Maternal and Child Health Services
Title V Block Grant

State Narrative for WASHINGTON

Application for 2007
Annual Report for 2005

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Table of Contents

I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

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

C. Assurances and Certifications

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

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Office of Maternal and Child Health
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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

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

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

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

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

II. Needs Assessment

In application year 2007, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

III. State Overview

A. Overview

Washington State encompasses over 66,000 square miles of the northwest corner of the United States. It is bordered north and south by British Colombia and Oregon, east and west by Idaho and the Pacific Ocean. The Cascade Mountains divide the state into distinct climatic areas. Western Washington, sandwiched between the Pacific Ocean and the Cascades, has an abundance of rain. The geographically larger area east (and in the rain shadow) of the Cascades is much dryer.

While the average population density in the state in 2000 was similar to the national rate at 88.5 persons per square mile, nearly 80 percent of Washington's population is concentrated west of the Cascades. The three most populous counties, King, Pierce, and Snohomish are located on and prosper from Puget Sound. Another western county, Clark, gains economically from proximity to Portland, Oregon, while the city of Spokane and Spokane County in Eastern Washington, are near enough to benefit from Coeur d'Alene, Idaho.

Geography, climate, and economic resources influence Washington's population distribution. Population density ranges from 817 persons per square mile in King County to 3 persons per square mile in Garfield and Ferry counties.(1) Washington has 39 counties, each with its own local government. These counties form 35 independent Local Health Jurisdictions (LHJs), funded with varying amounts of federal, state, and local dollars.

Population Density(2)

(See attached map)

Economy

Washington State continues to struggle with an economic slowdown resulting from a combination of factors. The burst dot.com bubble and the decline of airplane demand after September 11, 2001 significantly affected Washington's technical and industrial economic base. In addition, the first case of bovine spongiform encephalopathy (BSE or "mad cow disease") was found in Mabton, Washington in November 2003. This resulted in economic challenges for Washington's beef farmers and agriculture industry. In November 2003, the State's seasonally adjusted unemployment rate was 7.2 percent. Washington's unemployment rate remains one of the highest in the nation, ranked as 38th. The state's unemployment rate was 5.5 percent (as of April 2005) compared to 5.4 percent nationally (February 2005). (3)
/2007/Washington State's economy remains slow after the 2001 downturn. In March 2006, Washington's unemployment rate was 4.6 percent, which is comparable to the national unemployment rate of 4.7 percent (April 2006). Washington is ranked 30th among all the states for unemployment.//2007//

Several years of economic doldrums, combined with spending constraints and spending limits from voter-approved initiatives, have produced a continuing budget crisis for Washington. In the past, state revenue "surpluses" have been available to backfill revenue shortfalls faced by local governments. Continuing budget problems greatly reduce the state's capacity to subsidize local government revenue shortfalls, with the result that many local programs are struggling financially.

Economic hard times also increase the need for public health services, so the current decrease in funding is having a major impact on local public health. As the economic and state fiscal crisis continues, future reductions in local public health are expected. LHJs are currently being forced to reduce staff and programs.

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

Population

Washington's population continues to grow. The 2000 Census indicated the state's population was 5,894,121, an increase of 21.1 percent since the 1990 Census.(4) The Washington Office of Financial Management's (OFM) preliminary intercensal population estimate for the state in 2004 was 6,167,800.(5)
/2007/ The population of Washington State more than doubled between 1960 and 2005. Fifty to seventy five percent of the growth is the result of net migration and the rest is from natural increase. OFM's preliminary intercensal population estimate for 2005 was 6,256,400.//2007//

In the early 1990s, Washington's population grew by over two percent per year, nearly twice the national rate. According to the 2000 Census, Washington ranked seventh in the country in numerical population growth and tenth in percentage population growth since 1990.(6) However, from 1995-2000 growth slowed to an average of 1.3 percent per year and since 2000, has averaged 1.1 percent per year. Since 1995, natural population increase (births minus deaths) has remained fairly constant, while net migration (people moving into the state versus people moving out) has decreased from 68.3 in 1995 to an estimated 23.1 in 2003.(7) This decrease was most likely due to the strong national economy of 1990s and the increasingly poor economy in Washington in the past few years, resulting in fewer people looking for employment opportunities in Washington.(8)
/2007/ OFM is projecting a significant increase in the number of people migrating to Washington in the coming years.//2007//

Race/Ethnicity in Washington State

The majority of Washington's population identifies itself as White and non-Hispanic. In the 2000 Census, 81.8 percent of Washington's population reported its race as White, 5.5 percent Asian, 3.2 percent Black, 1.6 percent American Indian or Alaskan Native, 0.4 percent Native Hawaiian and other Pacific Islander, and 3.9 percent Other. Individuals who reported two or more races accounted for 3.6 percent. Finally, 7.5 percent of the population reported Hispanic or Latino ethnicity.(9)

Although the majority of Washington's population remains White and non-Hispanic, the state's other race and ethnic minority populations increased rapidly in the last decade. Together, non-Whites and Hispanics in Washington increased from 13.2 percent of the overall population in 1990 to 21 percent (1,241,631) of the population in 2000. The state population of Asian/Pacific Islanders increased by 78 percent; Blacks by 35 percent; and American Indians, Alaska Natives, and Aleuts by 29 percent.

The Hispanic population in Washington State has more than doubled since the 1990 Census, from 214,570 in 1990, to 441,509 in 2000. Counties with large proportions of Hispanics tend to be located in rural areas of Eastern and Central Washington. In Adams County, the Hispanic population rose from 32.8 percent in 1990 to 47.1 percent in 2000; Franklin County saw an increase from 30.2 percent to 46.7 percent; and Yakima County saw an increase from 23.9 percent to 35.9 percent. While Hispanics make up a large proportion of the population in these counties, most Hispanics live in King, Pierce, and Snohomish counties. The majority (74.7 percent) of Hispanics in Washington are from Mexico, 20.6 percent are from "other countries" (Central and South America), 3.7 percent from Puerto Rico, and 1.0 percent from Cuba.(10) In 2000, there were approximately 289,000 migrant and seasonal farm workers and dependents living in Washington, most of whom were Hispanic. Migrant and seasonal farm workers are more

likely to face language barriers, and to have low family incomes and limited transportation options. Most rely on Community and Migrant Health Centers (CMHC) for their health care.

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

Languages

According to the 2000 Census, approximately 15 percent, or 168,000, of Washington's children age 5-17 years speak a language other than English at home. Of these children, 43 percent speak Spanish, 29 percent speak Asian and Pacific Islander languages, 26 percent speak other Indo-European languages, and 4 percent speak other languages. A similar figure of 14 percent, or 512,000, of the adult population age 18-64 years does not speak English at home. Of those who do not speak English at home, 88 percent of the children and 75 percent of the adults speak English "very well" or "well." Twelve percent of the children and 25 percent of the adults, speak English "not well" or "not at all."(11)

Approximately 40,700 Spanish-speaking students were enrolled in the English as a Second Language program in Washington State for the 1999-2000 school year. Other languages with high enrollments were Russian (5,500), Vietnamese (3,200), Ukrainian (2,900), Korean (1,800), Cambodian (1,400), and Tagalog (1,000). (11)

Age

In 2003, there were 80,482 resident births in Washington State. The 2000 Census population counts show that almost 22 percent, or 1.29 million of the estimated 5.9 million people in Washington in 2000, were women of reproductive age (age 15-44 years). Nearly 29 percent, or 1.68 million, were children age 19 years and younger. There were over 125,000 women age 15 to17 years. Adolescent pregnancy rates (age 15-17 years) declined in Washington from 57.9 per 1,000 women in 1990 to 28.8 per 1,000 women in 2003.(12) A State forecast predicts that over the next 30 years, as the children of baby boomers reach adulthood, the number of women of reproductive age will increase substantially. The school age population (age 5-17 years) is expected to remain stable through 2010 and then gradually increase. In 2004, there were an estimated 1,120,913 children and adolescents aged 5 to 17 years. (13)
/2007/In 2004 there were 81,715 resident births in Washington State.//2007//

Urban/Rural

Seventy-two percent of population growth over the past decade occurred in the western portion of the state, where the majority of the population lives. While there are many rural areas in Western Washington, the most rural counties are located in Eastern Washington. Rural county residents tend to have lower median household incomes, higher poverty rates, and higher unemployment rates. A recent review of health status indicators found some differences between the health status of rural and urban residents, though it is difficult to assess specifically whether the decreased health status is linked to rural location, isolation, or decreased access to care.(14)

Poverty and Health Insurance

According to the 2004 Washington State Population Survey, an estimated 24.5 percent of Washington households had a family income below 200 percent of the Federal Poverty Level

(FPL), compared to 18.8 percent in 2002. An estimated 9.9 percent of households had an income below the 100 percent of the FPL.(15) Data on households with children is not yet available, but according to the 2002 Washington State Population Survey, an estimated 35 percent (approximately 574,000) of children in Washington were living below 200 percent of the FPL (FPL = $18,392 for a family of four in 2002), compared to 33.4 percent in 2000. An estimated 18 percent (about 284,000) of the children were living below 100 percent of the FPL and 11 percent (about 180,000) were living at or below 50 percent of the FPL.(16)
/2007/ According to the 2004 Washington State Population Survey, an estimated 38 percent (approximately 640,985) of children in Washington were living below 200 percent of the FPL. An estimated 19 percent (about 322,188) of the children were living below 100 percent of the FPL and 10 percent (about 169,573) were living at or below 50 percent of the FPL.//2007//

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

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

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(1) Washington State Office of Financial Management, US Census 2000 Maps

(2) Washington State Office of Financial Management, US Census 2000 Maps

(3) US Department of Labor, Bureau of Labor Statistics, April 2005

(4) Washington State Office of Financial Management, Population Forecasting Division, Census 2000 results show Washington's population increased by over 1 million during the 1990s, 12/28/2000.

(5) Washington State Office of Financial Management, 2004 State Estimates.

(6) US Census Bureau, Census 2000 Redistricting Data (P.L. 94-171) Summary File and 1990 Census, 4/02/2001.

(7) Washington State Data Book 2003, Components of Population Change Table.

(8) Washington State Office of Financial Management, Population Forecasting Division, Washington's Population Growth Continues to Slow, 6/30/2000.

(9) US Census Bureau, Census 2000, Table DP-1, Profile of General Demographic Characteristics: 2000.

(10) 1990 and 2000 Census, Office of Financial Management.

(11) US Census Bureau, Census 2000 Supplementary Survey Summary Tables, Table PO35, Age by Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over.

(12) Washington State, Pregnancy and Induced Abortion Statistics 2003, Center for Health Statistics, March 2005.

(13) Washington State Office of Financial Management, Forecast of the State Population by Age and Sex, 1990 to 2030, November 2004.

(14) Schueler V, Stuart B. "Recent research and data on rual health in Washington State", Olympia, Washington, October 2000.

(15) Office of Financial Management, 2004 Washington State Population Survey, December 2004.

(16) Data provided by Washington's Office of Financial Management.

(17) Gardner, Erica. "The Uninsured Population in Washington State", 2004 Washington State Population Survey Research Brief No. 31, Washington State Office of Financial Management, March 2005.

(18) Cawthon, Laurie. "Characteristics of Washington State Medicaid Women Who Gave Birth", DSHS Research and Data Analysis, 2/23/2005.
An attachment is included in this section.

B. Agency Capacity

The Office of Maternal and Child Health (OMCH) works to protect and improve the health of people in Washington State with a focus on women, infants, children, adolescents, and families. OMCH programs work in close partnership with state and local agencies and consumers to promote effective health policies and quality systems of care. Maternal and child health (MCH) data are collected, analyzed, and shared with other agencies and organizations to help ensure sound decision-making around health care policies and practices. OMCH program activities emphasize infrastructure-building and population-based activities through preventive health information and educational messages to the public and to health care providers, early identification of health issues, referral and linkage to services, and coordination of services. Programs contract with 35 local health jurisdictions (LHJs) and several community-based organizations, universities and hospitals, direct service providers, family organizations, and other agencies and organizations to address MCH priorities and state and national performance measures.

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

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

Capacity for better understanding of cultural competence as an office and for staff has improved over the years due to continued participation in the division level Multicultural Workgroup. A number of staff assumed leadership positions in this group and all staff participate in initial and ongoing training.

OMCH addresses health disparities through the OMCH Health Disparities Workgroup. This group

was created several years ago to specifically address health disparities in the MCH population. Each OMCH section develops goals and objectives to reduce health disparities for the populations they serve. We are in the process of learning about and incorporating Culturally and Linguistically Appropriate Services (CLAS) created by the Office of Minority Health.

OMCH is comprised of seven separate sections, each with a specific focus. Three sections in OMCH target the major Title V populations: Maternal and Infant Health, Child and Adolescent Health, and Children with Special Health Care Needs. The other sections focus on issues that encompass the entire MCH population: Genetics, CHILD Profile, Immunizations, and MCH Assessment. Following is a brief description of the basic role of each OMCH section. Funding is through a combination of sources including Title V, State General Funds, the CDC, and Title XIX.
/2007/ In 2005, the Immunization Program and CHILD Profile sections merged. OMCH is now comprised of six sections plus the Office of the Director, which is called the Administration section. //2007//

Maternal and Infant Health (MIH)
MIH, comprised of 11.20 full time equivalents (FTEs), works to improve birth outcomes by promoting quality health and support services for pregnant and post-partum women and their infants. This work is accomplished through training, education, assessment, and intervention and with a system of regional perinatal care services that include the availability of quality tertiary care for high-risk women and newborns. Other services are provided through a collaborative network of state agencies, LHJs, and non-profit providers. This network provides confidential pregnancy testing (limited) and referral, maternity support services, child development, and parenting information and education.
/2007/MIH is comprised of 9.5 FTEs.//2007//

Child and Adolescent Health (CAH)
CAH, with 15 FTEs, works to promote and protect the health and well-being of children, adolescents, and their families in the context of their communities through assessing child and adolescent health status, developing strategies to improve health status, and assuring preventive health services. Through its programs, CAH promotes the use of national guidelines for well child and adolescent screening and referral, family support and leadership, teen pregnancy prevention, youth development, population-based oral health programs, promotion of social emotional well-being and mental health, and child care health consultation.
/2007/ CAH has 12 FTEs. The Oral Health Program recently moved to the Administration section of OMCH to better serve the entire MCH population and work with all OMCH Sections.//2007//

Children's Health Immunization Linkages and Development (CHILD) Profile (CP)
This section includes 5.5 FTEs. The work is twofold: an Immunization Registry and Health Promotion System for parents of young children. These two components assure that parents have information to assist and support them in making health care decisions about their children, providers have access to a repository of data to make immunization decisions, and public health has the information needed to protect the public from vaccine preventable diseases. DOH contracts with Public Health-Seattle King County and the University of Washington (UW) for primary CHILD Profile operations. This program will merge with Immunization Program in the next few months.
/2007/ In 2005, CHILD Profile merged with the Immunization Program to form the Immunization Program CHILD Profile section.//2007//

Children with Special Health Care Needs (CSHCN)
The CSHCN section has a total of 8.0 FTEs. The program promotes integrated systems of care that ensure that children with special health care needs and their families have the opportunity to achieve the healthiest life possible and develop to their fullest potential. CSHCN staff provide leadership in addressing health system issues that affect this population; work with families and other leaders to influence priority setting, planning and policy development; and support

community efforts in assessing the health and well-being of children with special health care needs and their families. This work is carried out through partnerships with other state-level agencies and contractual relationships with LHJs, private and non-profit agencies, the University of Washington, Children's Hospital and Regional Medical Center, other tertiary care centers, and family organizations. These contracts and partnerships significantly extend CSHCN program capacity in the areas of policy development, assessment, provider education, and family leadership development.
/2007/CSHCN has 7.2 FTEs.//2007//

Genetic Services
Genetic Services, with 7.0 FTEs, is focused on assuring high quality comprehensive genetic services throughout the state. This section also includes activities aimed at surveillance and intervention for secondary conditions affecting people with disabilities; fetal alcohol syndrome (FAS) prevention; genetics education; technical assistance to the newborn screening program; and promotion of early hearing loss detection, diagnosis, and intervention.
/2007/ Genetic Services has 8.0 FTEs. Activities to prevent FAS have shifted from the Genetic Services section to the Maternal Infant Health section.//2007//

Immunization Program (IP)
This program, with 20.0 FTEs and funding from the CDC and state, is committed to preventing the occurrence and transmission of childhood, adolescent, and adult vaccine-preventable diseases. The program provides leadership for an integrated and comprehensive immunization delivery system and universal vaccine access for all children less than 19 years of age. The IP expands public awareness of the need for immunizations throughout the life span and promotes community education, participation, and partnerships. The program has significant partnerships within the department including the Bioterrorism Prevention program, Communicable Disease and Epidemiology, CHILD Profile, Infectious Disease. Additionally, this program has established partnerships with the Washington Chapter of the American Academy of Pediatrics, the Washington Chapter of the Academy of Family Practice, a Vaccine Advisory Committee of expert physicians, a statewide coalition, and all local health jurisdictions.
/2007/ Immunization Program CHILD Profile (IPCP)
In 2005 the Immunization Program merged with the CHILD Profile program to form the Immunization Program CHILD Profile (IPCP) section. IPCP is comprised of 23.5 FTEs. IPCP is committed to two primary goals: 1) preventing the occurrence and transmission of childhood, adolescent, and adult vaccine-preventable diseases; and 2) ensuring that parents, health care providers, and state and local health agencies are working together to promote healthy families and increase use of preventive health care for children from birth to age six years. The section has created partnerships with the Washington Chapter of the American Academy of Pediatrics, the Washington Chapter of the Academy of Family Practice, a Vaccine Advisory Committee of expert physicians, a statewide coalition, and all local health jurisdictions. IPCP maintains the states' Immunization Registry and coordinates the Health Promotion System for parents of young children.//2007//

MCH Assessment (MCHAS)
This section, with 12.15 FTEs, provides data, analysis, research, surveillance, and consultative support and management of all assessment activities within OMCH. Specific activities include leading the Five Year Needs Assessment process, reporting performance measures and health indicator status data; administering and analyzing Pregnancy Risk Assessment Monitoring System data and developing data reports; collecting and analyzing data from child death reviews, cluster investigations, and birth defects surveillance; and implementing State Systems Development Initiative activities. MCHAS also designs and implements surveys and responds to data requests from OMCH, other programs within the Department of Health, local health jurisdictions, and other external stakeholders.
/2007/ MCHAS has 13.15 FTEs. The increase in FTE is the result of the transfer of contract work to "in-house" staff for assessment activities related to children with special health care needs. An additional FTE is expected to be added in the near future to accommodate

additional work related to child and adolescent health.//2007//

OMCH Administration
This section has a total of 4.8 FTEs and provides administrative support to the sections of the Office of Maternal and Child Health by way of policy and fiscal development and oversight.
/2007/OMCH Adminstration has 6.8 FTEs with the recent move of the Oral Health Program from the CAH Section to the OMCH Administration Section.//2007//

C. Organizational Structure

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

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

For a Department of Health organization chart, go to the following Internet link: http://www.doh.wa.gov/Org/org.htm

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

For an Office of Maternal and Child Health organization chart, see the attached file: IIIC_OrganizationalStructure.pdf

An attachment is included in this section.

D. Other MCH Capacity

The Office of Maternal and Child Health has a total of 83.65 FTEs with staff in a variety of specialty areas including: epidemiology, public health administration, public health nursing, social work, oral health, children with special health care needs, obstetrics, perinatal care, adolescents, early childhood, health education, nutrition, genetics, immunizations, and psychology. OMCH also employs a parent of a child with special health care needs as a full-time family consultant for the CSHCN program. This individual works with staff on all CSHCN issues and plays an instrumental role in facilitating family consultation and participation within OMCH and at the local, regional, and state level.
/2007/ The Office of Maternal and Child Health has a total of 80.10 FTEs.
OMCH's Family Consultant takes a leadership role in activities to increase family involvement in children with special health care needs (CSHCN) policy and program development, including implementation of the family leadership strategic plan to increase integrated systems of care for CSHCN and their families. The Family Consultant also develops and manages contracts, grants, and other program activities related to children with special health care needs and the broader maternal and child health population. The current Family Consultant for OMCH is one of four delegates from Washington to the Association of Maternal and Child Health Programs (AMCHP). The family perspective is an

integral component of developing high quality, culturally competent programs and public policy. //2007//

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

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

Mary Selecky has been the Secretary of Health for six years and was recently reappointed by Governor Christine Gregoire. She is a political science and history graduate of the University of Pennsylvania and past president of the Association of State and Territorial Health Officers (ASTHO). Prior to her appointment as Secretary of Health, Mary worked for 20 years as the Administrator of the North East Tri-County Health District in Eastern Washington.
/2007/ Mary Selecky is serving in her seventh year as the Secretary of Health.//2007//

Dr. Maxine Hayes serves as the Health Officer for DOH. Prior to this, she was the Assistant Secretary of Community and Family Health, the Title V Director, and president of the Association of Maternal and Child Health Programs. Dr. Hayes is Associate Professor of Pediatrics at the University of Washington, School of Medicine and is on the MCH faculty at the University's School of Public Health and Community Medicine.

Patty L. Hayes is the Assistant Secretary for the Division of Community and Family Health. Prior to this, she was Director of the DOH Office of Policy, Legislative and Constituent Relations, Assistant Professor of the Master's Program in Leadership and Public Policy at St. Martin's College, and Executive Director of the Nursing Care Quality Assurance Commission. In 2002, Patty L. Hayes was inducted to the Nursing Hall of Fame for Washington, sponsored by the Washington State Nurses Association.

Rick McNeely is the chief administrator for the Division of Community and Family Health. He has been with the Department of Health in a budget leadership role for over ten years. Rick received his bachelor's degree in accounting from Tuskegee University.

Jan Fleming is the Director of the Office of Maternal and Child Health. She is a registered nurse with a master of nursing degree and clinical specialty in children with special health care needs from the University of Washington. She has been with OMCH since 1990 and previously worked with children with special health care needs and their families in a university-affiliated program, in schools, public health departments, and as a Clinical Nurse Specialist in an early intervention program.

Kathy Chapman, manager of the Maternal and Infant Health section, has a master's degree in maternal and child health nursing from the University of Washington. She was previously the manager of the Children with Special Health Care Needs Section and also supervised the MCH Assessment Section for several years. Kathy has worked for more than 20 years in state and local public health programs focusing on maternal and child health issues.

Debra Lochner Doyle, manager of the Genetic Services section, has a bachelor of science degree in genetics from the University of Washington and a master of science degree in human genetics and genetic counseling from Sarah Lawrence College in New York. She is board certified by the American Board of Medical Genetics and the American Board of Genetic Counseling. She is also the past president of the National Society of Genetic Counselors and a founding member of the Coalition of State Genetic Coordinators.

Maria Nardella is the manager of the Children with Special Health Care Needs section. Maria has more than 20 years experience in state CSHCN programs. She is a Registered Dietitian with a bachelor of science degree in nutrition from Cornell University and a master of arts in nutrition

and mental retardation from the University of Washington, including clinical training at the university-affiliated program.

Nancy Reid, manager of the Child and Adolescent Health section, has a master of social work degree from the University of Washington and a bachelor of arts degree from the University of Maryland. Prior to coming to OMCH, Nancy worked for 21 years managing statewide sexual assault, domestic violence, and alcohol and substance abuse programs at the Department of Social and Health Services.
/2007/ Judy Schoder, became manager of the Child and Adolescent Health Section in June 2006. She received a bachelor of science degree in nursing from Idaho State University in Pocatello, Idaho and a master of nursing degree from the University of Washington. Judy was previously the adolescent health consultant for the Washington State Department of Health (DOH) for 18 years. Prior to working at DOH, Judy was a public health nurse in Ithaca, New York.//2007//

Janna Bardi, manager of the Immunization Program, has a master of public health degree in behavioral science and health education from the University of California, Los Angeles. She was previously the manager of the CHILD Profile Section and has experience in program analysis, policy development, systems development, inter- and intra-agency collaboration, and program evaluation. Janna is a 2003 scholar of the Northwest Public Health Leadership Institute.
/2007/In 2005, the CHILD Profile and Immunization Program sections merged. Janna Bardi is the manager of the Immunization Program CHILD Profile Section.//2007//

Dr. Riley Peters, manager of the MCH Assessment section, has a PhD in epidemiology from the University of Washington. He also holds a master's in public administration with an emphasis in health administration from the University of Southern California. He has worked in local and state public health for over 20 years.

E. State Agency Coordination

The following provides a brief description of the collaborative relationships the Office of Maternal and Child Health (OMCH) maintains within OMCH and within DOH, and with the MAA (Title XIX), other state agencies, and other organizations. The outcomes of many of these collaborations are described in more detail in other portions of this application.
/2007/ MAA changed its name to the Health and Recovery Services Administration (HRSA).//2007//

Washington State Board of Health (SBOH): The SBOH is an independent 10-member board appointed by the Governor. The Secretary of Health is a required member. OMCH works with SBOH on children's health issues, including newborn screening; prenatal screening; HIV testing of pregnant women; immunization requirements for school and child care attendance; and hearing, vision, and scoliosis screening in schools. OMCH also worked with the SBOH on a legislatively mandated study on genetics.

1. OMCH Relationships with Other Offices Within DOH

Assessment Operations Group (AOG): The MCH Assessment section (MCHAS) and other DOH epidemiology staff participate in a monthly department-wide AOG to set standards for all assessment functions within DOH, coordinate assessment activities, and facilitate communication across the department. The MCH Assessment section manager sits on the AOG. This collaboration has resulted in improved coordination with the Center for Health Statistics and local health jurisdiction (LHJ) assessment staff.

Community and Rural Health: OMCH works with the DOH Office of Community and Rural Health on several issues such as identifying unmet needs, women's health, obstetrical access,

immunization rates, and domestic violence.

The DOH Family Violence Prevention Workgroup: This agency workgroup is comprised of representatives from OMCH, Injury Prevention Program, Emergency Medical Services (EMS), and Family Planning. They meet monthly to coordinate activities and plan, evaluate, and secure resources to decrease family violence.

Environmental Health: CHILD Profile is working with Environmental Health to determine priority environmental health risks for children and develop educational materials to increase parental knowledge of how they can protect their children from several environmental toxins. The Office of Environmental Health Assessments and CHILD Profile developed the "Fish Facts for Good Health" brochure which explains the risks of ingesting high levels of mercury and how to limit exposure to mercury.
/2007/ The Immunization Program and the CHILD Profile sections merged to create the Immunization Program CHILD Profile (IPCP) section.//2007//

Office of Epidemiology: The childhood Lead Poisoning Prevention Program and CHILD Profile developed the "Lead and Your Kids" brochure, which is being distributed to parents of children 6 months of age. This brochure discusses how to reduce exposure to lead in and outside the home.

Office of Infectious Disease and Reproductive Health (IDRH): OMCH collaborates with the HIV/AIDS and Family Planning and Reproductive Health Programs (FPRH) in IDRH and other contractors through the MCH/HIV Workgroup. The focus of this workgroup is to develop effective policies and programs for HIV/AIDS prevention and care in the MCH population and increase the number of medical providers who recommend HIV testing for all pregnant women. OMCH also works with FPRH to reduce unintended pregnancies and promote the Take Charge Program.

/2007/ Communicable Disease Epidemiology Program (CDEP): IPCP has an agreement with CDEP to provide rash illness investigation and reporting.//2007//

Injury Prevention: OMCH collaborates with the Injury Prevention Program and partially funds data collection and reporting of intentional and unintentional injuries, youth suicide, and family violence. CHILD Profile partners with the Injury Prevention Program to provide product safety messages to Washington State parents with children between birth to six years of age.

Oral Health: The OMCH Oral Health Program collaborates with the DOH Environmental Health Division, Epidemiology Program, Office of Health Promotion, Office of Community and Rural Health, and HIV/AIDS Program to enhance preventive oral health care and address unmet needs. OMCH also works with the Office of Drinking Water on fluoridation. The Maternity Support Services Program (MSS) educates providers regarding pregnancy and oral health and makes educational materials available to women on Medicaid.

Healthy Child Care Washington (HCCW): HCCW works with the Division of Environmental Health, the Immunization Program, CHILD Profile, Bright Futures, Parent Education/Family Support, and Child Death Review (CDR) teams related to SIDS prevention and oral health.

Tobacco Control and Prevention Program (TCPP): OMCH continues to work closely with TCPP on maternal and infant health issues. TCPP funded development and training for the MSS tobacco cessation project, and worked with OMCH staff to successfully advocate for Medicaid coverage of smoking cessation treatment for pregnant women. TCPP contributes funds to the Healthy Mothers Healthy Babies (HMHB) toll-free line, which now asks callers about tobacco use and includes Tobacco Quit Line information in their prenatal and child health education packets. The TCPP is also involved in developing the Healthy Youth Survey (HYS) and provides major funding for this survey. TCPP works closely with the Pregnancy Risk Assessment Monitoring System (PRAMS) survey by helping to fund the survey and by providing guidance on tobacco-related questions and analysis.

/2007/TCPP funds MIH to exhibit tobacco-related materials at continuing medical education events.

HMHB is now called WithinReach: Essential Resources for Healthy Families. The maternal and child health hotline is called Family Health Hotline.//2007//

WIC: OMCH collaborates with the WIC Program to promote breast-feeding, exchange data, enhance referrals, address access to care issues between WIC and First Steps, coordinate coverage for special formulas for children covered by Medicaid, and provide cross-training. OMCH provides training and materials to WIC program staff on methods for identifying and intervening with victims of domestic violence and child abuse, and promoting good oral health practices. OMCH also collaborates with WIC through a contract with HMHB. MIH and WIC have collaborated to revise the parent education booklet titled, "Nine Months to Get Ready", which is used for client education by WIC and Maternity Support Services providers. Given federal requirements that WIC assess DTaP immunization completion, the Immunization Program and CHILD Profile are working with WIC to determine how to use the CHILD Profile Immunization Registry to fulfill this requirement and enhance immunization rates.

Women's Health Resource Network (WHRN): WHRN is a forum for department wide input and response to current and emerging women's health issues and service gaps including data on women's health, policy related to program services, quality assurance and standards development, and changes in the health care system. The goal of the WHRN is to assist DOH in building state and local capacity to address the needs of women and their health concerns throughout their lives. WHRN includes representatives from 16 Community and Family Health and Environmental Health programs.

/2007/ Office of Newborn Screening (ONBS): Early Hearing Loss Detection, Diagnosis, and Intervention (EHDDI) staff are co-located with ONBS dried blood spot staff at the Public Health Laboratory. This allows for strengthened networking and the sharing of resources for similar procedures. CSHCN works with ONBS to ensure coverage for nutrition products for children identified with metabolic disorders. //2007//

2. OMCH Relationships with Local Health Jurisdictions (LHJs)

In Washington State, OMCH contracts with 35 LHJs to address maternal and child health needs in local communities. OMCH program staff work closely with LHJs to oversee contract activities and provide consultation and technical assistance. OMCH administrators and staff meet regularly with the Nursing Directors of LHJs and other local MCH staff through quarterly MCH Regional meetings. OMCH provides technical assistance and data support for the local CDR teams throughout the state. Some of the activities provided by LHJs are described in the performance measure narratives. ***/2007/A report of LHJ activities is available by contacting Candi Wines at candi.wines@doh.wa.gov or 360-236-3459.//2007//***

3. OMCH Relationships with Department of Social and Health Services (DSHS)

DOH maintains close relationships with DSHS programs to best serve our similar population groups. The agencies collaborate to maximize federal administrative match, build on the strengths of each department to promote the best outcomes for clients, generate and utilize data needed by both agencies, provide coordinated program services for clients, and provide complementary services and avoid duplication.

Health and Recovery Services Administration (HRSA) (Title XIX) (formerly MAA): An interagency agreement between HRSA and OMCH has existed for 14 years. Partnerships between OMCH and HRSA have developed with the mutual goal of assuring quality health services for pregnant women, infants, children, and adolescents served by Medicaid.

OMCH participates on the Medicaid External Quality Review Organization Contract committee (EQRO), the HRSA Early Periodic Screening Diagnosis and Treatment (EPSDT) Improvement Committee, and the HRSA Immunization Partnership Committee.

HRSA provides administrative match for PRAMS activities not covered by the CDC grant. PRAMS data are stratified by Medicaid recipient status and used by the First Steps program to evaluate the effectiveness of program services.

CHILD Profile's partnership with HRSA resulted in matching funds for CHILD Profile activities, data sharing agreements, HRSA participation in developing the health promotion materials for parents, and HRSA participation in the CHILD Profile Advisory group. HRSA and CHILD Profile are working together to maintain and expand partnerships with the state's health plans.

The CSHCN Section staff work with HRSA to improve access to and quality of health services for children with special health care needs through CSHCN Communication Network meetings and to implement quality assurance measures and data sharing for Title V children in Medicaid managed care. HRSA and CSHCN have also worked closely to share information about undocumented children who were covered by state-funded Medicaid programs until September 30, 2002 when the state Legislature discontinued this funding. While a coverage option was provided through the Basic Health Plan for this population, all costs are not covered and a premium is required. The 2005 Legislature partially reinstated medical coverage for undocumented children. CSHCN will continue to work with HRSA to monitor the utilization of this coverage.

The Immunization Program works extensively with HRSA on the Vaccines for Children (VFC) Program to ensure VFC-qualified children receive adequate immunizations.

OMCH provides state funding match for Medicaid prenatal genetic counseling services. OMCH staff oversee the program and work with HRSA to ensure that up-to-date billing instructions are in place. Medicaid also covers genetic counseling services for new parents up to 90 days after birth.

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

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

Children's Administration (CA): OMCH works with CA, which includes Child Protective Services (CPS), Child Care, Foster Care, and other offices, on subjects of joint concern, such as chemically dependent pregnant women, child maltreatment, Child Death Review, and mental health. A cross-office and cross-agency group meets to improve services and coverage for children in foster care who are considered to be children with special health care needs.
/2007/CSHCN works with CA to address health care access issues in the foster care system.//2007//

Mental Health Division (MHD): The OMCH Mental Health Workgroup collaborates with MHD to identify services, available data, and possible gaps. CSHCN continues to provide MHD with data to comply with the Center for Medicaid and Medicare Services (CMS, formerly HCFA) requirements for the Medicaid 1915B waiver. This information provides the means to identify the number of children with special health care needs served by both Title V and MHD. DOH is represented by OMCH staff on the Children's Treatment and Services subcommittee of the MHD Mental Health Planning and Advisory Committee.
/2007/The Mental Health Workgroup no longer works with MHD.//2007//

Disability Determination Service (DDS) and Social Security Administration (SSA): The CSHCN section maintains a Memorandum of Understanding with DDS in order to provide information to families of children under the age of 16 who apply for SSI. DDS provides data files of all SSI applicants up to age 16 to the CSHCN program. Local CSHCN Coordinators contact families to inform them of local programs and services.

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

/2007/ Office of the Deaf and Hard of Hearing (ODHH): Genetic Services works with ODHH to link members of the Deaf and Hard of Hearing community to families with infants diagnosed with hearing loss.//2007//

Office of Procedures and Policy: This DSHS program participates on the Perinatal Partnership Against Domestic Violence (PPADV). The PPADV reviews training materials, provides training and marketing of the PPADV curriculum, locates funding, and promotes awareness of domestic violence in the perinatal period. The PPADV has recently expanded its partnerships and includes multiple organizations.
/2007/The PPADV no longer convenes.//2007//

4. OMCH Relationships with the Office of Superintendent of Public Instruction (OSPI)

OMCH maintains a collaborative partnership with OSPI through a number of programmatic efforts. The Immunization Program works with OSPI's Health Services Supervisor on issues involving immunization requirements for school entry. CAH has an interagency agreement with OSPI that pays the salary for a .5 FTE to coordinate school nurse issues. Washington State received a Coordinated School Health Grant from CDC. This is a partnership between DOH and OSPI. CSHCN and CAH participate on the Coordinated School Health Interagency Committee, and work to align this effort with related adolescent health and mental health planning initiatives. The CSHCN Program works with OSPI to identify appropriate health outcomes for children with special health care needs. OMCH also participates on an interagency team called STEPS (Sequenced Transition for Education in Public Schools) that addresses transition issues for children birth to school age. School Nurse Corps supervisors participate in MCH Regional meetings. Representatives from OSPI, CTED, DSHS, and the FPC make up the joint Healthy Youth Survey planning committee. These same organizations, along with other state and local agencies, are members of the Washington State Partnership for Youth (WSPY). The purpose of WSPY is to develop a plan for improving adolescent health in Washington State. The CAH Youth Development Team collaborated with OSPI and other stakeholders to develop the Guidelines for Sexual Health Information and Disease Prevention as directed by the state Legislature.
/2007/IPCP works with OSPI to distribute child development and school readiness information. CSHCN participates in monthly OSPI school nurse corps meetings.

The interagency agreement between CAH and OSPI that supported a .5 FTE to coordinate school nurse issues ended on 6/30/06 and was not renewed because of cuts in MCH block grant funding.//2007//

5. OMCH Relationships with Hospitals and Other Specialized Services.

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

Mary Bridge Children's Hospital and Health Center (MBCHHC): MBCHHC assists CSHCN in developing and disseminating guidelines to primary care providers for the care of high-risk infants as part of their discharge plan. Additionally, MBCHHC is the site of one of 14 MCH supported neurodevelopmental centers (NDCs) and the Maxillofacial Review Team for Southwest Washington.
/2007/The contract with MBCHHC to develop materials related to high-risk infants ended 6/30/06 and was not renewed because of cuts in MCH block grant funding. //2007//

Regional Genetic Clinics (RGC): Six RGCs are located throughout the state and are funded to provide clinical genetic services for the MCH population as well as provide educational outreach to the communities. Data generated by the RGCs are used for program planning and policy development.
/2007/There are 17 RGCs.//2007//

Regional Perinatal Programs: Through contracts with OMCH, four regional perinatal programs provide consultation and training to health care providers with a focus on specialized care for high-risk pregnant women and neonates.

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

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

Native American Tribes: OMCH works with the DOH tribal liaison to explore ways to expand and improve communication with tribes in Washington State. Specific actions include working with the American Indian Health Commission, expanded use of the DOH Tribal Connections Web site, and using expanded tribal email contact lists for dissemination of information.

Universities and Libraries: DOH collaborates with the UW in a project using the State Capacity Grant for Prevention of Secondary Disabilities. This project is supported by a cooperative agreement with the Centers for Disease Control and Prevention to assess the types and prevalence of secondary disabilities and form local advisory councils to promote a public awareness campaign and implement strategies to prevent secondary disabilities. CHILD Profile contracts with the UW to evaluate the CHILD Profile (CP) Health Promotion System, translate materials into additional languages, and maintain the CP Web site.

/2007/ Genetic Services works with the UW Center for Health Policy and the Institute for Public Health Genomics on a variety of training and research endeavors.//2007//

OMCH uses MCH block grant funds to contract with programs within UW's Center on Human Development and Disability (CHDD) that receive Leadership Education for Neurodevelopmental Disabilities (LEND) grants. These contracts extend and enhance MCH priorities in the areas of CHILD Profile, nutrition, high-risk infants and children, adolescent transition, medical home, and emotional behavior in very young children.

CAH works with the UW School of Education, Early Childhood, and Teen Telecommunications Network to foster leadership on issues of parents and teens and pre-teens at the state and local levels. OMCH works with the UW School of Pediatric Dentistry on oral health issues that impact pregnant women, infants, children, and youth.

6. OMCH Relationships with Other Agencies and Programs

Managed Care Plans: CSHCN staff, in partnership with HRSA and LHJs continue to work with Medicaid managed care plans to meet requirements of the CMS 1915B waiver requiring HRSA to identify, track, and coordinate care for children in managed care who are also served by Title V, and to allow families to request an exemption from managed care if needed. Plan representatives have become a part of the quarterly CSHCN Communication Network meetings. The CSHCN Program is also working with managed care plans to identify practical ways for providers to develop and provide medical homes for all children.

Foundation for Early Learning (FEL): CHILD Profile and FEL are partnering to revise and distribute both the birth to 18 months and the 18 months to 4 years development charts for parents. The charts address social, emotional, physical, language, motor, and cognitive development and provide parents with specific activities that will support their child's development. FEL also partnered with CP to distribute a booklet titled "Getting School Ready" to parents of 4-year olds in Washington State.
/2007/OMCH collaborated with FEL and the Head Start State Collaboration Office to develop Kids Matter, a strategic plan for improving early childhood services.//2007//

F. Health Systems Capacity Indicators

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	32.5	33.6	25.8	30.6	30.6
Numerator	1295	1342	1029	1226	
Denominator	398000	399421	399183	401222	
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
Data were unavailable for the year 2005.

Notes - 2004
These data come from the Washington State Hospital Discharge database (CHARS) and are updated annually. The numerator represents the number of hospital discharges for children less than 5 years of age who had a primary diagnosis of asthma (ICD-9 codes 493.0-493.9). The denominator represents the number of children less than 5 years of age in Washington from Office of Financial Management.

Notes - 2003

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

Narrative:
Data for this indicator Health Systems Capacity (HSCI) 01 are gathered from the Comprehensive Hospital Abstract Reporting System (CHARS), Washington State's hospital discharge database. Hospitalization rates for asthma decreased from 2000 to 2003, but increased slightly in 2004. Further investigation needs to be conducted to confirm this increase.

The Office of Maternal and Child Health (OMCH) seeks to improve rates related to the number of children hospitalized for asthma through the Bright Futures Guidelines Early Childhood Initiative, which promotes appropriate health care practices in child care and early learning settings, well-child visits, and establishing a Medical Home. In addition, Child Care Health Consultants (CCHCs) throughout the state promote and support appropriate health practices for young children with asthma in child care settings and help children with asthma access safe and healthy child care settings. OMCH's Child and Adolescent Health (CAH) Section is funding the statewide Child Care Resource and Referral Network to do environmental health outreach to ensure healthy physical environments in child care settings. OMCH also participates on a division-wide asthma initiative led by the Office of Community Wellness and Prevention.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	85.0	97.0	98.6	98.6	98.6
Numerator	31453	31435	32487	35011	
Denominator	37003	32407	32948	35509	
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
Data were unavailable for the year 2005.

Notes - 2004
Data: 35,011/35,509 = 98.6%

Note: These data are based on the Washington State 2004 HEDIS Report from the Department of Social and Health Services and reflect the estimated statewide proportion of children who turned 15 months old during the reporting year, who were enrolled from 31 days of age in Medicaid or SCHIP and who received at least one well child visit. Data from seven managed care plans (who serve approximately 70% of the Medicaid enrollees less than 15 months) contributed to this report. Children not covered by managed care plans include those on SSI, in foster care, and resident who live in counties without a managed care option. The 2004 HEDIS percentage was used as an estimate for 2005, since no new data are available.

Notes - 2003
These data are based on the Washington State 2004 HEDIS Report from the Department of Social and Health Services and reflect the estimated statewide proportion of children who turned 15 months old during the reporting year, who were enrolled from 31 days of age in Medicaid or SCHIP and who received at least one well child visit. Data from seven managed care plans (who

serve approximately 70% of the Medicaid enrollees less than 15 months) contributed to this report. Children not covered by managed care plans include those on SSI, in foster care, and residents who live in counties without a managed care option.

Narrative:
In 2003, 98.6 percent of Medicaid enrollees less than one year of age had at least one initial periodic screen. These data, which were gathered from the Department of Social and Health Services' (DSHS) 2004 HEDIS Report, reflect an increased proportion of Medicaid enrolled infants who received at least one periodic screening. However, data collection methodology has fluctuated in recent years and caution should be taken when interpreting trends.

The Maternal and Infant Health (MIH) Section seeks to improve the percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen through supporting the Family Health Hotline(formerly Healthy Mothers Healthy Babies) operated through an organization called WithinReach: Essential Resources for Healthy Families (formerly Healthy Mothers Healthy Babies). The hotline refers parents to resources to help them enroll in and access Medicaid services for their children. Maternity Support Services (MSS) and Infant Case Management (ICM) also refer and link Medicaid eligible children to providers who offer periodic screening services, including immunizations and well-child care. The Child and Adolescent Health (CAH) and Children with Special Health Care Needs (CSHCN) Sections participate with other state agencies on an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Improvement Team to promote and improve access to and implementation of EPSDT across the state. In addition, the Early Childhood Comprehensive Systems Grant (Kids Matter) promotes Medical Homes - including access to Medicaid, EPSDT, and a medical provider - as one of the focus areas for promoting improvement and coordination in services for young children and their families. OMCH will continue to work with partners to develop new strategies to address this HSCI through the Early Childhood Comprehensive Systems Grant (Kids Matter) and EPSDT Improvement Team. For example, OMCH is hosting a State Leadership workshop on improving implementation of EPSDT. OMCH will invite state agency decision-makers to participate in this meeting.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	85.0	NaN	NaN	0.0	0.0
Numerator	5244	0	0	0	0
Denominator	6169	0	0	1	1
Is the Data Provisional or Final?				Final	Final

Notes - 2005
Data were unavailable for the year 2005. This is a very small population, and the numbers are not reportable. Because data specific to the CHIP enrollees are not available through HEDIS for this age group, this measure currently cannot be reported. Washington CHIP covers from 200 to 250% of the poverty level.

Notes - 2004
The data from the previous years reflects all CHIP enrollees, not just children less than 1 year. In 2004, there were approximately 298 children less than 15 months during the reporting year who were covered by the State Children's Health Insurance Plan. A little over half of these children were enrolled in managed care plans. Their well child experience is included in the Washington

State 2004 HEDIS Report from the Department of Social and Health Services. Because data specific to the CHIP enrollees are not available through HEDIS for this age group, we are currently unable to report on this measure. Washington CHIP covers from 200 to 250% of the poverty level.

Notes - 2003
HSC3: The data from the previous years reflects all CHIP enrollees, not just children less than 1 year. In 2003, there were approximately 194 children less than 15 months during the reporting year who were covered by the State Children's Health Insurance Plan. A little over half of these children were enrolled in managed care plans. Their well child experience is included in the Washington State 2004 HEDIS Report from the Department of Social and Health Services. Because data specific to the CHIP enrollees are not available through HEDIS for this age group, we are currently unable to report on this measure. Washington CHIP covers from 200 to 250% of the poverty level.

Narrative:
Data for this indicator (HSCI 03) are gathered from the DSHS 2004 HEDIS Report. Data collection methodology has fluctuated over previous years, therefore caution should be taken when interpreting trends. For example, data from previous years reflect all SCHIP enrollees, whereas years 2003 and 2004 reflect enrollees less than 15 months old.

OMCH seeks to improve outcomes related to this measure through supporting the Family Health Hotline operated by an organization called WithinReach: Essential Resources for Healthy Families. The hotline refers parents to resources to help them enroll in and access SCHIP services for their children. Maternity Support Services (MSS) and Infant Case Management (ICM) also refer and link SCHIP eligible children to providers who offer immunizations and well-child care.

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	70.8	71.1	66.3	61.6	61.6
Numerator	49117	48547	41128	41243	
Denominator	69377	68324	62080	66926	
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
Data were unavailable for the year 2005.

Notes - 2004
These data come from the Washington State Center for Health Statistics Birth Certificate Files and are updated annually. The numerator represents the number of resident women (15-44 with a live birth) whose Adequacy of Prenatal Care Utilization (APNCU) index is greater than or equal to 80%. The denominator represents all resident women (15-44) with a live birth during the reporting year. Approximately 18% of the data fall outside the range of acceptable weight range (400-6000 grams) or are missing information describing the number of prenatal care visits and month prenatal care visits began.

In 2003 a new birth certificate form was implemented. It collects some information differently, and

caution should be used in interpreting year to year changes from 2002 to 2003. Specifically, changes in prenatal care may be due wholly or in part due to reporting changes.

Notes - 2003
These data come from the Washington State Center for Health Statistics Birth Certificate Files and are updated annually. The numerator represents the number of resident women (15-44 with a live birth) whose Adequacy of Prenatal Care Utilization (APNCU) index is greater than or equal to 80%. The denominator represents all resident women (15-44) with a live birth during the reporting year. 23.7% of the data are missing information describing the number of prenatal care visits and month prenatal care visits began.

In 2003 a new birth certificate form was implemented. It collects some information differently, and caution should be used in interpreting year to year changes from 2002 to 2003. Specifically, changes in prenatal care may be due wholly or in part to reporting changes.

Narrative:
Data for HSCI 04 are gathered from the Washington State Center for Health Statistics Birth Certificate Files, which are updated annually. Fluctuations in the data prevent any noticeable trends from being observed.

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

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	91.5	88.1	85.9	85.1	0.2
Numerator	540687	563000	584657	590428	
Denominator	590667	639177	680979	694163	
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
Data were unavailable for the year 2005.

Notes - 2004
Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

2004 Indicator - 85.1%
Numerator - 590428
Denominator - 694163

The source of this data is the Client Services Database (CSDB), Research Data and Analysis, Washington State Department of Social and Health Services; and Office of Financial

Management (OFM). The numerator represents clients aged 1 to 21 years who were Medicaid eligible (TXIX) during the fiscal year and received medical services. The denominator represents all clients aged 1 to 21 who were Medicaid eligible (TXIX) during the fiscal year. The denominator should not be considered as a measure of all Washington residents who were potentially Medicaid eligible; it includes only residents who applied for Medicaid benefits. Not all potentially eligible residents apply for benefits.

Notes - 2003
Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

2003 Indicator - 88.9%
Numerator - 605669
Denominator - 681060

Technical Note: The source of these data is the Client Services Database (CSDB), Research Data and Analysis, Washington State Department of Social and Health Services; and Office of Financial Management (OFM). The numerator represents clients aged 1 to 21 years who are receiving medical assistance (Note: Clients receiving medical assistance in SFY 2003 included 20,974 who were not designated as Medically Eligible under Title XIX at some point during the years. The data in the denominator are the total number of medically eligible clients aged 1 to 21 years old.

Narrative:
In 2003, approximately 90 percent of potentially Medicaid eligible children in Washington received a service paid for by the Medicaid Program. Data are gathered from the DSHS Client Services Database (CSDB) and the Office of Financial Management. Trends over the previous few years from 2000 to present have shown relatively stable rates with little fluctuation.

OMCH seeks to improve the percent of potentially Medicaid eligible children who have received a service paid for by the Medicaid Program through Bright Futures Guidelines Early Childhood Initiative, which promotes well-child visits and establishing a Medical Home. The Early Childhood Comprehensive Systems Grant (Kids Matter) includes medical homes as one of the focus areas for promoting improvement and coordination in services for young children and their families. OMCH staff partner with other state agencies on an EPSDT Improvement Team to promote and improve the access to and implementation of EPSDT across the state. OMCH will continue to work with partners to develop new strategies through the Bright Futures Guidelines work, Early Childhood Comprehensive Systems Grant (Kids Matter), and EPSDT Improvement Team.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	50.5	53.8	55.0	55	55
Numerator	69496	75891	74122		
Denominator	137708	141160	134749		
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2005
Data is unavailable for 2005.

Notes - 2004
Data is unavailable for 2004.

Notes - 2003
These data come from the Department of Social and Health Services Medical Assistance Administration. The numerator represents the number of Medicaid enrolled children 6-9 who received any dental service in 2003. The denominator represents the total number of children ages 6-9 enrolled in Medicaid in 2003, in both Healthy Options (the MAA managed care program) and fee-for-service.

Narrative:
In 2003, the rate of EPSDT eligible children who received any dental services during the year was 55 percent, an increase over prior years. These data are gathered from the DSHS Health and Recovery Services Administration (HRSA). Data collection methodology has fluctuated over previous years, therefore caution should be taken when interpreting trends.

OMCH seeks to improve outcomes related to this measure through the following efforts. The Early Childhood Comprehensive Systems Grant (Kids Matter) includes medical homes as one of the focus areas for promoting improvement and coordination in services for young children and their families. OMCH staff partner with other state agencies on an EPSDT Improvement Team to promote and improve access to and implementation of EPSDT across the state. The OMCH Oral Health Program promotes access to dental care for low income children.

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

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	11.0	8.9	10.3	7.7	6.1
Numerator	1180	936	1171	910	875
Denominator	10720	10570	11418	11893	14300
Is the Data Provisional or Final?				Final	Final

Notes - 2005
The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and the Federal Social Security Administration. The numerator is the unduplicated number of children under the age of 18 with a CHIF form completed indicating they have SSI coverage in 2005 (875). The denominator is from state-specific data from Children Receiving SSI, 2005. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payor of last resort.

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

Notes - 2004

The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and the Federal Social Security Administration. The numerator is the number of children under the age of 16 with a CHIF form completed indicating they have SSI coverage in 2004 (910). The denominator is from state-specific data from the Healthy and Ready to Work National Center for SSI recipients December 2004. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payor of last resort.

Notes - 2003
The sources of these data are the Washington State CSHCN Child Health Intake Form (CHIF) database and the Federal Social Security Administration. The numerator is the number of kids with a Child Health Intake Form (CHIF) completed who have SSI in 2003 (1,171). The total number of entries in the CHIF database for 2002 was 10,399 The denominator is from state-specific SSI data from the Health and Ready to Work National Center. In Washington, this target is set low because Medicaid provides extensive benefits and the CSHCN program is the payer of last resort. Last year's figures have been updated.

Narrative:
Data from 2004 indicate that approximately eight percent of State SSI beneficiaries less than 16 years old received rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program, this is a slight decrease from the ten percent rate in 2003. These data are gathered from the State CSHCN Programs's Child Health Intake Form (CHIF), a program enrollment form completed at the local health jurisdiction and submitted to CSHCN quarterly. The number of state SSI beneficiaries who are less than 16 years old is calculated from the annual Children Receiving SSI report produced by the Social Security Administration. Data collection methodology has fluctuated in recent years; therefore caution should be taken when interpreting trends.

The CSHCN Program maintains and supports a variety of activities in order to influence this measure. Through a Memorandum of Understanding, a data file of all SSI applicants less than 16 years of age is provided to CSHCN on a quarterly basis by the Disability Determination Services unit in DSHS. Children not already receiving services through a local CSHCN program are provided with information about their local program, including contact information of the local CSHCN Coordinator. CSHCN Coordinators inform families they work with about SSI and may assist them in the application process.

In Washington State, every child SSI recipient is eligible to receive the State Medicaid Program's fee-for-service coverage. State Medicaid benefits include unlimited rehabilitative therapy when prescribed by a physician and when the condition of the child meets the appropriate medically necessary criteria. Because the State CSHCN Program's and the State Medicaid Program's financial eligibility criteria are identical, a maintenance level effort in providing rehabilitative services is appropriate.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2004	matching data files	6.9	5.5	6.2

Narrative:
Data for HSCI 05A are gathered from DSHS HRSA. Over the past few years, these data have shown that Medicaid recipients have higher proportions of low birth weight than do non-Medicaid recipients.

OMCH's efforts to improve this indicator include but are not limited to First Steps (e.g. Maternity Support Services (MSS) and Infant Case Management(ICM)) activities and data monitoring, analysis, and publication.

The First Steps database links vital statistics data with Medicaid data related to various perinatal indicators such as low birth weight. These data are tracked and categorized by Medicaid/non-Medicaid status.

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

The new 2006 MCH Data and Services Report provides data and information about related services associated with this HSCI in order to guide future decision-making.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2004	matching data files	7	4.4	5.6

Narrative:
Data for HSCI 05B are gathered from DSHS HRSA. These data show that Medicaid recipients have higher proportions of infant deaths than do non-Medicaid recipients. Overall, these rates have remained relatively stable in the last few years.

OMCH's efforts to improve this indicator include First Steps (e.g. MSS and ICM) activities and data monitoring, analysis, and publication.

The First Steps database links vital statistics data with Medicaid data related to various perinatal indicators such as infant deaths. These data are tracked categorized by Medicaid/non-Medicaid status.

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

The new 2006 MCH Data and Services Report provides data and information about related services associated with this HSCI in order to guide future decision-making.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2004	matching data files	69	88.3	79.3

Notes - 2007
This data reflect the infants born to pregnant women receiving prenatal care for the 2004 Medicaid birth cohort. Thus, the number is based on the number of Medicaid and non-Medicaid infants born in 2003. This number differs from NPM 18 because the source is cohort data, instead of period data.

Narrative:
Data for HSCI 05C are gathered from HRSA. These data show that Medicaid recipients are less likely to receive first trimester prenatal care than non-Medicaid recipients.

OMCH's efforts to improve this indicator include First Steps MSS activities and data monitoring, analysis, and publication.

The First Steps database links vital statistics data with Medicaid data related to various perinatal indicators such as prenatal care. These data are and tracked categorized them by Medicaid/non-Medicaid status.

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

The new 2006 MCH Data and Services Report provides data and information about related services associated with this HSCI in order to guide future decision-making.

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

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to	2004	matching data files	61.2	73.3	67.7

expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					

Notes - 2007
This data reflect the percent of pregnant women receiving adequate prenatal care for the 2004 Medicaid birth cohort. Thus, the number is based on the number of Medicaid and non-Medicaid infants born in 2003. This number differs from HSCI 04 because the source is cohort data, instead of period data.

Narrative:
Data for HSCI 05D are gathered from HRSA. These data show that Medicaid recipients are less likely to receive adequate prenatal care (based on Kotelchuck index), than non-Medicaid recipients.

OMCH's efforts to improve this indicator include First Steps MSS activities and data monitoring, analysis, and publication.

The First Steps database links vital statistics data with Medicaid data related to various perinatal indicators such as low birth weight. These data are tracked and categorized by Medicaid/non-Medicaid status.

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

The new 2006 MCH Data and Services Report provides data and information about related services associated with this HSCI in order to guide future decision-making.

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2004	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2004	250

Narrative:
Data for HSCI 06A are gathered from the Washington State Poverty Guidelines. The data have not changed in recent years. In 2004, Medicaid eligibility was 200 percent of the Federal Poverty Level (FPL) for infants. SCHIP eligibility was 250 percent of the FPL. OMCH periodically responds to inquiries from policy makers in support of maintaining Medicaid and SCHIP eligibility at current levels for infants.

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

INDICATOR #06	**YEAR**	**PERCENT OF**

The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2004	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2004	250

Narrative:
Data for HSCI 06B are gathered from the Washington State Poverty Guidelines. The data have not changed in recent years. In 2004, Medicaid eligibility was 200 percent of the Federal Poverty Level (FPL) for infants. SCHIP eligibility was 250 percent of the FPL. OMCH periodically responds to inquiries from policy makers in support of maintaining Medicaid and SCHIP eligibility at current levels for children.

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

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2004	100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2004	

Notes - 2007
SCHIP does not serve adults.

Narrative:
Data for HSCI 06C are gathered from the Washington State Poverty Guidelines. The data have not changed in recent years. In 2004, Medicaid eligibility was 100 percent of the FPL for pregnant women. OMCH periodically responds to inquiries from policy makers in support of maintaining Medicaid eligibility at current levels for pregnant women.

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

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES	3	Yes

Annual linkage of infant birth and infant death certificates		
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2007

Narrative:
Access to data from other programs and agencies is built from gaining the trust from the agencies. OMCH, especially the MCH Assessment section, works to gain and maintain that trust. This past year, all OMCH sections have held meetings with each other and with other partners to discuss the advantages and challenges of sharing data. Two contracts were implemented to facilitate this effort. One contract focused on the program perspective and explored questions related to the advantages to clients of sharing data. The second contract focused on the technology side of the issue. An information technology contractor met with the programs' information technology staff and vendors to discuss the technical feasibility of this effort.

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

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

Notes - 2007

Narrative:

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

IV. Priorities, Performance and Program Activities

A. Background and Overview

See Form 14 for a list of the 9 MCH population priorities that are described in detail in the comprehensive 5 year needs assessment for 2005. (See Section XA for the entire needs assessment.)

/2007/During the past year OMCH has been refining its priorities and developing issue briefs for each priority. These processes prompted some changes to the priorities, which are reflected in Form 14. Briefly, the changes involved merging two related priorities into one comprehensive priority and creating a new priority related to reducing health disparities. See Section IIC for an updated Needs Assessment Summary.//2007//

OMCH is in the process of completing the 5-year needs assessment, and is coordinating that effort with the development of a 5-year organizational and performance plan. The needs assessment describes the process and the products generated including population priorities, performance measures, activities, and outcome measures. The 5-year organizational and performance plan includes an assessment of the work we do and how we do it in relation to the 9 priorities developed through the 5-year needs assessment.

/2007/OMCH staff contributed to the development of the Community and Family Health (CFH) Division 2-Year Strategic Plan. The 2005 Needs Assessment process and resulting MCH priorities helped shape the CFH Strategic Plan and served as the basis for developing the Division's priorities.//2007//

The 5-year needs assessment includes stakeholder involvement, data collection and analysis, and a thorough review of program activities to redefine the priorities for the MCH population in Washington State. The priorities developed through the 2005 needs assessment process are very similar to those developed in the 2000 needs assessment; however, they are more universal, addressing needs across the MCH population rather than specific groups within the MCH population. This process served to reaffirm that Washington's MCH programs are appropriately focusing resources on the most pressing needs of the MCH population in the state. In most cases, the needs reflected in these priorities are more pronounced than they were in previous years due to significant reductions, and in some cases complete elimination, of program funding at the federal and state levels, and increased economic hardship statewide.

Detailed descriptions of OMCH's work on the national and state performance measures are provided in this section under items, "C. National Performance Measures," and "D. State Performance Measures."

B. State Priorities

2000 -- 2004 OMCH Priorities

The following summarizes the relationship between Washington State's OMCH priorities and the state and national performance measures, outcome measures, and health systems capacity indicators for the 2000 -- 2004 Priorities.

Improving access to comprehensive prenatal care.
NPM 15, 17, 18
SPM 3, 6, 8
OM 1-5
HSCI 4, 9a

Improving oral health status and access to oral health care services.
NPM 9

HSCI 9a

Improving the coordination of services for children with special health care needs.
NPM 2 - 7
SPM 4
HSCI 1, 8, 9a

Improving early identification, diagnosis and intervention services and coordination of services.
NPM 1, 7, 12 - 14
SPM 7, 8, 10
HSCI 2, 3, 5 - 8, 9a

Decreasing family violence.
SPM 6
HSCI 9a

Decreasing unintended pregnancy and teenage pregnancy.
NPM 8
SPM 1
HSCI 9a

Improving mental health status.
NPM 16
SPM 7
HSCI 9a

Ensuring surveillance capacity for children with special health care needs.
SPM 4
HSCI 9a

Decreasing tobacco use.
SPM 2, 5, 8
HSCI 9a, 9b

Improving nutritional status.
NPM 11
SPM 9
HSCI 9a, 9c

NOTE: For the 2000 - 2004 Priorities, one performance measure and one outcome measure (NPM10 and OM 6), are not directly addressed, but are addressed by OMCH through partnership and collaboration with our partners in the Injury Prevention Program.

2005 -- 2009 OMCH Priorities

As part of the 2005 Five Year Needs Assessment, OMCH developed nine priorities. Attached is a crosswalk between the 2000 - 2004 priorities and the new 2005 - 2009 priorities and a crosswalk between the old state performance measures and the new state performance measures. As the 2005 Needs Assessment is finalized, more state performance measures will be developed based on the nine priorities established in the needs assessment process and added to the 2007 MCH Block Grant Application.

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

Appropriate nutrition and physical activity for the MCH population
NPM 11, 15
OM 1-5
SPM 7
HSCI 5, 9a
HSI 1a-b, 2a-b

Lifestyles free of substance use and addiction among adolescents and women
NPM 10, 15
OM 1-5
SPM 2, 3
HSCI 1, 9b
HSI 1a-b, 2a-b, 3a-c, 4a-c

Optimal mental health and healthy relationships
NPM 2, 6, 11, 16
OM 6
SPM 4
HSCI 4

Healthy physical and social environments/communities for the MCH population
HSCI 1

Safe environments/communities for the MCH population
NPM 10, 16
OM 6
SPM 3
HSI 3a-c, 4a-c

Healthy physical, emotional, cognitive and social development of all children
NPM 6, 11, 12
SPM 4, 8

Sexually responsible and healthy adolescents and women
NPM 8, 18
SPM 1, 3
HSCI 4
HSI 5a-b

Access to preventive and treatment services for the MCH population
NPM 3-7, 9, 12-14, 17-18
OM 1-5
SPM 1, 3, 6, 7
HSCI 3-8

Screening, identification, intervention, and care coordination for the MCH population
NPM 1-3, 5-7, 9, 12, 17, 18
OM 1-5
SPM 3 ,4, 6, 8
HSCI 2-5, 7

/2007/ The "Healthy physical, emotional, cognitive and social development of all children" priority has been revised to "Healthy physical growth and cognitive development" to reflect that healthy emotional and social development are addressed in the "Optimal mental health and healthy relationships" priority.

The "Healthy physical and social environments/communities for the MCH population" and the "Safe environments/communities for the MCH population" priorities have been combined into one priority called "Safe and healthy communities for the MCH population." An additional priority is being developed to address health disparities.

The relationship between the new priority (Safe and healthy communities) and the state and national performance measures, outcome measures, health status indicators, and the health system capacity indicators is as follows:

Safe and healthy communities for the MCH population
HSCI 1
NPM 10, 16
OM 6
SPM 3
HSI 3a-c, 4a-c

The "Reduce health disparities for the MCH population" priority is under development. Relationships between this priority and the performance measures, outcome measures, health status indicators, and health sytems capacity indicators will be determined as we continue to develop this priority.//2007//

C. National Performance Measures

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	99.5	99.6	99.7	99.7	95
Annual Indicator	93.6	93.9	89.3	100.0	100.0
Numerator	44	46	50	88	77
Denominator	47	49	56	88	77
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

Notes - 2005
PERFORMANCE OBJECTIVES: The Newborn Screening program expects to maintain 100% of screen positive newborns receiving timely follow up. Therefore, for the period of 2006-2010, the future objectives will be 100%.

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

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

Notes - 2004
The percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, hemoglobinapathies, and congenital adrenal hyperplasia with appropriate referral.

These data come from Form 6. The numerator is the number of live born infants born in Washington that were reported by the Office of Newborn Screening as screened and were a confirmed case that received treatment. The denominator is the number that were screened and were a confirmed case. In 2004, 99.6% of newborns received a newborn screening. The state currently screens for PKU, congenital hypothyroidism, galactosemia, sickle cell disease, congenital adrenal hyperplasia, MCAD deficiency, biotinidase, maple syrup urine disease (MSUD), and homocystinuria. See Form 6 for details on conditions.

Notes - 2003
The percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, hemoglobinapathies, and congenital adrenal hyperplasia with appropriate referral.

These data come from Form 6. The numerator is the number of live born infants born in Washington that were reported by the Office of Newborn Screening as screened and were a confirmed case that received treatment. The denominator is the number that were screened and were a confirmed case. In 2003, 98.7% of newborns received a newborn screening. The state currently screens for adrenal hyperplasia, PKU, hypothyroidism, congenital adrenal hyperplasia, and hemoglobinopathies. Washington began screening for galactosemia in FFY 2003. See Form 6 for details on conditions.

a. Last Year's Accomplishments
The Department of Health (DOH) established and convened a Cystic Fibrosis Technical Review Committee in response to a motion adopted by the State Board of Health (SBOH). The committee reviewed available information about the benefits of newborn screening for cystic fibrosis and made a preliminary determination regarding whether this condition meets criteria established for newborn screening tests in Washington. The committee found sufficient evidence for screening newborns for cystic fibrosis.

The Newborn Screening Program presented information to SBOH regarding the American College of Medical Genetics (ACMG) recommendations for a uniform national newborn screening panel.

DOH implemented real-time polymerase chain reaction in the Newborn Screening Laboratory to help refine the diagnosis and clinical prognosis of galactosemia, MCAD deficiency, and a clinically significant hemoglobinopathy (a form of alpha thalassemia). This allows us to obtain DNA results in far less time and at a lower cost.

CHILD Profile mailed a Health & Development Record booklet to approximately 80,000 families, which represents about 86 percent of the annual births in Washington. The booklet includes a message encouraging parents to talk with their health care providers about health screenings and provides a centralized area to record information about screenings such as newborn blood spot and hearing screening, vision screening, and lead screening. The Health & Development Record booklet is available in English and Spanish and is distributed as part of the introductory packet that arrives 4-6 weeks after an infant is born. CHILD Profile asked several parent and professional review teams for input on the usefulness, layout, and information contained in the record. CHILD Profile made significant revisions to the record and began mailing the new version in May 2005. (Fig. 4a, NPM 1, Act. 3)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor every non-military infant born in Washington for appropriate screening and follow up on those with incomplete testing.				X
2. Contract with pediatric specialists and comprehensive care clinics to provide expert diagnostic and treatment services for infants with abnormal screening results.				X
3. Update and develop new professional and lay educational information via different venues: Web sites, provider manuals, on-site hospital visits, disorder-specific fact sheets and pamphlets, etc.				X
4. Determine family eligibility for financial and support services and coordinate through state and county CSHCN programs and medical homes.		X		
5. Purchase and distribute medically necessary formulas and low-protein foods for individuals with PKU and other metabolic disorders.		X		
6. Collect long-term outcome data to evaluate the benefit of various components of treatment, compliance, and intervention.				X
7. Develop a data system linking newborn screening records with hearing screening.				X
8.				
9.				
10.				

b. Current Activities

Subsequent to the findings of the Cystic Fibrosis Technical Review Committee during the previous reporting period, DOH convened an advisory committee broadly representative of those with interests in infant health. The group evaluated cystic fibrosis (CF) in the context of the criteria that SBOH adopted to evaluate conditions for inclusion in the screening battery. This group concluded that CF met the criteria and recommended that the Board revise the screening regulations to include CF in the mandatory newborn screening panel. The Board accepted the recommendations. At a public hearing on December 7, 2005, SBOH voted unanimously to revise the regulations and directed DOH's Newborn Screening Program to implement the new screening as quickly as feasible and no later than June 2006.

Following the Board's decision to add CF to the screening panel, the Newborn Screening Program worked to obtain the necessary equipment and develop screening protocols. The Newborn Screening Program worked closely with the region's cystic fibrosis clinical treatment and diagnostic centers to develop linkages to services and follow-up protocols.

The Newborn Screening Program implemented cystic fibrosis screening for all infants born in Washington on March 15, 2006.

During this year, the Newborn Screening Program continued to expand and refine our screening protocols, particularly for the new disorders (including cystic fibrosis) added to the newborn screening panel. Necessary adjustments and revisions are being made based on department experience and that of other newborn screening programs.

The Newborn Screening Program and SBOH filed the paperwork necessary to begin considering the additional disorders recommended by the ACMG report.

CHILD Profile continues to distribute a Health & Development Record booklet as part of the

introductory packet sent to Washington State parents 4-6 weeks after the birth of an infant. (Fig. 4a, NPM 1, Act. 3)

c. Plan for the Coming Year

DOH's Newborn Screening Program will continue to work with SBOH to consider each of the 16 disorders in the ACMG report that are not in the current newborn screening battery for Washington. The plan calls for a review of medical issues through a technical advisory committee followed by a broadly representative Newborn Screening Advisory Committee. SBOH will consider the findings and recommendations of these groups.

The Newborn Screening Program will work with policy staff to convene a work group that will review the adequacy and stability of funding needed to support clinical care for children detected through newborn screening. The group will also look at funding sources and may recommend changes to the funding system.

CHILD Profile will continue to distribute its Health & Development Record booklet as part of the introductory packet sent to Washington State parents 4-6 weeks after the birth of their child. (Fig. 4a, NPM 1, Act. 3)

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			54.9	54.9	56
Annual Indicator		54.9	54.9	54.9	54.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	56.5	57	57.5	58	58.5

Notes - 2005

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

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

Notes - 2004

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

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003

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

a. Last Year's Accomplishments
The Children with Special Health Care Needs (CSHCN) section contracted with Children's Hospital and Regional Medical Center (CHRMC) to publish local and statewide data from the National Survey of CSHCN, county profiles, and other data sources. CSHCN introduced the publication at a conference in May 2005 and released it in July 2005. (Fig. 4a, NPM 2, Act. 1)

The CSHCN section promotes the family perspective in policy and program development and employs a full-time family consultant. At the fall 2004 Family Leadership Institute, parents attended sessions on national performance measures, MCH data, and the National Survey of CSHCN. Family leaders partnered with Title V, Child and Adolescent Health Measurement Initiative, Family Voices, and the National Center on Cultural Competence to conduct workshops to increase parents' knowledge and use of data. Pre- and post-conference surveys provided information on ways to involve family leaders in decision-making and integrate systems of care.

CSHCN supported parents in taking leadership roles in the Washington Integrated Services Enhancement Grant (WISE) that ended in August 2005. Agencies, community organizations, and other family support programs developed partnerships through work related to the WISE grant. Grant participants incorporated family input and ultimately recommended shared care coordination, common application, integrated data, and blended funding strategies for system integration.

The CSHCN section collaborated with the Washington Family to Family Network (WFFN) to develop a statewide Family Leadership Plan. WFFN refined its vision and purpose statement and addressed strategic planning around the national performance measures. CSHCN helped develop cross-agency linkages on the WithinReach (formerly Healthy Mothers, Healthy Babies (HMHB)) Answers for Special Kids (ASK) Line Web site, and facilitated adding pictures of fathers and youth to ASK Line materials. CSHCN contracted with WithinReach's On-Line Access Project (OLAP) to involve parent consultants in ensuring that the WISE grant recommendations were followed.

Local CSHCN Coordinators continued to work with families to make decisions about care and services for children. The CSHCN Communication Network continued to involve parent organizations and parents. Meetings during this time focused on transition from early intervention programs to school; Supplemental Security Income (SSI) for children; the foster care system; and collaborations between public health nurses and families.

The CSHCN section contracted with Washington State Parent to Parent, and Washington State Fathers Network to provide statewide support and resource information to parents of children with special needs. A contract with the Center on Human Development and Disability (CHDD) at the UW helped support parents as members of feeding teams. Guidelines on the development of community-based feeding teams were revised and posted electronically. (Fig. 4a, NPM 2, Act. 2)

Table 4a, National Performance Measures Summary Sheet

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

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

b. Current Activities
The CSHCN section contracts with CHRMC to review available data and develop evaluation measurements for six performance measures. (Fig. 4a, NPM 2, Act. 1)

The CSHCN section and the section's family consultant continue to promote inclusion of the family perspective in all Office of Maternal and Child Health (OMCH) programs, activities and planning. The CSHCN section, through its new strategic plan and the work of the family consultant, continues to take a leadership role in identifying and implementing strategies to increase the number of families involved as decision-makers and who are satisfied with the services they receive. Program contractors involve families as an integral component to achieving and measuring satisfaction with services.

The CSHCN section and the WFFN updated the Family Leadership Plan/Logic Model to include integrated cross-program and cross-contract work and opportunities within the national performance measures. CSHCN conducted a survey to identify the types of family leadership training activities being implemented statewide and assess CSHCN-funded Web sites. CSHCN partnered with Family Voices to develop the Family to Family Health Information Center, and played an active role in developing the On Line Access Project and HMHB name change. Family advisors continue to be recruited and mentored. They are given opportunities for leadership roles in work related to Medical Home and Adolescent Transition, Bright Futures, Family Voices, On Line Access Project, Autism Task Force, Family Leadership Team, and Family to Family Health Information Center. The CSHCN and Genetic Services sections provided scholarships for parents to attend the Infant and Early Childhood Conference (IECC); Fetal Alcohol Spectrum Disorders State Retreat; Early Hearing Loss Detection, Diagnosis, and Intervention (EHDDI) Summit; and the Duncan Seminar.

Parent involvement as regular participants and as special presenters continues at the CSHCN Communication Network meetings. Meetings during this current year highlighted: health plans' educational offerings; care coordination and coverage for children with special needs; premature and low birth weight infants; emergency preparedness for the general public and specific preparation for children with special needs; and the state's early learning initiative.

CSHCN continues to support a network of community-based feeding teams that include parents as members through a contract with CHDD. (Fig. 4a, NPM 2, Act. 2)

c. Plan for the Coming Year
The CSHCN section staff will work with MCH Assessment to provide ongoing analysis of available data on family satisfaction and involvement, including NS-CSHCN, the NS-Children's Health and other Washington State data sources. (Fig. 4a, NPM 2, Act. 1)

The inclusion of a family perspective in all OMCH programs, activities, and planning will remain a priority for the CSHCN section. Efforts to identify opportunities and implement strategies to increase the involvement of families in activities that promote decision-making and policy planning will be sustained. Contracts will include appropriate activities to boost family involvement as an integral component. Measures of satisfaction with services will also be included where appropriate.

Family advisors will continue to be recruited, mentored, and provided with opportunities to take leadership roles within the areas of the national performance measures, with a focus on Medical Home, Adolescent Transition, Bright Futures, Family Voices, WFFN, Parent to Parent, Fathers Network, On Line Access Project, Autism Task Force, Family Leadership Team, and Family to Family Health Information Center. Scholarships will be provided to parents to attend IECC, Duncan Seminar, and other selected conferences and trainings.

Family to Family Health Information Center partnership and the Autism Task Force will be a focus in the coming year. Family leaders will use the assessment of family leadership training activities and the Web site analysis conducted in the previous year to select priority areas of activity and development.

Quarterly Communication Network meetings will continue to promote parent involvement as regular participants as well as presenters of specific topics of interest to the group. The network of community-based feeding teams with parents as members will continue to be supported through a contract with the UW. (Fig. 4a, NPM 2, Act. 2)

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			53.6	53.6	53
Annual Indicator		53.6	53.6	53.6	53.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	53	53	53	54	54.5

Notes - 2005
PERFORMANCE OBJECTIVES: The National Survey of CSHCN was only conducted once and new data won't be available until 2007, thus preventing the ability to conduct trend analyses. Trends will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 0.5% was chosen through 2010.

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

Notes - 2004
The source is the CHSCN Survey from the MCHB. No new data were available.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
The source is the CHSCN Survey from the MCHB. No new data were available.

a. Last Year's Accomplishments
The CSHCN section contracted with CHRMC to publish local and statewide data from the National Survey of CSHCN, county profiles, and other data sources. CSHCN introduced the publication at a conference in May 2005 and released it in July 2005. (Fig. 4a, NPM 3, Act. 1)

CSHCN continued to support the activities of Medical Home Leadership Network (MHLN) through funding, staff involvement, and leadership from CSHCN staff. CSHCN contracted with MHLN to conduct key informant interviews of medical home physician team members in order to identify targeted education strategies for promoting medical homes, recruiting new medical home teams, and building the agenda for the Fall 2004 action meeting. Additionally, MHLN analyzed data from the 2004 key informant interviews of parents who attended the CHDD Clinic to provide medical home strategies for outpatient clinic settings. An evaluation of the Child Health Notes was completed. Family members of MHLN teams and the project's co-director participated in the Family Leadership Institute where they received training on the national performance measure on medical homes.

CSHCN identified methods to better integrate the MHLN with the CSHCN Nutrition Network and network of community-based feeding teams.

The CSHCN section contracted with the Mary Bridge Children's Hospital and Health Center (MBCHHC) to disseminate and provide training on two publications about low birth weight. One thousand four hundred copies of The "Critical Elements of Care" and "Watching your Low Birth Weight Infant Grow" were marketed and distributed to a number of professional associations.

WISE Grant pilot sites concluded their test care coordination models. The CSHCN section completed an assessment of the WISE Grant (2002-2005) and developed final recommendations to improve state services for children with special health care needs. The recommendations were distributed to key stakeholders and included information regarding care coordination, common application, data integration, and blended funding.

The CSHCN section continued to support the Maxillofacial Review Teams and provide opportunities for training, technical assistance, resources, and materials to local CSHCN Coordinators. CHRMC developed a Fact Sheet for medical providers to improve early identification of cleft palates. CSHCN's Contract with the Maxillofacial Review Teams encouraged review boards to promote family-centered care and medical homes.

Seventeen of the 21 medical home teams in communities across the state include the local CSHCN Coordinator. One local team developed and promoted a resource guide for providers. Another team developed an Individualized Health Plan that includes a picture of the child; information presented in the first person; parent's visions for their child's future; and updated medical information. (Fig. 4a, NPM 3, Act. 3)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work with MCH Assessment to provide analysis of available data on children with special needs, including the NS-CSHCN, the NS-Children's Health and other Washington State data sources.				X
2. Contract with the MHLN to support the Medical Home website, increase awareness of medical homes statewide and build the medical home leadership network.				X
3. Contract with LHJs for activities that increase awareness of, access to, and staff participation in medical homes within their communities.		X		
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
The CSHCN section contracted with CHRMC to review available data and develop additional evaluation measurements for this performance measure. A user friendly tool will be ready in June that measures attainment of the strategic goals of the CSHCN section and refines reporting capabilities regarding the National Performance Measures for CSHCN. (Fig. 4a, NPM 3, Act. 1)

The CSHCN section incorporated findings from the WISE Grant into care coordination system activities across state agencies, and contracted with the Center for Children with Special Needs to assemble, disseminate, and evaluate care coordination tools. These tools are posted on their Web site. The CSHCN section's Nutrition Consultant is working with contractors to compose a plan to better integrate the MHLN with the CSHCN Nutrition Network and the network of community-based feeding teams. (Fig. 4a, NPM 3, Act. 2)

The importance of medical homes for all children will continue to be a topic of CSHCN Coordinator meetings both regionally and at the state level. Information gathered from the MHLN evaluation survey was shared with all CSHCN Coordinators and the MHLN project coordination attended Regional CSHCN Coordinator meetings to publicize the medicalhome.org Web site and Child Health Notes. Medical home team participation was encouraged as part of the CSHCN Coordinator's public health role in the community.

A grant proposal utilizing recommendations from the WISE Grant to increase the state's capacity for providing enhanced care coordination within a medical home was submitted but not funded.

The CSHCN section continues to support the Maxillofacial Review Boards and provides ongoing information regarding medical homes. Increasing family-centered care continues to be written into maxillofacial contracts. (Fig. 4a, NPM 3, Act. 3)

c. Plan for the Coming Year
Work with MCH Assessment to provide analysis of available data on medical homes for children with special needs, including the NS-CSHCN, the NS-Children's Health, and other Washington State data sources. (Fig. 4a, NPM 3, Act. 1)

The 2006-2010 Washington State Medical Home State Plan has been revised and will be implemented and monitored this coming year. Parents and representatives from state agencies, the Washington Chapter of the American Academy of Pediatricians (AAP), the Early Childhood Systems Grant, medical home teams, and health plans developed the plan. Efforts will focus on three strategic areas: 1) Promotion and Endorsement, 2) Performance and Quality, and 3) Financing.

Recommendations from the WISE Grant will continue to be woven into strategic planning activities for the program, interagency collaborative efforts, agency-supported legislative proposals, and future grant proposals. The CSHCN section will work with the Catalyst Center and strategic state partners to develop financing strategies for care coordination within the medical home model.

Activities that will occur this year include: development of a marketing plan and tools for providers and families to use in marketing medical homes; a conference of the existing medical home teams who are part of the Medical Home Leadership Network; and convergence of workgroups to address reimbursement for care coordination and involvement of families at all levels of the strategic plan. A logic model, created from this plan, will guide the development of an evaluation plan. The evaluation plan will track progress on achieving the objectives and will be monitored

with the indicators selected in the past year. (Fig. 4a, NPM 3, Act. 2)

Through contracts, the CSHCN section will support the Maxillofacial Review Boards and their efforts to provide family-centered care in a medical setting, including continuing to provide current and innovative information about medical homes.

A CSHCN section staff member will provide leadership for a DOH initiative to promote the medical home approach to health care for all residents of Washington State. The governor's priorities prompted the creation of this initiative.

Local health jurisdictions (LHJs) will be encouraged to continue as part of each one's local medical home team. In communities without a medical home team, the CSHCN section will promote and support ongoing efforts by public health nurses to increase community providers' involvement in the spectrum of care for children with special needs. (Fig. 4a, NPM 3, Act. 3)

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			64.4	64.4	63
Annual Indicator		64.4	64.4	64.4	64.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	64.5	66	67.5	69	70.5

Notes - 2005
PERFORMANCE OBJECTIVES: The National Survey of CSHCN was only conducted once and new data won't be available until 2007, thus preventing the ability to conduct trend analyses. Trends will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors, policy changes in other state agencies, and program decisions about how these factors could influence future targets. An annual increase of 1.5% was chosen through 2010.

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

Notes - 2004
The source is the CHSCN Survey from the MCHB. No new data were available

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
The source is the CHSCN Survey from the MCHB. No new data are available.

a. Last Year's Accomplishments
To assist in the development of the MCH 5 Year Needs Assessment, additional insurance data from the National Survey of CSHCN was analyzed for use in planning priorities. In anticipation of the release of the 2005 National Survey of CSHCN, strategies for further analysis of the data and use of insurance data were considered for inclusion in the state publication released in 2005.

Insurance coverage was specifically addressed in the 2005 Children and Youth with Special Health Care Needs Data Report. Data included insurance indicators derived from the National Survey of CSHCN and percent of children served by our state's Medicaid program by county. (Fig. 4a, NPM 4, Act. 1)

Through the CSHCN section's contract with Strategic Services, ongoing technical assistance and training was provided for the Child Health Intake Form (CHIF) database, a statewide database of children served by the CSHCN. Revisions to the software and enforcement of rules regarding data entry improved quality and comparability of statewide data, including data about insurance coverage.

CSHCN continued to provide limited diagnostic and treatment funds to fill the gaps in medically necessary services not covered by any other source.

The CSHCN section's Nutrition Consultant worked with CHRMC and other pilot sites to collect nutrition assessment data on children with special needs. Two reports resulted from the collection of these data: 1) a draft report based data collected in Spokane from 1996-2003 and 2) a final report on CSHCN Special Formula Fund usage (1987-2005), which was distributed to CSHCN Coordinators and other stakeholders. (Fig. 4a, NPM 4, Act. 2)

A variety of methods has resulted in increasing collaboration with managed care plans, the most recent of which was that with Group Health Cooperative. The CSHCN section and the Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA) continue to address concerns on coverage issues for children on Medicaid by reviewing systems issues that affect solutions.

The CSHCN section reviewed and updated parent and provider resource information contained in the presentation "Paying the Bills" and presented this at the Infant and Early Childhood Conference. A session on financing for children with special needs was also given by staff from the CSHCN section, the state Medicaid agency, and the state Office of the Insurance Commissioner. (Fig. 4a, NPM 4, Act. 3)

The CSHCN section monitored the use of diagnostic and treatment funds for undocumented children with special health care needs and shared information with partners as appropriate. Information from the anecdotal survey of CSHCN Coordinators on the effects of Medicaid loss for undocumented children was included in the Kaiser Report on Medicaid and the uninsured. (Fig. 4a, NPM 4, Act. 4)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work with MCH Assessment to provide analysis of available data on children with special needs, including the NS-CSHCN, the NS-Children's Health and other Washington State data sources.				X
2. Collect and analyze statewide program information from CHIF and Health Service Authorizations to identify children who have insurance.				X
3. Collaborate through various interagency forums such as Communication Network, Medicaid Integration Team, the Washington Family to Family Health Information Center (Family Voices) and interactions with managed care plans.				X
4. Provide limited diagnostic and treatment funds to fill gaps in		X		

services for children with the CSHCN section, including those for undocumented children with special needs.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The CSHCN section contracted with CHRMC to review available data and develop additional evaluation measurements for this performance measure. The CSHCN section's Nutrition Consultant is working with MCH Assessment staff and dietitians in Spokane to finalize a nutrition report about children with special nutritional needs and services from 1996-2003. (Fig. 4a, NPM 4, Act. 1)

The CSHCN section continues to monitor standards in the Child Health Intake Form data collection system to measure quality, including third-party payment sources for medical coverage. Strategic Services assists local health department staff to improve data quality and to utilize their own data to determine gaps in services.

The CSHCN Nutritionist is contributing to developing an appropriate dissemination plan for the results of nutrition assessment data for children with special health care needs. (Fig. 4a, NPM 4, Act. 2).

Multiple state and local agencies continue to collaborate through various forums such as the CSHCN Communication Network and Medicaid Integration Team (MIT). Collaboration with managed care plans also continues. The section works with a variety of partners to connect with more commercial insurance plans about issues for children with special needs and their families. Legislation to use state funds to provide Medicaid coverage to undocumented children whose families are below 100 percent of the federal poverty level was passed, and the CSHCN section worked with HRSA partners to develop a plan and then assist in outreach enrollment efforts. Local CSHCN Coordinators were contacted by the CSHCN section Manager to alert them to processes and deadlines to assist families. The section is monitoring the effects of this on enrollment in local CSHCN sections. The CSHCN section continues to respond to proposals about coverage issues for children on Medicaid, particularly concerns about changes to Medicaid coverage and reimbursement rates for nutrition products.

By invitation, the CSHCN section will again present information on financing services at the Infant and Early Childhood Conference in early May 2006. (Fig. 4a, NPM 4, Act. 3)

The CSHCN section continues to utilize limited diagnostic and treatment funding for medically necessary services not covered by another source to fill the gaps in services for children with special health care needs, including undocumented children. (Fig. 4a, NPM 4, Act. 4)

c. Plan for the Coming Year
Work with MCH Assessment to provide analysis of available insurance coverage data on children with special needs including the NS-CSHCN, the NS-Children's Health, and other Washington State data sources.

The CSHCN section will continue to monitor standards in the Child Health Intake Form (CHIF) data collection system to assess data quality, including data on third-party payment sources for medical coverage. Strategic Services will continue to assist LHJ staff in reporting requirements. (Fig. 4a, NPM 4, Act. 2).

The CSHCN Communication Network will continue as a venue to discuss and share information and concerns regarding access and financial coverage. The CSHCN section will also continue to work with the Medicaid program and other programs serving children with special needs, such as Foster Care and Early Intervention, to work on solutions to problems related to access to and coverage for care. The section will partner with the Family to Family Health Information Center, Family Voices, WFFN, Parent to Parent, Washington State Father's Network (WSFN), WithinReach (formerly HMHB), and other partners to increase families' access to information about financing, insurance, and navigation of the health care system. The section will continue to address coverage issues for children on Medicaid, particularly concerns about the new changes to Medicaid coverage and reimbursement rates for nutrition products. (Fig. 4a, NPM 4, Act. 3)

Limited diagnostic and treatment funding for medically necessary services not covered by another other source will continue to be set aside in order to fill the gaps in services for children with special health care needs. (Fig. 4a, NPM 4, Act. 4)

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

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			74.1	74.1	74.6
Annual Indicator		74.1	74.1	74.1	74.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	75	76	77	78	79

Notes - 2005
PERFORMANCE OBJECTIVES: The National Survey of CSHCN was only conducted once and new data won't be available until 2007, thus preventing the ability to conduct trend analyses. Trends will be modified as more data becomes available. Therefore, current targets are based on a variety of environmental factors and program decisions about how these factors could influence future targets. An annual increase of 1% was chosen through 2010.

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

Notes - 2004
The source is the CHSCN Survey from the MCHB. No new data were available

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
The source is the CHSCN Survey from the MCHB. No new data were available.

a. Last Year's Accomplishments
CHRMC completed the "Children & Youth with Special Health Care Needs 2005: Washington State Report." The report contains data from the National Survey of CSHCN, county profiles, and results of other assessment activities. CHRMC released the report in the summer of 2005.

In response to the maternal and child health (MCH) 5-Year Needs Assessment, additional data from the National Survey of CSHCN were analyzed for planning priorities. (Fig. 4a, NPM 5, Act. 1)

WISE Grant sites ended their care coordination pilots. A final evaluation of the pilot site projects included family interviews and feedback on community-based services. The WISE Grant subcommittees developed recommendations on care coordination, integrated data, and common enrollment. A grant proposal to develop a Web-based common application portal was submitted but not funded. (Fig. 4a, NPM 5, Act. 2)

The CSHCN section developed better ways of integrating the Medical Home Leadership Network with the CSHCN Nutrition Network and community-based feeding teams. This improved access to coordinated services for families and their children.

The CSHCN Communication Network, which includes representatives from local CSHCN programs, state agencies, health plans and contractors, and family organizations met regularly. One recent meeting focused on possible solutions to problems related to transition from early intervention to school programs.

A statewide CSHCN Coordinator conference in May 2005 focused on partnerships and integration of care for children. It featured a model for successful community collaborations between Parent to Parent and CSHCN Coordinators. Other conference topics included data, autism, grief and loss, treatment for premature infants, and social marketing. Information booths included non-profit and family organizations.

CSHCN Coordinators who are members of local Interagency Coordinating Councils (ICCs) and Head Start boards act as Family Resources Coordinators and develop resource directories. Other examples from some of the LHJs include: convening health providers and school staff to discuss issues and reaching out to tribal school staff and parents to increase awareness of LHJ programs and services.

The CSHCN section continued to assist the WorkFirst Program at DSHS with collecting and summarizing information to identify gaps in services for families of children with special needs. (Fig. 4a, NPM 5, Act. 3).

The CSHCN section supported the infrastructure of 14 neurodevelopmental centers (NDCs), the ASK Line, and other contractors in order to obtain information about children and their families. (Fig. 4a, NPM 5, Act. 4)

The Legislature mandated the formation of the Caring for Washington Individuals with Autism Task Force. CSHCN identified parents, representatives from state agencies and school districts, State Representatives and Senators, and academic researchers and clinical practitioners to form the task force.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work with MCH Assessment to provide analysis of available data on children with special needs, including the NS-CSHCN, the NS-Children's Health and other Washington State data sources.			X	
2. Develop and implement strategies using the outcome evaluation from WISE pilots and other sources regarding community care coordination.			X	

3. Maintain the network of CSHCN Coordinators and interagency collaborations to provide forums for system improvement that include families as partners; and provide learning opportunities about local, state and national systems for children with special				X
4. Contract with Neurodevelopmental Centers (NDCs) to support community-based collaborations among NDCs, local health agencies, and other partners.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCN section continues its contract with CHRMC to review available data and develop additional baseline measurements to provide additional information on this performance measure. (Fig. 4a, NPM 5, Act. 1)

The CSHCN section completed an assessment of the WISE Grant and recommended options for improving state services for children with special health care needs. The recommendations were disseminated to key stakeholders along with information regarding care coordination, common application, data integration, and blended funding. (Fig. 4a, NPM 5, Act. 2)

Interagency collaboration between the CSHCN section, DSHS, and the local CSHCN Coordinators continues with the WorkFirst Children with Special Needs Initiative, which provides services to children and families participating in the WorkFirst Program. The CSHCN section continues collecting and summarizing information to identify gaps in services for families of children with special health care needs.

The CSHCN section continues to promote the inclusion of families as partners with CSHCN Coordinators and with other state agencies. Family representatives participate on panel presentations and in workgroups as appropriate. Several activities serve to better integrate the network of community-based feeding teams into both the CSHCN Nutrition Network and the MHLN teams to improve access for children seen by feeding teams to a wider array of community-based services.

CSHCN Coordinators and the CSHCN section are developing tools for providers and families to assist providers in care coordination. Families provide input regarding the care coordination tools. The CSHCN section posted a short-term survey on selected contractors' Web sites to identify types of users, assess gaps in target audiences, and prevent duplication. (Fig. 4a, NPM 5, Act. 3)

CSHCN section continues to support NDCs, the ASK Line, and other contractors in order to maintain current and ongoing sources of reliable information about children and their families. (Fig. 4a, NPM 5, Act. 4)

The CSHCN section provides staff support for the Caring for Washington Individuals with Autism Task Force. Membership includes parents, representatives from state agencies and school districts, State Representatives and Senators, and academic researchers and clinical practitioners. The task force held monthly meetings and heard from panels of experts regarding education, diagnosis, intervention, and health care. The task force also heard from panels of parents of individuals with autism spectrum disorders and individuals living with autism spectrum disorders. Each meeting included an opportunity for public comment, during which several

parents and care givers addressed the task force.

c. Plan for the Coming Year
The CSHCN section will work with MCH Assessment to analyze available data on community based systems for children with special needs including the National Survey of CSHCN, the National Survey on Children's Health, and other Washington State data sources. (Fig 4a, NPM 5, Act. 1)

Recommendations from the WISE Grant will be woven into strategic planning activities for the section, interagency collaborative efforts, agency-supported legislative proposals, and future grant proposals. (Fig. 4a, NPM 5, Act. 2)

CSHCN section involvement with the ASK Line and On Line Access Project will continue. Three CSHCN family advisors provide input into development of the On Line Access Project. The CSHCN section will involve family advisors in development of the new Medical Home Strategic Plan and spring 2007 conference. CSHCN section will take a lead role in assisting the Washington State Autism Task Force in developing recommendations to improve systems of care for individuals with Autism Spectrum Disorders throughout the lifespan.

The CSHCN section will evaluate the WorkFirst referral process between DSHS Caseworkers and CSHCN Coordinators and share the results of the evaluation with stakeholders.

The CSHCN section will continue to work with the community-based feeding teams and with the CSHCN Nutrition Network and the Medical Home Leadership Network to improve awareness and collaboration. Through these efforts, children and their families who are involved with feeding teams will have more information and access to other community services. (Fig. 4a, NPM 5, Act. 3)

The CSHCN section will develop and implement a new process to identify, contract, and fund NDCs across the state to determine if additional community-based centers can be supported to improve access to services for families. (Fig. 4a, NPM 5, Act. 4)

The Caring for Washington Individuals with Autism Task Force will submit a report and final recommendations to the Governor and state Legislature.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			5.8	5.8	8.3
Annual Indicator		5.8	5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	9.8	11.3	12.8	14.3	15.8

Notes - 2005

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

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

Notes - 2004
The source is the CHSCN Survey from the MCHB. No new data were available

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
The source is the CHSCN Survey from the MCHB. No new data were available.

a. Last Year's Accomplishments
The Adolescent Health Transition Resource Notebook was updated to include a section on culturally diverse transition stories, sexuality, and HIPAA regulations/privacy issues. Staff from the Adolescent Health Transition Project (AHTP) shared the information with schools, parent groups, and others who focus on the needs of adolescents with special health care needs.

A new health insurance document was developed in conjunction with the Office of Insurance Commissioner to assist adolescents with special health care needs and their parents as they transition into adulthood.

AHTP staff developed a work plan based on research into the use of youth advisory boards in planning and policy for adolescent services. Exploration of how best to recruit, mentor, and involve youth in addressing issues of importance to adolescents with special needs in this state is ongoing. (Fig. 4a, NPM 6, Act. 1)

In response to the Medical Home State Plan's (MHSP) goals to increase awareness and existence of medical homes for children and adolescents with special needs, AHTP staff drafted a five-year plan to improve adolescent health transition in Washington State. AHTP staff asked for input from the CSHCN section, Child and Adolescent Health (CAH) section, and other partners of the MHSP, including the representatives from the Washington Chapter of the American Academy of Pediatrics, the Center for Children with Special Needs at CHRMC, and family physicians. (Fig. 4a, NPM 6, Act. 2)

The CSHCN section's contract with CHRMC began a process to develop care plans for adolescents. Focus groups of adolescents, parents, and providers were identified to provide further input regarding planning for transition to adult medical care. (Fig 4a, NPM 6, Act. 3)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with the University of Washington, Adolescent Health Transition Project to provide transition information about federal, state, and community programs and services.				X
2. Partner with the CAH section, OSPI, FEPP, DDD and DVR to enhance transition services and access to them.				X
3. Work with MCH Assessment to provide analysis of available data, including the NS-CSHCN on adolescents with special				X

needs, the Washington State Healthy Youth Survey and other data sources.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The CSHCN section is funding the AHTP at the University of Washington to finalize and begin implementation of a 5 year Strategic Plan for providers, youth, and families to facilitate adolescent transition. The first step in the plan is to convene a Special Interest Group of medical providers who provide care to adolescents with special health care needs as they transition to adult care. Another step in the 5 year plan is to obtain Key Informant interview information from adult providers who have experience in accepting adolescents who have transitioned to adult care. (Fig. 4a, NPM 6, Act. 1)

Through the contract with CHRMC, the CSHCN section developed baseline indicators to more accurately assess the success of adolescents as they transition to adult medical care. (Fig. 4a, NPM 6, Act. 2)

A survey of parents of children with special needs is currently underway through a contract with CHRMC. They survey aims to assess parents' perception of care plans and identify the need to further evaluate how adolescents would use care plans together with their parents and medical providers. (Fig 4a, NPM 6, Act. 3)

c. Plan for the Coming Year
The CSHCN section will work with AHTP to continue moving forward on the 5 year Strategic Plan for Adolescent Health transition. MCH Assessment will conduct a survey of providers to assess barriers and needs that may be hindering providers' ability to accept adolescents with special needs into their practices. Providers will also be asked about successes in their practice around adolescents with special needs.

The CSHCN section will conduct a survey among youth with special needs to assess their knowledge of medical care plans and how they would use them. The survey will be based on information obtained from youth focus groups in the past year through a contract with CHRMC.

The Adolescent Transition Notebook will continue to be available on-line and in hard copy for those who work with adolescents with special health care needs. (Fig. 4a, NPM 6, Act. 1)

The CSHCN section will continue to partner with the CAH section of OMCH to refine and implement the Washington State Plan for Youth. OMCH will also partner with medical providers through the AHTP contract to develop practical tools providers may use to assist them in providing care for adolescents as they transition to adult health care. (Fig. 4a, NPM 6, Act. 2)

The CSHCN section will work with MCH Assessment to analyze available data on youth with special needs, including the National Survey of CSHCN, the National Survey on Children's Health, the Healthy Youth Survey, and other Washington State data sources. A white paper will be developed on disability disparities in youth and will be publicized through broader youth initiatives and used to develop strategies for addressing disparities. (Fig. 4a, NPM 6, Act. 3)

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	82.5	83	75	76.4	77
Annual Indicator	71.2	69.2	75.3	77.7	77.8
Numerator	56890	54681	61045	61962	62309
Denominator	79903	79019	81069	79745	80089
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	78	79	79	80	80

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

Numerator data came from the National Immunization Survey 2005, Centers for Disease Control and Prevention (CDC). This estimate is based on the provider-verified responses for children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. The numerator is the estimated number of children with completed immunizations. Denominator data came from the Washington State Office of Financial Management.

Notes - 2004
Numerator data came from the National Immunization Survey 2004, Centers for Disease Control and Prevention (CDC). This estimate is based on the provider-verified responses for children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. The numerator is the estimated number of children with completed immunizations. Denominator data came from the Washington State Office of Financial Management.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
Numerator data came from the National Immunization Survey 2003, Centers for Disease Control and Prevention (CDC). This estimate is based on the provider-verified responses for children who live in households with telephones. Statistical methods are used to adjust for children whose parents refuse to participate, those who live in households without telephones, or those whose immunization histories cannot be verified through their providers. The numerator is the estimated number of children with completed immunizations. Denominator data came from the Washington State Office of Financial Management. We adjusted the previous year's data to include only 2 year olds per the detail sheet for this performance measure.

a. Last Year's Accomplishments
Washington's vaccination coverage rate for children ages 19-35 months for 4:3:1:3:3 was 77.7 percent (±4.6%) in 2004. (National Immunization Survey data)

Native American Tribes with WIC programs had an opportunity to participate in Record Round-Up, a project that included collecting immunization records, referring children for immunizations, and entering data into the CHILD Profile Immunization Registry. (Fig. 4a, NPM 7, Act. 2)

The Immunization Program CHILD Profile (IPCP) section continued to encourage providers to report perinatal hepatitis B infections. Perinatal Hepatitis B Prevention program surveillance showed that maternal HBsAg screening rates remained at 98 percent. The number of infants born to HBsAg+ women completing the 3-dose hepatitis series by age 12 months also remained at 88 percent.

IPCP completed the final stage of testing a new perinatal hepatitis B surveillance database case management system. This module will be linked to the Immunization Registry. As of 2005, laboratories s are required to report HBsAg+ test results to LHJs.

IPCP continued to contract with LHJs to complete Assessment Feedback Incentives and eXchange (AFIX) site visits on at least 20 percent of all enrolled immunization provider sites in the state. IPCP provided training for staff and technical assistance as needed. Data regarding provider immunization coverage rate changes was shared with LHJs. IPCP began strategic planning for AFIX site visits, including increased use of the CPIR. (Fig. 4a, NPM 7, Act. 1)

IPCP continued to build partnerships with tribes and fund efforts to enhance vaccination coverage rates of native populations within the state. Technical assistance was provided regarding Indian Health Services' data system link (RPMS) with the Immunization Registry. IPCP facilitated tribal representation at the American Academy of Pediatrics (AAP) Vaccine Summit. (Fig. 4a, NPM 7, Act. 4)

IPCP worked with the State Board of Health to draft changes to the notifiable conditions rules to ensure that LHJs receive consistent reporting on all cases of hepatitis B.

As of September 30, 2005, the CHILD Profile System sent 557,436 total health and safety mailings to parents of children aged 0--6 years. The mailings included well-child checkup and immunization reminders as well as other parenting information. (Fig. 4a, NPM7, Act. 5)

The percentage of children aged 19--35 months with complete immunizations in the CHILD Profile Immunization Registry increased to 27 percent, compared to 23.8 percent in 2004. Implementation of the provider recruitment plan resulted in 60 percent of providers agreeing to participate in the registry, up from 48 percent in 2004. (Fig. 4a, NPM 7, Act. 6)

Washington partnered with Oregon to plan and implement a 4th DTaP Initiative aimed to increase immunization rates by promoting timely administration of the 4th DTaP dose. Activities included a media campaign and parent and provider education. (Fig. 4a, NPM 7, Act. 7)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Contract with LHJs and others to complete immunization AFIX visits to enrolled private provider sites.				X
2. Fund a collaborative statewide WIC/IP workgroup and Immunization Record Roundup Project in selected counties.				X
3. Partner with LHJs to conduct population-based surveys to assess immunization levels of two year old children.				X
4. Contract with federally recognized tribes to help build capacity to assess immunization coverage rates.				X

5. Send parents age-specific reminders of the need for well-child checkups and immunizations via CHILD Profile Health Promotion.			X	
6. Maintain and increase the number of health care providers participating in the CHILD Profile Immunization Registry to improve access to historical records and use the system's immunization recommendation schedule.				X
7. 4th DTaP Initiative to increase timely administration of the 4th DTaP dose and overall immunization rates.		X	X	
8.				
9.				
10.				

b. Current Activities

Seven local agencies are planning a Locally Designed Activity that involves collaboration between WIC and Immunization programs and will include referring children for immunizations and entering data into the CHILD Profile Immunization Registry.

IPCP is developing a plan to give Early Head Start programs access to the Immunization Registry for immunization record verification and documentation.

IPCP, in coordination with the Asian Pacific Islander (API) task force, is to increase hepatitis B awareness and screening among API in community colleges. IPCP continues to support the Perinatal Hepatitis B Prevention program. IPCP and the OMCH Assessment section are planning to implement a hospital abstract project to evaluate screening and vaccination for infants who are prenatally exposed to hepatitis B.

IPCP contracts with LHJs to complete AFIX site visits on at least 20 percent of all enrolled immunization provider sites in Washington. IPCP provides training for new staff and technical assistance as needed. Data regarding provider immunization coverage rates are shared with LHJs. IPCP continues strategic planning for VFC/AFIX site visits, including increased use of the Immunization Registry. Four regional LHJ trainings will be held on AFIX Standards and the new CoCASA software. (Fig. 4a, NPM 7, Act. 1)

IPCP continues to fund interested tribes to participate in projects that include activities to enhance vaccination coverage rates of native populations within the state. Technical assistance is provided regarding the link between RPMS and the Immunization Registry. IPCP will co-host an information table at the Washington State Tribal Leader Health Summit. (Fig. 4a, NPM 7, Act. 4)

IPCP worked with the State Board of Health to adopt changes to the communicable disease rules. Changes included requiring immunity to varicella disease for school and child care entry as of July 1, 2006.

All local public health agencies have contracts with IPCP. LHJs work with local providers to assure proper use and storage of vaccines. Several LHJs administer vaccinations.

CHILD Profile Health Promotion continues working to increase the number of parents of children aged 0--6 years who are sent well-child checkup and immunizations reminders. The goal is to increase distribution from 86 percent to 90 percent. (Fig. 4a, NPM 7, Act. 5)

Currently, 498 (53%) private provider sites and 180 (90%) public sites participate in the CHILD Profile Immunization Registry. The statewide expansion goal for the Immunization Registry is to have 74 percent of providers participating by the end of 2006. (Fig. 4a, NPM7, Act. 6)

IPCP established registry-to-registry data sharing agreements with Idaho and Oregon, ensuring access to immunization information for children near those state boarders. (Fig. 4a, NPM 7, Act.

6)

IPCP continues to support a media campaign and parent and provider education related to the 4th DTaP Initiative. (Fig. 4a, NPM 7, Act. 7)

c. Plan for the Coming Year

IPCP will seek funding to in the 2007 CDC Federal Immunization Grant to support Locally Designed Activities that involve collaboration between WIC and Immunization programs and include referring children for immunizations and entering data into the Immunization Registry. (Fig. 4a, NPM 7, Act. 2)

During 2007, IPCP will implement a plan to allow Early Head Start programs access to the Immunization Registry for immunization record verification and documentation.

IPCP and the OMCH Assessment section will continue to collaborate on a hospital-based review of medical records. Information from the records review will assist focused educational outreach to hospitals and care providers. IPCP and CDC are working on a national-level medical record review for a snapshot of practices in our jurisdictions' hospitals.

IPCP will continue to contract with LHJs to complete AFIX site visits on at least 20 percent of all enrolled immunization provider sites in Washington. IPCP will provide training for new staff and technical assistance as needed. Data regarding provider immunization coverage rates will be shared with LHJs. IPCP will continue strategic planning for VFC/AFIX site visits, including increased use of the Immunization Registry. (Fig. 4a, NPM 7, Act. 1)

IPCP will continue to fund interested Washington tribes to participate in projects that include activities to enhance vaccination coverage rates of native populations within the state. Technical assistance will be provided as needed. IPCP will continue to participate in the Washington State American Indian Health Commission. (Fig. 4a, NPM 7, Act. 4)

IPCP will continue working with the State Board of Health to adopt changes to the communicable disease rules. These changes will update school and child care entry requirements for diphtheria, tetanus, and pertussis to be consistent with the Advisory Committee on Immunization Practice's 2006 Recommended Childhood and Adolescent Immunization Schedule.

All local public health agencies will continue to have contracts with IPCP. LHJs will continue to work with local providers to ensure proper use and storage of vaccines. Several LHJs will continue to administer vaccinations directly to community members.

CHILD Profile Health Promotion will continue working to increase the number of parents of children ages birth-6 years who are sent well child checkup and immunizations reminders. (Fig. 4a, NPM 7, Act. 5)

Implementation of the CHILD Profile Immunization Registry provider recruitment plan will continue. The statewide expansion goal for the Immunization Registry is to have 95 percent of providers participating by the end of 2007. (Fig. 4a, NPM 7, Act. 6)

IPCP will continue to make progress toward the Healthy People 2010 objective of 80 percent immunization rates of children aged 19--35 months for the 4:3:1:3:3 series. (Fig. 4a, NPM 7, Acts. 5, 7)

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	23	22.2	16.5	16.1	14
Annual Indicator	17.7	16.8	15.3	15.5	15.5
Numerator	2251	2151	1976	2006	
Denominator	127203	128193	128868	129120	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	15.5	15.4	15.4	15.3	15.3

Notes - 2005
PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. In 2005, discussions took place regarding the flattening of the rate to 14.0. The 75th percentile state was at 15.5, which is where Washington is at. Therefore, a 0.1 annual decrease was chosen.

Data were unavailable for the year 2005.

Notes - 2004
The source of these data is the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October). The numerator is defined as the number of live births to women ages 15-17. The denominator is the estimate of 15-17 year old women for the year 2003 in Washington on April 2005, from Office of Financial Management. Missing data are excluded. Less than 1% of the age data are missing.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
The source of these data is the Washington Center for Health Statistics Birth Certificate files (updated annually between September and October). The numerator is defined as the number of live births to women ages 15-17. The denominator is the estimate of 15-17 year old women for the year 2003 in Washington on February 2005, from Office of Financial Management. Missing data are excluded. Less than 1% of the age data are missing.

a. Last Year's Accomplishments
Three teen pregnancy prevention project sites in five separate counties implemented community-based interventions with a family planning component. Sites were awarded additional funding after successful completion of the initial 12-month project period. Annual project evaluation and monitoring continued. (Fig. 4a, NPM 8, Act. 1)

The CAH section contracted with a private media firm to launch a statewide abstinence education public awareness campaign in April 2005. Results from focus groups conducted in 2004 served as the basis for the campaign.

An abstinence-focused peer-to-peer media literacy curriculum was extended to additional communities after a successful pilot period. CAH continued to monitor and evaluate new sites to assess effectiveness. (Fig. 4a, NPM 8, Act. 2 and 3)

LHJs worked with pregnant and parenting teens to build their parenting skills and help them with issues around planning future pregnancies. One LHJ provided local statistics related to teen pregnancy to broadcast media to help increase awareness of the issue and of community

resources in their remote area. A large metropolitan LHJ provided 15 postpartum visits to all first time teen mothers. The visits aimed to encourage teen moms to stay in school and reduce or delay subsequent pregnancies. (Fig. 4a, NPM 8, Act. 4)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Select, fund, and evaluate 3 – 5 sites for the teen pregnancy prevention project, which targets youth in high risk situations and incorporates community-based interventions with a family planning component.	X	X		
2. Implement and monitor the abstinence-focused statewide public awareness campaign "No Sex No Problems" that targets youth ages 10 through 14 years and parents of young teens.			X	
3. Expand use of abstinence-focused media literacy curriculum (TISAM) to 12 community-based sites and continue evaluation.		X		
4. Partner with state and local agencies to continue to provide technical assistance, consultation and build capacity around comprehensive sex education through the use of DOH-OSPI Guidelines for at least three community sites.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CAH refined and implemented the second phase of a statewide abstinence education public awareness campaign that targeted younger youth and parents. The campaign was launched in January 2006 and will last until September 2006. Post-campaign evaluation results from last year show that 65 percent of youth surveyed remembered the campaign's specific headline.

An abstinence-focused peer-to-peer media literacy curriculum was extended from a few pilot sites to at least 12 communities statewide. Evaluation and monitoring of new sites to ascertain effectiveness continues. Evaluation results from last year indicate that youth receiving curriculum lessons were more likely to report ability to remain in control of decisions towards sex and towards resisting peer pressure. (Fig. 4a, NPM 8, Act. 2 and 3)

The availability of federal funding allowed the three teen pregnancy prevention project sites (in five separate counties) to continue to implement community-based interventions with a family planning component after successful completion of their initial 12-month project period. However, because of limited funding, other sites were not selected. Evaluation and monitoring continues on an annual basis. (Fig. 4a, NPM 8, Act. 1)

CAH also partnered with other state agencies and local organizations and received a grant from the Centers for Disease Control and Prevention to provide technical assistance to and build capacity for local communities around comprehensive sexuality education. The grant provides $160,000 per year for the next five years. The primary goal of this grant is to enhance, broaden, and measure the use of the DOH-Office of the Superintendent of Public Instruction (OSPI) Guidelines for Sexual Health Information and Disease Prevention. (Fig. 4a, NPM 8, Act. 4)

c. Plan for the Coming Year
Contingent on the availability of funds OMCH will continue to refine and implement a statewide public awareness campaign targeting younger youth and parents of young teens. New approaches and campaign messages may be designed. Depending on the evaluation results from the second phase of the campaign, new approaches and messages may be field tested prior to launching the campaign. OMCH hopes to continue funding community sites to implement an abstinence-focused media literacy curriculum. Curriculum improvements and changes will be made based on evaluation results. Site evaluations and monitoring will be sustained to ascertain program efficacy. (Fig. 4a, NPM 8, Act. 2 and 3)

Contingent on the availability of federal funding, three teen pregnancy prevention project sites (in five separate counties) will continue to implement community-based interventions with a family planning component. Evaluation results from the previous year will dictate programmatic changes to improve program effectiveness. Evaluation and monitoring will be sustained on an annual basis. (Fig. 4a, NPM 8, Act. 1)

OMCH will continue its partnership with other agencies and local organizations to provide technical assistance, consultation and build capacity around comprehensive sex education through the use of DOH-OSPI Guidelines for at least three community sites in the upcoming year. (Fig. 4a, NPM 8, Act. 4)

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	48.6	48.9	49.3	49.6	55.5
Annual Indicator	55.5	55.5	55.5	55.5	50.4
Numerator	50993	45800	46009	45689	41460
Denominator	91938	82570	82900	82322	82261
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	55.5	55.5	55.5	55.5	55.5

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

The 2005 Washington State Smile Survey is conducted by the Department of Health every five years. During the most recent survey, thirty nine Head start or ECEAP sites and sixty-seven public elementary schools with a 2nd or 3rd grade were randomly selected across the state during the 2004-2005 school year. All preschool children enrolled and present on the day of the screening were included in the sample unless the parent returned a consent form specifically opting out of the sample. Elementary schools could choose to use either an active or passive consent process. Each child participating in the survey received an oral screening exam to determine the child's caries experience, treatment need and urgency, and dental sealants needs. The indicator of 50.4% is gathered from the 2005 SMILE Survey. Denominator data came from the Washington State Office of Financial Management. The numerator is derived from these data.

Notes - 2004
The Smile Survey is currently being conducted, with results pending. New data were unavailable at this time.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
The Smile Survey is currently being conducted, with results pending.

These data were obtained from the Smile Survey 2000. The percent of third grade children who have received protective sealants on at least one permanent molar tooth is 55.5 (95% Confidence Interval is 52.7-58.3). For this survey, an electronic list of all public elementary schools in Washington was obtained from the Office of Superintendent of Public Instruction. Fifty-five schools with at least 25 children in second and/or third grade were randomly selected for participation. Seven of the schools refused to participate resulting in 48 schools with an enrollment of 6,814 children in second and third grade. Of the total 2,699 children who participated, 1,217 were in third grade. Schools who participated were more likely to have a low-income student body, and students who participated were also more likely to be low income. The children taking part in this survey are not representative of the state as a whole, since both minority children and low-income children were over-sampled. Since income has been shown to be related to sealant use, this estimate may underestimate the true percentage of third graders with at least one sealant on a permanent molar tooth. The denominator is the estimated number of 8 year-old children in 2000 reported by the Office of Financial Management, 2002.

a. Last Year's Accomplishments
In October 2004, Smile Survey screeners and LHJs were trained to use the "Epi-Info" oral health software for recording data. In 2005, Smile Survey data, including data about sealants on molars for third graders, were collected in elementary schools and child care centers.

OMCH and the Health Systems Quality Assurance (HSQA) Division evaluated the implementation and progress of legislation that expanded the scope of practice for dental hygienists to apply sealants and fluoride varnish in schools with general supervision and for dental assistants to do the same under close supervision.

OMCH continued to contract with the University of Washington (UW) School of Dentistry for expert assistance in developing the oral health component of the state adolescent health plan. UW also facilitated an interagency effort among DOH, DSHS, and OSPI to identify early intervention opportunities for children's oral health.

The Health Resources and Services Administration (HRSA) State Oral Health Collaborative Systems (SOHCS) grant funding was used to conduct and analyze the 2005 Smile Survey data. We started development of an OMCH Oral Health Strategic Plan, including a logic model for the school-based dental sealant program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate results from the 2005 State Smile Survey				X
2. Develop a state oral health surveillance system to monitor dental sealants and other oral health indicators.				X
3. Review Medicaid and other data on provision of sealants through annual consultation with DSHS, HRSA.				X
4. Provide funding to all LHJs through MCH consolidated		X	X	

contracts; LHJ activities may include support for, and referral to, sealant programs.				
5. Implement and evaluate the OMCH Oral Health Strategic Plan.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Smile Survey data were analyzed and a report was published in February 2006. The Smile Survey report was disseminated in the state through an official press release. (Fig. 4a, NPM 9, Act. 1)

OMCH is implementing a statewide surveillance system to monitor the prevalence of dental sealants and other oral health indicators. A document on oral disease burden will describe the information contained in the surveillance system in a reader-friendly format and be disseminated to the public, health professionals, and policy makers. (Fig. 4a, NPM 9, Act. 2)

OMCH oral health staff is reviewing Medicaid and other data on provision of sealants through annual consultation with DSHS HRSA and private providers delivering services in schools. (Fig. 4a, NPM 9, Act. 3)

OMCH and HSQA submitted a report to the State Legislature in December 2005 on the school-based Dental Sealant Programs.

Under the continuing SOHCS grant, we are implementing the OMCH Oral Health Strategic Plan, which aims to more fully incorporate oral health into the six different sections of OMCH. We are disseminating the completed OMCH Oral Health Strategic Plan to key stakeholders and will evaluate the plan. (Fig. 4a, NPM 9, Act. 5)

One member of the Oral Health Program staff is assigned as the state sealant coordinator. The coordinator's role is to promote and coordinate sealant programs around the state.

OMCH offers oral health funding to all LHJs through the consolidated contracts process. LHJ activities may include support for, and referral to, sealant programs. (Fig. 4a, NPM 9, Act. 4)

c. Plan for the Coming Year
The state sealant coordinator will work with LHJs and local communities to promote and implement new sealant programs.

The coordinator will put in to place a statewide data collection system for the school based sealant program.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**

Annual Performance Objective	3	3	2.9	2.9	2.5
Annual Indicator	2.8	2.7	2.9	1.8	1.8
Numerator	35	34	37	23	
Denominator	1258895	1260062	1256446	1257310	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	2.5	2.4	2.4	2.3	2.3

Notes - 2005
PERFORMANCE OBJECTIVES: Although there have been some fluctuations, over the past 12 years, an overall decrease has been observed. However, the 2004 rate looks like an anomaly. Rates are very volatile because trends are based on many years of data, therefore future targets may not appear to align with the most recent results. Using a conservative approach, a 0.1 decrease every two years was chosen.

Data were currently unavailable for 2005.

Notes - 2004
The source of the data is the Washington State Center for Health Statistics Death Certificate Files (updated annually between September and October). The numerator is defined as the number of Motor Vehicle Crash (MVC) deaths occurring to children aged 0-14 years. The denominator is the estimate number of children 0-14 years old in 2004 in Washington from the Office of Financial Management. The numerator data represent unintentional motor vehicle traffic-related deaths with the following ICD-10 codes: ICD-10 codes: V30-39(.4-.9), V40-49(.4-.9), V50-59(.4-.9), V60-69(.4-.9), V70-79(.4-.9), V81.1,V82.1,V83-V86 (.0-.3), V20-28(.3-.9), V29 (.4-.9), V12-14 (.3-.9), V19(.4-.6), V02-04(.1-.9),V09.2,V80(.3-.5),V87(.0-.8),V89.2.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
The source of the data is the Washington State Center for Health Statistics Death Certificate Files (updated annually between September and October). The numerator is defined as the number of Motor Vehicle Crash (MVC) deaths occurring to children aged 0-14 years. The denominator is the estimate number of children 0-14 years old in 2003 in Washington from the Office of Financial Management. The numerator data represent unintentional motor vehicle traffic-related deaths with the following ICD-10 codes: ICD-10 codes: V30-39(.4-.9), V40-49(.4-.9), V50-59(.4-.9), V60-69(.4-.9), V70-79(.4-.9), V81.1,V82.1,V83-V86 (.0-.3), V20-28(.3-.9), V29 (.4-.9), V12-14 (.3-.9), V19(.4-.6), V02-04(.1-.9),V09.2,V80(.3-.5),V87(.0-.8),V89.2.

a. Last Year's Accomplishments
Although state funding that supports the Child Death Review (CDR) program was eliminated from the state budget in July 2004, 20 of the 30 LHJs that had CDR teams continued to do some CDR work even without state funding support. CDR is a community process that reviews information about unexpected deaths of children, such as motor vehicle crash deaths, in order to make prevention recommendations. (Fig. 4a, NPM 10, Act. 3)

CHILD Profile health promotion materials including information about car seats, booster seats, air bag, and vehicle safety were sent to parents of children 0-6 years. CHILD Profile also partnered with the Washington Traffic Safety Commission and Children's Hospital to revise and mail a brochure on booster seat promotion. (Fig. 4a, NPM 10, Act. 1)

OMCH continued to maintain the CDR web-based reporting system and provide limited technical assistance for local teams. Aggregate data reports and prevention strategies are provided to numerous requesters using CDR data. (Fig. 4a, NPM 10, Act. 4)

A number of LHJs used MCH Block Grant funds to focus on motor vehicle safety activities, including providing inspections and free and reduced-cost car seats. (Fig 4a, NPM 10, Act. 2)

Other activities included one LHJ who supported training for a staff member on safe transport of children with special health care needs, then provided outreach to community providers about safe transport options. Another LHJ provided car seat safety education in Spanish for parents. A third LHJ did a needs assessment that showed a gap in car seat safety education and support. In response, they actively increased outreach and community visibility. (Fig 4a, NPM 10, Act. 2)

OMCH staff continued to collaborate with the Prevention and Trauma section of the DOH Office of Emergency Medical Services (EMS) and Trauma on activities that are common priorities for both programs. (Fig. 4a, NPM 10, Act. 6)

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

OMCH works with the 20 local CDR teams that continue to function. The state CDR Web-based reporting system continues to receive support. OMCH Assessment staff responds to requests for data from the CDR data and reporting system. Technical assistance continues to be offered to local teams. (Fig. 4a, NPM 10, Act. 3, 4)

CHILD Profile continues sending car seat, booster seat, and air bag safety information to parents of children 0 -- 6 years of age. Vehicle safety information is currently provided in nine CHILD Profile letters and five inserts. The information is refined as statewide data and laws change. (Fig. 4a, NPM 10, Act. 1)

OMCH Assessment published "The Adolescent Needs Assessment" in March 2006, which included data on youth risk factors associated with motor vehicle crashes. (Fig. 4a, NMP 10, Act. 8)

A number of LHJs used MCH Block Grant funds to focus on motor vehicle safety activities, including providing inspections and free and reduced-cost car seats. (Fig 4a, NPM 10, Act. 2)

OMCH participates in an advisory capacity to the Harborview Injury Prevention Resource Center to support a Centers for Disease Control and Prevention demonstration project with six local CDR

teams. The project links regional EMS injury prevention coordinators to local teams. Additionally, this project is developing a data analysis and decision-making tool to help CDR teams generate prevention recommendations. The tool is currently being pilot tested.
(Fig. 4a, NPM 10, Act. 5)

OMCH staff continue to collaborate with the DOH Office of EMS and Trauma, Prevention and Trauma section on activities that are common priorities for both programs including development of a State Injury Prevention Plan. (Fig. 4a, NPM 10, Act. 6, 7)

c. Plan for the Coming Year
OMCH will work with the 20 local CDR teams that are continuing to function. Technical assistance will continue to be offered to local teams. The state database and reporting system will continue to be supported for now. OMCH staff will participate with the National MCH Center for CDR to look at the feasibility of using a multi-state database instead of the current web-based system in Washington.

CHILD Profile will continue to send car seat, booster seat, and air bag safety information to parents of children 0 -- 6 years of age. Information will be refined as statewide data changes. (Fig. 4a, NPM 10, Act. 1)

OMCH will continue to participate in an advisory capacity to the Harborview Injury Prevention Resource Center to support a CDC demonstration project with six local CDR teams to link regional EMS injury prevention coordinators to local teams. The data analysis and decision-making tool will be refined and will be used by teams on a voluntary basis as a means of streamlining their review processes. (Fig. 4a, NPM 10, Act. 5)

OMCH will continue to work with LHJs to promote more collaboration and coordination with local injury prevention programs and activities to assist in public education efforts including educating parents. (Fig. 4a, NPM 10, Act. 2)

OMCH staff will continue to collaborate with the Prevention and Trauma section of the DOH Office of EMS and Trauma, on activities that are common priorities for both programs. The State Injury Prevention Plan will be finalized and implementation will begin using community partners to market the plan. (Fig. 4a, NPM 10, Act. 6, 7)

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					52
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	52	53	53	54	54

Notes - 2005
PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. Although data at six months has only been

available for the past two years, breastfeeding initiation data has been stable for years, as has breastfeeding at two months. Therefore, a one percent increase every two years has been chosen.

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

a. Last Year's Accomplishments

The NPM has changed from the percentage of mothers who initiate breastfeeding to the percentage of mother who breastfeed their infants for at least six months. This focus has changed because the greatest health benefits occur when breastfeeding continues for at least six months. The Healthy People 2010 Objective is to have at least 50 percent of mothers breastfeeding their babies for six months.

First Steps providers were required to talk about breastfeeding with all clients. In August 2005, First Steps introduced new documentation requirements that incorporated breastfeeding as a priority. (Fig. 4a, NPM 11, Act. 1).

At the First Steps ABC training, 85 new Maternity Support Services (MSS) providers received training in breastfeeding support and teaching techniques. (Fig. 4a, NPM 11, Act. 2)

First Steps and WIC teamed up to address issues around breastfeeding. For example, in the Spring/Summer of 2005, 34 MSS staff attended the Evergreen Medical Center lactation training (Fig. 4a, NPM 11, Act. 2).

In addition, three other training opportunities were posted on the First Steps listserv and First Steps and WIC finalized breastfeeding talking points that providers can use with clients. These talking points incorporated DOH handouts that supported women with issues around breastfeeding. (Fig. 4a, NPM 11, Act. 3).

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities
All First Steps providers continue to provide basic health messages around breastfeeding. Documentation of specific First Steps issues, such as breastfeeding, is required as of January 1, 2006. (Fig. 4a, NPM 11, Act. 1)

First Steps is currently developing an online breastfeeding training module that offers providers education on how to support women with breastfeeding issues (Fig. 4a, NPM 11, Act. 2).

First Steps is updating a resource guide listing resources for breast pump acquisition. (Fig. 4a, NPM 11, Act. 1)

First Steps and WIC continue to collaborate around breastfeeding by suporting staff to attend the Evergreen Medical Center lactation training, promoting local trainings on breastfeeding support, and reviewing data from WIC and the National Immunization Survey (NIS) regarding breastfeeding for at least six months. (Fig. 4a, NPM 11, Act. 2)

c. Plan for the Coming Year
All First Steps providers will continue to provide basic health messages around breastfeeding and document them in the new required forms. (Fig. 4a, NPM 11, Act. 1)

First Steps will distribute MSS provider talking points to help providers with conversations around initiating breastfeeding and supporting long term breastfeeding. (Fig. 4a, NPM 11, Act. 1)

First Steps will distribute an updated resource guide on free breast pump acquisition. (Fig. 4a, NPM 11, Act. 1).

First Steps will test their new online breastfeeding training module with a select group of providers. This module will offer providers education and help them with skills to support women to breastfeed for at least six months. (Fig. 4a, NPM 11, Act. 2)

First Steps and WIC will continue collaborate around breastfeeding and encourage staff to attend the Evergreen Medical Center lactation training, list local training on the First Steps Listserv and DOH Web sites, review WIC and National Immunization Survey data to determines the percentage of mothers who breastfeed for at least six months, and offer talking points that staff can use with medical providers to promote consistent information. (Fig. 4a, NPM 11, Act. 1 and 2)

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	30	50	70	90	90
Annual Indicator	40.9	62.2	81.0	85.0	88.0
Numerator	32028	47550	59619	67174	70830
Denominator	78310	76458	73649	79028	80489
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	90	92	94	96	98

Notes - 2005

PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. Given the 88% for 2005 and the continued modest increases, an annual 2% increase was chosen.

In CY 2005, 88% of infants born in Washington hospitals received newborn hearing screening.

Notes - 2004
In CY 2004, 85% of infants born in Washington hospitals received newborn hearing screening.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
In CY 2003, 81% of infants born in Washington hospitals received newborn hearing screening (59,619 hospital births in Washington (73,649).

a. Last Year's Accomplishments
The Early Hearing Loss Detection, Diagnosis, and Intervention (EHDDI) Program continued to add birthing hospitals to Phase I of the Tracking and Surveillance System. By September 30, 2005, 63 of 69 birthing hospitals were part of the system. (Fig. 4a, NPM 12, Act. 1)

Over 88 percent of all infants were screened for hearing loss in 2004, an increase from 81 percent in 2003. (Fig. 4a, NPM 12, Act. 2)

Staff presented data at the 2005 National Early Hearing Detection and Intervention meeting in Atlanta, Georgia. In April 2005, information about Universal Newborn Hearing Screening (UNHS) in Washington State was presented to the Washington State Board of Health. Presentations included information about hearing screening rates, collaborative efforts to support newborn hearing screening, status of the tracking and surveillance system, and ongoing issues related to UNHS in Washington.

The EHDDI program contracted with CHRMC to provide technical assistance to birthing hospitals and with Washington Sensory Disabilities Services (WSDS) to provide ongoing early intervention training to eight counties and the State Migrant Council via interactive videoconferences and on-site coaching. (Fig. 4a, NPM 12, Act. 3)

A second statewide EHDDI Summit was held in August 2005 at Skamania Lodge in Stevenson, Washington. Participants included a variety of professional groups, parents, and members of the deaf community, with representation from every county in Washington. Participants evaluated needs in their regions as well as across the state, and worked together to develop solutions. A final report was made available to participants in February 2006.

CHILD Profile mailed the "Health & Development Record" booklet, which contains spaces to record hearing screening results. CHILD Profile provided health promotion messages in both its 1-month and 3-month letters to encourage parents to speak with their health care provider if they have concerns about their child's hearing. CHILD Profile partnered with the Infant Toddler Early Intervention Program to distribute information on hearing milestones in its 3-month, 6-month, and 12-month mailings.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop an EHDDI tracking and surveillance system.				X
2. Conduct annual newborn hearing screening survey with				X

birthing hospitals across the state.				
3. Contract with Children's Hospital and Regional Medical Center (CHRMC) to promote universal newborn hearing screening in birthing hospitals.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The EHDDI Program continues to analyze data from Phase I and Phase II of the Tracking and Surveillance system. To date, 65 of 69 birthing hospitals are reporting hearing screening data to the EHDDI Program. The remaining four hospitals include one hospital in Southwest Washington that is not screening infants for hearing loss and three military hospitals that currently contract with Oregon. We hope to add the hospital in Southwest Washington to Washington's tracking and surveillance system before July 2006.

To date, an estimated 95 percent of all infants born in Washington received a hearing screening at birth. The average age of the infants upon initial screening, excluding those in the neonatal intensive care unit (NICU), was 1.5 days. Of those who did not pass their initial screen, 66 percent had rescreen outcomes recorded in the EHDDI tracking and surveillance system. The average age at rescreen for non-NICU infants was 15.5 days. (Fig. 4a, NPM 12, Act. 1)

During the summer of 2006, pediatric audiologists will review "Best Practices for Audiological Evaluation in Newborns" to determine if any changes or updates are needed.

OMCH will conduct a parent survey in the summer of 2006 to evaluate cultural competency of services accessed as well as reasons why recommended services were not accessed.

Through a contract with WSDS, early intervention provider training was expanded to include 10 additional counties, mostly in rural areas of Eastern Washington. County representatives will participate in an online interactive course called "Improving Early Hearing Detection and Intervention Service Delivery: Infants & Young Children with Hearing Loss, Ages Birth - 5 Years." Masters level trained early intervention providers who specialize in services for children who are Deaf or Hard of Hearing are providing consultation and one-on-one on-site coaching to county participants. The WSDS contract also provided funding for seven families with birth-to-three year olds with hearing loss to attend the annual family weekend May 12-14, 2006 in Ellensburg, WA.

The EHDDI Program continues to contract with CHRMC to provide technical assistance to hospitals with Universal Newborn Hearing Screening Programs. To date, CHRMC has provided technical assistance to over 15 hospitals. In addition, CHRMC is educating hospitals and physicians about the importance of risk factors for late-onset hearing loss. (Fig. 4a, NPM 12, Act. 3)

CHILD Profile continues to mail the "Health and Development Record" booklet, which contains spaces to record hearing screening results. CHILD Profile also continues to provide health promotion messages in its 1-month and 3-month letters to encourage parents to speak with their health care provider if they have concerns about their child's hearing. CHILD Profile maintains its partnership with the Infant Toddler Early Intervention Program to distribute information on hearing milestones in its 3-month, 6-month, and 12-month mailings.

c. Plan for the Coming Year
The EHDDI Program will continue to analyze data from Phase I and Phase II of the Tracking and Surveillance system to make further improvements to the system and to determine lost to follow-up rates in Washington. (Fig. 4a, NPM 12, Act. 1)

CHRMC will continue to provide technical assistance to hospitals with Universal Newborn Hearing Screening Programs. (Fig. 4a, NPM 12, Act. 3)

Early intervention provider training will be expanded to additional counties through a contract with WSDS. The EHDDI Program will continue to work with CSCHN, Office of the Deaf and Hard of Hearing, DSHS, and local and state Interagency Coordinating Councils to ensure infants are receiving timely and appropriate follow-up services.

CHILD Profile will continue to mail the "Health and Development Record" booklet, which contains spaces to record hearing screening results. CHILD Profile will also continue providing health promotion messages in its letters to encourage parents to speak with their health care provider if they have concerns about their child's hearing. CHILD Profile plans to maintain its partnership with the Infant Toddler Early Intervention Program to distribute information on hearing milestones.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	6.5	6.4	6.3	6.2	5
Annual Indicator	5.5	4.5	4.5	6.0	6.0
Numerator	83925	73077	73077	98000	97158
Denominator	1525907	1623925	1623925	1638000	1619803
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	5	5	5	5	5

Notes - 2005
PERFORMANCE OBJECTIVES: The Washington State Population Survey is conducted every two years. Based on previous years' results, the future target of five percent was chosen through 2010.

The data source is the 2004 Washington State Population Survey, from the Washington State Office of Financial Management (OFM). The State Population Survey is a telephone-based survey that takes place every two years, therefore the 2004 percent was used to create 2005 estimates. Children include persons 0 through age 18. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

Notes - 2004
The data source is the 2004 Washington State Population Survey, from the Washington State Office of Financial Management (OFM). The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 18. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
No new data for 2003.
The data source is the 2002 Washington State Population Survey, from the Washington State Office of Financial Management (OFM). The State Population Survey is a telephone-based survey that takes place every two years. Children include persons 0 through age 18. Insurance status was based on time of interview. Estimates are adjusted for missing income or insurance status data.

a. Last Year's Accomplishments
The CAH section coordinated with key organizations and agencies to ensure that children, teens, and their families have access to health care services, especially health insurance. CAH administered a contract to support the implementation and evaluation of a program called Kids Get Care, which was designed to increase children's access to health insurance.

CHILD Profile inserted the "Healthy Kids Now" flyer through collaboration with the Health Improvement Partnership. The target population for this flyer was the 4 - 6 year age group. The "Healthy Kids Now" insert provides information on how to access free or low-cost health insurance for children. Dissemination of this flyer through CHILD Profile was responsible for 19 percent of total calls received by the Healthy Kids Now hotline, which receives an average of 285 calls per month. (Fig. 4a, NPM 13, Act. 1)

CHILD Profile health promotion letters referred parents to HMHB (now known as WithinReach) to assist them in obtaining medical insurance for their children. (Fig. 4a, NPM 13, Act. 1)

Local efforts to better address the percent of children without health insurance included using assessment data to study insurance status and providing free services to a limited number of uninsured clients. To improve clients' access to health insurance and coordinated health care services, LHJ staff assisted clients with applying for public insurance and helped them work with insurers. Families also received help with accessing transportation and interpreter services through Medicaid. Non-English speaking families, especially those new to the state, often face barriers to health care because they cannot communicate. LHJs are key in helping them with both information and in building confidence in their own ability to access services.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

CAH continues to coordinate with other key organizations and agencies to ensure that children, teens, and their families have access to health care services, especially health insurance. (Fig. 4a, NPM 13, Act. 1)

CAH will partner with Medicaid to facilitate a state-level meeting to develop a plan to improve utilization of the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. (Fig. 4a, NPM 13, Act. 2)

CHILD Profile continues to disseminate the "Healthy Kids Now" insert in the health promotion mailings to provide parents with information on how to access free or low-cost health insurance for children. CHILD Profile health promotion letters refer parents to WithinReach (formerly HMHB) to assist them in obtaining medical insurance for their children. (Fig. 4a, NPM 13, Act. 1)

c. Plan for the Coming Year
CAH will work with key organizations and agencies to implement a plan to improve utilization of EPSDT services. (Fig, 4a, NPM 13, Act 2).

CAH will coordinate with other key partners to ensure that children, teens, and their families have access to health care services, especially health insurance.

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

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator	22.6	22.5	23.1	29.3	29.2
Numerator	19234	19477	19760	25713	24679
Denominator	84936	86432	85632	87693	84520
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	29	29	29	29	29

Notes - 2005
PERFORMANCE OBJECTIVES: Prevalence of overweight children is increasing both nationally and in Washington state. A variety of environmental, genetic, and lifestyle factors are influencing this trend. Only BMI's based on the 95th percentile and above are available for national and state comparison. From 2001-2003 Washington's rates for children on WIC were much lower than the national rate, but the last two years show higher rates than the nation. This may be due in part, to the fact that different states report on different populations. In Washington, the only data provided to CDC is for children on WIC. Other states may report on the entire population of children under 5. Importantly, data collection methodology changed in 2004, therefore the increase should be interpreted with caution since it is likely that much of the change is due to changes in data collection. Between the years 2004-2005, Washington State had a smaller percent increase than that seen in the nation.

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

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

a. Last Year's Accomplishments
This is a new performance measure, there were no related activities last year.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities
CHILD Profile materials are mailed to parents of children birth to six years old. These mailings contain age-appropriate nutrition information, including two nutrition brochures. Physical activity information is incorporated into materials on child growth and development. (Fig 4a NPM 14, Act. 1)

OMCH seeks opportunities to coordinate with internal and external partners around nutrition, physical activity, and obesity prevention. Examples include the DOH Nutrition and Physical Activity Policy Leadership Group and the Washington State Nutrition and Physical Activity Plan. (Fig 4a NPM 14, Act. 2)

Child care health consultants provide nutrition and physical activity information to child care providers. Detailed training is included in the child care health consultation education modules. (Fig 4a NPM 14, Act. 3)

OMCH is actively promoting the use of Bright Futures Health Promotion guidelines including those related to physical activity and nutrition. These two topics were chosen by some participants in the Bright Futures Early Childhood Project as areas of emphasis. The Early Childhood Project was designed to increase the use of Bright Futures in settings such as Head Start, Early Head Start, and the state preschool program. (Fig 4a NPM 14, act. 4)

MSS works to promote a healthy weight during pregnancy and appropriate physical activity to improve birth outcomes. MSS also promotes breastfeeding which helps to reduce the chances of overweight/obesity in children.

c. Plan for the Coming Year
OMCH plans to continue activities to promote nutrition and physical activity, including participating in and coordinating with internal and external groups working to promote healthy activities and prevent obesity in children and youth of all ages, their parents, and pregnant women.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					10.2
Numerator					
Denominator					
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	10	10	10	10	10

Notes - 2005
PERFORMANCE OBJECTIVES: Trend analyses based on the past six years have shown a decrease in women smoking in the third trimester of pregnancy. Washington has one of the lowest smoking rates in the nation, so a flattened rate is envisioned. Therefore, a 10% target was chosen through 2010.

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

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

a. Last Year's Accomplishments
This NPM is new. The following are related activities from last year's State Performance Measure 2. OMCH provided information to health care professionals about the Medicaid benefit that aims to increase the number of medical providers who do interventions for tobacco cessation. Information was provided through articles in professional newsletters, medical meeting exhibits, and professional Web sites. Through reports provided by DSHS HRSA, MIH tracked benefit billing data to evaluate how many providers are billing for the intervention. (Fig. 4b, SPM 2, Act. 2, 4 -- See Section IVD. State Performance Measures for this figure)

The MSS smoking cessation performance measure was integrated into a standardized charting system and provider training continued. (Fig. 4b, SPM 2, Act. 1)

MIH, DSHS HRSA, and the DOH Tobacco Prevention and Control Program continued the tobacco Champion Project for ten more First Steps agencies which provided additional motivational interviewing and systems change training, follow-up site visits, and technical assistance. Training and follow-up was completed by June 30, 2005. (Fig. 4b, SPM 2, Act. 8)

PRAMS data were collected and referenced to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups. (Fig. 4b, SPM 2, Act. 6)

Tobacco cessation for pregnant and parenting women and teens was an integral part of LHJ services to clients across the state. Many LHJs were leaders or active participants in their local Tobacco Coalitions. (Fig. 4b, SPM 2, Act 10)

The Tobacco Prevention and Control Program (TPCP) and the Tobacco Cessation Resource Center (TCRC) implemented the Quit Line Fax Back Referral Program. This is available to First Steps and obstetric providers. The provider asks about and documents tobacco use, advises users to quit, and assesses interest in quitting. Those interested in quitting are directly referred to the Washington Tobacco Quit Line using a faxed referral form. The Quit Line contacts the person to assist in developing a quit plan and arrange referrals. MIH worked with March of Dimes and TPCP on several events to inform medical providers and office staff about the fax referral program and Medicaid benefit. In addition, MIH, DSHS HRSA, and TPCP provided intensive training to ten Champion agencies. (Fig 4b, SPM 2, Act 7)

Operators of the Family Health Hotline (formerly HMHB) asked callers if anyone in the home smokes and offered referrals to the Quit Line. From October 2004 through September 2005, 448 callers were referred to the Quit Line. Quit Line pamphlets were included in 3,875 prenatal packets and 1,378 child health packets. (Fig 4b, SPM2, Act 9)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote the Smoking Cessation benefit for pregnant women through OMCH collaboration with DSHS HRSA.		X		
2. Increase smoking cessation among low income women on Medicaid by providing tobacco cessation intervention training to First Steps providers				X
3. Collect and reference PRAMS data to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups.				X
4. Inform and educate professionals about the FAX Back Referral program.				X
5. Disseminate the best practice guide for smoking cessation to medical providers.				X
6. Share tobacco data with First Steps providers and perinatal providers.				X
7. WithinReach refers callers with tobacco in their home to the Quit Line and sends tobacco cessation materials to callers as appropriate.			X	
8. Help build coalitions of local partners and support community efforts to decrease tobacco use during pregnancy.				X
9.				
10.				

b. Current Activities

MIH continues to inform providers of the Medicaid benefit through articles in professional newsletters, medical meeting exhibits, and professional Web sites. Through reports provided by DSHS HRSA, MIH is tracking benefit billing data to evaluate how many providers are billing for the intervention. (Fig. 4b, SPM 2, Act. 2, 4)

The MSS smoking cessation performance measure has been integrated into a standardized charting system and provider training continues. (Fig. 4b, SPM 2, Act. 1)

MIH is working with the Tobacco Prevention and Control Program to market the FAX Back Referral program to First Steps agencies and medical providers. For example, staff distributes information at continuing medical education meetings and conducts training for First Steps agencies. (Fig. 4b, SPM 2, Act. 7)

Operators of the WithinReach: Essential Resources for Family Health Family Health Hotline (formerly HMHB) ask callers if anyone in the home smokes, and if so, the operators offer referrals to the Quit Line. WithinReach continues to include Quit Line materials in prenatal packets and child health packets. (Fig 4b, SPM 2, Act 9)

First Steps agencies are receiving enhanced onsite technical assistance (including the Tobacco Champion Project for up to 35 First Step agencies) in order to strengthen working relationships with county tobacco prevention and control contractors; increase utilization of the state Quit Line; increase knowledge and skills in client centered tobacco cessation messages for pregnant women; and develop new policies that reinforce the value of tobacco cessation and protection against secondhand smoke for both staff and clients. Included with this project is an evaluation plan. Consultation continues for all First Steps agencies that participated in the Tobacco Champion Pilot and Project. (Fig 4b, SPM 2, Act 8)

PRAMS data are being collected and referenced to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups. (Fig. 4b, SPM 2, Act. 3, 6)

c. Plan for the Coming Year

MIH will continue to inform providers of the Medicaid benefit. (Fig. 4a, NPM 15, Act. 1)

The MSS smoking cessation performance measure will continue to be documented in a standardized charting system and provider training will continue. (Fig. 4b, SPM 2, Act. 1)

PRAMS data will be collected and referenced to measure smoking rates before, during, and after pregnancy; quit rates; relapse rates; third trimester smoking trends; and disparities between groups. (Fig. 4a, NPM 15, Act. 3)

MIH and its partners will inform First Steps providers and medical providers about availability and use of the FAX Back Referral system. (Fig. 4a, NPM 15, Act. 4)

Tobacco Cessation Training will continue for First Steps Providers. (Fig 4a, NPM 15, Act 2)

Continue to disseminate the "Smoking Cessation during Pregnancy" best practice booklet. (Fig. 4a, NPM 15, Act. 5)

WithinReach will continue to offer Quit Line referrals and distribute Quit Line pamphlets. (Fig. 4a, NPM 15, Act 7)

Data about smoking during pregnancy and efforts to reduce smoking during pregnancy are compiled to ensure that quality improvement can be measured over time and shared with providers. (Fig 4a, NPM 15, Act 6)

The Tobacco Champion Project will continue to provide opportunities for First Steps providers to receive additional motivational interviewing and systems change training. (Fig 4a, NPM 15, Act

2).

Some LHJs will continue to receive and use MCH block grant funds to provide smoking cessation activities that target pregnant women. (Fig 4a, NPM 15, Act 8)

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	11.7	11.7	8.5	8.4	8.9
Annual Indicator	8.0	8.7	9.6	10.2	10.2
Numerator	35	38	42	45	
Denominator	435035	437828	439282	442824	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	8.9	8.8	8.7	8.6	8.5

Notes - 2005
PERFORMANCE OBJECTIVES: Trend analyses and interdepartmental discussions took place to choose future objectives. Rates are very volatile because trends are based on many years of data, therefore future targets may not appear to align with the most recent results. A conservative annual decrease of 0.1% was chosen.

Data were unavailable for the year 2005.

Notes - 2004
The numerator for this rate is defined as the number deaths with ICD 10 Codes X60-X84 and Y87.0 and U03 for youth ages 15-19. The denominator is the estimated population for ages 15-19. The rate is per 100,000 population. The source for the data is the Washington Center for Health Statistics Death Certificate files (updated annually between September and October) and the Office of Financial Management, Intercensal and Postcensal Estimates of County Population by Age and Sex.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
The numerator for this rate is defined as the number deaths with ICD 10 Codes X60-X84 and Y87.0 and U03 for youth ages 15-19. The denominator is the estimated population for ages 15-19. The rate is per 100,000 population. The source for the data is the Washington Center for Health Statistics Death Certificate files (updated annually between September and October) and the Office of Financial Management, Intercensal and Postcensal Estimates of County Population by Age and Sex.

a. Last Year's Accomplishments
OMCH collaborated with the Injury and Violence Prevention Program as well as the Office of Epidemiology to implement an evaluation of the Youth Suicide Prevention Program (YSPP), which included data from the 2002 and 2004 Healthy Youth Survey. YSPP activities focused on raising public awareness, providing gatekeeper training to adults who interact with youth, and building community capacity to address suicide prevention locally and support youth in the community. (Fig. 4a, NPM 16, Act 1, 4)

OMCH supported YSPP activities by: promoting gatekeeper training through LHJs and other networks and partnerships; providing consultation on key questions and issues related to youth suicide; providing technical assistance and support to communities already engaged in youth suicide prevention efforts; supporting local and statewide efforts to promote early identification of children's mental health issues; incorporating suicide prevention as a key element in the Washington State Plan for Youth; and supporting data collection on risk behaviors through the Healthy Youth Survey. (Fig. 4a, NPM 16, Act. 5)

Most LHJs used Title V block grant funds for women and younger children. However, LHJs in more remote and isolated communities worked with people of all ages in the community. One Southwest Washington rural LHJ has consistently supported youth-focused community awareness and events for youth and long-range community support of youth in their community. In the past few years they have tracked suicides and suicide attempts and worked with the community to create support for youth. During the past year this LHJ assisted in a "youth issues" forum to find ways to provide youth with safe and healthy activities. As a result the community will establish a Boys and Girls Club, create a youth-oriented park, and continue to support a recently built skate park. (Fig. 4a, NPM 16, Act. 7)

OMCH maintained the state database on childhood deaths and provided technical assistance for the twenty local Child Death Review teams that were able to continue after losing state funds. The database continued to list recommendations for strategies directed at prevention of youth suicide. (Fig. 4a, NPM 16, Act. 2, 3)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with DOH Office of EMS and Trauma to implement Youth Suicide Prevention Program (YSSP).			X	
2. Work with Child Death Review (CDR) local team reviews of unexpected deaths (including suicides).				X
3. Conduct surveillance of suicide deaths through CDR and disseminate data.				X
4. Participate in evaluation of YSPP.			X	
5. Promote training and strategies of suicide prevention.				X
6. Develop State Injury Prevention Plan.				X
7. Support LHJ youth safety activities.			X	
8.				
9.				
10.				

b. Current Activities

OMCH continues to work with the DOH Office of Emergency Medical Services (EMS) and Trauma on injury and violence prevention to implement YSPP and reduce the teen suicide rate. YSPP activities continue to focus on raising public awareness, providing gatekeeper training to adults who interact with youth, and building community capacity to address suicide prevention. An added area of enhancement of YSPP activities includes 4 Pierce County institutions of higher education with a focus on youth ages 17-24 years. This age group is currently at higher risk than middle school and high school age youth. DOH sponsored two day-long trainings for these institutions in October 2005 and February 2006. (Fig. 4a, NPM 16, Act. 1, 4)

OMCH continues to assist with evaluating the YSPP program by comparing Healthy Youth Survey data from schools implementing the program to schools not utilizing the program. The current evaluation was completed in December 2005. (Fig. 4a, NPM 16, Act. 4)

LHJs continue to use Title V block grant funds to support youth safety activities such as promoting safe storage of firearms and gun safety classes, work with EMS and other first responders on how to respond to a suicide and persons with suicidal behaviors, and work with school personnel on emergency preparedness and safety plans including how to respond to a suicidal youth. (Fig. 4a, NPM 16, Act. 5, 7)

OMCH continues to maintain the state database on childhood deaths and provide technical assistance for the twenty local Child Death Review teams that continue to meet after receiving a cut in their funding. The database continues to list recommendations for strategies directed at prevention of youth suicide. (Fig. 4a, NPM 16, Act. 2 and 3)

OMCH Assessment published "The Adolescent Needs Assessment" in March 2006, which included data on youth risk factors associated with suicide. (Fig. 4a, NPM 16, Act. 3)

OMCH staff continue to collaborate with the Prevention and Trauma section of the DOH Office of EMS and Trauma on activities that are common priorities for both programs including development of a State Injury Prevention Plan. Youth Suicide is one of the focus areas of the plan. (Fig. 4a, NPM 16, Act. 6)

c. Plan for the Coming Year

OMCH will continue to work with the Office of EMS and Trauma Systems to implement YSPP throughout the state to reduce the teen suicide rate. Plans are to continue 2006 activities, gain further momentum in raising awareness of the problem of youth suicide, train people who work with youth on the skills for early intervention, and engage communities to address suicide through prevention and early intervention planning and skills building. Efforts will be made to expand efforts statewide through partnerships with the Community Health and Safety Networks as well as with Native American tribes. Additional efforts will continue with college and university campuses in Pierce County to include training and awareness campaigns. (Fig. 4a, NPM 16, Act. 1, 4)

OMCH will assist with evaluating YSPP program efforts by comparing Healthy Youth Survey data from schools with the program to schools without the program. This will be a focus of the program during the last half of 2007. (Fig. 4a, NPM 16, Act. 3)

LHJs will continue to use Title V block grant funds to support various youth safety activities such as promoting safe storage of firearms and gun safety classes, working with EMS and other first responders on how to respond to a suicide, and working with school personnel on emergency preparedness and safety plans including how to respond to a suicidal youth. (Fig. 4a, NPM 16, Act. 5, 7)

OMCH will continue to maintain the state database on child deaths and provide technical assistance for the remaining local Child Death Review Teams. The database will continue to list recommendations for strategies directed at prevention of youth suicide. (Fig. 4a, NPM 16, Act. 2, 3)

OMCH staff will continue to collaborate with the Prevention and Trauma section of the DOH Office of EMS and Trauma on activities that are common priorities for both programs. The State Injury Prevention Plan will be finalized and implementation will begin using community partners to market the plan. In addition, OMCH will apply for grant funding through SAMHSA to expand partner efforts and program activities. (Fig. 4a, NPM 16, Act. 6)

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	79.6	79.8	80	80.2	85
Annual Indicator	75.4	82.6	83.4	85.9	85.9
Numerator	582	617	627	691	
Denominator	772	747	752	804	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	86	87	87	88	88

Notes - 2005
PERFORMANCE OBJECTIVES: A combination of trend analyses and comparisons to other states were used to create the future objectives. The number of tertiary care hospitals has increased over time. Therefore, an increase of one percent every two years was chosen.

Data were unavailable for the year 2005.

Notes - 2004
The numerator is determined by the number of resident very low birth weight (VLBW) births that occur in-state delivered at a hospital providing perinatal intensive care (Level III). In addition to the eleven Level 3 facilities, Kadlec was included because it functions as a level 3 due to geography and services provided, although technically a Level 2. The denominator represents the total number of VLBW resident infants born in-state. The source for this data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October). Missing data are excluded. Less than 1% of the data are missing.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
The numerator is determined by the number of resident very low birth weight (VLBW) births that occur in-state delivered at a hospital providing perinatal intensive care (Level III). The denominator represents the total number of VLBW resident infants born in-state. The source for this data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October). Missing data are excluded. Less than 1% of data are missing.

a. Last Year's Accomplishments
Regional Perinatal Programs were funded to provide professional education, consultation, and to facilitate transport of high-risk pregnant women and neonates. In the four regional perinatal centers who collect and report these statistics, approximately 600 women were transported to one of four regional perinatal centers for high-risk birth and approximately 400 infants were transported from a community hospital to a regional perinatal center for neonatal intensive care. (Fig. 4a, NPM 17, Act. 2)

Regional Perinatal Programs continued to monitor delivery sites of very low birth weight babies and advocate for delivery of these infants at tertiary care facilities. (Fig. 4a, NPM 17, Act. 1).

In September 2005, the MCH epidemiologist presented statistics to the statewide Perinatal Advisory Committee about where very low birth weight babies were being delivered in the state.

About 82 percent of very low birth weight babies were born in tertiary level perinatal facilities in 2003.

Regional Perinatal Programs received funding to provide professional education and consultation and to facilitate transport of high-risk pregnant women and neonates. (Fig. 4a, NPM 17, Act. 2)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor delivery sites of very low birth weight babies and advocate for delivery of these infants at tertiary care facilities.				X
2. Fund Regional Perinatal Centers to provide professional education, consultation, and facilitate transport of high-risk pregnant women and neonates.		X		
3. Fund Regional Perinatal programs to coordinate and implement QI projects to improve pregnancy outcome statewide, including advocating delivery of VLBW babies at tertiary level perinatal facilities.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Regional Perinatal Programs are monitoring delivery sites of very low birth weight babies and actively advocating for delivery of these infants at tertiary level perinatal facilities until June 30, 2006. At that time, the regional program focus changes from a primary function of education and consultation to a different function -- that of coordinating and implementing state and regional quality improvement projects focused on decreasing poor pregnancy outcomes for which Medicaid clients are at disproportionately increased risk. (Fig 4a, NPM 17, Act. 3)

Regional Perinatal Program funding was significantly decreased beginning July 1, 2006 and no longer includes activities specifically focused on professional education and consultation or transport of high-risk pregnant women and neonates. However, selected quality improvement projects will function on the premise that very low birth weight babies have better outcomes when born at tertiary level perinatal facilities. (Fig. 4a, NPM 17, Act.1, 3)

c. Plan for the Coming Year

Regional Perinatal Programs will begin to implement quality improvement projects aimed at improving poor pregnancy outcomes. Monitoring delivery sites of very low birth weight babies will be important to assessing components that help ensure positive pregnancy outcomes. (Fig. 4a, NPM 17, Act. 1, 3)

Regional Perinatal Programs will receive less funding than in the past, but will continue to function on the premise that outcomes of very low birth weight babies are improved if born at facilities equipped for high-risk deliveries and newborn intensive care. (Fig. 4a, NPM 17, Act. 1, 3)

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	85.5	86	84.2	85.1	83
Annual Indicator	83.2	83.4	80.8	79.1	79.1
Numerator	60771	60076	52885	53037	
Denominator	73038	72055	65475	67060	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	80	81	81	82	82

Notes - 2005
PERFORMANCE OBJECTIVES: A new birth certificate was implemented in 2003. The specificity of the question, which asks for the exact date of prenatal care initiation, has resulted in a high amount of missing data. Therefore, a conservative decrease of one percent every two years was chosen. Due to the change in methodology, trend analysis crossing from 2002-2003 cannot be done, and trends can only be based on two years' worth of data (2003-2004).

Data were unavailable for the year 2005.

In 2003 a new birth certificate form was implemented. It collects some information differently, and caution should be used in interpreting year to year changes from 2002 to 2003. NCHS does not believe the methodology is comparable.

Notes - 2004
The numerator is the number of resident live births with a reported first prenatal visit before 13 weeks gestation. The denominator is the total number of resident live births. Missing data are excluded. In 2004, 17.9% of the data was missing for this measure. The source for these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October).

In 2003 a new birth certificate form was implemented. It collects some information differently, and caution should be used in interpreting year to year changes from 2002 to 2003. NCHS does not believe the methodology is comparable.

PERFORMANCE OBJECTIVES: Future targets were chosen from a combination of Maternal and Child Health staff discussions and trend analyses.

Notes - 2003
The numerator is the number of resident live births with a reported first prenatal visit before 13 weeks gestation. The denominator is the total number of resident live births. Missing data are excluded. In 2003, 8.7% of this data was missing for this measure. The source for these data is the Washington Center for Health Statistics Birth Certificate Files (updated annually between September and October).

In 2003 a new birth certificate form was implemented. It collects some information differently, and caution should be used in interpreting year to year changes from 2002 to 2003. NCHS does not believe the methodology is comparable.

a. Last Year's Accomplishments
The Maternal and Infant Health (MIH) section monitored the rise in medical liability insurance rates. Many obstetricians and family physicians quit obstetric care. MIH monitored this situation

and its relationship to access to prenatal care. (Fig. 4a, NPM 18, Act. 4)

OMCH contracted with LHJs to provide services such as referrals and assistance, links with Medicaid and needed prenatal care in the first trimester, and pregnancy tests. Many LHJs provide multiple services including pregnancy testing, family planning and emergency contraception. Women with positive pregnancy tests were referred to First Steps, WIC, and private health care providers. Other LHJ activities included: working with local hospitals to develop a referral system to behavioral health specialists for prenatal clients needing those services; providing "Dental Health for Moms-to-Be" classes to encourage healthy behaviors during pregnancy; and offering childbirth education classes that were attended by 100 women plus their coaches. (Fig. 4a, NPM 18, Act. 3)

Prenatal care utilization data were monitored and distributed to First Steps providers, included in the Perinatal Indicators Report, and shared with the Perinatal Advisory Committee. (Fig. 4a, NPM 18, Act. 4)

The WithinReach: Essential Resources for Family Health, Family Health Hotline responded to 8,301 calls from pregnant women in 2005. One thousand nine hundred and ninety two (24%) of these callers were not in prenatal care. Callers received referrals to the following services: WIC (6,502), Pregnancy Medicaid (2,117), Basic Food (434), Children's Medicaid (535), and others. (Fig. 4a, NPM 18, Act. 1)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide outreach and education through WithinReach to pregnant women to increase early enrollment in prenatal services.			X	
2. Continue MSS provider referrals to prenatal care if clients are not already enrolled and support women to stay in prenatal care.		X		
3. Continue LHJ provider referrals to prenatal care if clients are not already enrolled and support women to stay in prenatal care.		X		
4. Share prenatal care utilization data with MSS and perinatal providers.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OMCH continues to contract with 35 LHJs to provide maternal and child health services, which include routine referral and assistance linking with Medicaid and needed prenatal care. (Fig. 4a, NPM 18, Act. 3)

Prenatal care utilization data are being monitored and distributed to First Steps providers, included in the Perinatal Indicators Report,and shared with the Perinatal Advisory Committee. (Fig. 4a, NPM 18, Act. 4)

The WithinReach Family Health Hotline continues to refer pregnant women for Medicaid eligibility and link to prenatal providers. (Fig. 4a, NPM 18, Act. 1)

Linkage to prenatal care providers continues to be a required MSS activity. (Fig. 4a, NPM 18, Act. 2)

c. Plan for the Coming Year

OMCH will contract with LHJs to provide maternal and child health services including routine referrals and assistance linking with Medicaid and needed prenatal care. (Fig. 4a, NPM 18, Act. 3)

Prenatal care utilization data will be monitored and distributed to First Steps providers, included in the Perinatal Indicators Report, and shared with the Perinatal Advisory Committee. (Fig. 4a, NPM 18, Act. 4)

The WithinReach Family Health Hotline will continue to refer pregnant women for Medicaid eligibility and link to prenatal providers. (Fig. 4a, NPM 18, Act. 1)

Linkage to prenatal care providers will remain a required MSS activity. (Fig. 4a, NPM 18, Act. 2)

D. State Performance Measures

State Performance Measure 1: *The percent of pregnancies (live births, fetal deaths, abortions) that are unintended.*

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	44	41	53.9	52.8	
Annual Indicator	53.9	54.6	53.2	52.8	52.8
Numerator	56619	57047	56172	56110	
Denominator	105140	104449	105588	106283	
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	52	52	52	52	52

Notes - 2005

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

Data was unavailable for the year 2005.

Notes - 2004

Data were unavailable for 2004.

Notes - 2003

The percent of pregnancies that are unintended. The source for the data is the 2003 Washington State PRAMS. This numerator for this measure is derived from [the estimated percentage of unintended pregnancies from Washington State Pregnancy Risk Assessment Monitoring System (PRAMS) survey *(resident live births + reported resident abortions. The

denominator for this measure is the number of resident live births + reported resident abortions. Birth and Abortion data are obtained from the Washington State Center for Health Care Statistics Birth, Fetal Death, and Abortion files for 2003.

a. Last Year's Accomplishments
The WithinReach: Essential Resource for Family Health Family Health Hotline (formerly Healthy Mothers, Healthy Babies (HMHB)) received about 575 calls from people requesting family planning information including information about birth control, referrals to a provider (usually, family planning clinic or Take Charge provider), or assistance enrolling in Take Charge. WithinReach aslo operates a "Take Charge" toll free line, funded by DSHS, that receives 500-600 callers per month, about 80 percent of these are related to family planning. (Fig 4b, SPM1, Act 1)

Maternity Support Services (MSS) providers were offered updates on family planning information. (Fig. 4b, SPM 1, Act. 2, 3)

The Maternal and Infant Health (MIH) section shared reports about progress on family planning performance measure with First Steps agencies. (Fig. 4b, SPM 1, Act. 4)

MIH exhibited at four major medical professional meetings. Exhibits included information about emergency contraception and the Take Charge Program. (Fig. 4b, SPM1, Act. 6, 3)

PRAMS data on unintended pregnancy were shared with First Steps providers, incorporated into the Perinatal Indicators Report, and shared with the Perinatal Advisory Committee. (Fig. 4b, SPM 1, Act. 5)

The Office of Maternal and Child Health's (OMCH) CHILD Profile program included a message about birth spacing and family planning in the 30-day postpartum letter. A message about birth spacing was placed in the 3-month letter. Both letters targeted women who have delivered a baby during the specified time period and reside in Washington State and were sent to approximately 80,000 women. As of September 30, 2005, more than 156,500 health promotion materials were sent to parents throughout the state. (Fig. 4b, SPM 1, Act. 7)

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase referrals to family planning services and use of birth control.		X		
2. Provide Family Planning update training to MSS agencies.				X
3. Promote Medicaid Take Charge Program to increase family planning services for men and women.		X		
4. Share progress of family planning performance measure utilization data with MSS providers.				X
5. Collect and reference PRAMS data to measure unintended pregnancy rates, trends, and disparities between groups.				X
6. Include emergency contraception information in medical meeting displays to increase provider awareness and promote pre-exposure dissemination.			X	
7. Provide messages about birth spacing and family planning in the CHILD Profile parent education letter.			X	
8. Begin development of preconception health materials that includes birth control messages. Disseminate birth control brochures to providers.				X
9. Collaborate with Department of Corrections and DOH Family				X

Planning Program to increase reproductive health education materials and service linkages for female inmates in preparation for their release.				
10.				

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

MIH is revising the "Family Planning Update" training and exploring different means for delivering the training such as the Internet. For this reason, no "Family Planning Update" training is currently underway. (Fig 4b, SPM1, Act 2)

OMCH shares reports showing progress on the family planning performance measure with First Steps providers. (Fig. 4b, SPM 1, Act. 4)

PRAMS data on unintended pregnancy were incorporated into the Perinatal Indicators Report and shared with the Perinatal Advisory Committee, First Steps agencies, and local health jurisdictions (LHJs). (Fig. 4b, SPM 1, Act. 5)

MIH includes information about emergency contraception and the Take Charge Program in its medical meeting displays to increase provider awareness. (Fig. 4b, SPM1, Act. 6, 3)

OMCH's CHILD Profile Program includes a message about birth spacing and family planning in the 30-day postpartum letter. A message about birth spacing is placed in the 3-month letter. Both letters target women who have delivered a baby during the specified time period and reside in Washington State and are sent to approximately 80,000 women. (Fig. 4b, SPM 1, Act. 7)

OMCH is beginning groundwork to assess which preconception health materials related to family planning and birth spacing may be most useful for professionals and women of childbearing age. Activities include a student survey at one university in Washington that focuses on knowledge, attitudes, and use of emergency contraception by college-age men and women. OMCH is working with the DOH Family Planning Program to revise the current birth control brochure. OMCH is also developing a new preconception brochure that will include messages about birth control. (Fig 4b, SPM 1, Act 8)

OMCH is exploring collaboration with the Department of Corrections on reproductive health education for female inmates in preparation for their release. (Fig 4b, SPM1, Act 9)

c. Plan for the Coming Year
OMCH intends to continue work related to this performance measure through the year 2010.

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

Family Planning Update training will continue to be updated and different media will be explored; e.g., Web-based training. For this reason, no Family Planning Update training is scheduled for the coming year. (Fig 4b, SPM1, Act 2)

Reports will be shared with First Steps providers showing family planning performance measure progress by agency. (Fig. 4b, SPM 1, Act. 4)

PRAMS data on unintended pregnancy will continue to be incorporated into the Perinatal Indicators report and shared with the Perinatal Advisory Committee, First Steps agencies, and LHJs. (Fig. 4b, SPM 1, Act. 5)

MIH will continue to include emergency contraception information in its exhibits at medical meetings to increase provider awareness and promote pre-exposure dissemination. Providers will also continue to receive information about the Take Charge Program. (Fig. 4b, SPM1, Act. 6, 3)

OMCH's CHILD Profile Program will continue to include a message about birth spacing and family planning in the 30-day postpartum letter. A message about birth spacing will be placed in the 3-month letter. The letters will be sent to women who have delivered a baby during the specified time period and reside in Washington State. (Fig. 4b, SPM 1, Act. 7)

OMCH will disseminate the new birth control and preconception brochures. (Fig 4b, SPM1, Act 8)

OMCH will develop and implement collaborative activities with the Department of Corrections related to reproductive health education for female inmates in preparation for their release. (Fig 4b, SPM1, Act 9)

MCH Assessment is exploring options for more accurately measuring unintended pregnancy.

State Performance Measure 2: *The percent of pregnant women abstaining from smoking.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	87.5%	88.0%	88.5%	89.0%	
Annual Indicator	87.4	88.0	89.1	89.8	89.8
Numerator	67779	67727	70704	71197	
Denominator	77587	76929	79328	79265	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	89.5	90	90.5	91	91

Notes - 2005
PERFORMANCE OBJECTIVES: The percent of pregnant women abstaining from smoking has been increasing. The percentage is expected to level out. Therefore an annual increase of 0.5% was chosen for future objectives, as observed in previous years.

Data were unavailable for the year 2005.

Notes - 2004
Data were unavailable for 2004. In 2003 a new birth certificate form was implemented. It collects some information differently, and caution should be used in interpreting year to year changes from 2002 to 2003. Specifically, changes in smoking may be due wholly or in part to reporting changes.

Notes - 2003
Data were unavailable for 2004. The source for these data is the Washington State Center for Health Statistics Birth Certificate file. The numerator is the number of resident women who reported abstaining from smoking during pregnancy on the birth certificate. The denominator is all resident births in the reporting year. 2% of the data were missing in 2003 are excluded from the denominator. In 2003 a new birth certificate form was implemented. It collects some

information differently, and caution should be used in interpreting year to year changes from 2002 to 2003. Specifically, changes in smoking may be due wholly or in part to reporting changes.

a. Last Year's Accomplishments

Providers were informed about the Medicaid benefit that aims to increase the number of medical providers who do interventions for tobacco cessation through articles in professional newsletters, medical meeting exhibits, and professional Web sites. Through data provided by the Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA), MIH tracked billing to evaluate how many providers billed for the intervention. (Fig. 4b, SPM 2, Act. 2, 4)

CHILD Profile sent information on smoking cessation including the number for the Washington State Tobacco Quit Line to parents of children 0 - 6 years of age. CHILD Profile included smoking cessation messages in the SIDS brochure sent at birth and the 1-month postpartum, 3-month, and 4.5-year letters. (Fig. 4b, SPM 2, Act. 5)

MIH and DSHS HRSA worked on the MSS smoking cessation performance measure in order to integrate it into a standardized charting system for documentation. Provider training about the charting system continued. (Fig. 4b, SPM 2, Act. 1)

MIH, DSHS HRSA, and the Department of Health (DOH) Tobacco Prevention and Control Program (TPCP) continued the tobacco Champion Project for ten more First Steps agencies, which included additional motivational interviewing and systems change training, follow-up site visits, and technical assistance. Training and follow-up were complete by June 30, 2005. (Fig. 4b, SPM 2, Act. 8)

Operaters of the WithinReach Family Health Hotline (formerly HMHB) asked callers if anyone in the home smokes and offered referrals to the Quit Line. From October 2004 through September 2005, 448 callers were referred to the Quit Line. Quit Line pamphlets were included in 3,875 prenatal packets and 1,378 child health packets. (Fig. 4b, SPM 2, Act 9)

Local health jurisdictions (LHJs) promoted the no-tobacco message to everyone in their communities. OMCH supported activities such as: smoking cessation classes; a local mobilization board summit on maternal smoking; and assessment activities such as reviewing birth certificates for maternal smoking status and tracking smoking rates and low birth weight. (Fig. 4b, SPM 2, Act 10)

MIH worked with TPCP to implement and market the FAX Back Referral program to First Steps agencies and providers. MIH worked with the March of Dimes (MOD) and TPCP on several events to inform medical providers about the fax referral program and the Medicaid benefit. In addition, MIH, DSHS HRSA, and TPCP provided training on the FAX Back Referral program to First Steps Champion agencies. (Fig. 4b, SPM 2, Act. 7)

Eighty-five First Steps providers attended tobacco cessation trainings to build skills for working with pregnant clients. (Fig 4b, SPM 2, Act 3)

PRAMS data were collected to measure smoking rates; quit rates; relapse rates; third trimester smoking trends; and disparities between groups. (Fig. 4b, SPM 2, Act. 3, 6)

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ensure compliance with the MSS Smoking Cessation Performance Measure by integrating its use into a standardized charting system for documentation.				X

2. Work with DSHS HRSA to promote use of the Smoking Cessation benefit for pregnant women including dissemination of the Provider Reference Card.				X
3. Provide tobacco cessation intervention training to First Steps providers.				X
4. Share tobacco data with MSS and perinatal providers.				X
5. Provide information about, and resources, for smoking cessation to parents of children 0 – 6 years via the CHILD Profile Health Promotion Materials.			X	
6. Collect and reference PRAMS data to measure smoking rates before, during and after pregnancy, quit rates, relapse rates, third trimester smoking trends, and disparities between groups.				X
7. Work with TPCP to implement and market the FAX Back Referral program through the statewide Tobacco Quit Line.				X
8. Implement Tobacco Champion Project with First Steps agencies to improve intervention skills and success rate for tobacco cessation.				X
9. WithinReach Family Health hotline operators refer callers with tobacco in their home to Quit Line and sends tobacco cessation materials to callers as appropriate.				X
10. Help build coalitions of local partners and support community efforts to decrease tobacco use during pregnancy.				X

b. Current Activities

MIH continues to inform providers of the Medicaid benefit through articles in professional newsletters, medical meeting exhibits, and professional Web sites. Through reports provided by DSHS HRSA, MIH is tracking billing data to evaluate how many providers are billing for the intervention. (Fig. 4b, SPM 2, Act. 2, 4)

CHILD Profile is sending smoking cessation information to parents in the SIDS brochure that is sent at birth and in the 1-month, 3-month, and 4.5-year letters. CHILD Profile also provides the Washington State Tobacco Quit Line number as a smoking cessation resource for parents of children 0-6 years of age. (Fig. 4b, SPM 2, Act. 5)

The MSS smoking cessation performance measure is being integrated into a standardized charting system for documentation. Provider training about the documentation integration continues. (Fig. 4b, SPM 2, Act. 1)

MIH is working with the TPCP to implement and market the FAX Back Referral program to First Steps agencies and medical providers in the spring of 2006. (Fig. 4b, SPM 2, Act. 7)

First Steps agencies are receiving enhanced technical assistance (including the Tobacco Champion Project for up to 35 First Steps agencies) in order to strengthen working relationships with county tobacco prevention and control contractors; increase utilization of the state Quit Line; increase knowledge and skills in client-centered tobacco cessation messages for pregnant women; and develop new policies that reinforce the value of tobacco cessation and protection against secondhand smoke for both staff and clients. Included with this project is an evaluation plan. Consultation continues for all First Steps agencies who participated in the Tobacco Champion Pilot and Project. (Fig. 4b, SPM 2, Act. 8)

PRAMS data are being collected and referenced to measure smoking rates; quit rates; relapse rates; third trimester smoking trends; and disparities between groups. (Fig. 4b, SPM 2, Act. 3, 6)

The WithinReach Family Health Hotline operators continue to ask callers if anyone in the home smokes, and if so, offer referrals to the Quit Line. WithinReach continues to include Quit Line

materials in prenatal packets and child health packets. (Fig. 4b, SPM 2, Act 9)

Some LHJs are using MCH Block Grant funds for smoking cessation activities that target pregnant women. (Fig 4b, SPM 2, Act. 10)

c. Plan for the Coming Year
OMCH plans to continue work related to this performance measure through the year 2010.

MIH will continue to inform providers of the Medicaid benefit through articles in professional newsletters, medical meeting exhibits, and professional Web sites. Through reports provided by DSHS HRSA, MIH will track benefit billing data to evaluate how many providers are billing for the intervention. (Fig. 4b, SPM 2, Act. 2, 4)

First Steps agencies will receive enhanced technical assistance (including the Tobacco Champion Project). Included with this project is an evaluation plan. Consultation will continue for all First Steps agencies that participated in the Tobacco Champion Pilot and Project. (Fig. 4b, SPM 2, Act. 8).

CHILD Profile will continue sending information on smoking cessation and the Washington State Tobacco Quit Line to parents of children ages birth - 6 years in their SIDS brochure sent at birth and the 1-month, 3-month, and the 4.5 year letters. (Fig. 4b, SPM 2, Act. 5)

MIH will market and track use of the FAX Back Referral program to First Steps agencies and medical providers. (Fig. 4b, SPM 2, Act. 7)

The MSS smoking cessation performance measure will continue to be documented in a standardized charting system. Provider training for documentation integration will continue. (Fig. 4b, SPM 2, Act. 1)

PRAMS data will be collected to measure smoking rates; quit rates; relapse rates; third trimester smoking trends; and disparities between groups. (Fig. 4b, SPM 2, Act. 3, 6)

MSS and prenatal providers will continue to receive information about the availability and use of the FAX Back Referral program. (Fig. 4b, SPM 2, Act. 7)

Tobacco Cessation training will continue for First Steps providers. (Fig. 4b, SPM 2, Act. 3, 8)

Data about smoking during pregnancy and efforts to reduce smoking during pregnancy will be compiled to assure quality improvement can be measured over time and shared with providers. (Fig 4b, SPM 2, Act 3, 4)

Operators of the WithinReach Family Health Hotline will continue to ask callers if anyone in the home smokes, and if so, offer referrals to the Quit Line. WithinReach will continue to include Quit Line materials in prenatal packets and child health packets. (Fig. 4b, SPM 2, Act 9)

Some LHJs will continue to use MCH Block Grant funds for smoking cessation activities that target pregnant and parenting women (Fig 4b, SPM 2, Act. 10)

State Performance Measure 3: *The percent of women screened during prenatal care visits for smoking, alcohol use, illegal drug use, HIV status, postpartum birth control plans, domestic violence, and receive genetic counseling.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator	55.5	52.4	54.9	54.9	
Numerator	42869	40170	42838		
Denominator	77242	76661	78029		
Is the Data Provisional or Final?				Provisional	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	55	55	55	55	55

Notes - 2005
PERFORMANCE OBJECTIVES: This is a new performance measure. It is a combination of the previous measures SPM 3, SPM 6, and SPM 8. Recent data has shown a gradual increase, despite fluctuations between years. Therefore, a future objective of 55 was chosen through 2010.

Data were unavailable for the year 2005.

a. Last Year's Accomplishments
MIH worked with DSHS HRSA and provider groups to increase use of the Medicaid Smoking Cessation benefit. (Fig 4b, SPM 2, Act 2)

Prenatal care providers complied with First Steps performance measures by interviewing clients about family planning and smoking. (Fig 4b, SPM 3, Act. 4)

MIH worked with providers to improve skills for identifying and referring pregnant women who use tobacco, drugs, or alcohol or experience domestic violence (DV). Providers received best practice booklets on DV, tobacco cessation, and substance use. (Fig 4b, SPM 3, Act. 1, 2, 5).

MIH worked with DOH TPCP to implement the Fax Back Referral program. (Fig 4b, SPM 2, Act. 7)

MIH revised and disseminated the best practice booklet on HIV and pregnant women. Providers were informed about changes in the Washington Administrative Code for prenatal HIV testing. (Fig 4b, SPM 3, Act. 1, 5)

The Perinatal Partnership Against Domestic Violence (PPADV) reorganized to be the external workgroup to the DOH Family Violence Prevention Workgroup (FVPWG) on domestic violence and sexual assault issues. Its new name is the Community Partnership Against Sexual and Domestic Violence (CPASDV). (Fig 4b, SPM 3, Act. 3)

MIH revised and piloted the PPADV curriculum to include sexual assault issues. It targets all health professionals to promote universal screening of all women. (Fig 4b, SPM 3, Act. 5)

MIH promoted the Perinatal Domestic Violence Identification Services Guide for culturally relevant client care. (Fig 4b, SPM 3, Act. 1)

Using PRAMS data, MIH published and disseminated a DV and Pregnancy Fact Sheet to encourage providers to screen and refer clients. (Fig 4b, SPM 3, Act. 1, 5)

MIH and the Injury and Violence Prevention Program provided technical assistance to providers to establish and improve protocols, tools, and intervention strategies for women experiencing violence.

Local health jurisdictions (LHJs) used block grant funds to support efforts to encourage pregnant women to stop smoking, decrease the risk of domestic violence, and promote healthy and safe pregnancies. For example, one LHJ encouraged pregnant women to stop smoking by giving all

pregnant women diaper bags with a "tobacco free" logo. The bags contained a baby onsie and bib with a "Smoke-free Zone" logo, information about quitting smoking, and recommendations for smoke-free air for kids. (Fig. 4b, SPM 3, Act. 1, 3)

According to data from the Washington State Genetics Minimum Data Sets, approximately 6,500 families received prenatal diagnosis genetic counseling through the Regional Genetic clinic system in calendar year 2005. These data are comparable to data from the previous year. (Fig 4b, SPM 3, Act. 7)

PRAMS data for 2003 show that 82 percent of women were counseled about birth defects or genetic disorders. This rate is lower than in past years. These data help identify effectiveness of outreach education for health care professionals. (Fig 4b, SPM 3 Act. 8)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase prenatal screening and referrals by providers of pregnant women through dissemination of education materials.				X
2. Increase prenatal screening and referrals by providers of pregnant women through training and skill building.				X
3. Increase prenatal screening and referrals by providers of pregnant women through work conducted in internal and external partnerships.				X
4. Increase prenatal screening and referrals by providers of pregnant women through program requirements and provider incentives.				X
5. Ensure that education resources and best practice materials are current and evidence-based when possible.				X
6. Send genetic brochure through WithinReach with prenatal mailings.		X		
7. Collect and analyze data from the Regional Genetics Clinics minimum dataset.				X
8. Collect and reference PRAMS data to measure percent of women offered genetic testing.				X
9.				
10.				

b. Current Activities

MIH works with DSHS HRSA and provider groups to increase use of the Medicaid Smoking Cessation benefit. (Fig 4b, SPM2, Act. 2)

Prenatal care providers comply with First Steps performance measures by interviewing clients about family planning and smoking. (Fig 4b, SPM3, Act. 4)

MIH works with providers to improve skills for identifying and referring pregnant women who use tobacco, drugs, or alcohol or who experience DV. Activities include distribution of best practice booklets on DV, tobacco cessation, and substance use and providing materials at professional conferences. (Fig 4b, SPM3, Act. 1,2, 5)

MIH disseminates information about the Fax Back Referral program. All smokers are now eligible for this program. (Fig. 4b, SPM2, Act. 7)

MIH informs medical care providers about HIV testing during pregnancy, including use of the

rapid test in labor and delivery, and disseminates the 2005 best practice booklet. (Fig. 4b, SPM3, Act. 1, 5)

MIH participates on the DOH Family Violence Prevention Workgroup and the Community Partnership Against Sexual and Domestic Violence. (Fig 4b, SPM3, Act. 3)

CPASDV and DOH are working together to plan training for providers using the revised PPADV curriculum. Training will depend on the availability of funding. (Fig. 4, SPM3, Act. 2, 3)

MIH promotes the Perinatal Domestic Violence Identification Services Guide for culturally relevant client care. (Fig 4b, SPM3, Act. 1)

MIH is revising and will distribute the "Washington State Domestic Violence and Pregnancy Facts" sheet to reflect 2003-04 PRAMS data. (Fig. 4, SPM 3, Act.1, 5)

MIH and Injury and Violence Prevention Program continue to promote universal DV screening through activities such as developing the template for the Violence Against Women toolkit. (Fig. 4, SPM3, Act. 1, 2, 3)

LHJs use MCH funds to: increase the percent of pregnant women screened for domestic violence; provide parenting classes; provide drug, alcohol, and domestic violence education; and support their data systems. (Fig 4b, SPM3, Act. 1, 3)

OMCH supports the Regional Genetics Clinics, the compilation of data from the Washington Minimum Genetic Data Set, and the monitoring of PRAMS data related to genetic services. (Fig 4b, SPM3, Act. 9)

Brochures about genetic screening are included in the WithinReach (formerly HMHB) educational packets that are distributed to women who contact the Family Health Hotline. (Fig. 4b, SPM3, Act. 6)

OMCH is planning a day-long meeting for genetic counselors to be held in 2006 that will include presentations about the genetics of Fragile X syndrome as well as a peer review session, during which counselors will present interesting and challenging cases to their peers as a learning opportunity. (Fig. 4b, SPM3, Act. 2)

c. Plan for the Coming Year

MIH will continue work with DSHS HRSA and provider groups to increase use of the Medicaid Smoking Cessation benefit. (Fig 4b, SPM2, Act. 2)

Prenatal care providers will need to comply with First Steps requirements by screening clients for use of drugs, alcohol, tobacco, family planning methods, and risk for DV. (Fig 4b, SPM3, Act. 4)

MIH will continue to work with providers to improve skills for identifying and referring pregnant women who use tobacco, drugs, or alcohol and who experience DV. Activities will include the distributribution of safety cards and best practice booklets on DV, tobacco cessation, and substance use as well as other materials at professional conferences. (Fig 4b, SPM3, Act. 1, 2, 5)

MIH will market and track use of the FAX Back Referral program to First Steps agencies and medical providers. (Fig. 4b, SPM 2, Act. 7)

MIH will continue to inform medical care providers about HIV testing during pregnancy and disseminate the best practice booklet. (Fig. 4b, SPM3, Act. 1, 5)

MIH will continue to participate on the DOH Family Violence Prevention Workgroup and CPASDV. (Fig 4b, SPM3, Act. 3)

CPASDV and DOH will train providers to use the expanded PPADV curriculum. Training is dependent on the availability of funds. (Fig. 4, SPM3, Act. 2, 3)

MIH will increase efforts to promote the Perinatal Domestic Violence Identification Services Guide for culturally relevant client care. (Fig 4b, SPM3, Act. 1).

MIH will distribute the updated "Washington State Domestic Violence and Pregnancy Facts" sheet. (Fig. 4, SPM3, Act. 1)

Depending on the availability of funding, MIH and the Office of EMS and Trauma (Injury and Violence Prevention Program) will continue to promote universal DV screening through activities such as building and marketing the Violence Against Women toolkit. (Fig. 4, SPM3, Act. 1, 2, 3)

Local health is likely to continue to use MCH funds to: increase the percent of pregnant women who are screened for domestic violence; provide parenting classes; provide drug, alcohol, and domestic violence education; and maintain their data systems. (Fig 4b, SPM3, Act. 1, 3)

The Genetic Services Section will continue to support services through the Regional Genetics Clinics, compile data from the Washington Minimum Genetic Data Set and PRAMS to monitor prenatal diagnosis educational trends, and continue to support WithinReach for distributing educational brochures through their mailings. (Fig. 4b, SPM 3, Act. 6, 7, 8)

State Performance Measure 4: *Percent of children and youth who have people they can turn to for help when they feel sad or hopeless.*

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator		58.1	58.1	59.6	59.6
Numerator		46990	47698	53622	
Denominator		80877	82097	89970	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	60	60	60	60	60

Notes - 2005
PERFORMANCE OBJECTIVES: This is a new performance measure, and there are only two years of data available, since the Healthy Youth Survey is administered every two years. Future objectives are an extenuation of previous results. As more data becomes available, additional analysis will be conducted to determine appropriate future objectives.

No new data is available for the year 2005. The survey will be readministered in 2006.

a. Last Year's Accomplishments
Even though this is a new measure, OMCH partners and stakeholders have been addressing it in a variety of ways. In three LHJs there were activities related to improving mental health. One LHJ participated in a local child psychiatric coalition to develop a stronger mental health system for children in the county. Another LHJ made sure that trained personnel were available in schools to provide guidance and classes on mental health and to be mentors to students to help them make positive choices. A large Eastern Washington LHJ provided important information for

the needs assessment survey of the entire state regarding the role of public health agencies in children's mental health services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminate social, emotional, and mental health information to parents through CHILD Profile mailings.			X	
2. Evaluate Bright Futures Mental Health materials for foster parents training.				X
3. Update the Children's Mental Health needs assessment.				X
4. Organize and inform DOH participation in Mental Health Transformation (MHT) efforts with public and private partners.				X
5. Align mental health components of multiple statewide planning efforts, including MHT, ECCS, adolescent health, and coordinated school health.				X
6. Coordinate and inform OMCH mental health planning and program activities.				X
7. Provide training to First Steps providers on screening for maternal mood disorders among the low-income pregnant population.				X
8.				
9.				
10.				

b. Current Activities

The OMCH Mental Health workgroup coordinates and informs activities across OMCH. (Fig. 4b, SPM 04, Act. 6)

The Public Health Prevention Specialist (PHPS) from CDC completed the children's mental health needs assessment titled Children's Mental Health in Washington State: A Public Health Perspective Needs Assessment. He presented the results of the needs assessment at MCH regional team meetings, the Washington State Joint Conference on Health, and the American Public Health Association Conference. The report is available on the DOH Web site.

OMCH received a State Agency Partnerships for Child and Adolescent Mental Health Grant from the Maternal and Child Health Bureau. A curriculum was developed to train foster parents to use Bright Futures Mental Health materials. Ten trainings will be held in 2006. An evaluation is being developed by OMCH Assessment. (Fig. 4b, SPM 04, Act. 2)

Washington State received a State Incentive Grant for Mental Health Transformation (MHT) in the fall of 2005. DOH is represented on the working group that guides MHT implementation.

OMCH continues to fund a Child Development Specialist (CDS) to focus on child, youth and family mental health. The CDS organizes and informs DOH participation in MHT. The CDS also coordinates OMCH mental health activities with related planning efforts, including the Early Childhood Comprehensive Systems grant, the Adolescent Health Plan, and the Coordinated School Health grant. (Fig. 4b, SPM 04, Act. 5)

CHILD Profile continues to seek input from professional and parent groups about which social and emotional development issues and preventive measures to include in CHILD Profile Health Promotion mailings. CHILD Profile and the Talaris Research Institute continue to partner to distribute "Spotlight" child development educational materials to parents of children 0 -- 6 years. CHILD Profile and Project Lift-Off partner to distribute the "Getting School Ready" booklet to

parents of children aged 4 years. (Fig. 4b, SPM 04, Act. 1)

The Children with Special Health Care Needs (CSHCN) section supported the development of the "Child and Adolescent Depression and Anxiety Toolkit" and "Starting Point Resource Guide" by the Center for Children with Special Needs (available online at www.cshcn.org). The CSHCN program supports the Washington State Father's Network (WSFN) to provide emotional support, information, and resources to fathers of children with special needs, and promote awareness of fathers' issues at state and local levels. The CSHCN program also supports Washington State Parent to Parent to provide culturally competent emotional and informational support to parents of children with special health care needs.

The First Steps program in the Maternal Infant Health section works with the University of Washington to develop a training curriculum for First Steps providers on screening for maternal depression and pilot the training. (Fig. 4b, SPM 04, Act. 7)

c. Plan for the Coming Year

OMCH will continue to fund a Child Development Specialist (CDS) to focus on child, youth, and family mental health.

The internal OMCH Mental Health workgroup will continue to meet to coordinate, identify, and plan activities across OMCH. The OMCH mental health work plan will be revised based on current mental health related activities and opportunities for coordination and collaboration with other state agencies and organizations. (Fig. 4b, SPM 4, Act. 6)

CHILD Profile will continue to seek input from professional and parent groups about which social and emotional development issues and preventive measures should be incorporated in the CHILD Profile Health Promotion mailings. CHILD Profile and the Talaris Research Institute will continue to expand their partnership to distribute the "Spotlight" child development educational materials to parents of children 0 -- 6 years in Washington State. CHILD Profile and Project Lift-Off plan to continue their partnership to distribute the "Getting School Ready" booklet to parents of 4-year old children. (Fig. 4b, SPM 4, Act. 1)

In the second year of the State Agency Partnerships for Child and Adolescent Mental Health grant, the Children's Mental Health Needs Assessment will be updated, a strategic plan for OMCH mental health activities will be developed, and behavior change evaluation of the Bright Futures Mental Health for Foster Parents (one year after the training) will be completed. (Fig. 4b, SPM 04, Act. 2, 3, 6)

The CSHCN program will take a lead role in assisting the Washington State Autism Task Force in developing recommendations to address a range of issues, including mental health, for individuals with autism spectrum disorders across the lifespan. The CSHCN program will continue to support the Washington State Father's Network (WSFN) to provide positive emotional support and state-of-the-art information and resources to fathers of children with special needs, and promote awareness of fathers' issues at the state and local levels through WSFN. The CSHCN program will also support Washington State Parent to Parent to provide culturally competent emotional and informational support to parents of children with special health care needs.

The First Steps program will, with the assistance of the University of Washington, evaluate the effectiveness of the pilot sites for training in screening for maternal depression, refine the curriculum and expand the training to all First Steps providers. (Fig. 4b, SPM 04, Act. 7)

State Performance Measure 5: *Promote the use of Bright Futures materials and principles by health, social service, and education providers in Washington State.*

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

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					40
Numerator					
Denominator					
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	70	85	95	100	100

Notes - 2005
PERFORMANCE OBJECTIVES: This new performance measure for the period of 2005-2009, is a process measure, which differs from the other measures, which are outcome-oriented. The work being accomplished is groundbreaking and harder to quantify. Therefore, it will be assessed through benchmarks (statements describing the work that has been conducted each year). Since there are 20 benchmarks for the five year period, each benchmark is equivalent to five percentage points; at the end of the five years, 100% of the benchmarks seek to be attained. Each benchmark relates to the usage of Bright Futures materials and principles by providers in Washington State. The following benchmarks have been attained, including a few from Year 2 that were accomplished ahead of schedule.

Year 1
1.Form internal (DOH) Bright Futures working/advisory group
•Presented Bright Futures to MIH, CAH, CSHCN. Recruited one person from each section to be the Bright Futures point person.
2.Plan for establishing inter-agency Bright Futures group—including for example schools or OSPI, American Academy of Pediatrics national and state chapters, family practitioners, Medicaid (DSHS), health plans
•All of the above entities have been present at Bright Futures presentations, trainings, or other meetings.
3.Provide support and technical assistance to groups of professionals recently trained in use of Bright Futures: the school nurse corps supervisors, early childhood providers participating in Bright Futures in Early Childhood
•Contact continues with trained group of SNC nurses and the idea of training teams to reach others with less access is being explored.
•The Bright Futures in Early Childhood Project continues until June 30, 2006; a product and plan is being developed to disseminate lessons learned to other child care providers and health staff.
4.Develop plan for assessment of current use of Bright Futures by health, social service and education providers in the state
•Surveys have been done of school nurses, child care health consultants, and early childhood education staff, on if and how they use BF; level of awareness.
•Beginning evaluation of survey results.
5.Develop plan for using Bright Futures Oral Health in statewide trainings
•Presented Bright Futures as a tool for oral health at annual meeting of local health jurisdiction oral health coordinators.
•Continued coordination and dialogue between state oral health staff and Bright Futures staff and project participants.
6.Begin implementation of the grant-funded project to train foster families in mental health issues using Bright Futures
*Curriculum designed and training begun; to continue through spring 2006.

Year 2

7.Disseminate findings/successes/lessons learned from Bright Futures in Early Childhood Project
*Gathered preliminary evaluation data.
8.Begin assessment of the current use of Bright Futures by Washington State providers
*Surveys completed in year 1 of allied health providers.

Notes - 2004

Notes - 2003

a. Last Year's Accomplishments
DOH and the University of Washington (UW) Bright Futures staff administered three surveys on the use of Bright Futures in practice. Participants included school nurses, child care health consultants, and early learning providers who have been trained in Bright Futures, and those who have not. Survey results will be analyzed in order to assess the need for future training. (Fig. 4b, SPM 5, Act. 1)

The Bright Futures in Early Childhood Project completed training for the participants, intensified data collection, and prepared an evaluation and a tool kit to be used for future trainings. The project was extended to June 2006, which allowed data collection from Head Start, Early Head Start, and state preschool programs for one full session year. (Fig. 4b, SPM 5, Act. 2)

Bright Futures was presented as a basis for a consistent oral health message at the annual meeting of local health jurisdiction oral health coordinators. The state oral health program director is working to make Bright Futures known and to coordinate with other oral health groups who are using multiple curricula or programs. (Fig. 4b, SPM 5, Act. 5)

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assess the need for future training based on Bright Futures survey results.				X
2. Complete the Bright Futures in Early Childhood Project by June 2006.			X	
3. Implement Bright Futures Mental Health trainings for foster parents.			X	
4. Discuss formation of school nurse training teams.				X
5. Collaborate with DOH Oral Health staff to develop a consistent oral health message using Bright Futures.			X	
6. Build and maintain Washington Bright Futures Web site.				X
7. Participate in Family Voices Bright Futures for Families Project.			X	
8. Present Bright Futures projects at state and national conferences.				X
9.				
10.				

b. Current Activities
The Bright Futures in Early Childhood Project is coming to an end. A no-cost extension has been requested to continue work on the final product, which is a tool kit that will enable early childhood staff to use the tools and lessons learned. A final gathering of project participants is being planned to present and share the work and preliminary results of the evaluation. (Fig. 4b, SPM 5,

Act. 2)

A project funded by the Maternal and Child Health Bureau, Bright Futures for Children and Youth in Foster Care, began in September 2005. The project will convert Bright Futures in Practice: Mental Health into a health promotion curriculum for foster parents. The curriculum has been developed by the UW Bright Futures team and will be evaluated by the OMCH's Assessment section. Ten trainings are scheduled throughout the state with an estimated attendance of 300 foster parents. Included in the training will be mental health professional panels for foster parents to obtain resources and information in their communities about mental health. School nurses who attended the Bright Futures Mental Health training have volunteered to be a part of those panels. (Fig. 4b, SPM 5, Act. 3)

School nurses, who were trained on Bright Futures Mental Health materials a year ago, expressed interest in continuing to use what they learned by forming "training teams" of expert school nurses to reach those who are more isolated or not able to participate in large-scale trainings. The School Nurse Corps and DOH/UW Bright Futures staff are considering the feasibility of this idea. (Fig. 4b, SPM 5, Act. 4)

The Washington State Bright Futures Web site has been developed and is being continually reviewed and modified. (Fig. 4b, SPM 5, Act. 6)

c. Plan for the Coming Year
Washington State's Bright Futures work, and especially the Early Childhood Project, will be presented at local and national conferences in the coming year; three abstracts have already been accepted. A plan for distribution of the tool kit produced from the Early Childhood Project will be finalized and implemented. (Fig. 4b, SPM 5, Act. 8)

The Washington Bright Futures Web site will be expanded to include more training materials and to be a place where interested professionals can find out what others are doing and share ideas. (Fig. 4b, SPM 5, Act. 6)

State Performance Measure 6: *Percent of children 6-8 years old with dental caries experience in primary and permanent teeth.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator	55.6	55.6	55.6	55.6	59.0
Numerator	140000	137685	136477	136345	145873
Denominator	251798	247635	245462	245224	247243
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	52.2	48.8	45.4	42	42

Notes - 2005
PERFORMANCE OBJECTIVES: This is a new performance measure, and there are only two years of data available since the Smile Survey is administered every five years. As more data becomes available, additional analyses will be conducted to determine appropriate future objectives.

The source of the data is the 2005 Washington State SMILE Survey. The indicator reflects the

proportion of 6-8 year olds with dental caries experience in primary and permanent teeth. The source of the denominator data is the Office of Financial Management Population Forecast. The numerator is calculated from both of these.

a. Last Year's Accomplishments
In October 2004, screeners were trained to proctor the Smile Survey in preschools and elementary schools. The Smile Survey measures: decay experience, rampant decay, untreated decay, and disparities. Smile Survey data were collected and analyzed in 2005. (Fig 4b, SPM 6, Act. 1)

Oral Health program staff started to develop an OMCH Oral Health Strategic Plan, which aims to integrate oral health into the other OMCH Sections. (Fig 4b, SPM 6, Act. 5)

The Health Resources and Services Administration (HRSA) State Oral Health Collaborative Systems grant supported both of these activities.

Many LHJs extended oral health activities to clients being seen in other programs, such as WIC, where they provided simple dental screenings and/or varnishes to children, toothbrushes to all clients, and education about dental care for both children and adults. Access to dental care for Medicaid-covered clients was addressed in different ways: one LHJ participated in quarterly dental clinics for children and their parents; another developed and maintained a rotational referral system to dentists in their community; and a third worked to establish access to care at a community health center dental clinic for Head Start, ECEAP, and preschool children who did not have a dentist. The same LHJ also provided "Treasure Chests" to 26 elementary school nurses to teach good oral health habits to children in kindergarten through sixth grade.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Disseminate the results of the 2005 Smile Survey, which measured tooth decay indicators such as decay experience, rampant decay, untreated decay, and oral health disparities and other indicators.				X
2. Develop a state oral health surveillance system to monitor tooth decay indicators and preventive measures (water fluoridation and dental sealants).				X
3. Provide education on dental sealants and water fluoridation, the evidence-based preventive measures for tooth decay.				X
4. Promote use of Bright Futures Oral Health messages to promote oral health among families.				X
5. Implement and evaluate an Oral Health Strategic Plan that integrates oral health into all of the OMCH sections (MIH, IPCP, CAH, CSHCN, Genetics, and Assessment)				X
6. Fund local health agencies to assess local oral health needs and educate families and programs.		X	X	
7.				
8.				
9.				
10.				

b. Current Activities
The OMCH Oral Health program disseminated Smile Survey results to the public and stakeholders in March 2006 via a press release and the Internet. (Fig 4b, SPM 6, Act. 1)

A state oral health surveillance system is being developed to monitor tooth decay indicators and preventive measures (water fluoridation and dental sealants). (Fig 4b, SPM 6, Act. 2)

Education is being provided on dental sealants and water fluoridation, the evidence-based preventive measures for tooth decay. (Fig 4b, SPM 6, Act. 3)

The OMCH Oral Health program is promoting Bright Futures Oral Health Project to local health jurisdictions and MCH-related programs. (Fig 4b, SPM 6, Act. 4)

We are preparing to develop the implementation and evaluation components of the OMCH Oral Health Strategic Plan. (Fig. 4b, SPM 6, Act. 5)
OMCH is continuing to fund local health agencies to provide oral health education to families and programs. (Fig. 4b, SPM 6, Act. 6)

c. Plan for the Coming Year
The OMCH Oral Health program plans to implement the OMCH Oral Health Strategic Plan, continue to fund local health agencies, and continue to educate agencies and the public about the importance of using effective measures to prevent tooth decay. (Fig. 4b, SPM 6, Act. 3, 5, 6)

State Performance Measure 7: *Strengthen statewide system capacity to promote health, safety, and school readiness of children birth to kindergarten entry.*

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

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					25.2
Numerator					
Denominator					
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	54	82.8	97.2	100	100

Notes - 2005
See SPM 5 for more details about benchmarks/process measures.

Benchmarks: Year 1
1. Identify state OMCH activities to promote health, safety, and school readiness of children 0-5 years old.
-Created Inventory of EC services/programs across OMCH regarding health and school readiness
-Developed matrix of EC activities within OMCH
2. Provide training, technical assistance (TA) and consultation to Child Care Health Consultants (CCHCs) to raise awareness regarding health, safety, and school readiness.
-A full-time consultant is available to the child care health consultants to provide training and technical assistance.
-Quarterly regional meetings regarding consultation for infants/toddlers in child care include CCHCs, licensors, health specialists, others involved in child care and training for providers.
-CCHCs are connected to information and resources from the State Health and Safety Advisory Committee, and are offered a bi-annual conference on early childhood care.
3.Increase awareness and use of Early Childhood Comprehensive Systems (ECCS) plan (Kids Matter (KM)) by state & local partners.

-Completed Awareness and Evaluation Survey of Kids Matter to document baseline data regarding awareness and utilization of KM plan among early childhood stakeholders. See Stakeholder Survey Report and Methodological Report March 2006.
4.Track OMCH school readiness efforts based on KM plan.
-CHILD Profile integration of Early Learning Benchmarks into CHILD Profile Development Posters and Getting School Ready booklet integrated into mailings.
-DOH Medical Home Strike Team integrating Kids Matter focus on Medical Home in children 0-5 years.
-CSHCN, Medical Home Grant and Strategic Planning Process utilizing KM Plan.
-PHND-EC Logic Model development regarding PH services for children and families utilizing KM Plan.
-Infant Mental Health Strategic Planning efforts utilizing KM Plan.
-Mental Health Transformation Grant referencing KM Plan regarding prevention and children's mental health.
5. Facilitate OMCH Early Childhood Workgroup to address & increase integration regarding health, safety, and school readiness of children 0-5.
-Convened representatives from across sections in OMCH monthly to share integration opportunities between and among OMCH and Kids Matter and model reciprocal activities.
-Determining the need to formalize workgroup with appropriate charter.
-'Integration Continuum', by Konrad reference document for integration opportunities identified as reference for work across OMCH & school readiness.
6. Add representatives of Healthy Child Care Washington (HCCW) to the State Joint Early Childhood Advisory Committee of KM.
-HCCW will be represented through the ECCS Lead and CAH-Early Childhood Team Lead.
7. Expand CCHC and CHILD Profile activities into HCCW system.
-Conducted trainings for CCHCs in CHILD Profile registry at limited number of pilot sites; examining feasibility (system and fiscal) of expanded use.

a. Last Year's Accomplishments
This is a new performance measure, there were no related activities last year.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Make formal presentations regarding Kids Matter to OMCH sections and external early childhood (EC) stakeholders.				X
2. Complete Awareness and Utilization Survey of broad EC stakeholder group regarding ECCS grant (Kids Matter).				X
3. Use Kids Matter in various grant-writing opportunities across OMCH.				X
4. Continue coalition building efforts in order to implement the Kids Matter plan.				X
5. Integrate strategic planning activities across OMCH using Kids Matter framework.				X
6. Evaluate Kids Matter.				X
7. Integrate Bright Futures Guidelines across components of HCCW and Kids Matter.				X
8. Continue community mobilization work with partners to encourage use of Kids Matter framework at the local level.				X
9. Continue to support the statewide network of child care health consultants.		X		
10.				

b. Current Activities

The Early Childhood Comprehensive Systems (ECCS) Grant focuses on increasing systems capacity and integration of early childhood systems and services in Washington. (Fig. 4b, SPM 7, Act. 4, 5)

Two years of planning culminated in the outcome-based early childhood plan called Kids Matter: Improving Outcomes for Children in Washington State. Three statewide system building efforts combined to create this plan: ECCS (OMCH/DOH), the Build Initiative (a broad public-private partnership), and the Head Start-State Collaboration Office. Public and private partners across Washington State developed and support the use of this plan. (Fig.4b, SPM 7, Act. 4)

Kids Matter provides a framework and strategies that can be used to: 1) Improve early childhood outcomes; 2) Increase public will about early learning and school readiness; and 3) Build and sustain the public-private partnerships in order to facilitate changes in policies, programs and practices to achieve desired outcomes. Examples include: grant-writing opportunities focused at building public-private partnerships related to Medical Home, Bright Futures, Healthy Child Care Washington (HCCW), and early childhood systems capacity. (Fig. 4b, SPM 7, Act. 3, 4)

This year, Kids Matter focused on awareness and use of the plan. Activities included presentations across OMCH and to stakeholders. (Fig. 4b, SPM 7, Act. 1, 5)

An Awareness and Utilization Survey was completed to establish a baseline of awareness and use of the Kids Matter plan. Individuals associated with groups or organizations that have been introduced to the Kids Matter framework were surveyed. The response rate was 54.7 percent (273 respondents). ECCS staff plan to repeat this survey annually as an ongoing evaluation of Kids Matter implementation. The survey identified integration of the Kids Matter framework in many ways across OMCH, including grant writing, strategic planning, logic model development, early learning benchmarks, CHILD Profile posters, and transition of HCCW into broader early childhood systems. (Fig. 4b, SPM 7, Act. 2, 3, 6)

Integration of Bright Futures Guidelines is a key strategy addressing both the health and early care and education components of Kids Matter. This was supported by federal funding to mobilize local early childhood programs to use Bright Futures materials. (Fig. 4b, SPM 7, Act. 7, 8)

OMCH continues to support a statewide network of child care health consultants who provide consultation to child care providers of infants and toddlers. This work is funded through a contract with the Division of Child Care and Early Learning in the DSHS. The contract provides funds to local health jurisdictions, as well as supporting state level consultation and training, a Web-based data collection system, and an ongoing evaluation component. (Fig. 4b, SPM 7, Act. 9)

c. Plan for the Coming Year

Kids Matter will continue to be used as a resource with multiple audiences at a state and local level. Building connections to foster state level systems linkages with local communities will be key. Kids Matter provides a useful framework, supports collaboration, and connects the pieces of a currently fragmented system. It will promote improved outcomes for young children and their families because it identifies desired outcomes for young children and strategies to achieve them. (Fig. 4b, SPM 7, Act. 5, 8)

Kids Matter will support collaboration and integration at both state and local levels, engaging multiple public and private partners. This is addressed in the ECCS grant as 'Building Connections.' (Fig. 4b, SPM 7, Act. 4)

Key messages in Kids Matter presentations and partnerships include: keeping children and families as the focus; assuring that state agencies and organizations work with each other;

facilitating cross-system collaboration such as between health and education; guiding state policies and actions to support local communities; and encouraging public-private collaboration. (Fig. 4b, SPM 7, Act. 1, 4)

OMCH will continue to use the Kids Matter framework to identify ways to inform and guide the Early Learning Council and activities of the new Department of Early Learning and the private-public partnership, known as Thrive by Five. (Fig. 4b, SPM 7, Act. 4, 8)

Kids Matter will continue transition activities for Healthy Child Care Washington, identifying new opportunities for linkages with other early childhood partners, recognizing the importance of health, safety and school readiness birth to kindergarten entry. (Fig. 4b, SPM 7, Act. 4, 8)

OMCH Kids Matter staff will work with OMCH Assessment staff to explore the development of early childhood indicators. As Kids Matter represents a "system of systems," the identification and availability of data and the scope of data available both within OMCH and across external partners, creates significant challenges. (Fig. 4b, SPM 7, Act.6)

OMCH will continue to support a statewide network of child care health consultants who provide consultation to child care providers of infants and toddlers. It is expected that this work will continue to be funded through a contract with the Division of Child Care and Early Learning in DSHS, providing funds directly to local health jurisdictions as well as supporting state level consultation and training, a Web-based data collection system, and an ongoing evaluation component. (Fig. 4b, SPM 7, Act. 9)

E. Health Status Indicators

Data Usage

Health Status Indicator (HSI) data are used in a variety of reports and publications intended to influence policy, inform stakeholders, and educate the public.

HSI 01A, 01B, 2A, and 2B -- Low birth weight
Data regarding low birth weight and very low birth weight are used in the Perinatal Indicators Report (PIR) and the Maternal and Child Health Data and Services Report (MCHDSR). The PIR is frequently utilized by Department of Health (DOH) staff, medical providers, and external stakeholders. The MCHDSR is organized to be used in its entirety or as separate fact sheets for policymaking, educating the public, and supporting program activities.

HSI 03A, 03B, 03C, 4A, 4B, and 4C - Injuries and motor vehicle crashes
Data regarding unintentional injuries, motor vehicle crashes, and combinations of both are included in the MCHDSR chapters on "Unintentional Injury and Hospitalizations" and "Intentional Injury Hospitalizations."

HSI 05A and 05B - Chlamydia
Data on the reported cases of Chlamydia are used in the MCHDSR section on publicly funded services titled "Sexually Transmitted Diseases and HIV Services."

HSI 06A, 06B, 07A, 07B, 08A, 08B, 09A, and 09B -- Births and infant deaths enumerated by race and ethnicity
The MCHDSR includes population tables that report data from portions of HSIs 06A-B, 07A-B, 08A-B. A section of the MCHDSR describes publicly funded services and reports data related to HSIs 09A-B.

HSI 10, 11, and 12 -- Geographic living areas and poverty levels
Demographic data from HSIs 10, 11, and 12 illustrate the geographic distribution of Washingtonians and highlight underserved populations based on Federal Poverty Level guidelines. DOH is committed to reducing health disparities, and these data are used to better understand diverse populations and serve them accordingly.

Data Users

Raw data are used by DOH staff to produce reports and other publications, respond to legislative requests, and prepare presentations. Published documents are used by numerous stakeholders and the general public.

Important Trends

Overall, the rates of low birth weight for multiple or singleton births have increased by less than or equal to 1 percent, and the rates of very low birth weights for multiple or singleton births have remained relatively stable since 1996.

Nonfatal injury rates and mortality rates from unintentional injuries, in the age groupings of 14 years and younger and 15-24 years, have decreased. This trend is seen in both overall mortality rates as well as those associated with motor vehicle crashes.

Rates of Chlamydia in women ages 15-19 years and 20- 44 years increased slightly in recent years.

The remaining indicators reflect raw numbers instead of rates, therefore trends cannot be determined.

F. Other Program Activities

Bright Futures. OMCH increased its capacity to expand state and local efforts to implement Bright Futures as a best practice for child and adolescent health care. OMCH has: contracted with the Univeristy of Washington (UW) to complete statewide awareness activities; received additional federal funding to promote the use of Bright Futures in Head Start, preschools, and child care settings; and worked with the national Family Voices organization to implement "Family Matters: Using Bright Futures to Promote Health and Wellness for Children with Disabilities." This is a three-year grant funded by the CDC in which Washington State is one of the pilot sites.

EPSDT. The Medical Assistance Administration (MAA) developed a series of charting inserts for health care providers to use in documenting EPSDT exams. The purpose of the chart insert was to improve documentation and completion of EPSDT exams. This need was identified through the yearly review of the MAA Healthy Options Plans. The OMCH provided input into the content and format of the insert forms as well as sites to pilot the forms. The development of this standardized charting insert enabled CHILD Profile to create a Health and Development card for parents to use in keeping track of EPSDT/Well-Child Checkup information.
/2007/ The above activity is completed. OMCH applied for and was selected to host a State Leadership Workshop for Improving EPSDT, sponsored by the MCHB. Note that MAA changed its name to the Health and Recovery Services Administration (HRSA).//2007//

SIDS Reduction Project with African Americans Project. MIH contracts with the Tacoma-Pierce County Health Department to promote risk reduction for SIDS in the African American Medicaid-served community. Local outreach and education will be provided to First Steps providers, child care, churches, and African American leaders and community members.

First Steps Redesign Project. MAA in DSHS and the Department of Health have worked in coordination with providers to redesign the First Steps Program effective October 1, 2003. The revisions were in response to budget concerns and a major review of the service delivery model. Goals of redesign were to improve the quality of services; contain expenditure growth; and tie intensity of services to client need. The redesign included development of Core Services to include client screening, basic health messages, basic referrals/linkages and minimum level of intervention for identified risk factors. Over the first year of implementation, ongoing evaluation of revisions will occur, a standardized documentation system will be developed, monitoring and training plans will be developed, and group activities will be piloted in three sites across the state.

First Steps Outreach Project to Native Americans. MIH is contracting with Public Health Seattle and King County to assist the state program in providing outreach to tribes in an effort to increase utilization of First Steps among Native Americans. Recommendations from tribal representatives will be incorporated into the First Steps redesign which may include special staffing considerations for rural and tribal communities.

Drug-Endangered Children. OMCH is working with a local coalition on possible ways to provide legal protection for drug-endangered children.

Living Room Forums. The Genetic Services section contracted with Publicis Dialogue to conduct 15 informal forums with members of the public to gather qualitative data and opinions about three topics related to genetics. The topics were: newborn screening; equity of genetic services; and genetic discrimination. The results of the forums will be used to inform the state genetics plan. The Genetic Services section is now in the process of analyzing the data.
/2007/ Genetic Services contracted with Abt Associates to perform a qualitative analysis of the living room forum data. The analysis was completed in August 2005. Genetic Services is using the results to inform the State Genetics Plan and to write and publish a peer-reviewed article.//2007//

Prenatal Care Collaboration. Maternal and Infant Health, in collaboration with the Tobacco Prevention and Control Program, contracted with Insight Policy Research to conduct focus groups and key informant interviews with OB providers in Washington. The purpose of this project was to determine effective strategies for influencing and improving screening and intervention for prenatal substance abuse (including tobacco) and violence. A total of 36 providers participated in this research that was completed in December 2003. Physicians were most interested in practical, concise information for themselves and their office staff. MIH will use this information to help guide strategies to disseminate best practice issues to OB providers.

/2007/ Action Plan for Oral Health and Children with Special Health Care Needs. The Oral Health Program received a mini-grant to develop a state action plan regarding oral health issues for children with special health care needs. A forum will be held with key stakeholders to develop the plan.//2007//

/2007/Child Development Charts. IPCP received funding from three private foundations to support the development, revision, and increased dissemination of three child development charts. The charts address the five domain areas of the Washington State Early Learning and Development Benchmarks. This partnership will expand distribution of the development charts to non-parental caregivers such as child care, preschool, and health care providers.//2007//

OMCH Publications. In 2003, the OMCH distributed a variety of publications addressing issues of importance to the MCH population. These documents were made available in print and on the OMCH internet site to a number of public health stakeholders including state and federal agencies, public health professionals and associations, parent and family organizations, and the public.

Below is a list of OMCH publications for 2004:
•MCH Data Report
•Perinatal Indicators Report
•Healthy Child Care Washington Evaluation Report

/2007/Below is a list of OMCH publications for 2005 and 2006:
-2005 Children & Youth with Special Health Care Needs: Washington State Report
-WISE Grant Recommendation Report (2001 - 2005)
-Guidelines for the Development and Training of Community-Based Feeding Teams in Washington State (2005)
-2006 MCH Data and Services Report
-2006 Adolescent Needs Assessment
-2006 Children's Mental Health Needs Assessment
-2006 Perinatal Indicators Report//2007//

G. Technical Assistance

1. General Systems Capacity Issues

a. CSHCN Program
OMCH wants to provide training at each of four CSHCN regional meetings to local LHJ providers on how to interview families of children with special health care needs in a way that is culturally competent. One of the benefits of this training would be to improve the quality of data collected from families by local CSHCN providers to include elements of ethnicity, education, and economic levels so information can be used in program development. We need a trainer who could teach culturally competent interviewing strategies related to children with special health care needs and their families.

b. Cultural Competence
The U.S. Department of Health and Human Services' Office of Minority Health issued standards for Culturally and Linguistically Appropriate Services (CLAS). These standards and the implementation compendium are excellent guidelines for health provider agencies to use to better address the cultural and linguistic needs of the populations served. OMCH (Health Disparities Task Force) is requesting assistance in acquiring training on the implementation of these standards for state and local agency staff.
/2007/ This request has been removed.//2007//

c. Performance Measure Targets
OMCH seeks technical assistance for training on setting targets for performance measures. The audience for this training would be both assessment and program staff. The training would help us develop the skills to develop realistic targets for the national and state performance measures for the Maternal and Child Health Block Grant.
/2007/ This request has been removed.//2007//

/2007/b. Integration
OMCH needs expert facilitation to focus on intra-agency collaboration to improve the health services system for children and families. OMCH/DOH needs to integrate programs within the agency in preparation for cross-agency collaboration. Families often need services from a variety of state programs, agencies and community organizations, but find the services difficult to locate, navigate, and differentiate. OMCH/DOH is collaborating with multiple state and local agencies and organizations on four goals to make the health system work better for families: a common enrollment/application process for easy entry, care coordination to assist families in defining and meeting needs, cross-agency data linkages for program planning, and opportunities for blended funding to maximize

impacts.

c. Genetics Education
There have been many advances in the area of testing for Fragile X and some are advocating for targeted newborn screening. Therefore, an educational conference for genetic service providers is being planned for 2004/2005. Technical assistance funds are being sought to bring a nationally known speaker for this event.

d. Adolescent Health
The OMCH needs assistance to collaborate with other state and territorial adolescent health coordinators in order to improve access to national resources and experts on adolescent health. This will improve program development and expertise at the state and territorial level. The MCHB would provide support for travel and per diem to attend an annual meeting and funding or assistance in setting up bridge-lines for conference calls between regions.

e. Maternal and Infant Health
Preconception health care can improve birth outcomes by promoting and improving the health of a woman prior to pregnancy. Preconception health care consists of comprehensive screening, health education and promotion and interventions that reduce medical, behavioral, and social risk factors that may affect the health of the woman and future pregnancy outcomes. In order for OMCH to determine effective strategies to increase preconception health services and promote healthier lifestyles, we must collect data from providers practicing in WA State and women 18-30 living in Washington. OMCH needs assessment expertise to design qualitative research tools to conduct qualitative data collection related to preconception health attitudes, behaviors, and services. This data will be used to plan appropriate preconception health activities.//2007//

2. State Performance Measure Issues

a. Nutrition
This request relates to priority 1 for improving the nutrition status among the MCH population. Expert advice is necessary to review the strategic plan and food security activities developed to address nutrition status. A sound review of the strategic plan and activities will aid the MCH Nutrition Team in mobilizing and enlisting partner support to address hunger and food security in the MCH population.
/2007/Washington's state performance measures were revised during the 2005 Needs Assessment. This request relates to an old performance measure and has been removed.//2007//

b. Domestic Violence Prevention
PPADV committee members have requested a presentation on the new DV and Public Health Booklet published by the Family Violence Prevention Fund and written by Linda Chamberlain. Dr. Chamberlain agrees to present for half a day to the PPADV on this topic. MCH staff would like to set up consultation for state and local MCH staff regarding: PPADV curriculum revisions by SeaKing and State Injury Prevention, evaluation of DV training and developing measures for the effects of child witnessing of domestic violence. Dr. Chamberlain comes from Alaska.
/2007/Washington's state performance measures were revised during the 2005 Needs Assessment. This request relates to an old performance measure and has been removed.//2007//

c. Healthy Relationships
The Healthy Relationships Project would like some technical assistance from other MCH state youth projects. The project staff is exploring options within four different states. The purpose of the TA visit would be to: Review current HR proposals and results from external groups; develop a work plan that would provide direction for activities; and provide guidance. The person

selected would be a person who has a project within their state that focuses on prevention of intimate partner violence. This speaker would be invited to present at a MCH Teams meeting.
/2007/Washington's state performance measures were revised during the 2005 Needs Assessment. This request relates to an old performance measure and has been removed.//2007//

3. National Performance Measure Issues

a. Decision-Making and Comprehensive Care for Children with Special Health Care Needs
This request relates to NPM 2 and 3 in the areas of decision-making and comprehensive care for children with special health care needs. On-going leadership and skills development and cultural competence training are needed to ensure that families with children with special health care needs can partner in decision-making, serve as mentors, and participate in comprehensive systems development. OMCH would like to bring a consultant from the National Center for Cultural Competence to provide training related to family leadership for children with special health care needs and parent consultants.
/2007/This request has been removed.//2007//

/2007/. a. Immunization Speaker
This request relates to NPM 7. OMCH is planning a Northwest Immunization Conference with the Oregon State Immunization Program for May 15-16, 2007. The goals of the conference are to provide an immunization training opportunity for public and private immunization providers and partners, a venue for networking between the two states, and information that will help participants offer comprehensive immunization coverage for all age groups. Five hundred attendees are expected and will include anyone who gives immunizations or supports immunizations including, but not limited to, local and state health staff, medical professionals and students, and school and child care staff. The TA funds would be used to bring a nationally recognized immunization speaker to the conference to give information on immunization best practices and strategies for increasing immunization rates.

b. Medical Homes for Children with Special Health Care Needs
This request relates to NPM 3. The CSHCN section requests a national expert to present on "Medical Home Spread" at the spring 2007 Medical Home Leadership Network (MHLN) Meeting. At least 50 individuals from the MHLN Teams throughout the state will attend to include primary care providers, parents, CSHCN Coordinators and Family Resources Coordinators. Planning for this meeting will include input from the Title V CSHCN Program, Washington Chapter of AAP, and MHLN representatives.

c. Family-Professional Partnerships
This request relates to NPM 2. Family members, including those representing culturally diverse communities, must have a meaningful and consistent role in systems development at the state and community levels. To do this, diverse families must be able to partner in decision-making at all levels. The CSHCN Program requests a national expert to help in the planning of a Fall of 2007 training with the Washington Family to Family Network (WFFN), including Parent to Parent, Fathers Network, Family Voices, Title V CSHCN Program and other system partners to develop a process for increasing and measuring the number and effectiveness of culturally competent family-professional partnerships in WA At least 50 families, youth, and professionals will participate.

d. Adolescent Health Transition
This request relates to NPM 6. Adolescents with special health care needs face many barriers as they transition to adult health care, including lack of adult providers able to accept them as patients and fear of leaving the security provided by their pediatric practitioners. The CSHCN Program requests a national expert on adolescent health transition issues to provide consultation to the Adolescent Health Transition Project

Special Interest Group to assist in identifying and addressing barriers that hinder youth as they transition to adult health care. Strategies and tools for a successful transition would be the focus of the consultation.//2007//

/2007/4. Data Related Issues
a. Western Regional MCH Epidemiology Conference
The annual MCH Epidemiology conference is always held in the Southeast US (e.g. Florida or Georgia). MCH epidemiology staff from the Western US, particularly the Northwest, have a difficult time traveling that far. Maintaining skills in needs assessment and in MCH epidemiology is difficult under these conditions. OMCH requests that MCHB fund and promote a western regional MCH epidemiology conference to be held in 2007.//2007//

V. Budget Narrative

A. Expenditures

The state of Washington uses the Agency Financial Reporting System (AFRS) as its accounting system. Throughout the reporting year, direct program expenditure data are entered and tracked by the MCH Budget and Contracts Manager as well as program managers and fiscal coordinators. Aggregated data from this report are adjusted to add overhead costs, which have been entered through the agency allocation system (submitted to and approved by DHHS, Region X). The data from both these sources form the basis for the total expenditure data for the year.

The total expenditure data are entered onto spreadsheets by program. These data are apportioned across reporting forms three, four, and five according to percentages determined by program managers, staff, and local health jurisdictions. Expenditure data are then apportioned to the 30 percent-30 percent requirements, and the 10 percent administration requirement. The same expenditure data are also apportioned according to percentages designated for populations served (Form 4) and levels of the pyramid (Form 5). In this way, OMCH is able to demonstrate relationships among expenditures and requirements, populations served, and levels of the pyramid.

The results of the above calculations are then entered on additional spreadsheets, which contain historical data. From these latter spreadsheets come the variances. Significant variances are analyzed and accounted for. The information is used in building the budget for the coming federal fiscal year (FFY).

/2007/It should be noted that FFY05 represents a transitional year for a change in funding characterization that occurred in FFY04 and was implemented for budget preparation for FFY06. Significant variances resulted from assumptions regarding the availability of Health Service Account (HSA) expenditures to use for MCH Block Grant (MCHBG) match and applied to the total program effort.

Washington State will continue to experience significant variations between udgeted and expended amounts. In the past few years, two events occurred, which affected the variances:

- Significant funding cuts and resource re-allocation occurred.

- Re-characterization of funds in source categories made it difficult to compare across years of budgeted versus expended.

Signifcant funding cuts and resource re-allocation occurred:

The replacement in 2002 of General Fund-State with Health Service Account funds for Immunizations meant that OMCH could not budget to over-match although it would continue to report total expended effort in its annual reports.

Concurrently, local LHJ's experienced decreased funding. To help LHJ's protect service levels to the MCH population, OMCH permitted state funds to be used at the local level to achieve Medicaid (Title XIX) match. The result was that OMCH had less state dollars to use for Title V MCHBG Maintenance of Effort and thus needed to rely more on Health Service Account dollars for match.

Re-characterization of funds in source categories made it difficult to compare across years of budgeted versus expended:

The primary issue then became how to characterize the different sources of expenditure in discrete categories that made sense over time.

In 2002, Health Service Account fund expenditures were separated from General Fund-State match expenditures by categorizing the former as "Other Funds" on Form 2. This subsequently created confusion on how to report State funds that were expended as part of Medicaid (Title XIX) match.

By FFY2003, Health Service Account funds were budgeted on Form 2, line 3, "State Funds" along with General Fund-State to indicate the MCHBG match.

Continued fiscal reductions meant that the FFY2004 budget was for Maintenance of Effort only. With the FFY2004 reporting, OMCH experienced the impact of LHJ's utilizing state funds for Medicaid match. OMCH received clarification from MCHB that state funds for Medicaid could be budgeted and tracked on line 5, "Other Funds" in order to cleanly report the total expenditure effort for OMCH. Therefore, OMCH determined that General Fund-State funds and Health Service Account funds would be budgeted and reported on Form 2, line 3 "State Funds;" that local and solicited funds would be reported on line 4, "Local Funds;" and that State funds for Medicaid would be budgeted and tracked on line 5, "Other Funds." The budget for FFY06 reflects these distinctions as does the Annual Report for FFY05.

BY FFY07 the fund sources will cleanly match to the expenditure sources. However, OMCH will continue to experience signifcant budgeted versus expended variations until our fiscal picture improves and we can project more than Maintenance of Effort in our budget.//2007//

B. Budget

Washington State's biennium runs from July 1 of odd-numbered years through June 30, two years following. The Agency Financial Reporting System (AFRS), which contains past, present, and future time periods, does not allow for data input into a succeeding biennium until the new biennium has commenced.

Previously, Washington State Department of Health's (DOH) policy was to recognize federal grant allotments on the first day of the grant budget period, or upon receipt of the Notice of Grant Award, whichever was later.

For the biennium 03-05, Washington State implemented a new policy. Federal grant allotments were estimated for the whole biennium and entered in AFRS. Allotments were adjusted to reflect actual awards. This policy will continue through the 05-07 biennium.

The FY06 MCH Block Grant (MCHBG) application reflects the most recent award amount; consequently, FY05 will be used. For FFY06, actual expenditure data for FFY04 from Forms 3, 4 and 5 has been used in the projections. The Office of Maternal and Child Health (OMCH) adjusts this baseline information for known or anticipated funding or category allocations as well as economic conditions.

/2007/ The FY07 MCHBG application reflects the most recent award amount; consequently, FY06 will be used. For FY07, actual expenditure data for FY05 from Forms 3, 4 and 5 has been used in the projections. OMCH adjusts this baseline information for known or anticipated funding or category allocations as well as economic conditions.

For FY07 OMCH has designated the "Other" category on Form 2 to reflect Title XIX state funding as well as state funds not available for MCHBG match that contribute to the total effort. These funds are not considered in planning for and achieving Title V match/Maintenance of Effort.//2007//

While it is expected that the MCH program will achieve its maintenance of effort amount and 75 percent match, declining funding sources has meant that MCH does not anticipate being able to overmatch its federal allocation. Washington State's Maintenance of Effort is $7,573,626. For FY06, match will be achieved using state funding as well as Health Services Account (HSA) funding for the Immunization Program.
/2007/Some General Fund State dollars that were historically used to match MCHBG federal dollars have been made available for match at the local level to help alleviate shortfalls for Local Health Jurisdictions. Washington State's Maintenance of Effort is $7,573,626. For FY07, match will be achieved using state funding (not available for match at the local level or used as match for Title XIX) as well as Health Services Account (HSA) funding for the Immunization Program.//2007//

Recent legislation permitting solicitation of funds indicates that in the future, there will be funds available for MCH activities from corporate partners. This activity is still in its infancy; therefore, it is impossible to estimate budget amounts at this time. Should this occur in any significant manner, OMCH expects variances when it reports for FY06.
/2007/ Recent legislation permitting solicitation of funds indicates that in the future, there will be funds available for MCH activities from corporate partners. These funds are categorized in Local MCH Funds. This activity is still in its infancy; therefore, budget amounts may vary significantly from actual expenditures reported. OMCH expects variances when it reports for FY07. By FFY07 the fund cources will cleanly match expenditure sources (see Expenditure Narrative). However OMCH will continue to experience significant variations in budgeted versus expended until our fiscal picture improves and we can project more than Maintenance of Effort in our budget.//2007//

Other federal sources, including Title XIX; a number of HRSA and CDC grants; and DSHS Interagency Agreements, complement Washington State's total effort. Additionally HSA dollars and local funds support activities addressing the MCH population.
/2007/ OMCH is projecting a decrease of more than 20% in other federal funding for FFY07. In no case is the office projecting any increase in these sources. Special Projects of Regional and National Significance (SPRANS) grants are expected to decrease by 42%, accounted for by significantly less funds for Early Childhood Comprehensive Systems as well as Social Services and Income Maintenance Research, the latter being a demonstration grant this is wrapping up. Funding from the Centers for Disease Control for Immuniazations is expected to be reduced by over 23%. Finally it is expected that there will be less ability to obtain Medicaid Federal Financial Participation (Title XIX) by about 16%.//2007//

Through contracts providing funding to local health jurisdictions (LHJs), OMCH ensures that the minimum 30 percent-30 percent requirement is met. In order to receive funding the LHJs must submit a plan designating at least 30 percent to children with special health care needs (CSHCN) and preventive and primary care for children. The plan ties related activities to CSHCN and preventive and primary care for children, populations served and the MCH pyramid. The LHJs report their expenditure activity by populations served and levels of the pyramid. At the state level, these data form the basis for allocation of funds across programs. Using actual data from FY04, OMCH projects that 52.43 percent of its budget will be expended on preventive and primary care for children; and 31.34 percent will be expended for children with special health care needs. Finally, OMCH is budgeting 6.34 percent for Title V administrative costs.
/2007/Using actual data from FY05, OMCH projects that 54.95% of its budget will be expended on preventive and primary care for children; and 38.56% will be expended for children with special health care needs. Finally, OMCH is budgeting 5.59% for Title V Administrative costs.//2007//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.