreach activities to Asian Pacific Islander (API) populations about hepatitis B. Community projects and screenings are done based on 2007--08 key objectives to increase hepatitis B screening and immunization in the API population. (Fig 4A, SPM10, Act 2)

The Child and Adolescent Health section is funding two school based health centers (SBHC) and 11 SBHC planning grants targeting rural areas, schools with low test scores, and socio-economically and racially/ethnically diverse populations. (Fig 4b, SPM10, Act 3)

ECCS/Kids Matter is using the Race Matters Toolkit (www.aecf.org) to review policies and practices regarding inequitable outcomes for children, families, and communities. (Fig 4A, SPM10, Act 4)

c. Plan for the Coming Year

This process measure was selected to measure how the sections within the Office of Maternal and Child Health (OMCH) work to create health equity for women, infants, children, adolescents, and families. By selecting a measure that holds sections accountable for the process used to address health disparities, we hope to ensure continued efforts to achieve health equity. See the data notes for information on how this process measure will be reported in future block grant applications.

This measure aligns with Washington State's MCH priority "Health Equity." The focus of this priority is to promote activities and policies that reduce health disparities for all women, infants, children, adolescents, and families. We aim to do this through collecting and analyzing data to identify differences in health outcomes and creating, implementing, and evaluating programs to reduce or eliminate those differences.

MIH staff will complete a strategic plan for addressing disparities, and work with targeted communities to implement specific activities in the plan. For example, MIH plans to work with leaders in African American communities to plan a summit in Pierce and King Counties to strategize improving maternal and infant indicators, such as access to early prenatal care and infant mortality. (Fig 4A, SPM10, Act 1)

The Immunization Program CHILD Profile (IPCP) will collaborate on educational outreach activities to Asian Pacific Islander populations about hepatitis B. (Fig 4A, SPM10, Act 2)

ECCS/Kids Matter will continue working with the Annie E. Casey Foundation (AECF) and the National Build Initiative to review early comprehensive systems efforts through a racial equity lens. AECF reviewed the Kids Matter Executive Summary and the full report to provide a cross-walk between Kids Matter and the Race Matters Toolkit. The Toolkit was created to improve results by providing equitable opportunities for all. The approach described in the Toolkit deals specifically with policies and practices that contribute to inequitable outcomes for children, families, and communities. The Toolkit presents a framework for addressing unequal opportunities by race and results-oriented steps to help achieve goals.

The ECCS/Kids Matter partners are working to attend to culture and ethnicity by incorporating strategies that encourage viewing our work through a racial equity lens, addressing issues of racial equity and disparities across the system of systems represented in the ECCS work, and developing action oriented steps to reduce those disparities. (Fig 4A, SPM10, Act 4)

E. Health Status Indicators

Data Users

Raw data are used by DOH staff to produce reports and other publications, respond to legislative requests, and prepare presentations. Published documents are used by numerous stakeholders and the general public.

Important Trends

Overall, the rates of low birth weight for multiple or singleton births have increased by less than or equal to 1 percent, and the rates of very low birth weights for multiple or singleton births have remained relatively stable since 1996.

/2009/Overall, the rates of low birth weight for both multiple and singleton births have increased since 1990, although Washington remains one of the states with lowest rates. The rate of very low birth weight has also increased.//2009//

Nonfatal injury rates and mortality rates from unintentional injuries, in the age groupings of 14 years and younger and 15-24 years, have decreased. This trend is seen in both overall mortality rates as well as those associated with motor vehicle crashes.

/2008/Nonfatal injury rates and mortality rates from unintentional injuries, in the age groupings of 14 years and younger are showing a slight increase. The death rates per 100,000 for unintentional injuries among children ages 14 years and younger and youth 15-24 years, have decreased. Rates of nonfatal injuries among children aged 14 years and younger have decreased overall, although rates have been showing some increase since 2002. Rates of nonfatal injuries due to motor vehicle crashes in children ages 14 years and younger and youth ages 15-24 years have both decreased over recent years.//2008//

/2009/With the exception of non-fatal injuries due to motor vehicle crashes, no statistically significant changes in fatal or non-fatal injury rates have occurred since 1998. Non-fatal injuries due to motor vehicle crashes have decreased significantly among youth both <14 years and 15-24 years.//2009//

Rates of Chlamydia in women ages 15-19 years and 20- 44 years increased slightly in recent years.

/2008/Rates of Chlamydia in women ages 15-19 years and 20- 44 years have shown an increased trend in recent years.//2008//

/2009/Rates of Chlamydia in women ages 15-19 years and 20-44 years continue to show an increase in trend since 1999.//2009//

The remaining indicators reflect raw numbers instead of rates, therefore trends cannot be determined.

F. Other Program Activities

Bright Futures

In 2006, the Office of Maternal and Child Health (OMCH) completed work to implement Bright Futures as a best practice for child and adolescent health care. OMCH contracted with the University of Washington (UW) to complete statewide awareness activities; received additional federal funding to promote the use of Bright Futures in Head Start, preschools, and child care settings; and worked with the national Family Voices organization to implement "Family Matters: Using Bright Futures to Promote Health and Wellness for Children with Disabilities." This is a three-year grant funded by the CDC in which Washington State is one of the pilot sites.

EPSDT

The Health and Recovery Services Administration (HRSA) in the Department of Social and Health Services (DSHS) developed a series of charting inserts for health care providers to use in documenting EPSDT exams. The purpose of the chart insert was to improve documentation and completion of EPSDT exams. This need was identified through the yearly review of the MAA Healthy Options Plans. OMCH provided input into the content and format of the insert forms as well as sites to pilot the forms. Developing this standardized charting insert enabled CHILD Profile to create a Health and Development card for parents to use in keeping track of EPSDT/Well-Child Checkup information. The card is inserted in 125,000 CHILD Profile mailings.

In 2006, OMCH hosted a State Leadership Workshop for Improving EPSDT, sponsored by the MCHB. The workshop was held in September 2006.

/2009/Prenatal Care Outreach Project for African American Women

MIH contracts with the Tacoma-Pierce County Health Department to conduct outreach and deliver health messages to First Steps eligible pregnant women and women of child bearing age, with an emphasis on reaching African American women. The contractor is exploring ways to enhance outreach that are culturally competent for the African American community.

Maternal and Infant Disparities: Strategy Development

Maternal and Infant Health (MIH) is developing strategies to address disparities that engage affected communities and incorporate their feedback into planning for interventions. This work includes developing relationships with leaders in tribal, urban Indian, African American, low income and other communities. A report on MIH strategies to reduce disparities will be released in the fall of 2008./2009//

SIDS Reduction Project with African Americans Project

MIH contracts with the Tacoma-Pierce County Health Department to promote risk reduction for SIDS in the African American Medicaid served community. Local outreach and education will be provided to First Steps providers, child care, churches, and African American leaders and community members. In 2007, this work expanded to include all First Steps clients.

First Steps Redesign Project

DSHS HRSA and the Department of Health worked in coordination with providers to redesign the First Steps Program effective October 1, 2003. The revisions were in response to budget concerns and a major review of the service delivery model. Goals of redesign were to improve the quality of services; contain expenditure growth; and tie intensity of services to client need. The redesign included development of Core Services to include client screening, basic health messages, basic referrals/linkages and minimum level of intervention for identified risk factors.

Drug-Endangered Children

OMCH works with a local coalition on possible ways to provide legal protection for drug-endangered children.

Living Room Forums

The Genetic Services section conducted 15 informal forums with members of the public to gather qualitative data and opinions about three topics related to genetics: newborn screening, equity of genetic services, and genetic discrimination. The results of the forums will be used to inform the state genetics plan. Genetic Services completed an analysis of the data in August 2005. Genetic Services is using the results to inform the State Genetics Plan and to write and publish a peer-reviewed article.

Prenatal Care Collaboration

Maternal and Infant Health, along with the Tobacco Prevention and Control Program, conducted focus groups and key informant interviews with obstetrics providers in Washington. The purpose was to determine effective strategies for influencing and improving screening and intervention for prenatal substance abuse (including tobacco) and violence. A total of 36 providers participated in this research. It was completed in December 2003. Physicians were most interested in practical, concise information for themselves and their office staff. MIH uses this information to help guide strategies to disseminate best practice issues to obstetrics providers. See MCH Journal 2007; Vol 11(3), 241-247.

Action Plan for Oral Health and Children with Special Health Care Needs

The Oral Health Program received funds to develop a state action plan for oral health for children with special health care needs. The Oral Health Program and the Children with Special Health

Care Needs section hosted a forum with key stakeholders to develop the plan.

/2009/In 2007, the Oral Health Program received a federal TOHSS grant to improve access to oral health services for Children with Special Health Care Needs with minor to moderate chronic conditions and eligible for Medicaid and State Children's Health Insurance Program. The funding will be used to implement a part of the Action Plan for Oral Health and Children with Special Health Care Needs./2009//

Child Development Charts

IPCP received funding from three private foundations to support the development, revision, and increased dissemination of three child development charts. The charts address five areas of the Washington State Early Learning and Development Benchmarks. This partnership expanded distribution of the development charts child care, preschool, and health care providers. Charts were distributed to approximately 20,000 health and child care providers and are mailed to about 240,000 parents per year. They are also available to the public through an online ordering system.

OMCH Publications

OMCH distributes a variety of publications addressing issues of importance to the MCH population. These are available in print or on the OMCH Internet site to public health stakeholders including state and federal agencies, public health professionals and associations, parent and family organizations, and the public.

2005

- WISE Grant Recommendation Report
- Children & Youth with Special Health Care Needs: Washington State Report
- Guidelines for the Development and Training of Community-Based Feeding Teams in Washington
- Guidelines for Sexual Health Information and Disease Prevention

2006

- MCH Data and Services Report
- Perinatal Indicators Report
- /2009/updated 2008//2009//***
- MCH Data and Services Report
- Adolescent Needs Assessment
- Children's Mental Health Needs Assessment
- Community Based Nutrition Services for CSHCN in Spokane County, Washington

2007

- WA State Oral Disease Burden Document.
- Youth With Disabilities: Risk Factors for Injury Data Monograph
- Medical Home Data Monograph
- Medical Home "Key Messages"
- Care Coordination within a Medical Home
- Children's Mental Health Needs Assessment Update
- Healthy Child Care Washington Evaluation Report
- /2009/Women's Health and Pregnancy Fact Sheet***
- Health of WA State chapters: Adolescent Pregnancy, Unintended Pregnancy, Singleton Low Birth Weight, Infant Mortality, CSHCN, Mental Health, Oral Health, People with Disabilities, Youth Violence, Child Abuse and Neglect, Medical Home, Access to Prenatal and Preconception Care//2009//***

2008

- Starting Point and Guia para Padres con Niños que Necesitan Cuidado Especializado (2008-09)

-Summer Camp Directory

Child Health Notes (2007-08)

-Decision Tree: Child with Special Needs Referral Process

-Health Supervision for Children in Foster Care

-Tube Feedings: Managing the Nutrition Issues

-Autism Spectrum Disorders: Early Identification

G. Technical Assistance

1. General Systems Capacity Issues

a. Cultural Competency

OMCH wants to provide training at each of four CSHCN regional meetings to local LHJ providers on how to interview families of children with special health care needs in a way that is culturally competent. One of the benefits of this training would be to improve the quality of data collected from families by local CSHCN providers to include elements of ethnicity, education, and economic levels so information can be used in program development. We need a trainer who could teach culturally competent interviewing strategies related to children with special health care needs and their families.

b. Integration

OMCH needs expert facilitation to focus on intra-agency collaboration to improve the health services system for children and families. OMCH/DOH needs to integrate programs within the agency in preparation for cross-agency collaboration. Families often need services from a variety of state programs, agencies and community organizations, but find the services difficult to locate, navigate, and differentiate. OMCH/DOH is collaborating with multiple state and local agencies and organizations on four goals to make the health system work better for families: a common enrollment/application process for easy entry, care coordination to assist families in defining and meeting needs, cross-agency data linkages for program planning, and opportunities for blended funding to maximize impacts.

c. Genetics Education

There have been many advances in the area of testing for Fragile X and some are advocating for targeted newborn screening. Therefore, an educational conference for genetic service providers is being planned for 2004/2005. Technical assistance funds are being sought to bring a nationally known speaker for this event.

/2008/The Fragile X Forum was held August 28, 2006, and featured keynote speaker Randi Hagerman, MD, Medical Director of UC Davis Medical Institute of Neurodevelopmental Disorders. Parents, genetic counselors, care givers, and local researchers attended and participated in the forum.//2008//

d. Adolescent Health

The OMCH needs assistance to collaborate with other state and territorial adolescent health coordinators in order to improve access to national resources and experts on adolescent health. This will improve program development and expertise at the state and territorial level. The MCHB would provide support for travel and per diem to attend an annual meeting and funding or assistance in setting up bridge-lines for conference calls between regions.

In order to ensure that Washington youth are receiving medically and scientifically accurate information OMCH will work with the Washington Office of Superintendent and Public Instruction to develop a list of curricula that are medically and scientifically accurate and have the characteristics of effective sexual health education programs. OMCH requests technical assistance for expert consultation in order to develop criteria for reviewing sexual health education curricula for medical and scientific accuracy. The Child and Adolescent Health section

(CAH) will fund three school-based health centers (SBHCs) in Washington State. CAH will request technical assistance from the National Assembly for School-Based Health Care, Public Health - Seattle & King County, and Oregon Department of Human Services, Public Health Division. These organizations are experts on the development and operation of a SBHC system. Technical assistance will include training to address: best practices, data collection, service delivery methods, and policies.

e. Maternal and Infant Health

Preconception health care can improve birth outcomes by promoting and improving the health of a woman prior to pregnancy. Preconception health care consists of comprehensive screening, health education and promotion and interventions that reduce medical, behavioral, and social risk factors that may affect the health of the woman and future pregnancy outcomes. In order for OMCH to determine effective strategies to increase preconception health services and promote healthier lifestyles, we must collect data from providers practicing in WA State and women 18-30 living in Washington. OMCH needs assessment expertise to design qualitative research tools to conduct qualitative data collection related to preconception health attitudes, behaviors, and services. This data will be used to plan appropriate preconception health activities.

/2009/We no longer plan to submit this request for assessment expertise to design qualitative research tools./2009//

f. Oral Health

The Oral Health Program needs to convene a group of local oral health experts to develop a new funding formula for the distribution of funds to support oral health activities in local health jurisdictions. A collaborative approach to developing a funding formula is recommended by the Public Health Improvement Partnership (PHIP) Funding Allocation Review Process and Allocation Principles. TA funds supporting travel and per diem expenses for work group members who to attend meetings will help achieve a true collaborative experience.

/2009/TA funds were used to support travel and per diem expenses for work group members who traveled to attend meetings. The workgroup plans to propose the new funding formula in May 2008. The new funding formula will be implemented for 2009-2010 biennium./2009//

/2009/g. Public Health Nursing

The CSHCN section has been working with local CSHCN Coordinators to develop a logic model to measure the impact of care coordination through public health nursing on children with special needs and their families. The CSHCN section is seeking funding to support a statewide conference for local CSHCN Coordinators to finalize the logic model and develop a uniform set of measures and outcomes to be used statewide. Data gathered would be used at the local and state levels to ensure ongoing public health support for this population. Additional topics of interest would include grief and loss, self-care, and personal wellness./2009//

2. State Performance Measure Issues

3. National Performance Measure Issues

a. Medical Homes for Children with Special Health Care Needs

This request relates to NPM03. The CSHCN section requests a national expert to present on "Medical Home Spread" at the spring 2007 Medical Home Leadership Network (MHLN) Meeting. At least 50 individuals from the MHLN Teams throughout the state will attend to include primary care providers, parents, CSHCN Coordinators and Family Resources Coordinators. Planning for this meeting will include input from the Title V CSHCN Program, Washington Chapter of AAP, and MHLN representatives.

/2009/We no longer plan to submit this request./2009/

b. This request relates to NPM03. The CSHCN section requests funding to support participation at a one day Expert Meeting to be held on October 26, 2007 in Seattle. The purpose of the meeting is to identify best practice approaches to providing a Medical Home that can be used to improve the quality of pediatric health care and to define the changes and measures the medical practices that enroll in a statewide learning collaborative will use. Team enrollment begins in December of 2007 with the first learning session planned for May 2008. Funding is needed to support the travel and honorariums for five key participants for the Expert Meeting in October.

/2009/We no longer plan to submit this request./2009/

c. Family-Professional Partnerships

This request relates to NPM02. Family members, including those representing culturally diverse communities, must have a meaningful and consistent role in systems development at the state and community levels. To do this, diverse families must be able to partner in decision-making at all levels. The CSHCN Program requests a national expert to help in the planning of a Fall of 2007 training with the Washington Family to Family Network (WFFN), including Parent to Parent, Fathers Network, Family Voices, Title V CSHCN Program and other system partners to develop a process for increasing and measuring the number and effectiveness of culturally competent family-professional partnerships in WA. At least 50 families, youth, and professionals will participate.

/2009/We no longer plan to submit this request./2009/

d. Adolescent Health Transition

This request relates to NPM06. Adolescents with special health care needs face many barriers as they transition to adult health care, including lack of adult providers able to accept them as patients and fear of leaving the security provided by their pediatric practitioners. The CSHCN Program requests a national expert on adolescent health transition issues to provide consultation to the Adolescent Health Transition Project Special Interest Group to assist in identifying and addressing barriers that hinder youth as they transition to adult health care. Strategies and tools for a successful transition would be the focus of the consultation.

e. Immunization Rates

IPCP may request funding to bring in an immunization expert to provide training on increasing immunization rates and addressing parent immunization hesitancy and funding to support local partners in attending the training.

f. Child Death Review Teams

This request related to NPM10 (Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes) and NPM16 (Rate of suicide deaths among youths aged 15 to 19 years). OMCH will request funds to provide 1.5-2 days of training to 15-19 local Child Death Review Teams (CDR) on topics and issues of interest to the teams. The teams previously identified statewide training as a priority. Local CDR Teams provide surveillance and collect data from child death reviews that allow them to make recommendations on how these deaths could be prevented. The data and recommendations are used to generate reports to county commissioners, boards of health and community groups that help inform strategies to reduce by motor vehicle crashes and suicide. Developing skills in being able to interpret data, develop strategies and engage the community in prevention activities will help teams be more effective in promoting strategies to address intentional and non-intentional injuries.

/2009/g. Family Leadership Development

Family leadership development is an ongoing focus of the CSHCN section and is a primary responsibility of the section's Family Integration Consultant. The section will request funds to provide 2-day "Effective Presentations" trainings for an additional 50 parents in

the state. The trainings would be a combination of an initial training and a follow-up mentoring.//2009//

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 a difficult time traveling that far. Maintaining skills in needs assessment and in MCH epidemiology is difficult under these conditions. OMCH requests that MCHB fund and promote a western regional MCH epidemiology conference.

/2009/b. Qualitative Assessment and Analysis:

OMCH plans to request funding for training and technical assistance to family organizations in order to increase those organizations' capacity to survey and assess quality of life issues their organizations work to improve. For example, staff from Fathers Network wish to develop a valid survey tool to measure the impact on the relationships with partners and children of men who are regular participants in local and/or state Fathers Network activities.//2009//

/2009/c. Qualitative Research Methods

OMCH needs to build capacity and expertise in qualitative research methods and analysis especially as we begin planning for the 2010 Needs Assessment. Over the past few years, the OMCH Assessment section has increasingly been asked to use qualitative methods and provide technical assistance on the use of qualitative methods to complement quantitative methods in planning program evaluations and program-specific needs assessments. Most of the staff in OMCH Assessment have expertise solely in quantitative methods, so we are requesting TA funds to build internal capacity related to designing and conducting focus groups and analyzing qualitative data.//2009//

V. Budget Narrative

A. Expenditures

The state of Washington uses the Agency Financial Reporting System (AFRS) as its accounting system. Throughout the reporting year, direct program expenditure data are entered and tracked by the OMCH Budget and Contracts Manager as well as program managers and fiscal coordinators. Aggregated data from this report are adjusted to add overhead costs, which have been entered through the agency allocation system (submitted to and approved by DHHS, Region X). The data from both these sources form the basis for the total expenditure data for the year.

The total expenditure data are entered onto spreadsheets by program. These data are apportioned across reporting forms three, four, and five according to percentages determined by program managers, staff, and local health jurisdictions. Expenditure data are then apportioned to the 30 percent-30 percent requirements, and the 10 percent administration requirement. The same expenditure data are also apportioned according to percentages designated for populations served (Form 4) and levels of the pyramid (Form 5). In this way, OMCH is able to demonstrate relationships among expenditures and requirements, populations served, and levels of the pyramid.

The results of the above calculations are then entered on additional spreadsheets, which contain historical data. From these latter spreadsheets come the variances. Significant variances are analyzed and accounted for. The information is used in building the budget for the coming federal fiscal year (FFY).

/2007/It should be noted that FFY05 represents a transitional year for a change in funding characterization that occurred in FFY04 and was implemented for budget preparation for FFY06. Significant variances resulted from assumptions regarding the availability of Health Service Account (HSA) expenditures to use for MCH Block Grant (MCHBG) match and applied to the total program effort.

Washington State will continue to experience significant variations between budgeted and expended amounts. In the past few years, two events occurred, which affected the variances:

- Significant funding cuts and resource re-allocation occurred.
- Re-characterization of funds in source categories made it difficult to compare across years of budgeted versus expended.

Significant funding cuts and resource re-allocation occurred:

The replacement in 2002 of General Fund-State with Health Service Account funds for Immunizations meant that OMCH could not budget to over-match although it would continue to report total expended effort in its annual reports.

Concurrently, local LHJ's experienced decreased funding. To help LHJ's protect service levels to the MCH population, OMCH permitted state funds to be used at the local level to achieve Medicaid (Title XIX) match. The result was that OMCH had less state dollars to use for Title V MCHBG Maintenance of Effort and thus needed to rely more on Health Service Account dollars for match.

Re-characterization of funds in source categories made it difficult to compare across years of budgeted versus expended:

The primary issue then became how to characterize the different sources of expenditure in discrete categories that made sense over time.

In 2002, Health Service Account fund expenditures were separated from General Fund-State match expenditures by categorizing the former as "Other Funds" on Form 2. This subsequently created confusion on how to report State funds that were expended as part of Medicaid (Title XIX) match.

By FFY2003, Health Service Account funds were budgeted on Form 2, line 3, "State Funds" along with General Fund-State to indicate the MCHBG match.

Continued fiscal reductions meant that the FFY2004 budget was for Maintenance of Effort only. With the FFY2004 reporting, OMCH experienced the impact of LHJ's utilizing state funds for Medicaid match. OMCH received clarification from MCHB that state funds for Medicaid could be budgeted and tracked on line 5, "Other Funds" in order to cleanly report the total expenditure effort for OMCH. Therefore, OMCH determined that General Fund-State funds and Health Service Account funds would be budgeted and reported on Form 2, line 3 "State Funds;" that local and solicited funds would be reported on line 4, "Local Funds;" and that State funds for Medicaid would be budgeted and tracked on line 5, "Other Funds." The budget for FFY06 reflects these distinctions as does the Annual Report for FFY05.

BY FFY07 the fund sources will cleanly match to the expenditure sources. However, OMCH will continue to experience significant budgeted versus expended variations until our fiscal picture improves and we can project more than Maintenance of Effort in our budget.//2007//

/2008/In FFY06, the impacts of decreased funding were evident in the spread of expenditures throughout the MCH pyramid categories. The most dramatic was that OMCH spent 81% less than was budgeted for Direct Services. This change signals a further shift away from direct service in the face of reduced funds. Activities focused on Enabling, Population Based and Infrastructure Building. Other Federal Funding is a significant part of OMCH's ability to address the needs of the MCH population. In FY06, OMCH experienced a \$400,000 decrease in SPRANS Bright Futures expenditures and a \$700,000 decrease in CDC expenditures for the Immunization/CHILD Profile program. These reductions were offset by a \$200,000 increase in Title XIX federal funding participation and OMCH achieved this by directing more state dollars to leverage the funds. This strategy will be lessened in FY08.//2008//

/2009/As in previous years, any activities involving vaccines increased the variance of budgeted to expended amounts. Health Service Account funds are limited to achieving the Maintenance of Effort for budget projections. However total actual expenditures are allowable for annual reporting purposes (see prior years' notes).

Overall OMCH expenditures increased by slightly over 1% compared to FFY06. While State total expenditures for FFY07 increased by about 5%, the increase was due to a 14% increase in HSA expenditures over FFY06. A 17% decrease in state matchable fund expenditures occurred because OMCH leveraged more of the state dollars for Medicaid Match, increasing those expenditures by 29% over FFY06. Additionally, Other Federal Funding decreased 6%. For FFY08, OMCH would expect to see the affect of budget reduction decisions.

Expenditures by type of individuals served revealed OMCH's Administrative expenditures increased over FFY06 by almost 25%. Programs took advantage of carryforward for the second year of FFY06 to cover increased operations costs such as rent, salaries, benefits and inflation. Expenditures for CSHCN increased by 25%, Infants by 19% and Others by 16%, whereas pregnant women decreased 3% and Children 1-22 decreased 5%.

Direct Service expenditures increased by 105% from FFY06-FFY07. The primary providers are the local health jurisdictions and their contract is on a calendar year basis, consequently, the substantial increase can be attributed to timing differences. The annual report reflects the second year of spending for FFY06 and the first year of spending for

FFY07. A comparison of budgeted amounts for FFY06 to FFY07 shows that the amount budgeted actually decreased by 29% reflecting the budget reductions. All other expenditures by type of service had small increases or decreases, except Infrastructure which increased by 7%. While the other categories showed only slight changes, this is masked by the overall reductions in ability to spend and the timing in which it is realized.//2009//

B. Budget

Washington State's biennium runs from July 1 of odd-numbered years through June 30, two years following. The Agency Financial Reporting System (AFRS), which contains past, present, and future time periods, does not allow for data input into a succeeding biennium until the new biennium has commenced.

Previously, Washington State Department of Health's (DOH) policy was to recognize federal grant allotments on the first day of the grant budget period, or upon receipt of the Notice of Grant Award, whichever was later.

For the biennium 03-05, Washington State implemented a new policy. Federal grant allotments were estimated for the whole biennium and entered in AFRS. Allotments were adjusted to reflect actual awards. This policy will continue through the 05-07 biennium.

The FY06 MCH Block Grant (MCHBG) application reflects the most recent award amount; consequently, FY05 will be used. For FFY06, actual expenditure data for FFY04 from Forms 3, 4 and 5 has been used in the projections. The Office of Maternal and Child Health (OMCH) adjusts this baseline information for known or anticipated funding or category allocations as well as economic conditions.

/2007/ The FY07 MCHBG application reflects the most recent award amount; consequently, FY06 will be used. For FY07, actual expenditure data for FY05 from Forms 3, 4 and 5 has been used in the projections. OMCH adjusts this baseline information for known or anticipated funding or category allocations as well as economic conditions.

For FY07 OMCH has designated the "Other" category on Form 2 to reflect Title XIX state funding as well as state funds not available for MCHBG match that contribute to the total effort. These funds are not considered in planning for and achieving Title V match/Maintenance of Effort.*//2007//*

While it is expected that the MCH program will achieve its maintenance of effort amount and 75 percent match, declining funding sources has meant that OMCH does not anticipate being able to overmatch its federal allocation. Washington State's Maintenance of Effort is \$7,573,626. For FY06, match will be achieved using state funding as well as Health Services Account (HSA) funding for the Immunization Program.

*/2007/*Some General Fund State dollars that were historically used to match MCHBG federal dollars have been made available for match at the local level to help alleviate shortfalls for local health jurisdictions. Washington State's Maintenance of Effort is \$7,573,626. For FY07, match will be achieved using state funding (not available for match at the local level or used as match for Title XIX) as well as Health Services Account (HSA) funding for the Immunization Program.*//2007//*

Recent legislation permitting solicitation of funds indicates that in the future, there will be funds available for MCH activities from corporate partners. This activity is still in its infancy; therefore, it is impossible to estimate budget amounts at this time. Should this occur in any significant manner, OMCH expects variances when it reports for FY06.

*/2007/*Recent legislation permitting solicitation of funds indicates that in the future, there will be funds available for MCH activities from corporate partners. These funds are categorized in Local

MCH Funds. This activity is still in its infancy; therefore, budget amounts may vary significantly from actual expenditures reported. OMCH expects variances when it reports for FY07. By FFY07 the fund sources will cleanly match expenditure sources (see Expenditure Narrative). However OMCH will continue to experience significant variations in budgeted versus expended until our fiscal picture improves and we can project more than Maintenance of Effort in our budget.//2007//

Other federal sources, including Title XIX; a number of HRSA and CDC grants; and DSHS Interagency Agreements, complement Washington State's total effort. Additionally HSA dollars and local funds support activities addressing the MCH population.

/2007/ OMCH is projecting a decrease of more than 20% in other federal funding for FFY07. In no case is the office projecting any increase in these sources. Special Projects of Regional and National Significance (SPRANS) grants are expected to decrease by 42%, accounted for by significantly less funds for Early Childhood Comprehensive Systems as well as Social Services and Income Maintenance Research, the latter being a demonstration grant this is wrapping up. Funding from the Centers for Disease Control for Immunizations is expected to be reduced by over 23%. Finally it is expected that there will be less ability to obtain Medicaid Federal Financial Participation (Title XIX) by about 16%.//2007//

Through contracts providing funding to local health jurisdictions (LHJs), OMCH ensures that the minimum 30 percent-30 percent requirement is met. In order to receive funding the LHJs must submit a plan designating at least 30 percent to children with special health care needs (CSHCN) and preventive and primary care for children. The plan ties related activities to CSHCN and preventive and primary care for children, populations served and the MCH pyramid. The LHJs report their expenditure activity by populations served and levels of the pyramid. At the state level, these data form the basis for allocation of funds across programs. Using actual data from FY04, OMCH projects that 52.43 percent of its budget will be expended on preventive and primary care for children; and 31.34 percent will be expended for children with special health care needs. Finally, OMCH is budgeting 6.34 percent for Title V administrative costs.

/2007/Using actual data from FY05, OMCH projects that 54.95% of its budget will be expended on preventive and primary care for children; and 38.56% will be expended for children with special health care needs. Finally, OMCH is budgeting 5.59% for Title V Administrative costs.//2007//

/2008/The FY08 MCHBG application reflects the most recent award amount; consequently, FY07 will be used. For FY08, actual expenditure data from FY06 from Forms 3, 4 and 5 has been used in the projections.

For FY08 OMCH continues to designate the "Other" category on Form 2 to reflect Title XIX state funding as well as state funds not available for MCHBG match that contribute to the total effort. These funds are not considered in planning for and achieving Title V match/Maintenance of Effort.

Using actual data from FY06, OMCH projects that 41% of its budget will be spent on Preventive and Primary Care for Children and 38% will be expended for Children With Special Health Care Needs. OMCH is budgeting 4% for Title V Administrative costs.

Through a variety of contracts and state level efforts, OMCH ensures that it meets the minimum 30% -30% requirement. Contractors are encouraged to adhere to the same formula. OMCH tracks Local health jurisdiction and other contractors' activities through performance-based contracts.

While it is expected that the MCH program will achieve its maintenance of effort amount and 75% match, declining funding sources has meant that MCH does not anticipate being able to overmatch its federal allocation. Some General Fund State dollars, which were historically used

to match MCHBG federal dollars, have been made available for match at the local level to help alleviate shortfalls for local health jurisdictions. Additionally General Fund State dollars have been used to leverage Title XIX federal financial participation funds. Washington State's Maintenance of Effort is \$7,573,626. For FY08, match will be achieved using state funding (not available for match at the local level or used as match for Title XIX) as well as Health Services Account (HSA) funding for the Immunization Program.

Recent legislation permitting solicitation of funds indicates that in the future, there will be funds available for MCH activities from corporate partners. These funds are categorized in Local MCH Funds. Budget amounts may vary significantly from actual expenditures reported until funding streams are stable. OMCH expects variances when it reports for FY07. Currently, only Immunizations/CHILD Profile (IPCP) and Child & Adolescent Health (CAH) have utilized corporate partnerships. IPCP has tackled issues around the extent of involvement in OMCH work and the ethics of funding by businesses. CAH is involved in forming partnerships around school based health clinics. During FY08 OMCH will research this funding resource regarding its potential and how it is used.

Reductions in MCH Block Grant funding and the lack of carry over funds from previous years along with projected decreases in other federal and state sources such as Title XIX, HRSA and CDC grants, and DSHS Interagency Agreements will result in further program and service cuts in Washington. Federal funding reductions include the loss of the Abstinence Education funding effective June 30, 2007.

OMCH is facing a serious deficit due to continued flat funding of MCHBG as well as reductions in the other federal programs. State funding increased only minimally for our new 07-09 biennium. The deficit was further affected by cost of living increases that federal funding must absorb.

Additionally, for 2.5 years OMCH has been in contract negotiations with DSHS and CMS regarding its long-standing interagency agreement. This contract naturally evolved when DOH separated from DSHS almost 20 years ago. Because DSHS and DOH are separate agencies, the work by DOH to support Medicaid's state plan must happen in a contract as part of Medicaid Administrative Match. CMS has developed more concrete guidance for this kind of work, including increased administrative tasks, special timekeeping requirements and more narrowly interpreted definitions of acceptable activities. Consequently, OMCH has the potential to lose as much as 30% of its federal financial participation from Title XIX.

For the past few years, OMCH has been able to weather the decreases in state dollars followed by the current situation through careful planning and use of Title V's carryforward option. This is no longer an option adding further stress.

In response to the above fiscal factors, OMCH initiated internal procedures to produce as much savings as possible. When this strategy was exhausted, the office was forced to engage in budget reductions to contractors. These decisions were made carefully within the driven by MCHBG priorities, state priorities and OMCH priorities. These decisions affected projected funding to direct and enabling services for FY08.

//2008//

/2009/OMCH anticipates continued flat funding at the federal level. To that end, budget reductions occurring in FFY07 will still be in effect. OMCH received the final award in the first week of July 2008. The award was \$11,000 less than projected. Continued decision-making will also occur regarding how to manage the additional shortfall. For the 09-11 Biennium, OMCH is currently involved in an exercise to reduce 10% of state funding. The DSHS contract is expected to result in less Medicaid match. OMCH's priorities, NPM, and SPM form the basis for decision making to assure activities continue to support MCHB's focus, especially for CSHCN and Primary and Preventive Care.

Maintenance of collaborations with partners and stakeholders serving the MCH population is paramount. Of the Federal-State Partnership, the funding majority will be incurred in Population-Based services because of the large amount of activity around vaccines. Infrastructure Building was allocated the next greatest amount, followed by Enabling, and Direct Services.

From the SFY08 Legislative session, OMCH received state funding for some restoration of core public health activities. OMCH also received funding for vaccines, First Steps, Neurodevelopmental Centers, Maxillofacial activities, Miscarriage Management, and a Parkinson Disease Registry. In order to protect OMCH's core activities, some of the latter funding may be returned as part of a state reduction exercise. On the other hand, OMCH has identified and is applying for grant funding that would respond to identified needs in the MCH population.

FFY09's budget provides 37% MCHBG funding for Primary and Preventive Care, 40% for CSHCN and 4% for Administration.//2009//

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.