Washington State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
Promote mental wellness and resilience through increased access to behavioral health and other support services.	Through September 30, 2025, building from the completion of the revised maternal mortality review panel report to the Washington State Legislature, DOH staff will share the findings widely with partners and community members around the state and participate in conversations about ways to involve community members in implementing recommendations. DOH will also include applying lessons learned from the AIHC listening sessions in our work to implement the report's recommendations.	Build on efforts to identify scope of impacts of substance use, including inequities, at the local and state levels. Support efforts to address and mitigate individual and community effects of substance use. Support interventions to address suicide ideation among pregnant and parenting people. Increase and improve reimbursement for behavioral health care from preconception through all phases of pregnancy and the first year postpartum, including screening, treatment, monitoring, and support services. Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges. Implement trauma-informed services into community services, health care systems, and the public sector. Explore implementation of Maternal Levels of Care in Washington state.		SPM 1: Substance use during pregnancy	
Promote mental wellness and resilience through increased access to behavioral health and other support	Through September 2025, ensure 80 percent of birthing hospitals in Washington state have established processes to universally screen everyone giving birth for substance use disorders and perinatal mood and anxiety disorders as part of the Alliance for Innovation on Maternal Health (AIM) patient safety maternal mental health protocols.	Support interventions to address suicide ideation among pregnant and parenting people. Support efforts to address and mitigate individual and community effects of substance use. Build on efforts to identify scope of impacts of substance use, including inequities, at the local and state levels. Increase and improve reimbursement for behavioral health care from		SPM 2: Provider screening of pregnant women for depression	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
services.	By September 2025 we will continue to review cases of maternal mortality in Washington by facilitating meetings with the Maternal Mortality Review Panel. We will provide training opportunities for the panel on health equity and align our work with the CDC.	preconception through all phases of pregnancy and the first year postpartum, including screening, treatment, monitoring, and support services. Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges. Implement trauma-informed services into community services, health care systems, and the public sector. Explore implementation of Maternal Levels of Care in Washington state. Promote standardized depression, anxiety, and substance use screening across the life course. Promote verbal screening for substance use for every person giving birth, using validated tools. Improve the care of infants with neonatal abstinence syndrome (NAS) and neonatal opioid withdrawal syndrome (NOWS). Support interventions to address suicide ideation among pregnant and parenting people.			
Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.	Through September 2025, collaborate with community birth experts from the doula, home visiting, nursing, and community health worker workforce, to identify a process for birth equity priorities and funds distribution and program development in line with anti-racist values. Through September 30, 2025, create training opportunities for perinatal care providers on mood disorders and suicide risk during and after pregnancy, and determine	Support women during the “fourth trimester”; enhance postpartum care to allow providers to check in with mothers about their mental health and other medical issues. Promote standardized depression, anxiety, and substance use screening across the life course. Address the need for more services, support, providers, and insurance coverage, particularly in rural communities and remote areas. Support active engagement by birthing hospitals, licensed birth centers, and perinatal providers in quality improvement efforts that reduce the leading causes of maternal mortality and morbidity. Support healthy pregnancies, births, and maternal recovery; address	ESM WWV.1 - Percentage of women reporting in PRAMS that they had a preventive medical visit in the prior year	NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	feasibility of modifying existing legislation requiring mandatory provider suicide training to include content on maternal suicide, risk factors, and interventions. Through September 2025, support implementation of community birth worker projects that address racial disparities in birth outcomes. Through September 2025, continue to collaborate with Tribal partners to meet the needs of Tribal communities impacted by maternal mortality through additional listening sessions and data quality improvement. By December 2023, support access to prenatal genetic services and technical assistance and disseminate data and trends on prenatal genetic services to stakeholders. By September 2025, convene the prenatal genetics work group to identify prenatal topics that need updated provider resources, and support dissemination of the existing published prenatal genetic resources.	inequities and prevent maternal mortality and morbidity. Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges. Implement trauma-informed services into community services, health care systems, and the public sector. Support interventions to address suicide ideation among pregnant and parenting people. Support efforts to address and mitigate individual and community effects of substance use. Build on efforts to identify scope of impacts of substance use, including inequities at the local and state levels. Increase and improve reimbursement for behavioral health care from preconception through all phases of pregnancy and the first year postpartum, including screening, treatment, monitoring, and support services. Support access to prenatal genetic services. Provide technical assistance by offering all prenatal genetic providers paid subscription access to the Teratogen Information System (TERIS) database. In collaboration with our clinical partners, assure access to prenatal genetic services in rural and/or underserved communities. Disseminate data and trends on service utilization of prenatal genetic services to stakeholders. In collaboration with our clinical partners, disseminate printed published prenatal genetic resources to non-genetic clinicians ordering prenatal genetic tests.			NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		In collaboration with our clinical partners, create and publish new prenatal resources on topic areas of unmet need.			NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD
Identify and reduce barriers to quality health care.	By September 2025 prepare an intervention design that will enable the full implementation of the universal PPV NPM in the next fiscal year to include identifying the scope of the intervention, responsible staff, and data sources that could be utilized to track the success of the intervention in coming years.	Support healthy pregnancies, births, and maternal recovery; address inequities and prevent maternal mortality and morbidity.	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Enhance and maintain health systems to increase timely access to preventive care, early screening,	.By December 31, 2025, complete a statewide gap analysis for perinatal substance use services, and align this analysis with county-level maternal and infant data. By December 2025, support access to pediatric genetic	Collaborate with Office of Immunization on infant vaccine promotional messaging to providers and families. Support and promote bidirectional referral and linkage systems at the local, regional, and statewide levels. Identify and develop methods to monitor systems and data gaps and improvements needed in preventive care, early screening, and referral.		SPM 3: Universal developmental screening system participation	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
referral, and treatment to improve population health across the life course.	services. By September 2025, collect and analyze service utilization data on pediatric genetic services. By September 2025, support critical congenital heart disease (CCHD) newborn screening providers in birthing hospitals and midwifery clinics. By September 2025, test and support interoperability of EHRs with Strong Start through HIE By September 2025, expand UDS user base to include Early Care and Education (ECE) providers. By September 2025, support implementation and promotion of Spanish language version of Strong Start data system.	Engage partners and stakeholders, including those in historically marginalized communities, to promote the value of universal developmental screening and use of the data system. Provide training and technical support to data system end users. Conduct data analysis and generate reports to inform decision-making and program planning. Identify existing disparities and work with historically marginalized communities to develop tailored outreach and education. Support access to pediatric genetic services. Conduct data analyses and create summary reports for birth hospitals and midwifery clinics on Critical Congenital Heart Disease (CCHD) diagnoses data. Through contractual collaboration with our clinical partners, assure the provision of and access to pediatric genetic services in rural and/or underserved communities. Collect and analyze critical congenital heart disease (CCHD) diagnoses data and publish a hospital summary report of findings for birth hospitals and midwifery clinics. Collect, analyze, and disseminate data and trends on service utilization of pediatric genetic services to stakeholders. Create a landing page and publish a comprehensive resource for families on the most prevalent pediatric genetic rare diseases. Through contractual collaboration with a clinical partner, work with IT support and Strong Start vendor to test and support interoperability. Conduct outreach to Early Care and Education (ECE) partners and providers to inform development of Strong Start ECE dashboard. Conduct promotional campaign and collaborate with local partners to encourage widespread use of Strong Start UDS system Spanish version in			

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		Latinx communities.			
Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.	Annually, partner with at least eight local health jurisdictions to offer perinatal home visitation services to low income women in local communities, supporting well-newborn visits, on-schedule vaccination, and breastfeeding initiation/sustenance. Continue to promote awareness and training opportunities to health care providers on provider bias and disparities on an ongoing basis. By September 20, 2025, in partnership with Child Protective Services at the Department of Children, Youth, and Families and Help Me Grow, finalize piloting the diagnostic definition for neonatal abstinence syndrome as a central component to improve care of substance-affected newborns in Yakima and Pierce counties. By December 31, 2024, complete the development of a new data system for the Birth Defects Surveillance System (BDSS), which will combine birth defects reporting data from providers and facilities with existing information from vital statistics, including birth, death, fetal death, and hospital discharge data.	Promote breastfeeding and lactation support programs and services. Promote home visiting to provide support to families where they are. Implement trauma-informed services into community services, health care systems, and the public sector. Implement and promote fatherhood inclusion opportunities and support resources. Support active engagement by birthing hospitals, licensed birth centers, and perinatal providers in quality improvement efforts that reduce the leading causes of maternal mortality and morbidity. Support healthy pregnancies, births, and maternal recovery; address inequities and prevent maternal mortality and morbidity. In collaboration with internal and external partners, provide health equity learning and education opportunities, including implicit and explicit bias and antiracism trainings, for perinatal health providers across Washington state and members of the Maternal Mortality Review Panel. Provide training for birthing hospital clinical staff about the policy definitions for infants exposed to substances and the online referral process for notification and wrap around services. Integrate motivation interviewing and reflective listening training into hospital trainings to facilitate trauma-informed communication about notification and reporting requirements. Promote and facilitate education for health care professionals and systems regarding stigma, cultural sensitivity, and implicit bias in perinatal health care systems. Identify and develop methods to monitor systems and data gaps and improvements needed.	***Inactive -*** *ESM BF.1 - Percentage of eligible facilities certified "Breastfeeding Friendly Washington" by Department of Health* ***Inactive -*** *ESM BF.2 - Percentage of births taking place in facilities certified as Breastfeeding Friendly by Department of Health* ESM BF.3 - Percentage of births taking place in facilities certified as compliant with LIFE by Washington State Department of Health.	NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		Develop monitoring systems to identify leading causes of infant mortality/morbidity.			
Child Health					
Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across the life course.	By September 30, 2025, increase the number and proportion of families with children (ages 0-3) who receive information about developmental screening, developmental milestones, and resources to support healthy child development. By September 30, 2023 and ongoing, increase the number of pediatric health care practices who are using the Strong Start statewide universal developmental screening and referral data system as part of their practice. By September 30, 2025, identify improved methods to track the proportion of children who are receiving timely developmental screenings Through September 2025, increase the proportion of children who receive timely well-child visits and are up-to-date on recommended vaccination By September 2025, collaborate with health care partners to develop and implement a project to improve the transition from prenatal to pediatric care for new	Promote Universal Developmental Screening: Increase early identification and intervention for developmental concerns through promotion of developmental screening and ongoing development/promotion of the Strong Start Universal Developmental Screening data system with providers, families, and other partners Promote Access to and Utilization of Child Well-Visits: Promote well-child visits for children ages 0-11 years through parent and provider education, and system change strategies. Advance Health Systems Change to Improve Access to Equitable, Integrated, Family-Centered Health Care: Collaborate with health care providers, family leaders, and community and system partners to identify and implement health care system strategies to improve the organization, content, and quality of care in early childhood. Strengthen Coordinated Intake and Referral System(s): Help families with young children connect to health care, developmental screening, and other supports through ongoing development and implementation of the statewide Help Me Grow WA system and other local systems	***Inactive -*** *ESM DS.1 - Number of ASQs provided by WithinReach to callers* ***Inactive -*** *ESM DS.2 - Number of children reported by HCA as receiving developmental screening* ***Inactive -*** *ESM DS.3 - Percentage of children screened by Home Visiting/MIECHV programs* ESM DS.4 - Number of developmental screens completed through Help Me Grow Washington.	NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS	NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	parents. By September 2025, increase the number of health care providers using online referral to connect families to HMG WA.				
Promote mental wellness and resilience through increased access to behavioral health and other support services.	Through Septeber 2025, implement the early childhood comprehensive systems strategic plan in collaboration with state partners and families. Through September 2025, increase the number of health care providers who have received training and are incorporating focus on early relational health and screening for social and economic needs in routine care.	Support Early Childhood Comprehensive Systems Development: In alignment with ECCS initiative, contribute leadership and cross-sector coordination for development of an integrated and comprehensive early childhood system of services and supports that helps set the odds for healthy development and child well-being. Enhance Coordination of Community Supports for Families (P-3): In alignment with ECDHS initiative, work with selected communities and state partners to better meet the social, emotional, economic, and other needs of families with young children through improved coordination of local family resource coordinators, community navigators, home visitors and other supports for families.		SPM 6: Social and emotional readiness among kindergarteners	
Promote mental wellness and resilience through increased access to behavioral health and other support services.	From January 2021 through January 2025, work with partners to expand access to behavioral health and other support services for children ages 11 and under and families. Through September 2025, increase the number of health care providers who have received training and are incorporating focus on caregiver well-being, early relational health, and screening for social and economic needs in routine care.	Expand Availability of Child and Family Mental and Behavioral Health Services and Supports: Participate in state and local efforts to expand access to and availability of infant, early childhood, child, and family relational and behavioral health services and supports, including culturally aligned supports and innovative models (e.g., community health workers).		SPM 5: Ease of receiving mental health treatment or counseling	
Optimize the health and well-being of children and	By September 2025, increase community-based primary prevention programs, practices, policies, and systems to reduce	Sustain and Grow Collaborative Partnerships for Child and Family Well-being: Lead the ongoing development of collaborative partnerships through convening and facilitation of partner meetings and working groups to advance a common vision for child and family flourishing.		SPM 12: Percent of families showing 4 or more factors indicating high resilience to challenges.	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
adolescents, using holistic approaches.	childhood adversity and promote child and family well-being. By October 1, 2023 and on-going, develop a sustainability plan to continue progress on strategies and actions identified in collaboration with Essentials for Childhood partners. By December, 2024 and on-going, develop a positive community norms campaign or educational awareness campaign focused on child well-being in the context of their families and communities. By September 2025, advance program, policy, and system changes that increase the proportion of families with children who have sufficient household income plus concrete supports to meet basic needs. By September 2024, develop an approach to measure and monitor community contextual resilience/community factors that reduce or mitigate childhood adversity and support positive child and family well-being outcomes. By September 30, 2024, launch a communications campaign focused on supporting middle childhood mental well-being (ages 6-11 years), including addressing	Build Capacity to Address ACEs, PCEs, and Resilience: Expand capacity to prevent child and family adversity, promote well-being, and advance equity through collaborative learning, advocacy, and increased access to data. Cultivate the Community Conditions that Children and Families Need to Thrive: Support efforts to measure, monitor, and promote community level factors that reduce childhood adversity and promote child and family well-being. Strengthen Family Economic and Parent/Parenting Supports: Identify and implement program and policy solutions that support family economic stability and family well-being. Increase Fatherhood Inclusion and Support: Elevate attention to the needs of fathers and father-figures across child and family-serving programs. Communicate the Importance of Social Connections and Relational Health: Research and disseminate emerging information about the importance of family cohesion, social connectedness, and relational health for child and family well-being, and opportunities to address concerning trends and issues. Support Child Fatality Review and Prevention: Contribute to understanding and reducing preventable child deaths through support of state and local child fatality review and prevention efforts.			

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	impacts of social media use and bullying. Through September 2025 and beyond, establish a comprehensive state Child Fatality Review Program to identify preventable factors contributing to child deaths, develop recommendations for addressing these factors, and create state and local prevention plans. By September 2025, increase the number of programs within DOH that are intentionally working to increase fatherhood inclusion and support. By September 30, 2025, develop and disseminate materials focused on promoting family cohesion, social connectedness, and relational health, including increasing awareness of early relational health, impacts of technology on parenting and child development, and harms of verbal abuse and bullying on child well-being.				
Enhance and maintain health systems to increase timely access to preventive care, early screening,	By September 2025 prepare an intervention design that will enable the full implementation of the universal MH NPM in the next fiscal year to include identifying the scope of the intervention, responsible staff, and data sources that could be utilized to track the	Partner with other MCHBG staff to design an intervention to ensure children with or without special health care needs have a medical home.	ESM MH.1 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
referral, and treatment to improve population health across the life course.	success of the intervention in coming years.				through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Adolescent Health					
Promote mental wellness and resilience through increased access to behavioral health and other support services.	By September 30, 2025, implement 1-2 recommendations of the Youth Advisory Council focused on improving behavioral health supports for teens and young adults. By September 30, 2025, provide funding to support health campaigns in SBHCs that promote awareness/reduce stigma around adolescent substance use. By September 30, 2025, increase the number of school-based health centers with licensed mental health services by 5 percent. By September 30, 2025, host 2-3 meetings for the new YAC's	Improve the knowledge and ability of health care professionals to deliver comprehensive evidence-based/informed services, including integrated mental health and chemical dependency screening and interventions for adolescents and young adults. Promote standardized depression, anxiety, and substance use screening that are adolescent and young adult-friendly. Take action to reduce stigma surrounding adolescent and young adult behavioral health conditions and implement trauma-informed services specific to adolescents and young adults in community services and health care systems. Expand access to and the quality of behavioral health services in SBHCs. Build on efforts to identify scope of impacts of substance use, including inequities among adolescents and young adults from priority populations. Support efforts to address and mitigate individual and community effects of substance use among adolescents and young adults.		SPM 7: Percentage of tenth grade students who have an adult to talk to when they feel sad or hopeless	

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	Mental and Behavioral Health Subcommittee. By September 30, 2025, collaborate with Youth Voice volunteers to create and post social media about youth mental health to raise awareness and address stigma. By September 30, 2025, follow up on the needs assessment with recommendations and actions for improvement By September 30, 2025, develop and provide technical assistance for youth-serving health care providers to improve/increase youth-friendly care practices By September 30, 2025, partner with the Washington School Based Health Alliance and other DOH programs to present information about School-Based Health Centers, and their importance in improving access to health care and well visits for adolescents. Through September 2025, implement efforts to expand trainings to additional adolescent and young adult friendly providers. Through September 30, 2025, identify and/or develop behavioral health interventions for young	Support interventions to address suicide ideation among youth, especially among those marginalized by mainstream society. Respond to data collection activities, including top barriers for adolescents and young adults in seeking health care services as identified by young people and their health care providers. Foster measurable quality improvements in preventive care across the health system to increase adolescent and young adult-friendly care. Promote school-based health strategies to serve adolescent populations where they are. Promote the use of evidence-based practice guidelines, like Bright Futures, among adolescent health providers. Increase the proportion of Washington adolescents who receive age-appropriate, evidence-based clinical preventive services. Promote preventive care screening and wellness visits for adolescents and young adults.			

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	people based on the ideas and recommendations of the Youth Advisory Council.				
Promote mental wellness and resilience through increased access to behavioral health and other support services.	By September 30, 2025, increase the number of school-based health centers with licensed mental health services by 5 percent. By September 30, 2025, meet with the third cohort of the YAC to discuss operationalization of YAC recommendations, and develop a plan of action.	Support efforts to address and mitigate individual and community effects of substance use among adolescents and young adults. Build on efforts to identify scope of impacts of substance use, including inequities among adolescents and young adults from priority populations.		SPM 8: Percentage of tenth grade students who report having used alcohol in the past 30 days	
Identify and reduce barriers to quality health care.	By September 30, 2025, develop and provide technical assistance for school-based health centers and adolescent health providers so they report the ability to appropriately bill insurance for 50 percent of services delivered. By September 2025, promote holistic sexual health through partnerships with community based organizations from historically underserved communities. By September 30, 2025, partner with youth volunteers to develop and implement an adolescent health promotional campaign using social media.	In collaboration with payers and health coverage organizations, understand and mitigate issues related to financial eligibility for health care and other support services. Conduct needs assessment to identify existing strengths and gaps in data, as well as top barriers for adolescents and young adults in seeking health care services. Ensure all adolescents and young adults, regardless of race, ethnicity, sexual orientation, and gender identity, have a full range of education, access, and ability to utilize health services that meet their individual needs. Support and enhance efforts to increase health literacy among adolescents and young adults.	ESM AWV.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Optimize the health and well-being of children and adolescents, using holistic approaches.	By September 30, 2025, meet with the third cohort of the YAC to discuss operationalization of YAC recommendations, and develop a plan of action. By September 30, 2025, develop and provide technical assistance for school-based health centers and adolescent health providers so they report the ability to appropriately bill insurance for 50 percent of services delivered.	Include adolescents in this work through strategies such as building and supporting a youth advisory council, and identify other meaningful ways to engage the population to be served. Collaborate with internal and external partners to identify and implement solutions that support accessible, affordable, and quality childcare, including care that meet the needs of families with CYSHCN. Promote school-based health strategies to serve adolescent populations where they are.	ESM AWV.1 - Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year	NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Teen birth rate, ages 15

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB
Improve the safety, health, and supportiveness of communities.	By September 30, 2025, continue work to promote and support violence prevention efforts with partners, including DOH Injury and Violence Prevention and the Office of the Superintendent of Public Instruction (OSPI). By September 30, 2025, continue to promote resources and information about, and support projects that promote healthy relationships for young people. By September 30, 2025, continue to participate in OSPI's monthly School Safety and Student Wellbeing Workgroup to align efforts with agency partners.	Support violence prevention efforts and promote healthy relationships among adolescents and young adults. Build networks and resources in communities to enable and enhance community and peer support.		SPM 9: Adolescents reporting at least one adult mentor	
Children with Special Health Care Needs					
Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.	Through September 2025 explore opportunities to work with the Community Health Worker (CHW) program to increase CHW knowledge of developmental screening and milestones. Implement the Autism and Developmental Disabilities module as part of broader training curriculum for CHWs. Develop strategies for linking trained CHWs to autism diagnostic network.	Improve overall awareness of the complex needs of the children and youth with special health care needs (CYSHCN) population as a demographic identity, with distinctive cultural needs for access to communities and systems of care. Partner with the Medical Home Partnerships Project to provide state-level subject matter expertise and technical assistance, and coordinate with the UW LEND program and Seattle Children's Hospital to support communities in workforce development, resource development, and ongoing training on family-centered, comprehensive systems of care for CYSHCN. Provide targeted subject matter expertise to contractors and providers, including CYSHCN Coordinators, on areas of expertise such as complex	ESM MH.1 - Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
	By September 30, 2025, increase the number of dietitian members of the Nutrition Network with CYSHCN training and the number of community-based feeding teams working with CYSHCN. Prioritize training and support given to those in counties with limited resources and those with ability to provide services via telehealth. By December 2023, support access to clinical genetic services. By December 2025, collect and analyze service utilization data on patients utilizing clinical genetics services, and disseminate the information to our stakeholders.	nutrition for CYSHCN, children and youth with clinical and behavioral complexity, including autism, navigating state systems and policy, care coordination, family navigation, and community referral systems and clinical linkages. Identify and develop methods to establish baseline data on CYSHCN, systems of care, gaps, and barriers to equitable, quality care. Make data accessible via a CYSHCN dashboard and other dissemination efforts. Utilize data to identify referral opportunities and strategies, and community needs for local health care resources and equitable service delivery. Support access to clinical genetic services.			NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC
Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their families.	By September 30, 2025, increase the percentage of CYSHCN ages 0-17 who receive care in a well-functioning system by 5 percent.	Provide services to CYSHCN and family members of CYSHCN so they can be trained, engaged, supported, and involved at all levels of program planning and implementation of services for CYSHCN. Implement and promote inclusion opportunities and support resources for fatherhood, foster parents, grandparents, kinship care. Partner with the Washington State Leadership Initiative collaborative and community-based organizations to elevate family voices and provide connections so family voices can effectively influence the development of systems and services for CYSHCN. Promote and facilitate successful transitions including transition from hospital to home, from Birth to 3 into school and community-based services, and from pediatric to adult specialty services. Through partnerships, address the need for improved access to affordable services, and increased availability of CYSHCN service providers, quality healthcare, access to insurance, and adequate health care financing,	ESM AI.1 - 15.1 Increase the percentage of CYSHCN who report having insurance when receiving services	NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured (Adequate Insurance, Formerly NPM 15) - AI	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		particularly in rural communities and remote areas regardless of language spoken, gender identity, race and ethnicity, immigration status, or insurance status of families. Through partnerships, facilitate innovative programming and technology solutions such as telehealth and remote services to address gaps in rural and remote areas and other barriers to access to care. Enhance and maintain health systems and improve financing options to improve care coordination and family navigation.			NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care,

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
					Formerly NOM 25) - FHC
Promote mental wellness and resilience through increased access to behavioral health and other support services.	By September 30, 2025, decrease the percentage of 10th grade CYSHCN who report they have considered attempting suicide by 5 percent. By September 30, 2025, create and disseminate health education publications specific to autism and other developmental disabilities that are adopted by the suicide prevention program as part of their health education resources and curricula for the state-level suicide prevention plan.	Take action to reduce stigma surrounding behavioral health, treatment and related challenges. Support interventions to address suicide ideation among CYSHCN. Identify opportunities to infuse trauma-informed care into working with CYSHCN. Collaborate with surveillance and epidemiology Healthy Youth Survey leads to advocate for including questions about special health care needs in all Healthy Youth Surveys. Identify and disseminate data for analysis on risk of suicide ideation for CYSHCN, including focus on youth with autism and other developmental disabilities. In the evidence base, increase representation of youth with disabilities as a complex disparate group with a high intersectionality between other known populations vulnerable to high risk factors.		SPM 10: Suicide ideation among youth with special health care needs	
Promote mental wellness and resilience through increased access to behavioral health and other support services.	By September 30, 2025, decrease the percentage of 10th grade CYSHCN who report they have considered attempting suicide by 5 percent. By September 30, 2025, create and disseminate health education publications specific to autism and other developmental disabilities that are adopted by the suicide prevention program as part of their health education resources and curricula for the state-level suicide prevention plan. By September 30, 2025, increase the percentage of CYSHCN ages 0-17 who receive care in a well-functioning system by 5 percent.	Take action to reduce stigma surrounding behavioral health, treatment, and related challenges. Support interventions to address suicide ideation among CYSHCN. Collaborate with surveillance and epidemiology Healthy Youth Survey leads to advocate for including questions about special health care needs in all Healthy Youth Surveys. Identify and disseminate data for analysis on risk of suicide ideation for CYSHCN, including focus on youth with autism and other developmental disabilities. In the evidence base, increase representation of youth with disabilities as a complex disparate group with a high intersectionality between other known populations vulnerable to high risk factors. Provide services to CYSHCN and family members of CYSHCN so they can be trained, engaged, supported, and involved at all levels of program planning and implementation of services for CYSHCN. Implement and	ESM AI.1 - 15.1 Increase the percentage of CYSHCN who report having insurance when receiving services	NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured (Adequate Insurance, Formerly NPM 15) - AI	NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS NOM - Percent of children who

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
		promote inclusion opportunities and support resources for fatherhood, foster parents, grandparents, kinship care. Partner with the Washington State Leadership Initiative collaborative and community-based organizations to elevate family voices and provide connections so family voices can effectively influence the development of systems and services for CYSHCN. Promote and facilitate successful transitions including transition from hospital to home, from Birth to 3 into school and community-based services, and from pediatric to adult specialty services. Through partnerships, address the need for improved access to affordable services, and increased availability of CYSHCN service providers, quality healthcare, access to insurance, and adequate health care financing, particularly in rural communities and remote areas regardless of language spoken, gender identity, race and ethnicity, immigration status, or insurance status of families. Through partnerships, facilitate innovative programming and technology solutions such as telehealth and remote services to address gaps in rural and remote areas and other barriers to access to care. Enhance and maintain health systems and improve financing options to improve care coordination and family navigation.			have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC