Washington State Action Plan Table 2024 Application/2022 Annual Report

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Women/Maternal Health					
Promote mental wellness and resilience through increased access to behavioral health and other support services.	Build on efforts to identify scope of impacts of substance use, including inequities, at the local and state levels. Provide training for clinical staff providing care at birthing hospitals Improve the care of infants with neonatal abstinence syndrome (NAS) and neonatal opioid withdrawal syndrome (NOWS). Support efforts to address and mitigate individual and community effects of substance use.	By September 30th, 2024, and in partnership with the Child Welfare Division at the Department of Children, Youth, and Families, Within Reach and the Washington State Hospital Association, implement the state's new portal and policy for infants who are born substance exposed, including promotion of supports for the substance-affected mother/infant dyad.	SPM 1: Substance use during pregnancy		
Promote mental wellness and resilience through increased access to behavioral health and other support services.	Support interventions to address suicide ideation among pregnant and parenting people. Support efforts to address and mitigate individual and community effects of substance use. Build on efforts to identify scope of impacts of substance use, including inequities, at the local and state levels. Increase and improve reimbursement for behavioral health care from preconception through all phases of pregnancy and the first year postpartum, including screening, treatment, monitoring, and support services. Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges. Implement trauma-informed services into community services, health care systems, and the public sector.	Through September 30, 2025, building from the completion of the revised maternal mortality review panel report to the Washington State Legislature, covering the deaths that occurred to women during pregnancy or within one year of pregnancy, inclusive of deaths resulting from suicide, substance overdose, homicide, and deaths that occurred out of state, and covering data from 2014-2020. The report will include identification of gaps and issues contributing to preventable, pregnancy-related deaths in the maternal behavioral health system and recommendations for improvement. Recommendations will address disparities and health	SPM 2: Provider screening of pregnant women for depression		

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	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.	equity improvements to reduce maternal mortality and will include contributions from our tribal and Indigenous partners. Through September 2025, ensure 80 percent of birthing hospitals in Washington state have established processes to universally screen everyone giving birth for substance use disorders and perinatal mood and anxiety disorders as part of the Alliance for Innovation on Maternal Health (AIM) patient safety maternal mental health protocols. By September 2025 we will continue to review cases of maternal mortality in Washington by facilitating meetings with the Maternal Mortality Review Panel. We will provide training opportunities for the panel on health equity and align our work with the CDC.			
Optimize the health and well-being of adolescent girls and adult women, using holistic approaches that empower self-advocacy and engagement with health systems.	Integrate MCH COVID communications into the DOH COVID team communications and maintain current guidance documents and communications. Support the “One Vax Two Lives” campaign to dispel misinformation, and address fears some expecting families may have about COVID vaccines. This campaign is a partnership with The University of Washington‘s Center for an Informed Public and the UW Medicine‘s Department of OB-GYN. Support access to and communication clarity around emerging guidance for COVID-19 vaccination during pregnancy and lactation. Support access to and communication clarity around emerging guidance	By Sept 2023, maintain communications and guidance documents for COVID and pregnancy/birth/postpartum/children to reflect up-to-date COVID data and understanding, to include racial disparity considerations. By December 2022, distribute health promotion materials in relation to Senate Bill 6128 passed by the Washington State Legislature to expand Medicaid coverage to one year postpartum.	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	ESM 1.1: Percentage of women reporting in PRAMS that they had a preventive medical visit in the prior year	NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations NOM 3: Maternal mortality rate per 100,000 live births NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term

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	for COVID-19 vaccination during pregnancy and lactation. Support women during the “fourth trimester”; enhance postpartum care to allow providers to check in with mothers about their mental health and other medical issues. Promote standardized depression, anxiety, and substance use screening across the life course. Address the need for more services, support, providers, and insurance coverage, particularly in rural communities and remote areas. Support active engagement by birthing hospitals, licensed birth centers, and perinatal providers in quality improvement efforts that reduce the leading causes of maternal mortality and morbidity. Support healthy pregnancies, births, and maternal recovery; address inequities and prevent maternal mortality and morbidity. Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges. Implement trauma-informed services into community services, health care systems, and the public sector. Support interventions to address suicide ideation among pregnant and parenting people. Support efforts to address and mitigate individual and community effects of substance use. Build on efforts to identify scope of impacts of substance use, including inequities at the local and state levels. Increase and improve reimbursement for behavioral health care from preconception through all phases of pregnancy and the first year postpartum, including screening, treatment, monitoring, and support services.	Through September 2025, collaborate with community birth experts from the doula, home visiting, nursing, and community health worker workforce, to identify a process for birth equity priorities and funds distribution and program development in line with anti-racist values. Through September 30, 2025, create training opportunities for perinatal care providers on mood disorders and suicide risk during and after pregnancy, and determine feasibility of modifying existing legislation requiring mandatory provider suicide training to include content on maternal suicide, risk factors, and interventions. By December 2022, collaborate with tribal partners to hold a listening session that includes plans to better understand maternal mortality in tribal and Indigenous communities, and content to be included in the next Maternal Mortality Review Panel report that includes recommendations centered on the tribal context, with added consideration of unique challenges and opportunities of tribal members and nations in relation to quality improvement. Through September 2025, support			births (37, 38 weeks) NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births NOM 10: Percent of women who drink alcohol in the last 3 months of pregnancy NOM 11: Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth

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	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.	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.			
Perinatal/Infant 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.	Support the “One Vax Two Lives” campaign to dispel misinformation, and address fears some expecting families may have about COVID vaccines. This campaign is a partnership with The University of Washington‘s Center for an Informed Public and the UW Medicine‘s Department of OB-GYN. Support access to and communication clarity around emerging guidance for COVID-19 vaccination during pregnancy and lactation. Collaborate with Office of Immunization on infant vaccine promotional messaging to providers and families. Support and promote bidirectional referral and linkage systems at the local, regional, and statewide levels. Identify and develop methods to monitor systems and data gaps and improvements needed in preventive care, early screening, and referral.	By September 30, 2023, support infant vaccinations as outlined by the CDC, and continue COVID-19 vaccination campaign efforts for pregnant people through providers, managed care organizations, pharmacies, and local health jurisdictions. By June 30, 2023, secure funding through 2023 legislative session to fully support the EHDDI program’s data system, referral services, and outreach activities to ensure quality, family-centered newborn hearing screening, diagnostic, and early support services are provided in Washington.	SPM 3: Universal developmental screening system participation		

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	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.	.By December 31, 2022, complete a statewide gap analysis for perinatal substance use services, and align this analysis with county-level maternal and infant data. By February 1, 2024, launch statewide roll-out of implementation phase of new developmental screening program, working with early childhood partners as part of a statewide effort to increase developmental screening rates and connection to responsive services. By December 2023, support access to pediatric genetic services and disseminate data and trends on clinical genetic services and CCHD hospital summary reports to stakeholders.			
Improve infant and perinatal health outcomes and reduce inequities that result in infant morbidity and mortality.	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.	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	NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	***Inactive -*** *ESM 4.1: Percentage of eligible facilities certified "Breastfeeding Friendly Washington" by Department of Health* ***Inactive -*** *ESM 4.2: Percentage of births taking place in facilities certified as Breastfeeding Friendly by Department of Health*	NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.5: Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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	In collaboration with internal and external partners, provide health equity learning and education opportunities, including implicit and explicit bias and antiracism trainings, for perinatal health providers across Washington state and members of the Maternal Mortality Review Panel. Provide training for birthing hospital clinical staff about the policy definitions for infants exposed to substances and the online referral process for notification and wrap around services. Integrate motivation interviewing and reflective listening training into hospital trainings to facilitate trauma-informed communication about notification and reporting requirements. Promote and facilitate education for health care professionals and systems regarding stigma, cultural sensitivity, and implicit bias in perinatal health care systems. Identify and develop methods to monitor systems and data gaps and improvements needed. Develop monitoring systems to identify leading causes of infant mortality/morbidity.	Services at the Department of Children, Youth, and Families and Help Me Grow, finalize piloting the diagnostic definition for neonatal abstinence syndrome as a central component to improve care of substance-affected newborns in Yakima and Pierce counties. By December 31, 2023, complete the development of a new data system for the Birth Defects Surveillance System (BDSS), which will combine birth defects reporting data from providers and facilities with existing information from vital statistics, including birth, death, fetal death, and hospital discharge data.		ESM 4.3: Percentage of births taking place in facilities certified as compliant with LIFE by Washington State Department of Health.	
Child Health					
Enhance and maintain health systems to increase timely access to preventive care, early screening, referral, and treatment to improve population health across	Provide leadership, staffing, and funding support for the ongoing development and implementation of the statewide Help Me Grow WA system and related collaborative statewide initiatives that include explicit focus on connecting families to developmental screening and resources. Communicate developmental screening and developmental milestones information through a variety of social media and virtual/live modalities. Incorporate Vroom™ brain building tips and other child development resources in Watch Me Grow Washington mailings. Promote utilization of Strong Start Universal Developmental Screening data system with all health care provider practices serving young children	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	NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	***Inactive -*** *ESM 6.1: Number of ASQs provided by WithinReach to callers* ***Inactive -*** *ESM 6.2: Number of children reported by HCA as receiving developmental screening*	NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) NOM 19: Percent of children, ages 0 through 17, in excellent or very good health

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the life course.	in Washington State. Promote Strong Start with state and local partners that work closely with families of children birth through age five, and provide training and technical assistance, as well as information about resources and supports related to early childhood development. Continue coordination between Strong Start and Help Me Grow WA to ensure alignment of developmental screening data systems and services. Encourage the coordination of pediatric screening efforts, results, and referrals among clinical care settings, medical homes, child-care settings, schools, and other organizations. Explore options to improve availability and usability of Medicaid data provided through HCA-DOH mutual data share agreement. Explore data agreements with other insurers or other sources to track developmental screening rates. Incorporate developmental screening data from Strong Start UDS data system. Promote routine well-child visits and recommended preventive care in early and middle childhood (birth to age 11). Activities include Patient/Parent education (communications campaign, social media posts, school flyers, public education ads, etc), and provider education (webinars, communications, clinic collaborations, etc.). Partner with pediatric and primary care clinic systems to engage over-due or unestablished members/children into the practice to receive well-child visits. Establish partnerships with early learning focused organizations and school-based health centers to identify and deploy collaborative activities to improve well-child visits.	universal developmental screening and referral data system as part of their practice. By September 30, 2024, identify improved methods to track the proportion of children who are receiving timely developmental screenings Through September 2025, increase the proportion of children who receive timely well-child visits and are up-to-date on recommended vaccination		***Inactive -*** *ESM 6.3: Percentage of children screened by Home Visiting/MIECHV programs* ESM 6.4: Number of developmental screens completed through Help Me Grow Washington.	
Promote mental	Partner with pediatric and family medicine organizations to promote focus on strengthening parent-child relational health in well-child visits.	Through January 2025, implement the early childhood comprehensive	SPM 5: Ease of receiving mental health treatment or		

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wellness and resilience through increased access to behavioral health and other support services.	Support training for clinical and community health workforce on early relational health concepts, promotion of parent and child social-emotional skill development. Promote routine use of social determinants of health screening tools. such as evidence-based Safe Environment for Every Kid (SEEK) tool in pediatric health care settings. Participate in state efforts to expand access to infant, early childhood and child behavioral health services and supports, including the efforts of the state Child and Youth Behavioral Health Work Group. Promote standardized depression, anxiety, and substance use screening for children and their parents per the AAP Bright Futures, school-based health center models, and specific needs of communities. Support interventions to address suicide ideation among children, especially among children who are involved in child welfare systems, LGBTQIA2S+, BIPOC. Identify and support evidence-based practices to prevent and reduce the harmful impacts of bullying and social media on children, especially in the middle childhood period. Support efforts to address and mitigate effects of parental substance use on children and prevent early initiation in children. Take action to reduce stigma surrounding behavioral health conditions, treatment, and related challenges. Increase knowledge, visibility of and access to parent and child behavioral health resources and services available locally. Promote linkages to services that meet unique client or subpopulation gaps in care. Work with HCA and other state partners to identify ways to increase diversity of child and family behavioral health service providers in order to better serve unique needs of BIPOC, immigrant, rural, and other populations	systems strategic plan in collaboration with state partners and families. Through September 2025, increase the number of health care providers who have received training and are incorporating focus on early relational health and screening for social and economic needs in routine care. From January 2021 through January 2025, work with partners to expand access to behavioral health and other support services for children ages 11 and under and families. From January 2021 through January 2025, work with partners to expand access to behavioral health and other support services for children ages 11 and under and families.	counseling		

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	Support the development and implementation of anti-racist, trauma-informed and healing-centered policies and practices within behavioral health, health care, and other service settings serving children and families. Build networks and resources in communities to enable and enhance community and peer support. Provide state leadership and coordination for development of an integrated and comprehensive early childhood system of services and supports through the Early Childhood Comprehensive System: Health Systems Integration project and other related state initiatives, such as Essentials for Childhood, State Early Learning Coordination Plan, and Pritzker's Prenatal-to-3 Children's Initiative. Identify and implement effective, equity focused strategies to engage parents, caregivers and those with lived experiences in decisions about the development and improvement of the early childhood system of services and support. Collaborate with state partners to increase health care provider engagement in state coordinated access and referral network through state Help Me Grow and local efforts. Work with families and state partners to identify and address ongoing structural barriers within state systems that impact the ability of families to access supports for themselves and their children. Prioritize efforts to eliminate barriers for families who identify as Black, Indigenous, People of Color, immigrant, or LBGTQ+ members; families of children with special health care needs; families who live in rural or geographically isolated areas; and families who experience trauma of parental incarceration, child welfare system involvement, homelessness, substance use disorder and mental illness, and other adverse experience				
Promote mental wellness and resilience through	Provide state leadership and coordination for development of an integrated and comprehensive early childhood system of services and supports through the Early Childhood Comprehensive System project and other related state initiatives.	Through January 2023, develop an early childhood comprehensive systems strategic plan in collaboration with state partners and families	SPM 6: Social and emotional readiness among kindergarteners		

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increased access to behavioral health and other support services.	Identify and implement effective, equity focused strategies to engage parents, caregivers and those with lived experiences in decisions about the development and improvement of the early childhood system of services and support. Collaborate with state partners to increase health care provider engagement in state coordinated access and referral network through state Help Me Grow and local efforts. Work with families and state partners to identify and address ongoing structural barriers within state systems that impact the ability of families to access supports for themselves and their children. Support the development and implementation of anti-racist, trauma-informed and healing-centered policies and practices within health care and other service settings serving children and families. Advocate for investment in prevention services for parents. Implement and promote fatherhood inclusion opportunities and support resources. Promote inclusion of additional people taking parenting roles, such as foster parents, grandparents, kinship care. Partner with pediatric and family medicine organizations to promote focus on strengthening parent-child relational health in well-child visits. Support training for clinical and community health workforce on early relational health concepts, promotion of parent and child social-emotional skill development. Promote routine use of social determinants of health screening tools. such as evidence-based Safe Environment for Every Kid (SEEK) tool in pediatric health care settings.	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.			
Optimize the health and well-being of children and adolescents, using holistic	Collaborate with Essentials for Childhood and other partners to promote state leadership, commitment, and investment in the vision of all children in WA State thriving in safe, stable, nurturing relationships and environments. Adopt and share concepts, tools, trainings, and practices aligned with the Healthy Outcomes from Positive Experiences (HOPE) Framework in state	By September 2025, increase community-based primary prevention programs, practices, policies, and systems to reduce childhood adversity and promote child and family well-being.	SPM 12: Percent of families showing 4 or more factors indicating high resilience to challenges.		

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approaches.	Essentials for Childhood initiative and other settings. Promote evidence-informed programs and policies to prevent and reduce adverse childhood experiences and promote positive experiences statewide through local health jurisdictions, community-based home visiting programs, and other prevention programs sponsored by DOH, HCA and DCYF. Promote school- and community-based health strategies for early and middle childhood to increase accessibility of services for children where they are, informed by parents of diverse races/ethnicities. Support community-led resilience building initiatives in communities with higher rates of child maltreatment and other adversity. Connect with DOH Health Equity Zones and other related initiatives. Incorporate learnings from the Inventory of What Works (to reduce child maltreatment/increase family resilience) Project for state and local prevention planning. Work with EfC partners to identify ongoing priorities and resources, and the most appropriate structure to support ongoing collaboration. Determine scope and scale of positive community norms campaign. Develop and test messaging, identify message dissemination strategies to support related areas of interest (e.g., ACEs, trauma-informed/healing centered services). Coordinate campaign development and implementation strategies with EfC partners and parents representing diverse communities. Collaborate with EfC partners and statewide initiatives (i.e., Governor's Dismantling Poverty Strategic Plan) to expand access to economic and concrete supports, through development and implementation of evidence-based policies, such as guaranteed basic income, and simplification of enrollment in state benefits programs.	By October 1, 2023, develop a sustainability plan to continue progress on strategies and actions identified in collaboration with Essentials for Childhood partners. By March 31, 2024, develop a positive community norms campaign or educational awareness campaign focused on child well-being in the context of their families and communities. By September 2025, advance program, policy, and system changes that increase the proportion of families with children who have sufficient household income plus concrete supports to meet basic needs. By June 30, 2024, develop an approach to measure and monitor community contextual resilience/community factors that reduce or mitigate childhood adversity and support positive child and family well-being outcomes. By September 30, 2023, complete a needs assessment focused on middle childhood health (ages 6-11 years), including examining existing state and local initiatives and opportunities improvement. By September 30, 2024, launch a			

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	Use a racial equity lens to prioritize economic stability strategies that address economic inequities experienced by BIPOC children and families. Participate in statewide efforts to expand access to affordable, high-quality child-care and evidence-based home visiting as strategies to support family financial well-being, reduce family stress, and promote healthy child development. Continue work with state and local partners to improve access to and navigation of family supports and services (including economic supports) through development of state and local coordinated access and referral networks (Help Me Grow WA and related local efforts). Work with Surveillance and Evaluation section and other partners to identify valid and reliable measures for ACEs/PCEs incidence and promising strategies at the state and community levels. Engage with academic partners to research potential community resilience questions, possible inclusion in existing survey tools, or other approaches to measurement. Pursue funding sources to implement recommended approach. Define future data needs to measure child and family health and well-being. Support current data collection activities in this population, such as the oral health basic screening survey. Advocate for additional resources to expand availability of child health and well-being data, such as through state roll-out of the Child Wellness Survey. Collaborate with other DOH sections, units, and state/local partners to identify existing data focused on middle childhood health. Develop and implement methods to assess current state and local assets and identify gaps and opportunities related to middle childhood health. Advocate for investment in prevention services for parents. Implement and promote fatherhood inclusion opportunities and support resources. Promote inclusion of additional people taking parenting roles, such as foster parents, grandparents, kinship care.	communications campaign focused on supporting middle childhood mental well-being (ages 6-11 years), including addressing impacts of social media use and bullying. Through September 2025 and beyond, establish a comprehensive state Child Fatality Review Program to identify preventable factors contributing to child deaths, develop recommendations for addressing these factors, and create state and local prevention plans.			

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	Identify and support evidence-based practices to prevent and reduce the harmful impacts of bullying and social media on children. Conduct research on need for and feasibility of communications strategy related to social media and bullying in middle childhood. Facilitate coordination and shared learning among Local Health Jurisdiction Child Death Review programs. Provide technical assistance to local Child Death Review (CDR) teams. Develop and implement processes for reviewing local CDR findings and creating recommendations for addressing preventable factors contributing to child deaths.				
Adolescent Health					
Promote mental wellness and resilience through increased access to behavioral health and other support services.	Improve the knowledge and ability of health care professionals to deliver comprehensive evidence-based/informed services, including integrated mental health and chemical dependency screening and interventions for adolescents and young adults. Promote standardized depression, anxiety, and substance use screening that are adolescent and young adult-friendly. Take action to reduce stigma surrounding adolescent and young adult behavioral health conditions and implement trauma-informed services specific to adolescents and young adults in community services and health care systems. Expand access to and the quality of behavioral health services in SBHCs. Support interventions to address suicide ideation among youth, especially among those marginalized by mainstream society.	By September 30, 2023, conduct an Adolescent Health Provider needs assessment to learn more about provider experiences with behavioral health screenings and risk assessments; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement. By September 30, 2022, award nine or more grants to SBHCs for behavioral health services. By September 30, 2023, partner with youth volunteers to develop and implement an adolescent behavioral health awareness campaign using social media. By September 30, 2025, provide	SPM 7: Percentage of tenth grade students who have an adult to talk to when they feel sad or hopeless		

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		accessible trainings for SBHC providers on trauma informed care, adolescent friendly services, and discussing sensitive topics. By September 30, 2025, implement efforts to expand trainings to additional adolescent and young adult friendly providers. By September 30, 2022, discuss mental and behavioral health with the Youth Advisory Council to learn more about their thoughts, ideas and recommendations for behavioral health needs and gaps, including stigma around BH care and suicide prevention. This objective has been completed. By September 30, 2025, identify/develop behavioral health interventions for young people based on the ideas and recommendations of the Youth Advisory Council. By September 30, 2023, conduct an Adolescent Health needs assessment among youth to learn more about adolescent experiences with medical and behavioral health care; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement.			
Promote mental wellness and	Support efforts to address and mitigate individual and community effects of substance use among adolescents and young adults.	By September 30, 2025, increase the number of school-based health centers with licensed mental health	SPM 8: Percentage of tenth grade students who report having used alcohol		

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resilience through increased access to behavioral health and other support services.	Build on efforts to identify scope of impacts of substance use, including inequities among adolescents and young adults from priority populations.	services by 5 percent. By September 30, 2023, hold at least 10 Youth Advisory Council meetings, where behavioral and mental health care – including substance use among youth– are discussed. By September 30, 2022, collaborate with internal and external partners (including OSPI and S/E) to identify strengths and gaps in data, and define strategies to address them. This objective has been completed. By September 30, 2023, provide funding to support health campaigns in SBHCs that promote awareness/reduce stigma around adolescent substance use.	in the past 30 days		
Identify and reduce barriers to quality health care.	In collaboration with payers and health coverage organizations, understand and mitigate issues related to financial eligibility for health care and other support services. Through partnerships, understand and mitigate issues related to financial eligibility for health care and other support services for adolescents and young adults. 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.	By September 30, 2025, develop and provide technical assistance for school-based health centers and adolescent health providers so they report the ability to appropriately bill insurance for 50 percent of services delivered. By September 30, 2023, have a sustainable comprehensive sexual health network focused on youth from historically underserved communities. By September 30, 2023, conduct an Adolescent Health needs assessment to learn more about	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	ESM 10.1: Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000 NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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	Support and enhance efforts to increase health literacy among adolescents and young adults.	adolescent experiences with health care; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement. By September 30, 2023, discuss key health topics with the Youth Advisory Council to learn more about their thoughts, ideas and recommendations for health needs and gaps. By September 30, 2023, identify/develop strategies and interventions to increase access to healthcare services for young people that are based on the ideas and recommendations of the Youth Advisory Council. By September 30, 2023, partner with youth volunteers to develop and implement an adolescent health promotional campaign using social media.			NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 23: Teen birth rate, ages 15

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					through 19, per 1,000 females
Improve the safety, health, and supportiveness of communities.	Support violence prevention efforts and promote healthy relationships among adolescents and young adults. Align violence prevention efforts with partners, including DOH Injury and Violence Prevention and the Office of the Superintendent of Public Instruction (OSPI) Build networks and resources in communities to enable and enhance community and peer support.	By September 30, 2025, reduce the percentage of 10th grade students receiving our interventions who reported that someone they were dating limited their activities, threatened them, or made them feel unsafe by 10 percent (from 9.5 to 8.5 percent). By September 30, 2025, continue to work to align violence prevention efforts with partners, including DOH Injury and Violence Prevention and the Office of the Superintendent of Public Instruction (OSPI) By September 30, 2025, continue to promote resources and information about, and support projects that promote healthy relationships for young people. By September 30, 2025, continue to participate in OSPI's monthly School Safety and Student Wellbeing Workgroup to align efforts with agency partners.	SPM 9: Adolescents reporting at least one adult mentor		
Optimize the health and well-being of children and adolescents, using holistic approaches.	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.	By September 30, 2022, form youth advisory council and hold at least one initial meeting and by September 30, 2023 discuss adolescent well visits and adolescent and young adult care and services. By September 30, 2023, conduct an Adolescent Health needs	NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.	ESM 10.1: Increase the percentage of 10th graders in school districts with active DOH-supported interventions who have accessed health care in the past year	NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000 NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 NOM 16.3: Adolescent suicide rate, ages 15 through 19, per

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
		assessment to learn more about adolescent experiences with adolescent and young adult well visits, and transition care; by September 30, 2024, follow up on the needs assessment with recommendations and actions for improvement. By September 30, 2023, partner with the Washington School Based Health Alliance and the Health Systems Transformation Team to present information about School-Based Health Centers, and their importance in improving access to health care and well visits for adolescents. By September 30, 2022, award grants to plan, start, and improve school-based health centers throughout Washington, primarily in communities that have been historically underserved. This objective has been completed.			100,000 NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
					NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females
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.	Improve overall awareness of the complex needs of the children and youth with special health care needs (CYSHCN) population as a demographic identity, with distinctive cultural needs for access to communities and systems of care. Partner with the Medical Home Partnerships Project to provide state-level subject matter expertise and technical assistance, and coordinate with the UW LEND program and Seattle Children's Hospital to support communities in workforce development, resource development, and ongoing training on family-centered, comprehensive systems of care for CYSHCN. Provide targeted subject matter expertise to contractors and providers, including CYSHCN Coordinators, on areas of expertise such as complex nutrition for CYSHCN, children and youth with clinical and behavioral complexity, including autism, navigating state systems and policy, care coordination, family navigation, and community referral systems and clinical linkages. Identify and develop methods to establish baseline data on CYSHCN, systems of care, gaps, and barriers to equitable, quality care. Make data accessible via a CYSHCN dashboard and other dissemination efforts. Utilize data to identify referral opportunities and strategies, and community needs for local health care resources and equitable service delivery. Provide services to CYSHCN and family members of CYSHCN so they can be trained, engaged, supported, and involved at all levels of program planning and implementation of services for CYSHCN. Implement and	Through September 2025 explore opportunities to work with the Community Health Worker (CHW) program to increase CHW knowledge of developmental screening and milestones. Implement the Autism and Developmental Disabilities module as part of broader training curriculum for CHWs. Develop strategies for linking trained CHWs to autism diagnostic network. By September 2022, update provider training needs assessment and plan for at least two trainings to address provider training needs related to working with CYSHCN populations. This objective has been completed. By September 30, 2025, increase the number of dietitian members of the Nutrition Network with CYSHCN training and the number of community-based feeding teams working with CYSHCN. Prioritize training and support given to those in counties with limited resources	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	ESM 11.1: Percentage of primary care providers participating in the ECHO Project who indicate they can provide a medical home to their patients	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
	promote inclusion opportunities and support resources for fatherhood, foster parents, grandparents, kinship care. Partner with the Washington Statewide Leadership Initiative collaborative and community-based organizations to elevate family voices and provide connections so family voices can effectively influence the development of systems and services for CYSHCN. Promote and facilitate successful transitions including transition from hospital to home, from Birth to 3 into school and community-based services, and from pediatric to adult specialty services. Through partnerships, address the need for improved access to affordable services, and increased availability of CYSHCN service providers, quality healthcare, access to insurance, and adequate health care financing, particularly in rural communities and remote areas regardless of language spoken, gender identity, race and ethnicity, immigration status, or insurance status of families. Through partnerships, facilitate innovative programming and technology solutions such as telehealth and remote services to address gaps in rural and remote areas and other barriers to access to care. Enhance and maintain health systems and improve financing options to improve care coordination and family navigation. Support access to clinical genetic services.	and those with ability to provide services via telehealth. By September 30, 2025, increase the percentage of CYSHCN ages 0-17 who receive care in a well-functioning system by 5 percent. By December 2023, support access to clinical genetic services, and clinical genetic travel clinics to rural and underserved areas.			
Identify and reduce barriers to needed services and supports for children and youth with special health care needs and their	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.	By September 30, 2025, increase the percentage of CYSHCN ages 0-17 who receive care in a well-functioning system by 5 percent.	NPM 15: Percent of children, ages 0 through 17, who are continuously and adequately insured	ESM 15.1: 15.1 Increase the percentage of CYSHCN who report having insurance when receiving services	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
families.	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.				NOM 19: Percent of children, ages 0 through 17, in excellent or very good health NOM 22.1: Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months NOM 22.2: Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine NOM 25: Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year
Promote mental wellness and resilience	Take action to reduce stigma surrounding behavioral health, treatment and related challenges. Support interventions to address suicide ideation among CYSHCN.	By September 30, 2025, decrease the percentage of 10th grade CYSHCN who report they have considered attempting suicide by 5	SPM 10: Suicide ideation among youth with special health care needs		

Priority Needs	Strategies	Objectives	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
through increased access to behavioral health and other support services.	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.	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.			